Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday, 22 November 2024 – Friday, 20 December 2024
Monday, 18 August 2025,
Monday, 5 January 2026 – Thursday, 8 January 2026
Tuesday, 13 January 2026
Wednesday, 15 July 2026 – Thursday, 16 July 2026

Virtual Hearing

Name of Registrant:	**Dawn Alison Ellerby**
NMC PIN	12J0124E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental Health Nursing (level 1) - 21 January 2013
Relevant Location:	West Yorkshire
Type of case:	Misconduct and lack of competence
Panel members:	Darren Shenton (Chair, lay member) Shorai Dzirambe (Registrant member) Angela Kell (Lay member)
Legal Assessor:	Gelaga King (22 November 2024) Charles Conway (25 November 2024 – 20 December 2024) Cyrus Katrak (18 August 2025) Robin Hay (5 – 8 January 2026) Justin Gau (13 January 2026) Elisa Hopley (15 - 16 July 2026)
Hearings Coordinator:	Stanley Udealor Amira Ahmed (18 August 2025)
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter

Mrs Ellerby:	Present and represented by Briony Molyneux, instructed by the Royal College of Nursing (RCN) (22 November 2024 – 20 December 2024) Present and not represented (18 August 2025) Present and not represented (5 – 8 January 2026) (15 – 16 July 2026)
Facts proved by admission:	Charges 1, 2, 3, 4a, 5, 6, 7, 8b, 8f, 8g (i), 8g (ii), 8h (iv), 13a, 14a, 14b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d, 19b, 19d (i), 19d (ii), 19d (iii), 19e and 21.
No case to answer:	Charges 4b, 8e and 9b (ii)
Facts proved:	Charges 8a, 8c, 8d, 8h (i), 8h (ii), 8h (iii), 9a, 9b (i), 9c, 9d, 9e, 10, 11a (i), 11a (ii), 11a (iii), 11b, 11c, 12, 13d, 15a, 15b, 16d (i), 16d (ii), 18, 19a and 19c
Facts not proved:	Charges 13b, 13c, 16d (iii) and 20
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, between 22 October 2018 and 2 August 2019 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse, in that you:

1) On one or more occasion, removed the medication keys off Stanley Ward when going on break.

2) On the morning of 21 November 2018, incorrectly administered Patient A Procyclidine instead of Venlafaxine 75mg.

3) On or around 20-22 January 2019 did not administer an unknown Patient their morphine at nighttime as prescribed.

4) On 22 January 2019;

    a) Started to write a prescription for ‘paracetamol’ on Patient C’s medication card.

    b) Attempted to administer an unprescribed dose of paracetamol to Patient C.

5) Refused to fully cooperate/comply with a Preceptorship Programme imposed around 23/24 January 2019

6) On 8 January 2020, refused to engage with a support plan put into place by your employers

7) Did not complete an Action Plan put into place around 17 January 2020

8) On or around 1 February 2020 whilst working on Crofton Ward;

a) Did not know how to deactivate the ward alarms.

b) Were unable to undertake the moving and handling of one or more patients.

c) Left Patient F who required personal care/assistance at the end of their bed whilst you went and had breakfast/toast.

d) Did not assist colleagues with Patient H's personal care requirements.

e) Failed to complete a Mental Health Care Plan for Patient H.

f) Did not respond to assistance alarms.

g) Were unable demonstrate proficiency in areas of;

i) Cardiometabolic assessments;
ii) Mental Health Clusters

h) During level 2 observations for Patient G/After Patient G had slid onto the floor;

i) Did not assist Patient G
ii) Did not call for assistance/pull;
iii) Continued to eat food.
iv) Used words for the effect *'I can't lift him.'*

And in light of the above your fitness to practise is impaired by reason of your lack of competence.

That you, a registered nurse;

9) On 28 January 2019;

a) Requested Colleague Y [Katrina Turfrey] sign off your Medicines with respect to documentation in one shift.

b) Behaved aggressively towards Colleague Y [Katrina Turfrey], in that you;

i) Shouted/raised your voice at Colleague Y [Katrina Turfrey].

ii) Pointed your finger at Colleague Y [Katrina Turfrey].

c) Inaccurately informed Colleague Y [Katrina Turfrey] that you were allowed to hold medication keys for Stanley Ward.

d) Demanded access to the medication keys for the Stanley Ward.

e) Inaccurately informed Colleague Y [Katrina Turfrey] that the action plan/support plan/preceptorship programme were no longer needed.

10) Your actions in one or more of charges 9 c) and & 9 e) were dishonest in that you sought to misrepresent the level of local restrictions placed upon your practice.

11) On 29 January 2019 following Colleague Y [Katrina Turfrey]'s instructions to request a prescription/further medication for Patient D;

a) Did not adequately explain the situation surrounding Patient D to Dr X [Dr Harry Williams] regarding the prescription/medication, in that you did not explain;

i) Whether Patient D was thought disordered.

ii) Whether Patient D was attempting to assault others.

iii) Whether Patient D had assaulted others.

b) Inaccurately informed Colleague Y [Katrina Turfrey] that Dr X [Dr Harry Williams] had verbally authorised a stat dose of Lorazepam for Patient D.

c) Inaccurately informed Colleague Y [Katrina Turfrey] that Dr X [Dr Harry Williams] requested Colleague Y [Katrina Turfrey] to administer the Lorazepam.

12) Your actions in one or more of charges 11 b) & 11 c) were dishonest, in that you sought to mislead Colleague Y [Katrina Turfrey] into believing that Dr Harry Williams [Dr X] had provided verbal authority for prescribing/administering Lorazepam for Patient D.

13) On 31 January 2019 intimidated Colleague Y [Katrina Turfrey], in that you;

a) Requested a meeting with Colleague Y [Katrina Turfrey] and shut the office door.

b) Laughed at Colleague Y [Katrina Turfrey].

c) Accused Colleague Y [Katrina Turfrey] of sending emails regarding your practice to senior members of staff.

d) Raised your voice at Colleague Y [Katrina Turfrey].

14) On 29 March 2019 worked outside the scope of your competency in that you;

a) Wrote/signed for a prescription of Clozapine on Patient B's Prescription and/or Administration Record Chart

b) Administered an unprescribed dose of Clozapine to Patient B

15) On 21 March 2020;

a) Behaved in a confrontational manner towards Colleague Z [Toni Burns].

b) Raised your voice/shouted over/at Colleague Z [Toni Burns].

c) When asked to reflect on your behaviour used words to the effect *'I have done and I'm offering you an apology what more do you want*'

d) Left your work keys unattended on the reception hatch.

16) On or around 12 April 2020, whilst restricted from holding medication keys and administering medication;

a) Offered to take the medication keys from a bank nurse.

b) On one or more occasion took the medication keys when the bank nurse/Colleague W [Anthony Walsh] went for a break.

c) Administered/assisted with the administration of medication to Patient F

d) Following Patient F suffering an unwitnessed fall

i) Did not carry out any neurological observations of Patient F.

ii) Did not check Patient F for any injuries.

iii) Did not call the duty Doctor.

That you a registered nurse, whilst working at the Barnsley Intensive Home Based Treatment Team ('IHBTT') at South West Yorkshire Partnership NHS Foundation Trust ('the Employer');

17) Between May 2022 – September 2022, failed to disclose that you were restricted from giving/supplying medication & holding the medication keys to one or more colleagues, including;

a) Senior Mental Health Practitioner, Colleague U [Ronilyn Gange].
b) Service Manager, Colleague T [Mick Oldhan];
c) Clinical Lead, Colleague V [Shelley Seward (nee Drake)];
d) Deputy Manager, Colleague S [Grace Bandwa].

18) Your actions in one or more of charges 17 a), 17 b), 17 c) & 17 d) were dishonest, in that you sought to conceal your restrictions from one or more colleagues.

19) On or around 8 August 2022;

a) Initially retrieved pregabalin from the clinic/controlled drug cupboard without signing the controlled drug book;
b) Checked/countersigned pregabalin in the controlled drug book;
c) Incorrectly placed Patient P's pregabalin, into Patient Q's medication bag;
d) Before giving/dispensing Patient Q's medication, did not adequately check Patient Q's;

i) Prepackaged medication was for the correct patient/dose;

ii) Medication card.

iii) Patient Q's Prescription Drug/Chart.

e) Incorrectly supplied/dispensed Patient P's pregabalin to Patient Q.

20) Your actions in on or more of charges 19 a), 19 b), 19 c), 19 d) i), 19 d) ii), 19) d) iii) & 19 e) were outside the scope of your competence, in that you were supplying/retrieving/managing medication whilst subject to local restrictions/not deemed safe to do so.

21) On 9 August 2022 incorrectly recorded that you were advised that Patient Q was prescribed pregabalin.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kennedy, on behalf of the Nursing and Midwifery Council (NMC), to amend the following wordings of charge 7, the stem of charge 8, charges 8f, 8h, 10 and 12:

That you, a registered nurse:

7) *Did not complete ~~at~~ **an** Action Plan put into place around 17 January 2020*

8) *On or around 1 February 2020 whilst working ~~of~~ **on** Crofton Ward*

   *f) Did not ~~response~~ **respond** to assistance alarms*

   h) During level 2 observations for Patient G/After Patient G had slid onto the floor;
   *~~ii)~~ **iii)** Continued to eat food.*
   *~~iii)~~ **iv)** Used words for the effect 'I can't lift him.'*

*10) Your actions in one or more of charges ~~8c and & 8e~~ **9 c) and & 9 e)** were dishonest in that you sought to misrepresent the level of local restrictions placed upon your practice.*

*12) Your actions in one or more of charges ~~10 b) & 10 c)~~ **11 b) & 11 c)** were dishonest, in that you sought to mislead Colleague Y [Katrina Turfrey] into believing that Dr X [Dr Harry Williams] had provided verbal authority for prescribing/administering Lorazepam for Patient D.*

Mr Kennedy submitted that there were some typographical errors in the above-mentioned charges and the proposed amendments would provide clarity and more accurately reflect the evidence.

