Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 13 October – Friday 17 October 2025
Tuesday 13 January 2026

Virtual Hearing

Name of Registrant:	**Alan McArdle**
NMC PIN:	12A0966E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (12 March 2012)
Relevant Location:	Northumberland
Type of case:	Misconduct
Panel members:	James Carr (Chair, Lay member) Mary Pocock (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	William Hoskins (13 – 17 October 2025) Breige Gilmore (13 January 2026)
Hearings Coordinator:	Emma Hotston
Nursing and Midwifery Council:	Represented by Samprada Mukhia, Case Presenter (13 – 17 October 2025) Represented by Samantha Forsyth (13 January 2026)
Mr McArdle:	Not present and unrepresented
Facts proved:	Charges 1a i), 1a ii), 1b), 2a), 2b), 2c), 3a), 3b), 4a), 4b), 5.
Facts not proved:	None

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order for 18 months**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr McArdle was not in attendance and that the Notice of Hearing letter had been sent to Mr McArdle's registered email address by secure email on 11 September 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr McArdle

The panel next considered whether it should proceed in the absence of Mr McArdle. It had regard to Rule 21 and heard the submissions of Ms Mukhia who invited the panel to continue in the absence of Mr McArdle. She submitted that Mr McArdle had voluntarily absented himself.

Ms Mukhia submitted that since a telephone call between Mr McArdle and the case coordinator on 27 August 2025 to advise the date of hearing and confirm his attendance, there had been no engagement at all by Mr McArdle with the NMC in relation to these

proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

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

- No application for an adjournment has been made by Mr McArdle;
- Mr McArdle has not engaged with the NMC since August 2025 and has not responded to any of the letters, emails or telephone calls sent to him about this hearing since;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- One witness has attended today to give live evidence, two others are due to attend;
- 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 2021;
- 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 McArdle in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email 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 if identified. Furthermore, the limited disadvantage is the consequence of Mr McArdle'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 McArdle. The panel will draw no adverse inference from Mr McArdle's absence in its findings of fact.

Decision and reasons on first application to amend the charge

The panel heard an application made by Ms Mukhia, on behalf of the NMC, to amend the wording of charges numbers 2a) and 4c).

The proposed amendment to charge 2a) was to include the word 'on'. It was submitted by Ms Mukhia that the proposed amendment was to correct a typo.

The proposed amendment to charge 4c) was to make this a separate charge, where 4c) becomes charge 5. The proposed amendment to this charge also includes the additional wording of 'On one or more occasions swore when speaking to Colleague A,' to provide clarity and to more accurately reflect the evidence.

'That you, a registered nurse:

…

2. *On 4 June 2021:*

    a. *Slept during a shift while not **on** a break*

…

5. ***On one or more occasions swore when speaking to Colleague A and/or*** *Were confrontational towards them.'*

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 determined that such amendments, as proposed, were in the interest of justice. It was satisfied that there would be no prejudice to Mr McArdle 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 ensure clarity and accuracy.

Decision and reasons on second application to amend the charge

Following the conclusion of hearing the evidence from all witnesses, the panel heard an additional application made by Ms Mukhia, on behalf of the NMC, to amend the wording of charges numbers 1a) i) and 2b).

The proposed amendment to charge 1a)i) was to include the wording of 'and/or ate them,' at the end of the charge. It was submitted by Ms Mukhia that the proposed amendment would address the mischief more appropriately, in light of the evidence given by the witnesses.

The proposed amendment to charge 2b), was to include the wording of 'without being present,' at the end of the charge, to also address the mischief more appropriately, in light of the evidence given by the witnesses.

'That you, a registered nurse:

1. *On 2 June 2021:*

a. In relation to Patient A:

i. Removed chocolates belonging to Patient A from Patient A's room ***and/ or ate them***

2. On 4 June 2021:

b) Asked Colleague A to sign progress notes on your behalf with 'student nurse on behalf of AMc' ***without being present****.'*

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 determined that it was not content to amend charge 1a) i) as this would be a substantial amendment and Mr McArdle has not had an opportunity to respond to this element of the charge. The panel noted that it has been four years since the original charges were made, and as the panel has proceeded in the absence of Mr McArdle for this hearing, it determined that it would be a material injustice to not allow Mr McArdle to have the opportunity to provide a response to this amended charge.

For the proposed amendment to charge 2a), the panel was of the view that such an amendment, as proposed, was in the interest of justice and it was content to amend this charge. The panel noted that Mr McArdle had admitted in his written statement that he was not present at the time of the incident related to charge 2b) on 4 June 2021, and therefore the panel was satisfied that there would be no prejudice to Mr McArdle and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as proposed, to ensure clarity and accuracy.

Details of charge

That you, a registered nurse:

1. On 2 June 2021:

    a. In relation to Patient A:

        i. Removed chocolates belonging to Patient A from Patient A's room
        ii. Upon removing the chocolates from Patient A's room said "that's the least she can fucking do", or words to that effect

    b. Left the ward on more than one occasion leaving the ward with no qualified nurse present

2. On 4 June 2021:

    a. Slept during a shift while not on a break
    b. Asked Colleague A to sign progress notes on your behalf with *'student nurse on behalf of AMc'* without being present
    c. Refused to add thickener to multiple patients' drinks

3. On 13 July 2021:

    a. Reheated food containing medication for Patient B
    b. Refused to provide personal care to Patient C after they had urinated

4. On 15 July 2021:

    a. Asked Colleague A to sign Kardex records with your signature
    b. When asked by Colleague A to sign off their competencies you replied 'I don't know why you are bringing that in here as I am not fucking signing it', or words to that effect

5. On one or more occasions swore when speaking to Colleague A and/or Were confrontational towards them.

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

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

At the outset of the hearing, Ms Mukhia made a request that this case be held partly in private on the basis that proper exploration of Mr McArdle's case involves reference to matters related to his health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Mukhia indicated that she supported the application to the extent that any reference to matters relating to Mr McArdle's health should be heard in private.

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

The panel determined that the hearing would be part heard in private and that it would go into private session in connection with matters related to Mr McArdle's health.

Decision and reasons on application to admit the unsigned local fact find report and investigation meeting notes, referenced in the statement of Witness 1

The panel heard an application made by Ms Mukhia under Rule 31 to allow the unsigned local fact find report and investigation meeting notes produced by Witness 1 and attached to her witness statement, into evidence. The fact find report included accounts obtained by

the fact finder from witnesses in relation to the allegations and the unsigned investigation meeting notes consisted of an interview with Mr McArdle. Witness 1 was not present for the accounts included in the Fact Finding report and was not present at the investigation meeting. These documents were therefore hearsay evidence.

The panel accepted the advice of the legal assessor which included reference to Rule 31 of the NMC Fitness to Practise rules 2004 and the principles contained in the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel noted that it had not been provided with any explanation or the absence of either of the witnesses who conducted the Fact Finding report and investigation meeting.

However, the content of these documents was not the sole and decisive evidence in relation to any of the charges. The panel was due to hear oral evidence from Witness 2 in relation to these specific allegations. Mr McArdle had seen these documents and had raised no objection. There was no suggestion of fabrication and the documents included his denials in relation to certain allegations. In all of the circumstances the panel concluded that this evidence was relevant and that it was fair to admit it.

The weight to be given to this evidence was a matter for which the panel would carefully consider during its deliberation on facts.

Background

The charges arose while Mr McArdle was employed as a registered mental health nurse by [PRIVATE] on Ward [PRIVATE] (“the Ward”).

This referral resulted in an investigation by the NMC, which identified the regulatory concerns set out below.

The regulatory concerns are:

1. Failure to treat people in your care with dignity - in that you took chocolates belonging to a patient from their room.

2. Leaving patients in your care unattended – in that you:
- Left the ward without a qualified nurse present on several occasions during shifts on 2 and 4 June 2021;
- Slept during a shift while not on a break on 4 June 2021.

3. Poor patient care – in that you:
    - Declined to add thickener to patients' drinks when required on 4 June 2021;
    - Instructed a colleague to reheat food containing medication for a patient contrary to your employer's policy on 13 July 2021;
    - Failed to ensure that a patient who had been incontinent of urine received timely personal care on 13 July 2021.

4. Poor record keeping – in that you asked a colleague to make or sign records on your behalf.

5. Poor medication practice – in that you instructed a colleague to incorrectly dispose of medication concealed in food on 13 July 2021.
6. Unprofessional behaviour and communication towards a colleague.

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 Mukhia on behalf of the NMC.

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

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

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

- Witness 1: Associate Nurse Director at [PRIVATE], as managed under [PRIVATE] ("the Trust"), at the material time.
- Witness 2: Student Nurse on Ward [PRIVATE], at the material time.
- Witness 3: Band 6 Clinical Lead Nurse at [PRIVATE], managed by [PRIVATE] ("the Trust"), at the material time.

The panel had sight of documentary evidence from:

- Ms 1 who was Mr McArdle's line manager and carried out the fact find report.
- Ms 2 who a senior HR advisor who interviewed Mr McArdle at the investigation meeting.