Ms Molyneux, on your behalf, did not oppose the application.

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

The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

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

Ms Molyneux made an application that this case should be held partly in private on the basis that proper exploration of this case involves references to your health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Kennedy did not oppose the application.

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 accepted the advice of the legal assessor.

The panel determined to hold this hearing partly in private. It will go into private session as and when matters relating to your health are raised in order to protect your privacy.

Background

The charges arose whilst you were employed as a registered nurse by Southwest Yorkshire NHS Foundation Trust (the Trust). The NMC received two referrals relating to you from the Trust in September 2019 and September 2022 respectively.

You commenced your substantive employment at the Trust in October 2018 where you worked on Stanley Ward in Field Head Hospital. Stanley Ward is a twenty-two bedded adult acute psychiatric care ward.

It was alleged that in the first few months on Stanley Ward, you had made medication errors: on 21 November 2018, you allegedly gave Patient A Procyclidine instead of Venlafaxine 75mg; in January 2019, it was alleged that you did not give Morphine to a service user as prescribed; you also started to write a prescription for Paracetamol and attempted to give it to Patient C. Furthermore, you allegedly failed to demonstrate required proficiencies as a Band 5 nurse on Stanley Ward.

As a result of the alleged medication errors and your lack of proficiency, you were directed by the Trust to refrain from completing medication rounds on your own without appropriate clinical support and not to hold medication keys for Stanley Ward. You were further placed on a support plan within a preceptorship style programme in order to strengthen your practice. However, it was alleged that you disagreed with and resented being placed on the preceptorship style programme and support plan and therefore did not fully engage with them.

This alleged resentment led to an alleged demonstration of aggressive behaviour by you towards Ms Katrina Turfrey on 28 January 2019. It was also alleged that you inaccurately informed Ms Turfrey that you were allowed to hold medication keys for Stanley ward and that the support mechanisms put in place by the Trust were no longer required.

It was alleged that on 29 January 2019, you failed to provide full information to a Dr Harry Williams in relation to Patient D and inaccurately informed Ms Turfrey that the doctor had verbally authorised the administration of a stat dose of Lorazepam to Patient D. It was further alleged that on 29 March 2019, you signed/wrote for a prescription of Clozapine on Patient B's medicines administration record ('MAR') chart, and then administered the Clozapine to Patient B.

Disciplinary proceedings were conducted by the Trust in August 2019 in relation to your alleged medication errors and you were thereafter issued a written warning. You were not satisfied with the way you had allegedly been treated, and you commenced grievance proceedings which proceeded to stage three. At the conclusion of the grievance proceedings, you were requested to complete an action plan. However, you allegedly refused to complete the support/action plan put in place following the grievance process.

You were transferred from Stanley Ward to Crofton Ward on 19th August 2019 to allow a fresh start in a different environment. Crofton Ward is also an acute psychiatric ward, which catered for older patients with a range of health conditions. However, it was alleged that further concerns were raised about your proficiencies as a Band 5 nurse, whilst working on Crofton Ward in February 2020.

You were thereafter transferred by the Trust to the Intensive Home-Based Treatment Team (IHBTT) in April 2020. This was due to the Trust restriction on your nursing practice from administering medication and holding medication keys. It was alleged that you failed to inform the IHBTT management team and your colleagues about the medication administration restriction on your nursing practice. You were allegedly involved in another medication administration error in which you incorrectly supplied/dispensed Patient P's Pregabalin to Patient Q in August 2022.

You thereafter resigned from the Trust on 2 November 2022.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Kennedy under Rule 31 to admit the following into evidence:

1. Witness statement of Ms Debbie Wragg and its associated exhibits.
2. The local statement of Ms Kellie Bragger contained in her email dated 14 April 2020.
3. The local statement of Mr Jack Bushell contained in his email dated 14 April 2020.

Mr Kennedy referred the panel to Rule 31 and submitted that it is an established principle of law that a panel could admit hearsay evidence subject to the test of relevance and fairness. He informed the panel that the hearsay evidence of Ms Wragg was in relation to charge 16 in its entirety. He highlighted that given that charges 16a, 16b, 16c had been admitted, the contentious matter remains charge 16d in its entirety.

Mr Kennedy referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He stated that there are two paragraphs of the decision in that case, paragraph 45 and paragraph 56, which are of importance, in considering the admissibility of hearsay evidence. He highlighted that, in paragraph 45, the Court considered four relevant principles in relation to the admission of hearsay evidence. The first principle is that the admission of the hearsay evidence should not be regarded as a routine matter as the fitness to practise rules require the panel to consider the issue of fairness before admitting the evidence. The second principle is the fact that the absence of the witness can be reflected in the weight to be attached to the hearsay evidence which is a factor to be considered in the balance but will not always be a sufficient answer to the objection to admissibility. The third principle is the existence or otherwise of a good and cogent reason for the non-attendance of the witness. However, the absence of a good reason does not automatically result in the exclusion of the evidence. The fourth principle is where such evidence is the sole or decisive evidence in relation to the charges, the decision of whether or not to admit it requires a careful assessment weighing up the competing factors. Mr Kennedy stated that the panel must be

satisfied that the evidence is either demonstrably reliable or alternatively, that there will be some means of testing its reliability.

Mr Kennedy further highlighted that the case of *Thorneycroft* laid out the following factors to be considered in admitting hearsay evidence. Mr Kennedy proceeded to address each factor respectively:

i. Whether the statements were the sole or decisive evidence in support of the charges:

Mr Kennedy submitted that, with respect to charge 16d, the panel should consider that apart from the hearsay evidence of Ms Wragg, the respective local statements of Ms Bragger and Mr Bushell also support the charge. He acknowledged, however, that those local statements were also hearsay evidence as neither of their authors would be called as witnesses in this case. He therefore accepted that the evidence of Ms Wragg would be the sole or decisive evidence in relation to charge 16d. He nevertheless submitted that the respective statements of Ms Wragg, Ms Bragger and Mr Bushell would be admissible on the basis that they are relevant in this case.

ii. The nature and extent of the challenge to the contents of the statements:

Mr Kennedy stated that the panel would hear the submissions of Ms Molyneux in relation to the nature and extent of your challenge to the hearsay evidence.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Mr Kennedy submitted that there is no evidence to suggest that any of the authors of the hearsay evidence had fabricated their statements. He highlighted that you had accepted a substantial part of the evidence of Ms Wragg, Ms Bragger and Mr Bushell based on your admissions to charges 16a, 16b and 16c.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Mr Kennedy submitted that although charge 16d is serious, it only forms part of one of the twenty-one charges against you. He submitted that given the nature of the charges already admitted and other unadmitted charges, the panel may consider that it is unlikely that charge 16d would have a major impact on you if found proved, but this remains a matter to be decided by the panel.

v. Whether there was a good reason for the non-attendance of the witness:

Mr Kennedy submitted that although Ms Wragg had clearly signed her witness statement which contained a declaration of her willingness to attend this hearing as a witness, yet she has failed to attend the hearing and the NMC was not aware of any reason for her non-attendance.

vi. The regulator had taken reasonable steps to secure the witness's attendance:

Mr Kennedy referred the panel to the NMC Hearsay Bundle. He submitted that there had been a total of seventeen attempted contacts made by the NMC to Ms Wragg in order to secure her attendance at this hearing. He submitted that, from 5 September 2024 to 14 November 2024, the NMC had made unsuccessful attempts to contact Ms Wragg via numerous emails, letters and telephone calls. Mr Kennedy further stated that the NMC had also utilised the assistance of tracing agents to confirm the address of Ms Wragg. He accepted, however, that the NMC had not applied for a witness summons in order to compel the attendance of Ms Wragg. Mr Kennedy submitted that the NMC did not attempt to secure the attendance of Ms Bragger and Mr Bushell as they had not provided witness statements to the NMC.

vii. Whether the registrant had prior notice that the witness statement would be read:

Mr Kennedy submitted that the NMC had provided adequate notice to you and Ms Molyneux that a hearsay application would be made at this hearing.

In conclusion, Mr Kennedy submitted that, in determining the issue of fairness, the panel should consider not only your interest but also the interest of the NMC. He submitted that the NMC had taken all reasonable steps to secure the attendance of Ms Wragg and it would be fair to admit the respective statements of Ms Wragg, Ms Bragger and Mr Bushell into evidence.

With respect to the issue of the unsigned pages of the witness statement of Ms Wragg, Mr Kennedy explained that Ms Wragg had presumably only signed the front pages of her witness statement as it was double sided. He stated that Ms Wragg therefore signed pages one and three of the statement but not pages two and four, which were the reverse sides of the document.

Ms Molyneux highlighted that the NMC hearsay application involves three distinct hearsay statements with three separate authors. She submitted that the panel should not make a blanket decision covering the hearsay application, but each hearsay evidence should be considered separately.

Ms Molyneux submitted that, with respect to the hearsay evidence of Ms Bragger, the NMC had accepted that it had not made any attempt to secure the attendance of Ms Bragger or to obtain a witness statement from her. She submitted that this failure by the NMC was despite the fact that it has had the local statement of Ms Bragger as contained in her email dated 14 April 2020 for a number of years. Ms Molyneux submitted that it was therefore reasonable to conclude that there was no cogent reason for the non-attendance of Ms Bragger and that there were no reasonable steps taken by the NMC to secure her attendance. She submitted that the hearsay evidence of Ms Bragger forms part of the sole and decisive evidence of charge 16d as the culmination of the hearsay evidence of Ms Wragg, Ms Bragger and Mr Bushell respectively goes to the heart of the charge.

Ms Molyneux submitted that her submissions with respect to the hearsay evidence of Ms Bragger also applied to the hearsay evidence of Mr Bushell. She submitted that there had been no steps taken by the NMC to secure the attendance of Mr Bushell and there was no cogent reason for his non-attendance. She submitted that it would also be unfair to you if the hearsay evidence of Mr Bushell is admitted given that it highlighted allegations which had not been charged against you in this case.

Ms Molyneux submitted that, with respect to the hearsay evidence of Ms Wragg, although the NMC had taken some steps to secure her attendance, it should be noted that the earliest time that the NMC had made such attempts was in September 2024. She highlighted that Ms Wragg had signed her statement in September 2023, but the NMC did not take any reasonable step to secure her attendance for a period of one year from the date of her signature. Ms Molyneux submitted that it was therefore unsurprising that the NMC had not been able to contact Ms Wragg.

Ms Molyneux submitted that although the respective hearsay evidence of Ms Wragg, Ms Bragger and Mr Bushell is relevant to charge 16, it would be unfair to you if such hearsay evidence is admitted in this case. She submitted that this is because it is the sole and decisive evidence for charge 16. She asserted that the fact that there are three respective statements in support of charge 16 from Ms Wragg, Ms Bragger and Mr Bushell, does not imply that they do not constitute the sole and decisive evidence for charge 16. Ms Molyneux submitted that the hearsay principle was made to protect the balance of fairness in such situation where there is witness evidence against a registrant which is unchallengeable and untestable by the non-attendance of such witness. She submitted that this is the situation in this case. Ms Molyneux therefore invited the panel to reject the NMC hearsay application. She submitted if the panel is minded to admit the hearsay documents into evidence, the respective paragraphs in the witness statement of Ms Wragg that relates to charge 16d should be redacted.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far

as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the hearsay application.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the evidence of Ms Wragg is the sole or decisive evidence with respect to charge 16 in its entirety. It took into account that there is other evidence which had been presented by the NMC in support of charge 16 including the witness statement of Ms Diane Taylor and her relevant exhibits. It also noted that Ms Taylor is scheduled to attend the hearing to give oral evidence on the allegations. The panel further noted that the respective emails of Mr Bushell and Ms Bragger dated 14 April 2020, albeit hearsay evidence, also supports the allegations. You had also made admissions to charges 16a, 16b and 16c. The panel therefore decided that the evidence of Ms Wragg is not the sole or decisive evidence with respect to charge 16 in its entirety.

The panel noted that the NMC had notified you prior to this hearing that there would be a hearsay application with respect to the witness statement of Ms Wragg as well as its associated exhibits. The panel took into account that you had challenged the hearsay application of the NMC to admit these documents into evidence. However, the panel was satisfied that there was no suggestion that Ms Wragg had any reason to fabricate her evidence.

The panel considered the charges to be serious as any adverse finding could have a negative impact on your nursing career. The panel considered the submissions of Mr Kennedy that numerous attempts had been made by the NMC to contact Ms Wragg to attend the hearing but there has been no response from her. In this regard, the panel had sight of the NMC Hearsay Bundle which contained evidence of the steps taken by the NMC. Although there has been no reason provided for the non-attendance of Ms Wragg at

the hearing, the panel was satisfied that the NMC had taken all reasonable steps to attempt to secure the attendance of Ms Wragg.

The panel took into consideration that the local statement of Ms Wragg was made contemporaneously in the course of the Trust's investigation, and her local statement is consistent with her witness statement. Although the second and last page of Ms Wragg's witness statement was not signed by her, the panel could attach what it deems appropriate weight once it had heard and evaluated all the evidence.

The panel acknowledges the extent to which you will be able to effectively challenge the evidence of Ms Wragg is clearly lessened, as you will not be able to cross-examine her. The panel was of the view that you can however, question Ms Taylor about the fairness of the investigation process and the allegations. You will also be able to provide evidence of your own explanation of these events which in the context of this case are likely to be of considerable significance. It will then be a matter for the panel to compare and evaluate the evidence from the NMC and you and attach any weight it may deem fit.

Having considered these factors, the panel determined that it is relevant and fair to admit the witness statement of Ms Wragg and its associated exhibits into evidence.

In relation to the local statements of Mr Bushell and Ms Bragger contained in their respective emails dated 14 April 2020, the panel took into account that there is other evidence which had been presented by the NMC in support of charge 16 including the witness statement of Ms Taylor and its relevant exhibits. It also noted that Ms Taylor is scheduled to attend the hearing to give oral evidence on the allegations. You had also made admissions to charges 16a, 16b and 16c. The panel therefore decided that the evidence of Mr Bushell and Ms Bragger is not the sole or decisive evidence with respect to charge 16 in its entirety.

The panel noted that the NMC had notified you prior to this hearing that there would be a hearsay application with respect to the local statements of Mr Bushell and Ms Bragger as

well as its associated exhibits. The panel took into account that you had challenged the hearsay application of the NMC to admit these documents into evidence. However, the panel was satisfied that there was no suggestion that Mr Bushell and Ms Bragger had any reason to fabricate their evidence.

The panel considered the charges to be serious as any adverse finding could have a negative impact on your nursing career. The panel noted that there was no explanation provided by the NMC for the non-attendance of Mr Bushell and Ms Bragger nor was there any evidence provided to demonstrate any reasonable steps taken by the NMC to secure their attendance at the hearing.

The panel took into consideration that the respective local statements of Mr Bushell and Ms Bragger were made contemporaneously in the course of the Trust's investigation into the allegations. The panel noted that the respective local statements of Mr Bushell and Ms Bragger are consistent with each other, and they are also consistent with the local statement of Ms Wragg.

The panel acknowledges the extent to which you will be able to effectively challenge the respective evidence of Mr Bushell and Ms Bragger is clearly lessened, as you will not be able to cross-examine them. The panel was of the view that you can, however, question Ms Taylor about the fairness of the investigation process and the allegations. You will also be able to provide evidence of your own explanation of these events which in the context of this case are likely to be of considerable significance. It will then be a matter for the panel to compare and evaluate the evidence from the NMC and you and attach appropriate weight to it.

Having considered these factors, the panel determined that it is relevant and fair to admit the local statements of Mr Bushell and Ms Bragger contained in their respective emails dated 14 April 2020, into evidence.

Decision and reasons on application to oppose the admission of the document *'Clinical supervision with Dawn Ellerby 14th December 2018 Plus additional information'* into evidence

The panel requested and received a number of documents from the Trust which had been used in its investigation process into the alleged concerns against you. However, Ms Molyneux opposed the admission of the document *'Clinical supervision with Dawn Ellerby 14th December 2018 Plus additional information'* (the Supervision Document) into evidence.

Ms Molyneux submitted that the Supervision Document was a hearsay document which is generally not admissible in evidence. She asserted that hearsay evidence can only be admissible if it passes the test of relevance and fairness. She submitted that it was not sufficient for the panel to only determine that it would attach any relevant weight to the hearsay evidence for it to be admissible.

Ms Molyneux submitted that you accept that the Supervision Document was clearly relevant to this case as it purports to show a supervision session between the Trust and you. She however asserted that it would be unfair if the Supervision Document were to be admitted into evidence. She highlighted that the Supervision Document was unauthored, unsigned and undated. She stated that although the Supervision Document mentions a date of 14 December 2018, it could have been written at any time after that date or even last week. She submitted that there was no evidence to suggest that the date of 14 December 2018 was accurate.

Ms Molyneux submitted that given that the author of the Supervision Document was unknown, you were therefore deprived of the opportunity to question the authenticity and content of the document and conduct any cross-examination on the myriads of issues raised in the document. She submitted that you totally reject the contents of the document as it contains prejudicial information against you however you have no opportunity to challenge it.

In conclusion, Ms Molyneux invited the panel to not admit the Supervision Document into evidence as it would amount to gross unfairness and prejudice to you if the Supervision Document was admitted into evidence.

Mr Kennedy highlighted that the Supervision Document was disclosed by the Trust at the direction of the panel. He stated that the disclosure became necessary because the panel had heard it put in terms to witnesses that only one supervision took place. Therefore, having examined the chronology and the appendices to the Trust Investigation Report dated March 2020, it appeared to the panel that there may have been other supervision sessions conducted by the Trust with you.

Mr Kennedy submitted that the Supervision Document, on the face of it, suggests that there was a clinical supervision that took place with you on 14 December 2018. He submitted that this potentially casts into doubt the assertion that there was only one supervision conducted by Mr Peter Phiri. Mr Kennedy submitted that the Supervision Document was thus clearly relevant to this case.

In relation to the issue of fairness, Mr Kennedy submitted that although the Supervision Document was neither signed nor dated, it should be noted that the document was a record of a supervision conducted by the Trust with you on 14 December 2018. He submitted that it was therefore fair for it to be admitted into evidence.