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

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

There was limited documentary evidence before the panel. The allegations were based on what was allegedly seen by Witness 2 and her oral evidence was supplemented by what she had reported to Witness 3 and by the information obtained by those carrying out investigations.

The panel considered that Witness 1 provided consistent evidence about the Trust's processes and procedures, which was corroborated by the other witnesses. The panel noted however, that much of Witness 1's evidence was hearsay and therefore gave it appropriate weight.

The panel considered that Witness 2 was the direct witness to the incident. The panel found her evidence to be clear, detailed and consistent across her local statement, witness statement, and oral evidence.

The panel found Witness 3 to be credible and noted that she regarded Witness 2 as a model student nurse. The panel considered this relevant in light of Mr McArdle's assertion that his concerns about Witness 2's performance might have motivated her to make false allegations.

The panel noted that Mr McArdle stated in his final reflective piece that he felt the allegations against him were made by Witness 2 as he considered that she was homophobic and was upset that he had raised a number of performance issues with her. The panel noted that Mr McArdle appears to have [PRIVATE] but was presented with no evidence that the allegations made were made as a result of discrimination. The panel noted that there was no evidence before it that these alleged concerns were raised with the Trust. Witness 3 had received no performance issues relating to Witness 2 escalated to her, and when asked directly by the panel, confirmed that there was no performance plan in existence which related to Witness 2. On the contrary, she described Witness 2 as one of the best student nurses that she had ever worked with.

The panel considered Mr McArdle's documentary evidence to be inconsistent and at times deflected from addressing the concerns raised.

Charge 1a) i)

'That you, a registered nurse, on 2 June 2021:

1. a) In relation to Patient A:

i) Removed chocolates belonging to Patient A from Patient A's room'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel first considered the oral evidence and written statement of Witness 2. It noted that during her oral evidence, Witness 2 explained that during the medication round on a night shift whilst working as a second year student nurse working under the supervision of Mr McArdle that he removed a handful of individually wrapped 'Milky Way' chocolates belonging to Patient A from a side table in Patient A's room. Witness 2 explained that Patient A was not independently mobile and had a diagnosis of [PRIVATE]. Witness 2 noted that Mr McArdle offered her some of the chocolates and although she declined, he put a handful of the chocolates on a medication tray and then took the chocolates away and ate these chocolates in the medication room in front of Witness 2.

Witness 2 stated that she could not recall if there were restrictions as to why Patient A may not have been able to eat the chocolates. She also stated that she did not believe the motive for Mr McArdle removing the chocolates was due to a choking hazard because Patient A could not have independently picked up the chocolate due to their limited mobility.

While the panel noted that Witness 1 said that there was a possibility that Patient A may have been at a risk of choking, due to their diagnosis [PRIVATE], she noted that it would have been unusual for chocolates to be left out on a side table for a patient at a choking risk and it would have been expected that these would have been removed, if this was the case. She further stated that chocolates would usually be returned to the patient's family if the patient was unable to eat them, rather than for the chocolates to be shared with staff and noted that the Trust's policy on patient belongings would have prohibited staff from taking the chocolates without permission from the patient's family. However, Witness 1 did note that the removal of the chocolates would have fallen into Mr McArdle's duties if he perceived Patient A to be at risk of choking.

The panel noted that the evidence from Witness 1 relating to the Trust's policy on patient belongings was corroborated by oral evidence from Witness 3, who stated that it was forbidden to take a patient's property, and that patient would have been assessed for choking risk and would not have had chocolates in their room. However, Witness 3 also stated that there was potential that a relative may have brought the chocolates in for Patient A.

The panel next considered the responses of Mr McArdle in the local Investigation Meeting Notes where Mr McArdle stated:

> *'The only time I've taken chocolates from a patient's room, I think I remember the patient, there were things that relatives and people would bring in and they weren't appropriate due to the diet required. I would always take them to the nurse's office...'* [sic]

The panel also considered the written regulatory concerns response form completed by Mr McArdle, where he stated:

'The chocolates were removed as they weren't suitable due to choking risk. The relative was informed of such and explained we could have the chocolates. The ward manager was notified and the chocolates remained in the staff room.' [sic]

The panel noted in the written regulatory concerns response form completed by Mr McArdle that he admitted removing the chocolates from a patient's room due to a choking risk and said that he had informed the patient's family. However, the panel noted that there was an inconsistency in his explanation for removing the chocolates compared with the statement given in the local investigation meeting notes referred to by Witness 1, where he stated that the chocolates were not appropriate due to dietary needs.

The panel determined that whilst there were different circumstances of removal, that it preferred the evidence of Witness 2, which was credible and consistent throughout her oral evidence, witness statement and local statement. Accordingly, on the balance of probabilities, the panel determined that it was more likely than not that Mr McArdle had taken the chocolates from Patient A's room and therefore, found this charge proved.

Charge 1a) ii)

'That you, a registered nurse, on 2 June 2021:

1. a) In relation to Patient A:

ii. Upon removing the chocolates from Patient A's room said "that's the least she can fucking do", or words to that effect'

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Investigation Meeting Notes and Mr McArdle's documentary evidence.

The panel considered the evidence of Witness 2 and determined that she gave clear, consistent, and detailed evidence that Mr McArdle made this remark when removing the chocolates from Patient A's room. The panel noted that her account of the specific words and phrases used by Mr McArdle was consistent across her local statement, witness statement, and oral evidence.

The panel further noted that Witness 1 and Witness 3 gave credible evidence regarding Mr McArdle's communication style and the professional expectations of the Trust. The panel noted in the local investigation meeting notes, as referred to by Witness 1, that Mr McArdle states that there are times where he thinks he may have been misinterpreted by Witness 2 and that she may have misinterpreted his sense of humour. He said:

> *'I do think there have been times where things have been misinterpreted. There's some things I may say with my sense of humour... The ironic thing about this as Witness 2 would regularly say "oh I love your sense of humour."'* [sic]

The panel noted that in the Investigation Meeting Notes it is stated that Mr McArdle probably said '*some sort of flippant remark to Witness 2*.' It was also noted in this interview with Ms 1 that she said Mr McArdle had '*a different sense of humour and you either get it or you don't*.'

The panel noted in Mr McArdle's documentary evidence that he states that 'his communication was often misunderstood.' He also stated that he '*has often experienced difficulties with communication and interpersonal skills and often experienced high levels of stress triggered by the clinical environment*,' which had been discussed previously at supervisions and appraisals.

Taking all of the evidence into account, the panel determined that on the balance of probabilities, it was more likely than not that Mr McArdle had made the comment alleged

or used words to that effect. While Mr McArdle was not present at the hearing to provide oral evidence or clarify his position, the panel had no reason to doubt the reliability of Witness 2's account. The panel therefore found this charge proved.

Charge 1b)

'That you, a registered nurse, on 2 June 2021:

b. Left the ward on more than one occasion leaving the ward with no qualified nurse present

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel considered the evidence of Witness 2, who stated that Mr McArdle left the ward on several occasions, leaving the ward with no qualified nurse present. Witness 2 stated that Mr McArdle left the ward by exiting through the manager's office without indicating where he was going or for how long. She recalled that at least once he told her that he was going out but did not specify where. This evidence was corroborated by the oral evidence of Witness 1, who confirmed that the Trust's policy required a registered nurse to remain on the ward at all times, and stated that the evidence of the duty rota demonstrated that the registrant was the only registered nurse on duty on 2 June 2021.

The panel considered the oral evidence from Witness 1, who stated that in the Trust's Fact Find Report, Mr McArdle initially denied the allegations relating to this charge and stated that he *'would never leave the ward without a qualified staff member.'*

The panel further considered the evidence of the Trust investigation meeting notes referred to by Witness 1, in which Mr McArdle admitted to regularly leaving the ward during shifts for cigarette breaks and stated that he '*likely did that every shift but certainly not more than twice a shift*.' Mr McArdle states that he does admit to leaving the ward on this occasion but stressed that the ward was settled. The panel noted that Mr McArdle also stated that he did not consider it practical to arrange cover for his cigarette breaks, as he stated that it would take 30 minutes to arrange cover for a three-minute break. He said:

> *'I wouldn't have left a hectic ward. Not long after this in a manager's meeting, it was brought up that if you are on a ward and you're the only qualified on duty, you have to call the night co-ordinator, who's based at* [PRIVATE] *but I don't want to be condescending it'll take you 30 minutes to get here for me to have a 3-minute break and then you'll have to go back.'* [sic]

Furthermore, the panel considered Mr McArdle's written reflective statement and noted that he admitted to the charge and felt '*very regretful for leaving the ward with no qualified cover*.' The panel noted in this statement that Mr McArdle stated that he had assessed the situation as being at very minimal risk. The panel noted that he also stated in his documentary evidence that when he left the ward it was staffed with very experienced support staff and that he remained off of the ward for less than five minutes and was contactable by phone, pager and ward phone.

The panel acknowledged the inconsistencies in the responses of Mr McArdle. The panel noted that while he initially denied the allegation during the Fact Finding Report referred to by Witness 1, he later admitted to leaving the ward in the Trust investigation meeting notes and in his written reflective statement and documentary evidence. The panel determined that although Mr McArdle admitted to the charge, his explanations changed over time and lacked corroborative detail.

The panel determined that it preferred the evidence of Witness 2, which was clear, consistent, and credible, and was supported by the evidence of Witness 1, including the Trust's Fact Find Report and Investigation Meeting Notes. It was satisfied that no other qualified nurse was present when Mr McArdle left the ward, and that he made no attempt to arrange appropriate cover before doing so.

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

Charge 2a)

'That you, a registered nurse, on 4 June 2021:

a. Slept during a shift while not on a break

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; the local Investigation Meeting Notes; the Trust Rostering Policy; and Mr McArdle's documentary evidence.

The panel considered the oral evidence of Witness 2 and noted that Mr McArdle told her that he was going to sleep in the manager's office during the night shift on 4 June 2021. She stated that Mr McArdle remained in the manager's office for several hours and that although she didn't see him sleeping, she heard his alarm sound multiple times. The panel acknowledged that Witness 2 stated that she thought it was unlikely that Mr McArdle may have been working, as there was no computer in the manager's office. She said that he also encouraged her to sleep in a discharged patient's room, but that she felt uncomfortable doing so and the bed in the room would not lower.

The panel considered the Fact Find report, referred to by Witness 1, and noted that Mr McArdle stated that he never took a break on a night shift. He stated that on one occasion

he felt unwell and went for a lie down in the staff room but stated that he was available on the ward if needed at any time.

The panel acknowledged that this evidence does not corroborate with the evidence from Witness 2, who said that Mr McArdle did not indicate that he was feeling unwell at the time of the allegation and that his actions appeared to be a deliberate decision to sleep rather than to take a permitted break. The panel found her evidence to be credible and consistent across her oral evidence, witness statement and local statement.

The panel next considered the Trust Investigation Meeting Notes referred to by Witness 1 where Mr McArdle stated that he took a longer break on quieter shifts as he '*was knackered from covering shifts*.' Furthermore, the panel noted that Mr McArdle stated that he was regularly working beyond his contracted hours and was often working seventy to eighty hours a week. The panel noted that Mr McArdle admitted that he would sometimes take around one and a half hours' break, instead of the forty minutes permitted, and that he also encouraged students to take longer breaks on quiet shifts. He said:

> *'I said to TD that we are allowed 38 or 42 minute breaks and I did those night shifts to help out – the nights when I didn't take breaks and when it's been busier, I've taken a longer break on quieter shifts. I took longer because I was knackered from covering shifts. I was in the ward and could hear any response alarms going off... I'd likely take an hour and a half rather than 40 minutes. What Witness 2 has failed to mention that as a student if there wasn't much happening, I'd tell her to take a longer break too.'* [sic]

The panel noted the inconsistencies in Mr McArdle's account, as while he stated in the Fact Find report that he never took breaks on night shifts and there was just one occasion where he went for a lie down in the staff room as he felt unwell, in the Trust Investigation Meeting Notes he admitted that he had slept during the night shift, explaining that he was exhausted and had been working excessive hours. Furthermore, the panel noted the corroborating evidence from Witness 2 which stated that in addition to telling her he was

going to sleep, Mr McArdle had set an alarm and encouraged her to sleep during her shift as well.

The panel was therefore satisfied, on the balance of probabilities, that Mr McArdle went to the manager's office to sleep and did so beyond the forty-minute time allocation permitted for a break. The panel therefore found this charge proved.

Charge 2b)

'That you, a registered nurse, on 4 June 2021:

b. Asked Colleague A to sign progress notes on your behalf with 'student nurse on behalf of AMc' without being present

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; and the local Investigation Meeting Notes.

The panel considered the oral evidence from Witness 2, who stated that she was asked to write progress notes on behalf of Mr McArdle. Witness 2 stated that she was asked by Mr McArdle to sign the progress notes using the format '*student nurse on behalf of AMc*.' The panel acknowledged that Witness 2 was unable to recall whether the entries were made under her own RIO account login or Mr McArdle's login. She explained that this incident occurred at the end of the night shift where she was being supervised by Mr McArdle, and that she was writing the notes on his behalf as he had just woken from sleeping and the day shift were due to start shortly. The panel noted that her oral evidence was consistent with her witness statement and the local statement.

The panel acknowledged that this evidence was corroborated by the evidence in the Fact Find report, which confirmed that a sample of three RIO entries were made by Witness 2 under Mr McArdle's login.

The panel noted that this evidence was corroborated by the oral evidence from Witness 3, who stated that it was acceptable for a student to make progress notes on a registered nurse's profile, but only if the registered nurse was present and supervising. The panel noted that Witness 3 confirmed that a registered nurse should always review and verify progress notes made under their name.

The panel considered the evidence from Mr McArdle, who in the Investigation Meeting Notes referred to by Witness 1, stated that although he would not share his logins with students directly, he would allow a student to write progress notes by signing them into RIO on his account, if they did not have their own login. The panel noted that Mr McArdle said that he would sign and validate entries written by students and stated that his preference was to be present when students entered progress notes. The panel noted that Mr McArdle admitted the allegation in the internal investigation and acknowledged that Witness 2 should have had her own login for RIO, and that he should have been present when entries were made using his credentials. He said:

> *'The only time I would say to a student to do progress notes for a shift and I would log them on, if they didn't have a login. They would do an entry in green and I would sign and validate. It would be on my account if she didn't have access to RIO. There was one of the two of them that didn't have a RIO account.'* [sic]

The panel noted inconsistencies in Mr McArdle's evidence, as although he stated that he would not share his logins with students, the Trust's Fact Find Report showed that entries were made by Witness 2 using his account.

Due to the inconsistencies in the Mr McArdle's evidence, the panel determined that it preferred the evidence from Witness 2, which was corroborated by the evidence from Witnesses 1 and 3, alongside the documentary evidence from the Fact Find report which demonstrated that entries had been made on RIO by Witness 2 using Mr McArdle's login.

It was satisfied that Mr McArdle had asked Witness 2 to make progress notes on his behalf using his RIO login and that he was not present at the time to provide supervision.

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

Charge 2c)

'That you, a registered nurse, on 4 June 2021:

c. Refused to add thickener to multiple patients' drinks

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1 and 2; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel considered the oral evidence from Witness 2 where she stated that during a night shift on 4 June 2021, Mr McArdle refused to add thickener to multiple patients' drinks, saying words to the effect of '*I can't be arsed*.' Witness 2 explained how she therefore followed Mr McArdle around the ward, thickening the drinks herself while he conducted the medication round. The panel found her oral evidence to be detailed and consistent with both her witness statement and local statement.

The panel considered the evidence in the Fact-Find Report, referenced by Witness 1, where Mr McArdle denied the allegation and stated that he would not have refused to give thickened fluids to patients that required them due to the high risk of aspiration and choking.

The panel next considered the evidence of the local Investigation Metting Notes, referred to by Witness 1, where Mr McArdle also denied the allegation. In response to the allegation, Mr McArdle stated, '*Do you seriously think for something that takes thirty*

seconds that I wouldn't do that?' He also implied that Witness 2 may have misinterpreted his sense of humour. He said:

> *'I may have said "oh I don't have time to do that" in a jovial manner. It takes 30 seconds to a minute to thicken drinks.'* [sic]

However, the panel noted inconsistencies in Mr McArdle's evidence, as in considering his documentary evidence, in his reflective statement he said that adding thickener to drinks 'can be delegated safely to support staff.' The panel determined that this statement suggested that he considered it an optional or delegable task rather than one he was personally responsible for completing.

The panel noted that Mr McArdle acknowledged in his written statement that he often experienced communication difficulties and that he could make remarks which could be misinterpreted. However, the panel considered that the phrase '*I can't be arsed*,' as recalled by Witness 2, was a clear and positive refusal rather than a comment that could be misinterpreted. The panel noted that even if the remark was intended as humour, it demonstrated an unwillingness to undertake the task, which the panel found inappropriate and unprofessional.

Due to the inconsistencies in the accounts from Mr McArdle, the panel preferred the evidence of Witness 2, which was consistent across her oral and written witness statements. The panel determined that there was no evidence that Mr McArdle had delegated the task appropriately, and the panel found that he chose not to perform it himself.

On the balance of probabilities, the panel was satisfied that Mr McArdle refused to add thickener to multiple patients' drinks, and the charge is therefore found proved.

Charge 3a)

'That you, a registered nurse, on 13 July 2021:

a. Reheated food containing medication for Patient B

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel considered the oral evidence from Witness 2, who stated that during a night shift on 13 July 2021, Mr McArdle reheated a meal for Patient B containing covert medication and asked her to serve it to them. Witness 2 said that at the time she was not aware that the food contained covert medication of Sodium Valproate, but learned this the following day when at the morning handover, she found out that Patient B had been transferred to hospital and Mr McArdle subsequently told her that '*they would both be sacked if anyone found out*.'