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

The panel first considered whether the Supervision Document was relevant to this case. The panel took into account that the Supervision Document formed part of the chronology of documents utilised by the Trust in its investigation into the alleged concerns against you. The panel noted that although the Supervision Document did not itself raise any specific allegation as contained in the charges, it provides detailed context into the relationship between you and the Trust as well as providing purported evidence to the

NMC's position that the Trust had conducted supervisory meetings with you. The panel therefore determined that the Supervision Document was relevant to this case.

The panel next considered whether admitting the Supervision Document would pose any unfairness to you. The panel took into account that the Supervision Document was unauthored, unsigned and undated. It noted that this posed a challenge to you as given its unauthored and unsigned nature, you were deprived of the opportunity to question its authenticity and to conduct any cross-examination as to its contents.

The panel further noted the submission of Ms Molyneux that this raises the possibility that the Supervision Document may have been fabricated. The panel took into account that the Supervision Document formed part of the chronology of documents utilised by the Trust in its investigation into the alleged concerns against you. In this regard, the panel had sight of the Trust Investigation Report dated March 2020. It further noted that the Supervision Document was disclosed by the Trust on the request by the panel. Therefore, the panel was satisfied that the Supervision Document formed part of the official records of the Trust Investigation. The panel determined that there was insufficient evidence to indicate that the Supervision Document was fabricated.

The panel noted that in considering the issue of fairness, there ought to be a balance of interests between the NMC and you. The panel considered that the Supervision Document provides evidence to the NMC's position that the Trust had conducted supervisory meetings with you. The panel considered that it was consistent with the evidence of Ms Turfrey and Ms Toni Burns respectively. It therefore does not constitute the sole or decisive evidence in this case. The panel was of the view that this mitigates any unfairness which may be posed to you as it is a matter for the panel to compare evidence from the NMC and you and attach any weight it may deem fit. Accordingly, the panel determined that it was relevant and fair to admit the Supervision Document into evidence.

Decision and reasons on application of no case to answer

At the conclusion of the NMC's case, the panel considered an application from Ms Molyneux that there was no case to answer in respect of charges 4b, 8a, 8e, 9b (ii), 16d (i), 16d (ii), 16d (iii) and 20. This application was made under Rule 24(7).

Ms Molyneux referred the panel to the test set out in the case of *R v Galbraith* [1981] 1 WLR 1039. She submitted that charges 4b and 9b (ii) fall under limb 1 of the test while charges 8a, 8e, 16d and 20 fall under limb 2 of the test.

With respect to charge 4b, Ms Molyneux submitted that a cursory examination of the evidence of Ms Abbie McHugh and the Medication Card of Patient C demonstrates that there was no evidence that you attempted to administer paracetamol to Patient C. She submitted that you did not complete the entry on the medication card of Patient C, neither did you retrieve the medication, nor did you approach Patient C to administer paracetamol. Ms Molyneux therefore concluded that there was no evidence to support charge 4b and there was no case to answer with respect to this charge.

In relation to charge 9b (ii), Ms Molyneux submitted that although Ms Turfrey had stated in her evidence that you had behaved aggressively towards her and you had raised your voice, she never stated in her evidence that you had pointed your finger at her. Ms Molyneux therefore asserted that there was no evidence to support charge 9b (ii) and there was no case to answer with respect to this charge.

With regard to charge 8a, Ms Molyneux submitted that the evidence of Mrs Lindsey Headley (nee Edmondson) contradicts the evidence of Ms Burns. She highlighted that Mrs Headley (nee Edmondson) had stated in her evidence that you had told her that you did not know how to deactivate the ward alarms, however, Ms Burns stated in her evidence that you had explained to her that although you had previously deactivated the ward alarms you would simply like to be shown again.

Ms Molyneux submitted that the evidence demonstrated that you had some knowledge in deactivating the ward alarms and you only wanted the process to be shown to you once more. She therefore asserted that the NMC evidence was contradictory and there was no case to answer with respect to charge 8a.

In relation to charge 8e, Ms Molyneux submitted that a failure implies that there was a positive duty to be performed but which was not done. She submitted that to demonstrate that there was a positive duty, there would have to be a policy or there would have to be firm evidence that there were an expectation and a requirement that a registrant act in a certain way, and that they have fallen short of that requirement. Ms Molyneux submitted that the panel had heard during evidence that it was the admission nurse's responsibility to complete the mental health care plan for Patient H and that it was not necessarily the responsibility of the named nurse to complete it. She stated that it could be that the named nurse was not even on shift when the patient was admitted, so therefore there cannot be said to have been a failure.

Ms Molyneux submitted that, in this case, there was no evidence of the timeline in which Patient H was admitted or the identity of the admission nurse. She stated that there was also no evidence of any Trust policy that stated that it was the duty of the named nurse to complete the care plans. Ms Molyneux asserted that there was therefore no evidence that it was your responsibility as the named nurse to have completed the mental health care plan. She submitted that both Mrs Headley (nee Edmondson) and Ms Burns accepted that the fact that you were the named nurse, did not necessarily mean that it was your responsibility to complete the mental health care plan for Patient H. Ms Molyneux concluded that the evidence is so weak that, consequently, there is no case to answer with respect to charge 8e.

With respect to charge 16d in its entirety, Ms Molyneux highlighted that the evidence supporting this charge was hearsay evidence. She submitted that the hearsay evidence was untested and therefore very little weight should be attached to it. She submitted that the hearsay evidence was in direct conflict with the Datix for Patient F and the Medical

Records for Patient F dated 11-13 April 2020. She highlighted that the Datix for Patient F, which was written on the day in question, shows that neurological observations were done, that there was a check for injuries and that the duty doctor was contacted. This was also supported by Patient F's medical records.

Ms Molyneux submitted that the panel had heard evidence that Patient F may have been on the floor for some time, so this could be the reason that the care assistants did not see those observations being done. She however submitted that this could not be ascertained given that Ms Wragg, Ms Bragger and Mr Bushell did not provide a witness statement, nor have they attended these proceedings as witnesses. Ms Molyneux concluded that the hearsay evidence was inconsistent with the documentary evidence for this charge, therefore there was no case to answer with respect to charge 16d in its entirety.

In relation to charge 20, Ms Molyneux referred the panel to the Letter from the Trust dated 8 April 2019, she submitted that the restrictions imposed on your practice was '*you will be required to refrain from giving medications or holding the medication keys with immediate effect*.' Ms Molyneux submitted that this restriction was further confirmed in the Letter from the Trust following Stage 3 Grievance hearing held on 19 December 2019 which confirmed the wording of the restriction as '*to refrain from giving medication, from administering it and from holding the medication keys*.'

Ms Molyneux submitted that although Mr Colin Hill had stated during his oral evidence that there was no practical difference in dispensing or administering medications, he eventually accepted that administering medication was different from dispensing medication. Ms Molyneux submitted that your conduct in merely dispensing medication does not amount to acting outside the scope of your competence as you were only restricted from administering medication or holding medication keys. She asserted that charge 20 was therefore faulty and incorrect. She submitted that the evidence supporting this charge was therefore weak, tenuous and inconsistent. She concluded that there was no case to answer in relation to charge 20.

Mr Kennedy stated that he agreed with the position of Ms Molyneux that there was no case to answer with respect to charges 4b and 9b (ii), under limb 1 of the *Galbraith* test. He submitted that although he accepted that there was no case to answer in relation to charge 20, it would fall under limb 1 of the *Galbraith* test rather than limb 2.

With respect to charge 8a, Mr Kennedy submitted that there was direct evidence of Mrs Headley (nee Edmondson) that you had told her that you did not know how to deactivate ward alarms on two occasions. He highlighted that this was despite the fact that Mrs Headley (nee Edmondson) had shown you how to deactivate the ward alarms on the second occasion. Mr Kennedy asserted that the evidence of Ms Burns was not contradictory in any shape or form as it rather supports the evidence of Mrs Headley (nee Edmondson). He stated that although you denied the allegation and insisted that you did turn off the alarm, this is a question of fact to be decided by the panel at a later stage. He submitted that your assertion that you only wanted to be shown once more on how to deactivate the ward alarms, further lends credence to the evidence of Mrs Headley (nee Edmondson). Mr Kennedy concluded that there was therefore sufficient evidence to support charge 8a.

In relation to charge 8e, Mr Kennedy submitted that the evidence of Mrs Headley (nee Edmondson) was that all patients should have a co-produced person-centred mental health care plan and it was usually done by the named nurse, where possible. He submitted that you were directed to perform a task by a senior nurse, therefore, you had a duty to perform that task. Mr Kennedy highlighted that Mrs Headley (nee Edmondson) confirmed in her evidence that you failed to complete the mental health care plan as directed, therefore there was a failure on your part to perform that duty. He concluded that there was therefore sufficient evidence to support charge 8e.

With regard to charge 16, Mr Kennedy highlighted that the panel had admitted the respective hearsay statements of Ms Wragg, Ms Bragger and Mr Bushell into evidence. He asserted that their respective statements were clear and consistent with each other. He submitted that there was therefore sufficient evidence to support charge 16. Mr

Kennedy submitted that the fact that you completed the Datix for Patient F's fall does not necessarily imply that you had conducted the required checks on Patient F or contacted the doctor. He highlighted that the Datix showed that Patient F's fall occurred at 10:15 and the duty doctor arrived at 10:30. However, it should be noted that the doctor's record of neurological observations timed at 11:15, which contains a record of neurological observations, precedes the entry made by you at 13:51, which only refers to a handover of physical observations.

In conclusion, Mr Kennedy submitted that there was sufficient evidence and a case to answer with respect to charges 8a, 8e and 16d.