The panel noted that there was some discrepancy in the evidence between Witness 2's local statement, where she referred to the item as a 'meal', and her oral evidence and witness statement, where she described it as rice pudding. The panel acknowledged that Witness 2 had stated that her memory of events was better at the time of the incident and determined that her account remained consistent that Mr McArdle reheated food and later disclosed that it contained covert medication. The panel accepted that such discrepancies were related to Witness 2's recall of detail, rather than the substance of the allegation.

The panel considered the evidence from Mr McArdle in the Trust Investigation Meeting Notes, referred to by Witness 1, where he did not deny reheating a meal for Patient B, but stated that as a rule, meals on the ward should not be reheated for patients due to a risk of food poisoning. He explained that the covert medication for Patient B was 20ml of liquid sodium valproate, which was administered in a cold dessert. He said:

'The patient in question would often refuse medications and it's in a care plan. The main meal didn't have the liquid in it though, the cold dessert had the red liquid (20ml) in it. I remember it as we tend to use the pots the same colour as the medicine so you can't tell it's in there i.e. strawberry dessert for red liquid.' [sic]

The panel noted that the evidence from Mr McArdle differed from the evidence given by Witness 2, as Mr McArdle stated that the medication had been administered in a cold desert, rather than the reheated meal that Witness 2 had discussed in her evidence. Mr McArdle also stated that he could not recall any conversation with Witness 2 in which he told her they would both be sacked. He said:

'Don't recall. The more you speak about the incident, the more I remember this guy – he was a little frail gentleman…He had underlying health issues and unfortunately he would often refuse his meals and that's why we would push the puddings and dietetic support such as shakes.' [sic]

Furthermore, the panel considered the Fact Find report discussed in the evidence of Witness 1, where Mr McArdle denied the charge and described it as 'nonsense.'

The panel concluded that Mr McArdle's response deflected from the charge and was inconsistent across his statements. Given the seriousness of the allegation, the panel observed that Mr McArdle had multiple opportunities during the Trust investigation, in his written reflective statement, and in the regulatory concerns response from within his documentary evidence, to explicitly deny reheating the food, yet he did not.

The panel also considered that Witness 3 explained that reheating food containing covert medication was prohibited by the Trust's policy, as it would decrease the efficacy of the medication. Witness 2 also explained that any reheating of food,

whether containing covert medication or not, was contrary to the Trust's policy. Therefore, the panel determined that even if there was uncertainty as to whether the food contained medication, reheating it would still represent a breach of procedure.

Due to the inconsistencies and lack of clear detail in the evidence of Mr McArdle, the panel determined that it preferred the consistent, detailed and credible evidence of Witness 2. On the balance of probabilities, the panel was satisfied that Mr McArdle likely reheated food that contained covert medication for Patient B and therefore, the panel found this charge proved.

Charge 3b)

'That you, a registered nurse, on 13 July 2021:

b. Refused to provide personal care to Patient C after they had urinated

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1 and 2; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel considered the oral evidence from Witness 2 and determined that she gave a clear and consistent account that during a night shift on 13 July 2021, Patient C had urinated. She stated that Mr McArdle indicated his refusal to provide personal care to Patient C, saying words to the effect of '*I'm not dealing with that*,' and '*I'm not fucking cleaning her piss up and neither are you*.' Witness 2 explained that she then provided personal care to the patient with latterly, the assistance of a nursing support worker. Furthermore, in her oral evidence, the panel noted that Witness 2 said that she found that in her experience of working with Mr McArdle, that he had a hierarchical attitude towards the delivery of personal care and believed that this was a task that should be delegated to

nursing support staff. The panel found the oral evidence from Witness 2 to be consistent in her local and witness statements.

The panel considered the evidence from Witness 1 of the Fact Find report, where Mr McArdle denied the allegation and described it as 'nonsense.' The panel also considered the evidence of the Trust Investigation Meeting notes, where Mr McArdle denied the allegations. He said:

> *'This is not how I would speak, it's not my style at all. Piss, no – I wouldn't use that. I may have said I was doing something else. It doesn't stipulate that a registered nurse was needed to do this task… If a registered nurse would be needed, I would certainly help. I wouldn't say what's been said and certainly not to a student.'* [sic]

Furthermore, the panel considered the documentary evidence from Mr McArdle, where in a written statement he denied the allegation and stated that often personal care would need to be delegated to nursing support staff. He said:

> *'My workload would depend on whether I assisted with personal care. Often, as the only registered nurse on night duty, personal care would need to be allocated to care staff. However, I would never neglect a patient and if needed especially, I would assist without issue.'* [sic]

The panel noted in his accounts that while Mr McArdle disputed the wording attributed to him, he did not specifically deny that he declined to provide personal care to Patient C. The panel also noted that Mr McArdle did not state whether he requested nursing support staff to assist with this task.

The panel found that Mr McArdle's accounts demonstrated an unwillingness to engage in what he considered to be a task that should be delegated to nursing support staff. The

panel came to this reasoning based on Mr McArdle's comments that personal care was a task that could be delegated.

The panel determined that without evidence to demonstrate that Mr McArdle had ensured that the task had been delegated appropriately, his evidence corroborated with the evidence from Witness 2 that he refused to provide personal care.

The panel further considered the evidence in Mr McArdle's reflective statement, where he admitted to the charge, as he stated that '*points highlighted in BOLD are correct*.' The panel noted that this admission of the charge was inconsistent with his denials of the allegation in the Investigation Meeting Notes.

The panel preferred the evidence of Witness 2 over the response of Mr McArdle, as it found that Witness 2 gave a consistent and detailed account of the incident, while it determined that there were inconsistencies in the evidence of Mr McArdle. On the balance of probabilities, the panel was satisfied that Mr McArdle made the alleged comment and refused to provide personal care to Patient C. It therefore found this charge proved.

Charge 4a)

'That you, a registered nurse, on 13 July 2021:

a. Asked Colleague A to sign Kardex records with your signature

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witnesses 1, 2 and 3; the local Fact Find Report; the local Investigation Meeting Notes; the documentary evidence of the Kardex records; and Mr McArdle's documentary evidence.

The panel considered the oral evidence from Witness 2, who stated that Mr McArdle asked her to sign Kardex record entries on his behalf using his initials. Witness 2 demonstrated the Kardex record entries in question to the panel and explained that the initials of Mr McArdle were written by her on his behalf. She stated that she signed several entries before another nurse highlighted to her that this was not permitted and she then stopped doing so. The panel found her evidence to be credible and was corroborated by the documentary evidence of the Kardex records in question.

The panel considered Mr McArdle's evidence in the Fact Find Report, referred to by Witness 1, where Mr McArdle denied the allegation and described it as *'nonsense.'*

The panel noted in this evidence that Mr McArdle had denied the allegation initially and acknowledged that this was inconsistent with his admission recorded in the Investigation Meeting Notes. In this evidence Mr McArdle stated that it was not unusual for student nurses to complete records under supervision using his initials and admitted that Witness 2 signed his initials on the Kardex under his supervision. He said:

> *'What would happen on a medication round if the patient was on leave, if you have a student nurse or newly qualified, there's usually 2 signatures. I don't know if she's making reference to the code or if I've been in the room with her possibly when I'm in her presence. Sometimes people will ask if you want to countersign. It's basically an initial and a code 3 and she did this under my supervision. For her to say I gave her full responsibility is nonsense. She would sign my initials if I was there. She was putting my initials on the Kardex and I would check them.'* [sic]

The panel accepted Witness 3's evidence that it is not acceptable for a registered nurse to ask or allow anyone to sign documentation on their behalf. Witness 3 stated that a registered nurse remains personally accountable for all entries and signatures in the Kardex. The panel noted that this evidence corroborates with the evidence from Ms 1, who in the Investigation Meeting Notes stated that a student would be required to have been

supported by a qualified nurse and the Kardex would have to include both of their initials. The panel acknowledged that by asking Witness 2 to sign Kardex records on his behalf, using his signature without a counter-sign for the student's signature, that Mr McArdle's actions went against the Trust's policy.

The panel found that Mr McArdle's admissions in the Investigation Report, combined with the corroborative evidence of Witnesses 2 and 3 and the documentary evidence of the Kardex records in question, clearly established that he had asked her to sign Kardex records entries using his signature. The panel further noted the inconsistencies in Mr McArdle's evidence and acknowledged that his initial denial of the allegation was inconsistent with his subsequent admissions, which undermined the credibility of his account.

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

Charge 4 b)

'That you, a registered nurse, on 13 July 2021:

b. When asked by Colleague A to sign off their competencies you replied 'I don't know why you are bringing that in here as I am not fucking signing it', or words to that effect

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witness 2; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel considered the oral evidence from Witness 2 where she stated that when she approached the registrant to ask him to sign her student competency documentation, he responded with words to the effect of, '*I don't know why you are bringing that in here as I am not fucking signing it*.' Witness 2 described feeling shocked and uncomfortable as a

result of Mr McArdle's comments. The panel found her oral evidence to be consistent and corroborated with her local statement and witness statement.