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

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved in relation to charges 4b, 8a, 8e, 9b (ii), 16d (i), 16d (ii), 16d (iii) and 20, and whether you had a case to answer in this regard.

The panel had regard to the test set out in the case of *R v Galbraith.* In *Galbraith*, Lord Lane set out the following test:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> > *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly*

convict upon it, it is his duty, upon a submission being made, to stop the case.

(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses' reliability or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury…There will of course as always in this branch of the law be borderline cases. They can safely be left to the discretion of the judge.'

Charge 4b

4. On 22 January 2019;
    b) Attempted to administer an unprescribed dose of paracetamol to Patient C.

The panel considered the submission of Ms Molyneux that there is no evidence to support this charge, under limb 1 of the *Galbraith* test. The panel took into account that Mr Kennedy did not oppose the submission of Ms Molyneux with respect to this charge.

The panel carefully considered the case before it and concluded that there was no evidence to support this charge. The panel therefore determined that there is no case to answer in relation to charge 4b.

Charge 8a

8) On or around 1 February 2020 whilst working on Crofton Ward;
    a) Did not know how to deactivate the ward alarms.

The panel took into account the oral evidence and witness statements of Mrs Headley (nee Edmondson) and Ms Burns. The panel was of the view that their evidence was clear and consistent with each other and not contradictory. The panel was therefore satisfied that the evidence with respect to this charge, when taken at its highest, could lead to the charge being proved. It therefore concluded that there was a case to answer in relation to this charge. The panel would attach any weight it deems fit to the evidence with respect to this charge, at the facts finding stage.

Charge 8e

8) On or around 1 February 2020 whilst working on Crofton Ward;
   e) Failed to complete a Mental Health Care Plan for Patient H.

The panel considered the oral and documentary evidence with respect to this charge. The panel took into account that Mrs Headley (nee Edmondson) stated that she had directed you to complete a mental health care plan for Patient H and that you told her that you did not know how to do it.

However, the panel noted that there was insufficient evidence before it to suggest that it was your duty to have completed the mental health care plan for Patient H before you were directed by Mrs Headley (nee Edmondson) to complete it. There was also insufficient evidence to indicate that you did not complete the mental health care plan for Patient H. Having carefully considered the evidence with respect to charge 8e, the panel concluded that the evidence was so tenuous that a properly directed panel could not find the facts of charge 8e proved. The panel therefore determined there was no case to answer with respect to charge 8e.

Charge 9b (ii)

9) On 28 January 2019;
   b) Behaved aggressively towards Colleague Y [Katrina Turfrey], in that you:

ii) Pointed your finger at Colleague Y [Katrina Turfrey]

The panel considered the submission of Ms Molyneux that there was no evidence to support this charge, under limb 1 of the *Galbraith* test. The panel took into account that Mr Kennedy did not oppose the submission of Ms Molyneux with respect to this charge.

The panel carefully considered the case before it and concluded that there was no evidence to support this charge. The panel therefore determined that there is no case to answer in relation to charge 9b (ii).

Charges 16d (i) (ii) (iii)

16) On or around 12 April 2020, whilst restricted from holding medication keys and administering medication;

d) Following Patient F suffering an unwitnessed fall

i) Did not carry out any neurological observations of Patient F.

ii) Did not check Patient F for any injuries.

iii) Did not call the duty doctor

The panel bore in mind that it had earlier admitted the hearsay statements of Ms Wragg, Ms Bragger and Mr Bushell respectively into evidence. The panel was of the view that their evidence was clear and consistent with each other. Although there was contradictory evidence which indicates that you had completed the Datix for Patient F, the panel was of the view that this does not necessarily mean that you had carried out neurological observations, checked Patient F for any injuries or called the duty doctor.

The panel was therefore satisfied that the evidence with respect to these charges, when taken at its highest, could lead to the charges being proved. It therefore concluded that there is a case to answer in relation to these charges. The panel would attach any weight it deems fit to the evidence with respect to these charges, at the facts finding stage.

Charge 20

20) Your actions in on or more of charges 19 a), 19 b), 19 c), 19 d) i), 19 d) ii), 19) d) iii) & 19 e) were outside the scope of your competence, in that you were supplying/retrieving/managing medication whilst subject to local restrictions/not deemed safe to do so.

The panel considered the submission of Ms Molyneux that there was no case to answer with respect to this charge under limb 2 of the *Galbraith* test, on the basis that the evidence was weak and inconsistent. The panel also considered Ms Molyneux's assertion that the charge itself was inchoate based on the Letter from the Trust dated 8 April 2019 which outlined that you were only restricted from giving/administering medications or holding the medication keys but not from handling or delivering them.

The panel also considered the submission of Mr Kennedy that he agreed that there was no case to answer in relation to charge 20 but this should be under limb 1 of the *Galbraith* test.

The panel took into account that both Mrs Shelley Seward (nee Drake) and Mr Hill, in their respective oral evidence, stated that it was the duty of the registered nurse to notify their colleagues and employers of any restrictions on their nursing practice. The panel also noted that Mrs Seward (nee Drake) had stated in the Trust Investigation Interview dated 2 December 2022 that only qualified nurses who are competent, could supply controlled drugs to service users.

The panel also heard oral evidence from Mr Hill and Mr Mick Oldhan that medication administration encompasses the process of retrieving, checking and signing out medication from the controlled drug store, as well as delivery of medication to the patient. The panel had sight of the IHBTT Offer Letter from the Trust dated 25 January 2021, which further confirmed that you were restricted from medication administration whilst working as a bank nurse.

The panel therefore concluded that there was sufficient evidence, which was not inherently weak or tenuous, that when taken at its highest, could result in this charge being found proved. It therefore concluded that there was a case to answer in relation to charge 20. The panel would attach any weight it deems fit to the evidence with respect to this charge, at the facts finding stage.

Decision and reasons on facts

At the outset of the hearing, Ms Molyneux informed the panel that you made full admissions to charges 1, 2, 3, 4a, 5, 6, 7, 8b, 8f, 8g (i), 8g (ii), 8h (iv), 13a, 14a, 14b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d, 19b, 19d (i), 19d (ii), 19d (iii), 19e and 21.

The panel therefore finds charges 1, 2, 3, 4a, 5, 6, 7, 8b, 8f, 8g(i), 8g(ii), 8h(iv), 13a, 14a, 14b, 15c, 15d, 16a, 16b, 16c, 17a, 17b, 17c, 17d, 19b, 19d (i), 19d (ii), 19d (iii), 19e and 21 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy and those made by Ms Molyneux.

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:

- Peter Phiri: Ward Manager on Stanley Ward at the time of the incidents.

- Abbie McHugh: Staff Nurse on Stanley Ward at the time of the incidents.
- James Jackson: Deputy Ward Manager on Stanley Ward at the time of the incidents.
- Dr Harry Williams: Duty Doctor on Stanley Ward at the time of the incidents.
- Ronilyn Gange: Senior Mental Health Practitioner at IHBTT at the time of the incidents.
- Lindsey Headley (nee Edmondson): Clinical Team Leader on Crofton Ward at the time of the incidents.
- Katrina Turfrey: Deputy Ward Manager on Stanley Ward at the time of the incidents.
- Toni Burns: Ward manager on Crofton Ward at the time of the incidents.
- Mick Oldhan: Service Manager at IHBTT at the time of the incidents.
- Colin Hill: Specialist Advisor for Staffing at the Trust at the time of the incidents.
- Shelley Seward (nee Drake): Clinical Lead for the Intensive Crisis Team at the time of the incidents.

The panel also heard evidence from you under affirmation.

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

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

Charge 8a

8) On or around 1 February 2020 whilst working on Crofton Ward;
   a) Did not know how to deactivate the ward alarms.

This charge is found proved.

The panel took account of the Statement of Concerns on Shift 1 February 2020 made by Mrs Headley (nee Edmondson). In this statement, Mrs Headley (nee Edmondson) stated that, whilst on a shift on 1 February 2020, bedroom alarms were going off, but you told her that you did not know how to turn them off. Mrs Headley (nee Edmondson) demonstrated to you how to turn them off by turning them off herself. Mrs Headley (nee Edmondson) further stated that, after she had left you, another bedroom alarm went off but she had to turn it off herself as you stated that you did not know how to turn it off.

The panel took into consideration that in the File Note dated 7 February 2020, Ms Burns stated that when she asked you whether it was correct that you did not know how to deactivate the ward alarm system, you stated that you had deactivated the alarms, but you would like to be shown how to do it again.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you knew how to deactivate the ward alarms, but you could not recall on how to deactivate bed alarms.

The panel noted that you had made a distinction between ward alarms and bed alarms. The panel considered that both words had been used interchangeably by both Mrs Headley (nee Edmondson) and Ms Burns during their respective oral evidence. Furthermore, the panel noted that Ms Burns had directly asked you about the ward alarm system during her discussion of the concerns with you on 7 February 2020 but there was no distinction made between ward alarms and bed alarms at that time. The panel noted that the File Note was recorded contemporaneously to that discussion. In this regard, the panel decided to consider ward alarms as encompassing all alarms on the ward including bed alarms.