The panel noted from Witness 2's oral evidence that this incident occurred shortly after the allegation relating to the signing of the Kardex records on Mr McArdle's behalf using his signature. Witness 2 stated that she had stopped signing medication records on the registrant's behalf once it was highlighted to her by another nurse on the ward that this was against Trust policy. Witness 2 also stated in her oral evidence that Mr McArdle appeared frustrated with her at the time. The panel acknowledged that this provided context for Mr McArdle's response and supported Witness 2's account in her oral evidence that he made the remark in response to her request for the sign-off of competencies in her student documentation. Furthermore, in her oral evidence, Witness 2 stated that Mr McArdle would often swear when speaking to her and explained that it was in his nature to be like this.

The panel considered the evidence from Mr McArdle that he denied the charge and stated that he was under pressure at the time of the incident, as he was supervising several students, and that his communication could sometimes be 'misinterpreted.'

The panel also considered Mr McArdle's evidence in the Investigation Meeting Notes, where he denied the allegations. He said:

> *'It's not how I am… My relationship has been really good with the students,* [PRIVATE] *would reiterate this. When I became Clinical Educator,* [PRIVATE] *were delighted. What's been said isn't true at all, why would in an office setting?'* [sic]

The panel considered the evidence in the Fact Find report, which was referred to by Witness 1, where Mr McArdle indicated that he believed that Witness 2 made the allegation due to a conversation that he had with her, in relation to her performance on her nursing placement on the ward. He said:

‘I feel that this is a reaction to a difficult conversation I had to have with the student regarding telling her that she had to up the ante as I felt that she was lacking in nursing skills. I am feeling paranoid that there is a conspiracy or vendetta against me.’ [sic]

While the panel considered Mr McArdle’s statement that he may have refused to sign the documentation due to performance concerns, the panel noted this was not supported by documentary evidence to demonstrate any performance concerns relating to Witness 2.

The panel noted that both Witness 1 and Witness 3 stated in their oral evidence that there had been no prior concerns raised with the Trust regarding Witness 2’s performance. On the contrary, the panel acknowledged that Witness 3 described her as ‘one of the best students that she had worked with.’ The panel determined that the oral evidence from Witnesses 1 and 3 directly contradicted Mr McArdle’s implication that his refusal to sign Witness 2’s competencies was performance related.

The panel found Witness 2’s evidence to be consistent and credible, and it preferred her account over the evidence from Mr McArdle, due to the inconsistencies in his evidence in regard to Witness 2’s performance issues. On the balance of probabilities, the panel determined that it was more likely than not that Mr McArdle made the alleged comment, or words to that effect, and therefore found this charge proved.

Charge 5)

‘That you, a registered nurse: On one or more occasions swore when speaking to Colleague A and/or Were confrontational towards them.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written witness statements provided by Witness 2; the local Fact Find Report; the local Investigation Meeting Notes; and Mr McArdle's documentary evidence.

The panel noted that Witness 2 stated in her oral evidence and in her local and witness statements that Mr McArdle swore at her or in her presence on multiple occasions and stated that his tone and manner was confrontational. In addition to the charges which include swearing, Witness 2 recalled Mr McArdle using phrases such as '*fuck the PIN*,' '*what the fuck are you still doing here*' and '*I'm not fucking signing it*.' Witness 2 also explained that Mr McArdle was confrontational towards her on 15 July 2021 in relation to charge 4 b), when she had asked him to sign her competencies and when he received feedback about his interactions with her.

The panel considered that Witness 2's oral evidence of Mr McArdle's language and confrontational manner was supported by her local and witness statements and was consistent with the language used in the findings of charges 1a) i) and 4b).

Furthermore, the panel considered that this evidence supported the oral evidence from Witness 3, who stated that although Mr McArdle was '*always lovely to her*,' as she was in a more senior position than him as a band 6 nurse at the time of the incident, she believed that he may have acted differently in her presence than he would with other staff on the ward.

The panel considered the evidence from Mr McArdle in the Trust Investigation Meeting notes and noted that he had denied the charge and said that he was not confrontational. He said:

> *'I said that if she had any concerns about me, I thought we were at the point where she could raise them with me. I didn't feel anything I had said had warranted them to go to* [PRIVATE]*. They could have quite easily come to me. I wasn't a tyrant and I wasn't unapproachable. If they'd said I have an issue*

with a,b,c,d, I would have welcomed that. It wasn't confrontational, I shared that I had feedback and asked if she could share what she wasn't happy about..' [sic]

The panel also considered Mr McArdle's evidence in a written statement within his documentary evidence where he acknowledged that his communication was often misunderstood. He also stated that he often experienced difficulties in communication and interpersonal skills and admitted that he experienced high levels of stress often triggered by the clinical environment, which was discussed at supervisions and appraisals.

The panel accepted that Mr McArdle's behaviour towards Witness 2 demonstrated both the use of inappropriate language and a confrontational manner on multiple occasions. It found Witness 2 to be an honest and credible witness and noted that her evidence was consistent across her oral evidence, local statement and witness statement. Furthermore, the panel acknowledged that she was a student nurse at the time of the allegations and that it would not have been easy for her to raise concerns about a senior colleague.

The panel therefore found it more likely than not that Mr McArdle swore when speaking to Witness 2 on multiple occasions and was confrontational towards her. On the balance of probabilities, the panel found this charge proved.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Ms Mukhia reminded the panel that there is no burden of proof on the NMC to prove misconduct as it is a matter for the panel to decide based on its professional judgement. She referred the panel to the comments of Lord Clyde in *Roylance v General Medical Council* [1999] UKPC 16 in which misconduct was defined:

> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'*

Ms Mukhia further referred the panel to the comments of Jackson J in *Calheam v GMC* [2007] EWHC 2606 (Admin) and Collins J in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), respectively:

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*

and

'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.

Ms Mukhia submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code) are engaged in this case and have been breached. They are sections: 1.1, 1.2, 1.4, 1.5, 6.2, 8.2, 9.3, 9.4, 10.3, 10.4, 11.2, 16.3, 16.5, 17.3, 18.2, 20.1, 20.2, 20.3, 20.5, 20.8.

Ms Mukhia identified the specific, relevant standards where in her submission, Mr McArdle's actions amounted to misconduct.

In relation to charge 1ai and ii, Ms Mukhia identified that the panel found that Mr McArdle had removed chocolates belonging to Patient A from their room and upon removing the chocolates he had said '*that's the least she can fucking do*' or words to that effect. Ms Mukhia noted that Mr McArdle has stated he had removed the chocolates due to their dietary requirement and/or because the patient presented choking risk. However, Ms Mukhia submitted that there is nothing before the panel to confirm that this was the case.

In relation to charge 1b, Ms Mukhia submitted that the panel found that Mr McArdle did leave the ward on more than one occasion without a qualified nurse present. The panel also found charge 2a proved where Mr McArdle slept during a shift when not on a break. Ms Mukhia submitted that Mr McArdle was the only registered nurse at Ward 2 on both night shifts on 2 June 2021 and 4 June 2021 and by leaving the ward unattended by taking several breaks and sleeping on duty, he was liable to put patients at risk of harm. Ms Mukhia submitted that the panel would have noted Ward 2 included very vulnerable patients. She also submitted that Mr McArdle may have been required for medication administration, responding to a deteriorating patient and liaising with other members of staff for any urgent matters. Ms Mukhia therefore submitted that Mr McArdle's conduct as set out at charges 1b and 2a meant that he would not have been able to provide immediate response if for example a patient's health was to deteriorate significantly and

as a result that patient could be at risk of harm. She submitted that he may also have been required to make urgent decisions and by not being there, he put junior staff members in a difficult situation.

With regards to charge 2b, Ms Mukhia submitted that although it is acknowledged that Witness 2 could sign the progress notes on behalf of Mr McArdle, Witness 2 has explained it was the way he did it. Witness 2 explained that he was not present when she completed the notes. She submitted that both Witnesses 1 and 3 were in senior positions at the Trust and were of the view that Mr McArdle should have been present when Witness 2 completed the progress notes. Furthermore, Ms Mukhia submitted that Witness 3 highlighted the risks of not supervising a student nurse when they are updating the progress notes on a Rio account on the registered nurse's account. Ms Mukhia therefore submitted that Mr McArdle fell below the standards expected of a nurse by not being present when asking Witness 2 to sign progress notes on his behalf with '*student nurse on behalf of AMc*' and breached fundamental tenants of the Code.

Ms Mukhia submitted that the panel found charge 2c proved and noted that Mr McArdle refused to add thickener to multiples patients' drinks. She submitted that the panel heard from the witnesses that some patients at Ward 2 had swallowing difficulties and were at risk of aspiration or choking. Ms Mukhia submitted that fluids therefore had to be at the required consistency of thickness for them to swallow without difficulties. She submitted that Mr McArdle breached Code 17.3 in that although he had knowledge of the importance of thickening liquid, he did not keep to the relevant policies about protecting and caring for vulnerable people who had swallowing difficulties. Ms Mukhia further submitted that there was a serious risk of harm to patients if the drinks had not been thickened by Witness 2.