The panel considered the evidence in this charge. It was of the view that Mrs Headley (nee Edmondson) and Ms Burns were both clear and consistent in their oral and documentary evidence that you did not know how to turn off ward alarms. The panel therefore accepted their accounts of the incident. The panel was of the view that your conduct in not deactivating the alarms twice, while on a shift with Mrs Headley (nee Edmondson) on 1 February 2020, despite being shown on how to deactivate them by Mrs Headley (nee Edmondson), demonstrated that you did not know how to turn off the ward alarms. This was despite the fact that you had been on the ward for six months. The panel further noted that your conversation with Ms Burns occurred six days after Mrs Headley (nee Edmondson) had shown you how to deactivate the ward alarms, but you still insisted that you would like to be shown again.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on or around 1 February 2020, you did not know how to deactivate the ward alarms whilst working on Crofton Ward. It therefore found charge 8a proved on the balance of probabilities.

Charge 8c

8) On or around 1 February 2020 whilst working on Crofton Ward;

c) Left Patient F who required personal care/assistance at the end of their bed whilst you went and had breakfast/toast.

This charge is found proved.

The panel took account of the Statement of Concerns on Shift 1 February 2020 made by Mrs Headley (nee Edmondson). In this statement, Mrs Headley (nee Edmondson) stated that, whilst on a shift on 1 February 2020, you had told her that you could not get Patient F off the bed, but Mrs Headley (nee Edmondson) explained to you that Patient F did not require any moving and handling. She stated that Patient F could be assisted and prompted to complete his personal care per his care plan. However, when Mrs Headley (nee Edmondson) left and returned to Patient F's room, a care assistant told her that you had left Patient F at the end of his bed on the lowest setting. Mrs Headley (nee Edmondson) stated that she saw that Patient F

'…*was left sat on the edge of his bed, not able to get up while Dawn was sat in the dining room eating her breakfast.'*

The panel took into consideration that this concern was raised with you during your discussion with Ms Burns on 7 February 2020 as contained in the File Note, but you denied the allegation and stated that you struggled in assisting the patient on your own. Ms Burns then advised you that if patients still required assistance, then this would not have been an appropriate time for you to have breakfast.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that Patient F required assistance with personal care and this involved moving and handling and that you had never undertaken this training. You stated that you requested assistance from a care assistant and then went to the dining room to support other patients to eat breakfast. You stated that staff members were allowed to eat breakfast with patients.

The panel noted that the name of Patient F was not properly redacted in the Statement of Concerns on Shift 1 February 2020, however, the panel was satisfied that the initials used in that document correlates with Patient F in the NMC Joint Schedule of Anonymity.

The panel considered the evidence in this charge. It noted that the Statement of Concerns on Shift 1 February 2020 was made contemporaneously to the date of the incident by Mrs Headley (nee Edmondson). The panel was of the view that Mrs Headley (nee Edmondson) and Ms Burns were both clear and consistent in their oral and documentary evidence in relation to the incident. The panel noted that the evidence of the care assistant was hearsay however it was consistent with the evidence of Mrs Headley (nee Edmondson) that she saw Patient F sat on the edge of his bed whilst you were having breakfast. The panel therefore accepted Mrs Headley (nee Edmondson)'s account of the incident and it did not consider it relevant that the incident was not investigated locally.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on or around 1 February 2020, whilst working on Crofton Ward, you left Patient F who required personal care/assistance at the end of their bed whilst you went and had breakfast/toast. It therefore found charge 8c proved on the balance of probabilities.

Charge 8d

8) On or around 1 February 2020 whilst working on Crofton Ward;
   d) Did not assist colleagues with Patient H's personal care requirements

This charge is found proved.

The panel took account of the Statement of Concerns on Shift 1 February 2020 made by Mrs Headley (nee Edmondson). In this statement, Mrs Headley (nee Edmondson) stated that, whilst on a shift on 1 February 2020, she saw through Patient H's bedroom shutter that, only two staff members were completing Patient H's personal care and you were sitting in the bedroom chair watching them. Mrs Headley (nee Edmondson) stated that you

told her that you could not do moving and handling and therefore you could not assist. However, Mrs Headley (nee Edmondson) noted that whilst Patient H required two staff for moving and handling, only one staff member was required for personal care which did not involve moving and handling and this could be completed at the same time.

The panel took into consideration that when this concern was raised with you during your discussion with Ms Burns on 7 February 2020, as contained in the File Note, you told her that you were not yet trained in moving and handling. Ms Burns further stated in the File Note that:

> '*Dawn stated that she has assisted with some personal cares* (sic) *and gave an example but stated that she had done some observing as this is new to her. I explained to Dawn that she has now worked on this Ward for 6 months and I expect her have reached this level of competency and participate in this task*.'

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that Patient H's personal care requirements involved an element of moving and handling, but you were not trained in moving and handling. You only completed personal care tasks which did not involve moving and handling as you prioritise the safety of your patients.

The panel considered the evidence in this charge. It noted that the Statement of Concerns on Shift 1 February 2020 was made contemporaneously to the date of the incident by Mrs Headley (nee Edmondson). The panel was of the view that Mrs Headley (nee Edmondson) and Ms Burns were both clear and consistent in their oral and documentary evidence in relation to the incident. The panel rejected your explanation that Patient H's personal care required moving and handling as it was satisfied that personal care tasks do not always involve moving and handling. With respect to this patient, the moving and handling requirements of the care were being undertaken by the other two staff members

present. The panel therefore accepted Ms Burns' account of the incident and rejected your account.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on or around 1 February 2020, whilst working on Crofton Ward, you did not assist colleagues with Patient H's personal care requirements. It therefore found charge 8d proved on the balance of probabilities.

Charges 8h (i), 8h (ii), 8h (iii)

8) On or around 1 February 2020 whilst working on Crofton Ward;
    h) During level 2 observations for Patient G/After Patient G had slid onto the floor
        i) Did not assist Patient G.
        ii) Did not call for assistance/pull.
        iii) Continued to eat food.

These charges are found proved.

The panel took account of the Statement of Concerns on Shift 1 February 2020 made by Mrs Headley (nee Edmondson). In this statement, Mrs Headley (nee Edmondson) stated that, whilst you were on level two observations for Patient G, Patient G slid onto the floor from his chair however you remained sat on your chair, eating your food. This occurred when Mrs Headley (nee Edmondson) had gone into the lounge to assess how best to give Patient G his medication. Mrs Headley (nee Edmondson) stated that you told her that you could not lift Patient G from the floor, a conversation that you accept took place, as you were not trained in moving and handling.

The panel took into consideration that when this concern was raised with you during your discussion with Ms Burns on 7 February 2020, as contained in the File Note, you denied

the allegation in part. Ms Burns stated that you told her that you requested assistance from other staff members at that time. Ms Burns further stated in the File Note that:

> '*I spoke with Dawn about the inappropriateness of eating whilst on the level of observation and that in future she must not allow herself to be distracted in anyway during this task. Dawn agreed and apologised for this.*'

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you requested assistance from other staff members at that time. You further asserted that although a colleague had brought a sandwich for you as you had missed lunch. You put the sandwich to one side and did not eat it in front of Patient G despite waiting twenty minutes for staff to come to your assistance.

In considering the evidence, the panel noted that the Statement of Concerns on Shift 1 February 2020 was made contemporaneously to the date of the incident by Mrs Headley (nee Edmondson). The panel was of the view that Mrs Headley (nee Edmondson) and Ms Burns were both clear and consistent in their oral and documentary evidence in relation to the incident. It noted that Mrs Headley (nee Edmondson) was so concerned about the incidents and other issues involving your practice that she reported the issues to a Freedom to Speak Up Guardian in an email dated 15 February 2020.

The panel took into account that Mrs Headley (nee Edmondson) had stated during her oral evidence that there were other ways you could have assisted Patient G such as providing reassurance to him or prompting him to get up, rather than merely sitting opposite him and eating your food. The panel also considered that if you had requested for assistance as you claimed, Mrs Headley (nee Edmondson) would have been aware of the incident and would not have gone to assess Patient G for his medication. Furthermore, you did not inform her that you had already requested for assistance from other staff members. The panel also noted that your assertion that you would not eat in front of a patient was inconsistent with your evidence that staff members were allowed to eat with patients.

In conclusion, the panel accepted Mrs Headley (nee Edmondson)'s account of the incident and rejected your account. Accordingly, based on the evidence before it, the panel found charges 8h (i), 8h (ii), 8h (iii) proved on the balance of probabilities.

Charge 9a

9) On 28 January 2019;
   a) Requested Colleague Y [Katrina Turfrey] sign off your Medicines with respect to documentation in one shift.

This charge is found proved.

The panel took account of the Statement of Events dated 28 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested for a chat with her, you demanded that she signed you off Medicines with Respect immediately to enable you to undertake bank shifts. She told you that she could not sign you off as you would need to be continually assessed over a period of weeks. Ms Turfrey stated that you became angry and aggressive following her response.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that although you could not clearly recall the conversation with Ms Turfrey, you knew from your previous workplace that it was possible to complete Medicines with Respect in a twelve-hour shift. You further stated that you later completed Medicines with Respect with Mrs Headley (nee Edmondson) and Ms Burns in one shift respectively.

The panel took into consideration that when asked whose signature was it below her signature on the Managerial Supervision document dated 22 January 2019, Ms Turfrey stated during her oral evidence that it was your signature as you had signed that document in her presence. However, the panel heard evidence from Mr Phiri that the

disputed signature was his signature as he had countersigned the document when you had refused to sign the document.