Ms Mukhia submitted that the panel found charge 3a proved and submitted that Mr McArdle breached Code 17.3 in that he did not keep to the relevant policies in place regarding reheating food containing medication. She submitted that the covert administration of medicines form clearly stated to avoid adding medicines to hot drinks/food where possible unless specified. She stated that Witness 1 has provided

evidence to suggest that avoiding hot food and drinks with medicines is fundamentally good practice as higher temperatures are a known cause or accelerant of drug denaturation/degradation. This occurs when medicines are exposed to higher temperatures, the chemical stability of the active ingredient (excipients) can be affected which may result in reduced effectiveness. Ms Mukhia submitted that Witness 3 also confirmed this during her evidence. Ms Mukhia submitted that this indicates that potential to risk of harm to patients cannot be discounted.

In relation to charge 3b, Ms Mukhia submitted that Mr McArdle breached Code 1.1 treating people with kindness, respect and compassion, 1.2 making sure he delivered the fundamentals of care effectively and 1.5 respect and uphold people's human rights. She submitted that by not agreeing to assist Patient C even after seeing her seated in a wheelchair with a pool of urine, this shows a complete disregard to care for Patient C in a timely manner. Ms Mukhia submitted that the fact that Patient C was using a wheelchair indicates how physically vulnerable Patient C was and by not providing her basic need to be cleaned up, Mr McArdle did not uphold her human rights.

Ms Mukhia submitted that the panel found charge 4a proved and submitted that by asking Witness 2 to sign the Kardex records with Mr McArdle's signature, he has breached Code 10 keep clear and accurate records relevant to his practice. Ms Mukhia stated that Code 10.4 clearly states that any entries made in any paper or electronic records should be made by the registrant, should be clearly written, dated and timed, and should not include unnecessary abbreviations, jargon or speculation. Ms Mukhia submitted that Mr McArdle has breached this part of the Code by asking Witness 2 to sign the Kardex on his behalf. She submitted that the intention behind this could not have been anything else than to suggest Mr McArdle signed the Kardex when he did not. Ms Mukhia submitted that while Mr McArdle was an experienced nurse who was supervising and assessing a student nurse, he clearly did not present himself as a role model by asking Witness 2 to do something that was against the Trust policy and the Code.

Ms Mukhia submitted that the panel also found charge 4b proved and submitted that Mr McArdle breached Code 1.1 in that he did not treat Witness 2 with kindness and respect, as well as Code 8.2, in that he did not maintain effective communication with Witness 2. Ms Mukhia also submitted that Mr McArdle was not supportive to Witness 2 in helping her to develop her professional competence and confidence by stating he was not signing her competencies as required by Code 9.4. She submitted it cannot be considered that he behaved in a professional manner by swearing as required by Code 9.3.

With regards to charge 5, Ms Mukhia submitted that Mr McArdle breached Code 9.3 as he did not deal with differences of professional opinion with Witness 2 by discussion but rather behaved in an unprofessional manner by being confrontational. She submitted that he also breached Code 1.1 and 8.2 by being confrontational and swearing on a number of occasions in front of Witness 2. Ms Mukhia stated that it cannot be said that by displaying such behaviour he acted in a kind, respectful and compassionate manner or maintained an effective communication. Ms Mukhia submitted that in fact, his behaviour indicated that he did not act as a role model of professional behaviour for students and newly qualified nurses.

Ms Mukhia therefore submitted that Mr McArdle's behaviour was a serious departure from the fundamental tenets of the profession and the professional standards and behaviour expected of a registered nurse. She submitted that misconduct should be found on the basis of the admitted charges already mentioned.

Submissions on impairment

Ms Mukhia highlighted that impairment is conceptually forward looking, and therefore the question for the panel is whether Mr McArdle's fitness to practise is currently impaired as at today's date. She referred the panel to the NMC Guidance on Impairment (DMA-1) and highlighted that the Guidance invites the panel to consider this question:

'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'

Ms Mukhia submitted that to answer this question would involve a consideration of both the nature of the concern and the public interest. She submitted that, in considering impairment, the panel should consider the test formulated by Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b and c of the *Grant* test are engaged in this case when looking at past conduct, and also when looking forward to the future.

Ms Mukhia submitted that although the NMC acknowledges that there was no patient harm in this case, Mr McArdle's actions were liable to put several vulnerable patients at risk of harm. She submitted that he left the ward with no registered nurse present several times in one shift and has admitted to doing so on most of his shifts. She submitted that he has also admitted to sleeping during a shift while not on a break. Ms Mukhia stated that these conducts were liable to put vulnerable patients at risk of harm. She submitted that if for example, a patient's health was to deteriorate, or the unregistered staff required an urgent decision to be made by a registered nurse on the ward whilst Mr McArdle was away, if he was not on the ward this would mean that the response would be delayed which may impact for example any treatment the patients may urgently require.

Ms Mukhia submitted that the conduct of reheating food containing medication for Patient B and refusing to add thickener to multiple patients' drinks was also liable to cause risk of harm to patients. She submitted that he clearly failed to follow the procedures in place which have been put in place to ensure patient safety. Ms Mukhia submitted that not adding the thickener could mean that there was a risk of aspiration or choking for patients who had difficulty swallowing food and the panel have heard evidence to suggest that food should not be reheated with medication in it however Mr McArdle did so despite knowing it should not be done. Ms Mukhia submitted that this shows clear disregard to patient safety and welfare, and for any harm that may be caused. She submitted that the panel has heard evidence from witnesses in senior positions who have confirmed that Mr McArdle as a registered nurse at the Trust would have been aware of both procedures and he has

completed his food safety awareness training in February 2021, so to take unreasonable risk with patient safety indicates that there may be attitudinal concerns.

Ms Mukhia submitted that Mr McArdle has not treated patients and colleagues with respect and kindness, for example, by removing chocolates from Patient A and not assisting Patient C after they had urinated. She also submitted that there are several examples of when Mr McArdle has not treated Colleague A/ Witness 2 with kindness by being confrontational or swearing when speaking to her. Ms Mukhia submitted that these incidents indicate that the risk to emotional or mental harm could not be discounted.

In relation to limb a of the Grant test, Ms Mukhia submitted that by the circumstances of Mr McArdle's conduct he has brought the reputation of the nursing profession into disrepute. She submitted that Mr McArdle's actions fell far short of that expected of a registered professional and this undermines public trust and confidence in the nursing profession.

In relation to limb b of the Grant test, Ms Mukhia submitted that the guidance notes that '*Not all breaches of the Code require a finding of impairment but where a breach of the Code involves breaching a fundamental tenet of the profession, the Committee would be entitled to conclude that a finding of impairment is required*.' She submitted that the finding of impairment would be required to mark the profound unacceptability of the behaviour, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards or behaviour.

In relation to limb c of the Grant test, Ms Mukhia reiterated that Mr McArdle had breached fundamental tenets of the profession as set out in sections 1.1, 1.2, 1.4, 1.5, 6.2, 8.2, 9.3, 9.4, 10.3, 10.4, 11.2, 16.3, 16.5, 17.3, 18.2, 20.1, 20.2, 20.3, 20.5, 20.8 of the Code. She submitted that his conduct demonstrates attitudinal concerns which are difficult to put right and therefore may be repeated in the future.

In considering whether Mr McArdle has demonstrated sufficient insight and strengthened his practice, Ms Mukhia referred the panel to the test set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). She submitted that the concerns in this case are not easily remediable, they have not been remedied and therefore, they are highly likely to be repeated.

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

Decision and reasons on misconduct

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

The panel was of the view that Mr McArdle's actions did fall significantly short of the standards expected of a registered nurse, and that Mr McArdle's actions amounted to a breach of the Code. Specifically, the following sections of the Code:

> *'**Prioritise people***
>
> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> ***1.1** treat people with kindness, respect and compassion*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***1.5** respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

8 Work cooperatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

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

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

To achieve this, you must:

9.1 *provide honest, accurate and constructive feedback to colleagues*

9.3 *deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times*

9.4 *support students' and colleagues' learning to help them develop their professional competence and confidence*

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:
10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

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

Preserve safety
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*

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

To achieve this, you must:

16.5 *not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code*

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

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

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first*
25.2 *support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel found that the following charges in particular amounted to misconduct, including 1b) leaving the ward on more than one occasion with no qualified nurse present; 2a) sleeping during a shift while not on a break; 2c) refused to add thickener to multiple patients' drinks; 3a) reheated food containing medication for Patient B; and 3b) refusing to provide personal care to Patient C after they had urinated.

The panel had no evidence that any harm was caused to patients, but all of these breaches of the code were particularly serious because they created a serious risk of harm to patients, both physically and emotionally.

In relation to charge 5) on one or more occasions swore when speaking to Colleague A and/or were confrontational towards them, the panel found that Mr McArdle's conduct towards Witness 2, as a student nurse at the time of the incident, undermined her confidence, affected her nursing placement experience, and could have discouraged her from pursuing her training to its full potential. In the panel's judgement, Charge 5 demonstrates repeated behaviour from a nurse in a position of authority towards a second year student and was a sufficient departure from the standards expected of a registered nurse as to amount to misconduct.

The remaining charges were all regrettable breaches of the Code but in the panel's judgement, were not sufficiently serious in themselves individually as properly to be characterised as misconduct.

Decision and reasons on impairment

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

The panel had regard to the NMC Guidance on Impairment (DMA-1) especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

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

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

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

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

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

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

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

d) *…*

The panel first considered whether any of the limbs of the Grant test were engaged as to Mr McArdle's past conduct. The panel was of the view that his misconduct of leaving a ward of highly vulnerable patients without a registered nurse on duty, on multiple occasions; sleeping during a shift while not on a break; refusing to add thickener to

patients' drinks; and refusing to provide personal care to Patient C after they had urinated, demonstrated a complete disregard for patient safety and a failure to follow policies and procedures, placing patients on the ward at unwarranted risk of physical and/or emotional harm.

Mr McArdle's confrontational attitude towards a student nurse under his supervision also showed a damaging lack of respect for her.

The panel found that Mr McArdle's misconduct constituted a serious breach of fundamental tenets of the nursing profession in that he failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. It determined that he failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that limbs a, b, and c of the Grant test are engaged in respect of Mr McArdle's past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* in which the Court addressed the issue of impairment with regard to the following three considerations:

a. *Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (FTP-15).

The panel first considered whether Mr McArdle's misconduct is capable of being addressed. In the NMC Guidance – Can the concern be addressed (FTP-15a), the panel noted the following paragraph:

> *'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *….*
>
> *Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*
>
> - *medication administration errors*
> - *poor record keeping*
> - *failings in a discrete and easily identifiable area of clinical practice*
> - *…'*

The panel was of the view that Mr McArdle's misconduct with respect to poor record keeping could be addressed through a process of insightful reflections, retraining in the areas of concern and evidence of good practice. Therefore, the panel determined that although difficult, it is capable of remediation. However, in regard to the identified attitudinal concerns, the panel determined that Mr McArdle's conduct might be capable of remediation, but it is more difficult to remediate due to its serious and attitudinal nature, and Mr McArdle's reluctance to accept the failings in his nursing practice.

The panel then went on to consider whether the concerns have been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b). The panel took into account the oral evidence from Witnesses 1, 2 and 3, in addition to Mr McArdle's reflective statement and documentary evidence.

Regarding insight, the panel considered that Mr McArdle's insight is limited in terms of the concerns raised and it is not highly unlikely that the concerns would be repeated. The panel took into account that Mr McArdle has demonstrated some insight into the seriousness of his behaviour in leaving the ward while on duty, with a qualified nurse, and the impact this had on patient safety, his colleagues, the nursing profession and the wider public. However, the panel noted that Mr McArdle demonstrated limited insight in relation to how he would act differently if a similar situation should occur in the future.

The panel noted that Mr McArdle had previously received management feedback about his communication and professional conduct but appeared not to have made any changes to his behaviour. The panel therefore noted that his behaviour demonstrated ongoing attitudinal issues.

The panel has no evidence that Mr McArdle has completed any training courses in the relevant areas of concern. The panel also noted that Mr McArdle had been working at a nursing home since July 2023, without any further concerns raised about Mr McArdle's nursing practice. In this regard, it had sight of two positive references made on his behalf by the Home Manager. However, the panel noted that the references were not dated, and brief in nature and that there were no further testimonials provided. Furthermore, the panel noted that although one reference states that Mr McArdle '*has displayed dignity and respect, and upholds the code of conduct*,' they do not discuss his practice in relation to the charges in any detail.

The panel acknowledged that there was evidence from Mr McArdle's reflective statement that he has demonstrated limited insight by discussing his regret for leaving the ward on multiple occasions whilst on duty, without a registered nurse. The panel noted that Mr

McArdle also explained in his reflective statement that he has changed his job since the incident and is feeling '*less tired and* [PRIVATE]', which has had a positive impact on his nursing practice. Furthermore, the panel noted in Mr McArdle's reflective statement that he had previously received feedback from management at the Trust in relation to his communication and attitudinal concerns but had not seen any evidence to suggest that Mr McArdle had changed his behaviour in relation to this.

Nevertheless, the panel considered that from Mr McArdle's accounts, that he has failed to recognise the importance of prioritising patient safety and is yet to demonstrate full insight into the impact of his behaviour on his patients, colleagues, the nursing profession and the wider public. The panel considered that Mr McArdle's journey of remediation requires him to step back more fully and objectively reflect on his misconduct rather than seeking to deflect to the perceived failings of others. The panel therefore determined that his insight is still developing.

In light of this, the panel was not satisfied that Mr McArdle's misconduct has been fully remediated. Accordingly, the panel determined that his misconduct is not highly unlikely to be repeated. Therefore, limbs a, b, and c of the *Grant* test are engaged as to the future.

The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection.

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

The panel had regard to the serious nature of Mr McArdle's misconduct and the public protection issues it had identified. It determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. For these

reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Mr McArdle's fitness to practise is currently impaired on both public protection and public interest grounds.

Interim order

Following the determination of misconduct and impairment, after careful and considered reflection, the panel adjourned this hearing due to a lack of time to conclude the sanction stage of these proceedings.

Ms Mukhia made an application for an interim order for 12 months due to the facts found proved by the panel. She submitted that an interim order is required on the grounds of public protection and in the public interest in light of the findings of this panel. She submitted that the appropriate order would be an interim suspension order. This application was made under Rules 32(5) of the Rules.

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 considered the information before it that Mr McArdle had been practising unrestricted and had no concerns raised by the last known employer, albeit, the information was limited as to Mr McArdle's role. However, the limited insight, lack of evidence of remediation and Mr McArdle's deflection of his responsibility to some of the

charges outweighs this along with the panel's finding of ongoing attitudinal concerns. The panel noted in its findings that it considered that there was a risk to patients.

The panel considered that it has found serious attitudinal concerns arising directly out of Mr McArdle's clinical practice and found a high risk of repetition. The panel concluded that it would be unable to formulate any workable conditions to address these attitudinal issues. Given this finding therefore, the panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case. The panel considered the impact the imposition of an interim suspension order would have on Mr McArdle, however the panel determined that the necessity of an interim order on public protection and public interest grounds outweighs any impact to Mr McArdle.

At the time of making this decision, it has been indicated to the panel that dates to resume these proceedings will not be before January 2026. The panel acknowledged that no dates for the resuming of this substantive hearing have been confirmed at the imposition of this interim suspension order. The panel therefore imposed an interim suspension order for a period of 12 months in order to adequately protect the public and maintain public interest until the resuming dates of this substantive hearing.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr McArdle was not in attendance and that the Notice of Resuming Hearing letter had been sent to Mr McArdle's registered email address by secure email on 19 December 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr McArdle

The panel next considered whether it should proceed in the absence of Mr McArdle. It had regard to Rule 21 and heard the submissions of Ms Forsyth who invited the panel to continue in the absence of Mr McArdle. She submitted that Mr McArdle had voluntarily absented himself.

Ms Forsyth submitted that there has been limited engagement by Mr McArdle with the NMC in relation to these proceedings. A telephone call took place between Mr McArdle and the NMC on 19 December 2025, where Mr McArdle advised that he would review the transcripts and call if he had any queries or intended to attend the hearing. Ms Forsyth submitted that there had been no engagement at all by Mr McArdle with the NMC since this date and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

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

- No application for an adjournment has been made by Mr McArdle;

- Mr McArdle has not engaged with the NMC since the telephone call on 19 December 2025 where he advised that he would review the transcripts and call if he had any queries or intended to attend the hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- The charges relate to events that occurred in 2021;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr McArdle in proceeding in his absence in that he will not be able to provide a response to the panel in regard to sanction.

Furthermore, the disadvantage is the consequence of Mr McArdle'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 McArdle. The panel will draw no adverse inference from Mr McArdle's absence in its decision on sanction.

Preliminary matters

At the start of the resuming hearing, Ms Forsyth made mention of a previous Rule 19 application but submitted that she would not likely stray into private matters during her submissions. However the panel agreed that should she do so, a Rule 19 would apply.

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 McArdle off the register. The effect of this order is that the NMC register will show that Mr McArdle 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Forsyth submitted that the NMC considers the appropriate and proportionate sanction in this case to be a Striking-off order.

Ms Forsyth submitted that in Mr McArdle's case, the following aggravating features apply:

- Behaviour which had the real potential to cause serious risk of harm to patients, both physically and emotionally.
- Mr McArdle showed a complete disregard for patient safety in leaving the ward without a nurse both in respect to physically leaving the ward and sleeping whilst on duty, refusing to carry out personal care, refusing to add thickeners to drinks and reheating food containing medication.
- He failed to follow policies and procedures.
- There was a lack of respect for the student nurse who he was mentoring. Panel may feel that his behaviour towards her demonstrated a pattern of misconduct.
- Attitudinal concerns which had not been addressed despite management feedback.
- Limited insight shown.
- No evidence of any further training completed.