The panel considered that Ms Turfrey was wrong about the disputed signature. Nevertheless, it was of the view that Ms Turfrey was clear and consistent in other aspects of her evidence. The panel noted that the Statement of Events dated 28 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey and her oral evidence in relation to charge 9a was consistent with this document. The panel was therefore satisfied that Ms Turfrey's error in relation to the signature on the Managerial Supervision document dated 22 January 2019 did not undermine her overall credibility and reliability of her evidence relating to this charge. The panel therefore accepted Ms Turfrey's account of the incident and rejected your account.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 28 January 2019, you had requested Ms Turfrey to sign off your Medicines with respect to documentation in one shift. It therefore found charge 9a proved on the balance of probabilities.

Charge 9b (i)

9) On 28 January 2019;
    b) Behaved aggressively towards Colleague Y [Katrina Turfrey], in that you
        i) Shouted/raised your voice at Colleague Y [Katrina Turfrey]

This charge is found proved.

The panel took account of the Statement of Events dated 28 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested a chat with her, you told her that you were not happy with her email in relation to a supportive medication plan. Ms Turfrey stated that you raised your voice against her in an extremely passive aggressive manner which made another staff member to knock on the office door. She

further stated that other staff members checked with her about the incident after overhearing the conversation.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that although you were upset about Ms Turfrey's email, you did not raise your voice or shout at her as you only queried her about her email.

The panel noted that the Statement of Events dated 28 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that Ms Turfrey was clear and consistent in her oral and documentary evidence in relation to the incident. The panel considered that you were not pleased with the medication/support plan and had expressed your frustration to Ms Turfrey by raising your voice. The panel also heard evidence from Ms Burns and other witnesses that you tend to raise your voice when you disagreed with a staff member. The panel therefore accepted Ms Turfrey's account of the incident and rejected your account.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 28 January 2019, you behaved aggressively towards Ms Turfrey, in that you shouted/raised your voice at Ms Turfrey. It therefore found charge 9b (i) proved on the balance of probabilities.

Charges 9c and 9d

9) On 28 January 2019;
   c) Inaccurately informed Colleague Y [Katrina Turfrey] that you were allowed to hold medication keys for Stanley Ward.
   d) Demanded access to the medication keys for the Stanley Ward.

These charges are found proved.

The panel took account of the Statement of Events dated 28 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested a chat with her, you told her that following your conversation with Mr Phiri on 24 January 2019, you were allowed to hold medication keys for Stanley Ward and you therefore demanded access to the medication keys. Ms Turfrey stated that she refused your request and referred you to the Trust emails outlining the medication/support plan for you.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you went to work on that day expecting to complete Medicines with Respect as you were aware that you could only hold the medication keys after its completion.

The panel noted that the Statement of Events dated 28 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that Ms Turfrey was clear and consistent in her oral and documentary evidence in relation to the incident. The panel considered that you were not happy about the medication/support plan and the restrictions on your practice, and you had expressed your frustration to Ms Turfrey. It noted that Ms Turfrey had stated during her oral evidence that she sent an email to Mr Phiri to verify your assertion that you were allowed to hold medication keys. Although this email was not provided to the panel, Mr Phiri confirmed during his oral evidence to the panel that he never had any conversation with you that indicated that you were allowed to hold medication keys. The panel therefore accepted Ms Turfrey's account of the incident and rejected your account.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 28 January 2019, you inaccurately informed Ms Turfrey that you were allowed to hold medication keys for Stanley Ward and demanded access to them. It therefore found charge 9c and 9d proved on the balance of probabilities.

Charge 9e

9) On 28 January 2019;

e) Inaccurately informed Colleague Y [Katrina Turfrey] that the action plan/support plan/preceptorship programme were no longer needed.

This charge is found proved.

The panel took account of the Statement of Events dated 28 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested a chat with her, you told her that following your conversation with Mr Phiri on 24 January 2019, you were allowed to hold medication keys for Stanley Ward and that the support plan/preceptorship programme was no longer needed. Ms Turfrey stated that when she asked you whether Mr Phiri had put this in writing, you did not respond to her. Ms Turfrey then refused your request and referred you to the Trust emails outlining the medication/support plan for her.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that Mr Phiri had requested you to go to the Ward to complete Medicines with Respect as a prerequisite to hold the medication keys. You also stated that although Mr Phiri had suggested a preceptorship style programme, it had been agreed by the Trust Human Resources department that it was not appropriate for a nurse qualified for six years.

The panel noted that the Statement of Events dated 28 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that Ms Turfrey was clear and consistent in her oral and documentary evidence in relation to the incident. The panel considered that you were not happy with the Trust direction that you should complete a preceptorship style programme as you felt it was humiliating and not appropriate for a nurse with your level of experience. The panel had regard to the Record of Job Role Supervision made by Mr Phiri which was a record of the meeting between you, Mr Phiri and another staff member, in which Mr Phiri discussed the various aspects of your nursing practice which required support, with you. In that meeting, he directed that you complete a preceptorship style programme and Medicines with Respect among other

requirements. The panel further noted that you had asserted at various times during your oral evidence that you did not have an induction/training on various medical competencies on the Ward. You accepted during your oral evidence that you had a managerial supervision/induction with Ms Turfrey on 22 January 2019. In this regard, the panel had sight of the Managerial Supervision document dated 22 January 2019. However, the panel noted that you had posited that you did not need the preceptorship style programme based on your six-year experience as a registered nurse, but that you required a level of induction into the workings of the Ward, which you asserted, was never provided.

The panel was of the view that your account that the preceptorship style programme was not required was inconsistent with your assertion that you were not provided with relevant induction/training on various medical competencies on the Ward. The panel also had sight of Mr Phiri's email dated 31 January 2019 in which he confirmed the necessity for the preceptorship style programme to you. Therefore, the preceptorship style programme was not a mere suggestion, but a mandatory programme imposed by the Trust on you. The panel also noted that, based on your Chronology of Events, you had only sent the complaint email to the Trust Human Resources department about the preceptorship style programme on 1 February 2019.

The panel rejected your account of the incident but accepted that of Ms Turfrey's.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 28 January 2019, you inaccurately informed Ms Turfrey that that the action plan/support plan/preceptorship programme were no longer needed. It therefore found charge 9e proved on the balance of probabilities.

Charge 10

10) Your actions in one or more of charges 9 c) and & 9 e) were dishonest in that you sought to misrepresent the level of local restrictions placed upon your practice.

This charge is found proved.

Having found charges 9c and 9e proved, the panel went on to consider whether your conduct in those charges was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that you denied this allegation and stated that you were informed that you had to complete Medicines with Respect before you could hold the medication keys and that the preceptorship style programme was no longer needed.

The panel had regard to the Record of Job Role Supervision made by Mr Phiri in which you were informed of the requirement to complete the preceptorship style programme and Medicines with Respect. The panel also had sight of Mr Phiri’s email dated 31 January 2019 in which he confirmed the necessity for the preceptorship style programme to you. Therefore, the preceptorship style programme was not a mere suggestion, but a mandatory programme imposed by the Trust on you. The panel also noted that, based on your Chronology of Events, you had only sent the complaint email to the Trust Human Resources department about the preceptorship style programme on 1 February 2019, three days after your interaction with Ms Turfrey. Mr Phiri also confirmed during his oral evidence to the panel that he never had any conversation with you that indicated that you were allowed to hold medication keys.

Consequently, on the basis of all the evidence before it, the panel was satisfied on the balance of probabilities that you knew on 28 January 2019 that Mr Phiri had not told you that you were allowed to hold medication keys nor that the preceptorship style programme was no longer needed. The panel therefore determined that you deliberately sought to misrepresent the level of local restrictions placed upon your practice to Ms Turfrey.

In applying the second limb of the test to this case, the panel was satisfied that your conduct by deliberately misrepresenting events that you knew not to be true in charges 9c and 9e would be considered dishonest by ordinary decent people.

Accordingly, the panel determined that your conduct in charges 9c and 9e was dishonest and it therefore found charge 10 proved on the balance of probabilities.

Charges 11a (i), 11a (ii) and 11a (iii)

11) On 29 January 2019 following Colleague Y [Katrina Turfrey]'s instructions to request a prescription/further medication for Patient D;
    a) Did not adequately explain the situation surrounding Patient D to Dr X [Dr Harry Williams] regarding the prescription/medication, in that you did not explain
        i) Whether Patient D was thought disordered.
        ii) Whether Patient D was attempting to assault others.
        iii) Whether Patient D had assaulted others

These charges are found proved.

The panel took account of the Statement of Events dated 29 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that Patient D was presenting as aggressive and attempting to assault staff. She then requested that you check whether Patient D already had any suitable medication prescribed. When you informed her that he did not

have, she asked you to contact Dr Williams for further medications to relieve Patient D's condition. Ms Turfrey stated that you returned and told her that Dr Williams had verbally authorised Lorazepam for Patient D and requested that Ms Turfrey administer it. Ms Turfrey told you to contact Dr Williams as it was not the Trust procedure for verbal orders to be given for prescriptions. Ms Turfrey stated that Dr Williams later arrived at the Ward and stated that he would have arrived earlier, but you had not explained the situation to him. Ms Turfrey stated that Dr Williams had told her that he had specifically asked you whether Patient D was thought disordered, was attempting to assault others or had assaulted others, to which you had answered in the negative.

The panel considered the Statement of Dr Williams in which he stated that on 29 January 2019, you had contacted him about a distressed service user on Stanley Ward and you had informed him, on enquiry from him, that Patient D had not acted violently to staff, de-escalation had been successful, and no one was at immediate risk of harm. Dr Williams stated that you did not use the '*SBAR'* handover tool which was standard procedure in reporting such situations.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you only saw Patient D shadow boxing and Ms Turfrey had requested for you to contact Dr Williams to write up a '*stat dose'* for the patient. You stated that you contacted Dr Williams and told him that Patient D was shadow boxing and you requested for Dr Williams to come to the Ward to write up a '*stat dose'*. You further stated that your conversation with Dr Williams occurred before Patient D's behaviour escalated and before Ms Turfrey took the decision to place Patient D under seclusion. You also stated that you were only asked about this seclusion during the Trust local investigation, and you had informed the Trust that you could not recall it.