Ms Forsyth submitted that in Mr McArdle's case, the following mitigating features apply:

- Mr McArdle references some [PRIVATE] within his reflective piece that were affecting him at the time of the incidents.
- He references tiredness with excessive overtime and supporting students so the panel will need to consider the context.

Ms Forsyth submitted that in regard to the available sanctions, the present case would not be appropriate for taking no action. She submitted that the SG states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, taking no further action would not be appropriate as it would not provide the restriction to Mr McArdle's practice that is required to protect the public.

Ms Forsyth submitted that similarly, a caution order would also not be appropriate as this would not mark the seriousness and would be insufficient to protect the public. Further, it would not maintain high standards within the profession or the trust that the public places in the profession. She submitted that the SG makes clear that a caution order is the least restrictive sanction which will only be suitable where the nurse presents no risk to the public. Given the concerns, there remains a significant risk to the public. She submitted that a caution order would not be appropriate in this case. It would not provide the restriction to Mr McArdle's practice that is required to protect the public.

Ms Forsyth reminded the panel of their decision on misconduct and impairment, including that Mr McArdle has demonstrated ongoing attitudinal issues in that he had previously received management feedback about his communication and professional conduct but appeared not to have made any changes to his behaviour. She submitted that a conditions of practice order would not be appropriate in this case, given that not only has Mr McArdle demonstrated a lack of respect for the student nurse, he has shown a complete disregard to patient safety by leaving the ward with no qualified nurse present, sleeping during a shift, reheating food containing medication and refusing to provide personal care considering that it was a job for the carers as opposed to the nurses. She submitted that he has not shown insight into how he would act differently in future to prevent similar incidents from occurring and it is questionable whether Mr McArdle would be willing to respond positively to retraining.

Ms Forsyth submitted that aside from the public protection issues in this case, a conditions of practice order would not address the public interest factors present. She submitted that

the conduct would seriously undermine public trust in the profession. She submitted that for those reasons a conditions of practice order is not suitable.

Ms Forsyth submitted that in the present case, a suspension order would not be sufficient to reflect the seriousness of the case or protect the public.

Ms Forsyth submitted that the NMC's guidance on suspension orders (SAN-3d) states that this sanction would be appropriate where there is:

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

Ms Forsyth submitted that the above matters apply in this case as this is not a single instance of misconduct. There are a number of issues that create a serious risk to patients, colleagues and members of the public.

Ms Forsyth submitted that on looking at whether there is evidence of repetition, the panel may feel that it's relevant that he had previously received feedback from management in respect of the communication and attitudinal concerns but then made no change to his behaviour.

Ms Forsyth submitted that in respect of insight, Mr McArdle has shown some insight by discussing his regret for leaving the ward on multiple occasions and the impact this had on patient safety, his colleagues, the nursing profession and the wider public but then only limited insight in relation to how he would act differently in future. There is still a significant risk of the behaviour being repeated.

She submitted that Mr McArdle has fallen far short of the standards expected and it can't be said that a period of suspension would be sufficient to protect patients, public confidence in nurses, or professional standards.

Ms Forsyth submitted that the concerns in this case raise fundamental questions about Mr McArdle's professionalism. She submitted that not only has his communication towards a student nurse been wholly inappropriate there are clinical aspects of his practice where he's shown a blatant disregard for patient safety. He hasn't followed various policies and procedures, and has created a serious risk for patients. She submitted that his insight is limited and focussed on leaving the ward unattended. She submitted that he attempted to deflect blame onto the student nurse when the allegations arose.

Ms Forsyth submitted that in this case, a striking-off order is the only sanction which will be sufficient to protect patients, and maintain public confident and professional standards.

Ms Forsyth submitted that she therefore invited the panel to make a striking-off order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr McArdle's fitness to practise currently impaired, 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 following aggravating features:

- Evidence of deep-seated attitudinal issues.

- The misconduct represented a pattern of behaviour over time, with more than one incident of misconduct.
- The misconduct presented a risk of harm to vulnerable patients and disregard for public safety.
- Abuse of a position of trust.
- Disregard for the impact of his actions on the student nurse that he was mentoring and the impact this may have on her training and nursing career.
- Limited evidence of insight, with no evidence of remediation or willingness to engage in further training to enhance professional performance.
- Mr McArdle did not address the previous concerns regarding his communication raised by management.
- Deflection and minimisation of his actions despite them being so serious.

The panel took into account the following mitigating features:

- Mr McArdle reported exhaustion due to working excessive hours during the COVID-19 pandemic.
- Mr McArdle was experiencing [PRIVATE] at the time.
- Mr McArdle has stated that he has since [PRIVATE].

The panel concluded that the mitigating factors carry limited weight when balanced against the seriousness and repetition of the misconduct and the absence of meaningful insight and remediation.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct, which involved a repeated pattern of behaviour, risk to patient safety and deep-seated attitudinal concerns. The panel decided that this sanction would not deal with the gravity of the misconduct found proved, and it would be neither proportionate, nor in the public interest to take no further action as it would not show the public how seriously matters such as those proved are taken.

It then considered the imposition of a caution order but again determined that, due to the serious nature of the charges, an order that does not restrict Mr McArdle's practice would not be appropriate in these 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 McArdle's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case as it would not protect the public and is not sufficient to mark the seriousness of the charges. The panel noted that Mr McArdle has demonstrated limited insight and remediation, and there is limited evidence that his behaviour would not be repeated. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr McArdle's registration would be a sufficient and appropriate response. The panel noted that a conditions of practice order is typically imposed in cases where the regulatory concerns can be remediated by a registrant's strengthened clinical practice through learning and retraining. However, the panel determined that in Mr McArdle's case, the deep-seated attitudinal concerns relating to his misconduct and lack of meaningful insight cannot be addressed by a conditions of practice order. The panel noted that Mr McArdle previously received management feedback about his communication and conduct but has failed to make changes to his behaviour. The panel was of the view that there are no practical or workable conditions that could be formulated in relation to public safety. There is no evidence that Mr McArdle would engage positively with retraining or comply with conditions. Furthermore, the panel concluded that the placing of conditions on Mr McArdle's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was of the view that Mr McArdle's conduct, as highlighted by the facts found proved and the seriousness of the misconduct, was a significant departure from the standards expected of a registered nurse. The panel considered that Mr McArdle's actions were not limited to a single event and represents a repeated pattern of misconduct which took place in 2021.

The panel noted that whilst Mr McArdle has demonstrated some limited evidence of reflection, this lacked meaningful insight and there was no evidence of sustained efforts to strengthen his practice. The panel was of the view that although a period of suspension would allow time for further reflection, insight or training, it has not had any evidence of insight for two years, since Mr McArdle submitted his reflective accounts in March 2023 and April 24.

Whilst the panel considered the mitigating factors related to this case, including that Mr McArdle was experiencing exhaustion and [PRIVATE], the panel considered that a suspension order in this case, which involves risks to vulnerable patients, would not sufficiently mark the seriousness of the concerns or protect the public. The panel acknowledged that there is evidence of deep-seated attitudinal concerns demonstrated by Mr McArdle's actions, which have persisted, despite feedback from management relating to his communication and being provided with ample opportunity for reflection and to make changes to his behaviour.

The panel considered that the reputation of the profession is more important than that of any individual member, and a registrant's right to work and remain on the register is not as important as maintaining the professional reputation of nurses. The panel was of the view that the nature of Mr McArdle's misconduct is so serious that it would be very difficult to remedy and there is a likelihood of repetition. There is no evidence before it that suspending his practice for a period of time would change his attitudes and behaviour.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in order to protect the public or maintain confidence in the profession.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel noted that Mr McArdle's actions were a significant departure from the standards expected of a registered nurse and breached the fundamental tenets of the nursing profession. The panel was of the view that Mr McArdle's proven actions are fundamentally incompatible with him remaining on the register. The panel noted that the findings in this particular case demonstrate the seriousness of Mr McArdle's misconduct, involving risks to patient safety, abuse of his position of trust and deep-seated attitudinal concerns, and to allow him to continue practising would undermine public confidence in the profession and in the NMC as the regulatory body. Furthermore, the panel was of the view that due to the pattern of behaviour of deep-seated attitudinal concerns, limited insight and lack of evidence of remediation, all points towards an ongoing risk of repetition.

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. The panel determined that this is the only order that would sufficiently protect patients and members of the public, whilst maintaining professional standards and upholding public confidence in the nursing profession, by removing an individual with attitudes and behaviours that are not compatible with remaining on the register. Having regard to the effect of Mr McArdle'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 has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mr McArdle in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Forsyth. She invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and in the public interest. She submitted that as the striking-off order will not take effect until after the 28-day period or until an appeal is disposed of or withdrawn, an interim order is necessary and proportionate to cover this intervening period to protect the public and meet the public interest in light of the serious concerns found.

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 determined that the charges found proved are so serious that they warrant a striking off order, therefore Mr McArdle's practice needs to be restricted during the appeal period.

Given its earlier decisions and the substantive order imposed, the panel determined that this restriction should be an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.