The panel noted that the Statement of Events dated 29 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that both Ms Turfrey and Dr Williams were clear and consistent in their oral and documentary evidence in relation to the incident. Although Dr Williams had told the panel during his oral

evidence that he could not recall his conversation with Ms Turfrey when he arrived at the Ward, the panel was of the view that Dr Williams' evidence did not contradict the evidence of Ms Turfrey.

The panel had regard to the Datix for Patient D dated 30 January 2019. The panel noted that Patient D's behaviour had escalated, and he had attempted to assault staff members, before Ms Turfrey had requested for you to contact Dr Williams. This indicated that you ought to have been aware of Patient D's escalating behaviour as otherwise, you would not have been told to contact Dr Williams for further medications. The panel took into consideration that there was a time lag between the time you had contacted Dr Williams and the time he had arrived on the Ward. The panel was of the view that the time lag indicated that you had not provided Dr Williams with the details outlined in charges 11a (i), 11a (ii), 11a (iii) as he stated that he would have arrived on the Ward earlier if he was aware of such details. The panel also had regard to the Trust Investigation Note Sheet Summary dated 5 March 2020. The panel noted that you informed the Trust that you could not recall anything on that shift, despite being presented with patient records to assist you to recall that shift. In this regard, the panel rejected your account of the incident as contained in your witness statement and oral evidence. Instead, the panel accepted both Ms Turfrey's and Dr Williams' accounts of the incidents.

Based on the evidence before it, the panel therefore found charges 11a (i), 11a (ii) and 11a (iii) proved on the balance of probabilities.

Charges 11b and 11c

11) On 29 January 2019 following Colleague Y [Katrina Turfrey]'s instructions to request a prescription/further medication for Patient D;
    b) Inaccurately informed Colleague Y [Katrina Turfrey] that Dr X [Dr Harry Williams] had verbally authorised a stat dose of Lorazepam for Patient D.

c) Inaccurately informed Colleague Y [Katrina Turfrey] that Dr X [Dr Harry Williams] requested Colleague Y [Katrina Turfrey] to administer the Lorazepam.

These charges are found proved.

The panel took account of the Statement of Events dated 29 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that Patient D was presenting as aggressive and attempting to assault staff. Having informed Ms Turfrey that there was no suitable medication already prescribed, she then requested that you should contact Dr Williams for further medications to relieve Patient D's condition. Ms Turfrey stated that you returned and told her that Dr Williams had prescribed Lorazepam for Patient D and requested that Ms Turfrey administered it. Ms Turfrey told you to contact Dr Williams as it was not normal procedure for verbal orders to be given for prescriptions.

The panel considered the Statement of Dr Williams in which he stated that on 29 January 2019, you had contacted him about a distressed service user on Stanley Ward and you had informed him, on enquiry from him, that Patient D had not acted violently to staff, de-escalation had been successful, and no one was at immediate risk of harm. Dr Williams stated that:

> *'At no point in the conversation did I state to give an IM medication which had not been prescribed neither would I ever advise for an unprescribed medication be given to a patient who had not been reviewed on the ward.'*

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you did not inform Ms Turfrey that Dr Williams had requested her to administer Lorazepam as you only told her that Dr Williams had agreed to come to the Ward.

The panel noted that the Statement of Events from Dr Williams had been completed in December 2019 as part of the Trust investigation. In completing this document, Dr Williams was provided with the medical records of the patient but could not specifically remember the event in question. His evidence, which was not challenged by you, was that he would not have given verbal authorisation for a prescription other than in life saving circumstances.

The panel noted that the Statement of Events dated 29 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that both Ms Turfrey and Dr Williams were clear and consistent in their oral and documentary evidence in relation to the incident.

The panel had regard to the Trust Investigation Note Sheet Summary dated 5 March 2020. The panel noted that you informed the Trust that you could not recall anything on that shift, despite being presented with patient records to assist you to recall that shift. In this regard, the panel rejected your account of the incident as contained in your witness statement and oral evidence. It however accepted both Ms Turfrey's and Dr Williams' accounts of the incidents.

Based on the evidence before it, the panel therefore found charges 11b and 11c proved on the balance of probabilities.

Charge 12

12) Your actions in one or more of charges 11 b) & 11 c) were dishonest, in that you sought to mislead Colleague Y [Katrina Turfrey] into believing that Dr X [Dr Harry Williams] had provided verbal authority for prescribing/administering Lorazepam for Patient D.

This charge is found proved.

Having found charges 11b and 11c proved, the panel went on to consider whether your conduct in those charges was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that you denied this allegation and stated that you did not inform Ms Turfrey that Dr Williams had requested her to administer Lorazepam as you only told her that Dr Williams had agreed to come to the Ward.

The panel considered the submissions of Ms Molyneux that there was a likelihood that either Ms Turfrey had misunderstood what you told her in the midst of the heightened situation at that time or you had misunderstood the instructions of Dr Williams. You had also stated that verbal prescription was normal practice in your previous employment.

The panel rejected those explanations as it was of the view that when Ms Turfrey had told you to contact Dr Williams for the second time to confirm his instructions, you ought to have clarified any mistaken information with her. Furthermore, you ought to have questioned Dr Williams if he had given verbal prescriptions to you given that it was not the Trust policy. The panel was therefore of the view that it was reasonable to infer on a balance of probabilities that you knew that Dr Williams had not verbally authorised a '*stat dose'* of Lorazepam nor requested for Ms Turfrey to administer it to Patient D. The panel determined that you deliberately sought to mislead Ms Turfrey into believing that Dr Williams had provided verbal authorisation for her to prescribe/administer Lorazepam for Patient D.

In applying the second limb of the test to this case, the panel was satisfied that your conduct in deliberately providing Ms Turfrey with an information that you knew was not true in respect of charges 11b and 11c would be considered dishonest by ordinary decent people.

Accordingly, the panel determined that your conduct in charges 11b and 11c was dishonest and it therefore found charge 12 proved on the balance of probabilities.

Charge 13b

13) On 31 January 2019 intimidated Colleague Y [Katrina Turfrey], in that you;
    b) Laughed at Colleague Y [Katrina Turfrey].

This charge is found NOT proved.

The panel took account of the Statement of Events dated 31 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested for a chat with her, you told her that you had received an email from Mr Phiri stating that he had been informed that you lacked insight into your support plan. Ms Turfrey stated that she told you that she was not aware of such an email however you started to laugh in her direction which left her confused.

The panel took into consideration that you denied the allegation in your witness statement and expressed surprise at such allegation during your oral evidence.

The panel was of the view that the evidence is unclear as to whether you had laughed at Ms Turfrey or at the situation at that time. It noted that, during her oral evidence, Ms Turfrey was unclear as to whether you had laughed at her at the time of the incident.

Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 13b not proved.

Charge 13c

13) On 31 January 2019 intimidated Colleague Y [Katrina Turfrey], in that you;
    c) Accused Colleague Y [Katrina Turfrey] of sending emails regarding your practice to senior members of staff.

This charge is found NOT proved.

The panel took account of the Statement of Events dated 31 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested for a chat with her, you told her that you had received an email from Mr Phiri stating that he had been informed that you lacked insight into your support plan. Ms Turfrey stated that she told you that she was not aware of such an email. Ms Turfrey further stated that you told her that you would prefer for her to inform you about any concern about your practice rather than informing Mr Phiri, however, she told you that Mr Phiri's email may had arisen from observations from other staff members.

The panel took into consideration that you denied the allegation in your witness statement as you stated that you were not aware that Ms Turfrey had sent any emails about you. You further stated that you were not on duty on that date.

The panel noted that the Statement of Events dated 31 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that Ms Turfrey was clear and consistent in her oral and documentary evidence in relation to the incident. The panel rejected your assertion that you were not on duty on that date as there was a contemporaneous record of the incident and there was evidence that you had used your work emails on that date. In this regard, the panel had sight of your email to Mr Phiri dated 31 January 2019.

Nevertheless, the panel considered that the wording of the charge referred to '*emails'* rather than one email. The panel noted that in her evidence, Ms Turfrey had only stated that you had accused her of sending one email to Mr Phiri. Consequently, although the panel accepted that the incident occurred as described in charge 13c, it was not satisfied that there is sufficient evidence to demonstrate that you had accused Ms Turfrey of sending emails regarding your practice to senior staff members. It therefore found charge 13c not proved.

Charge 13d

13) On 31 January 2019 intimidated Colleague Y [Katrina Turfrey], in that you;
    d) Raised your voice at Colleague Y [Katrina Turfrey].

This charge is found proved.

The panel took account of the Statement of Events dated 31 January 2019 made by Ms Turfrey. In this statement, Ms Turfrey stated that when you requested for a chat with her, you told her that you had received an email from Mr Phiri stating that he had been informed that you lacked insight into your support plan. Ms Turfrey stated that she asked you whether you had asked Mr Phiri for clarification about those comments, but you raised your voice against her telling her that you wanted to hear from her as you had only told her about your displeasure with the support plan.

The panel took into consideration that you denied the allegation in your witness statement as you stated that you were not on duty on that date.

The panel noted that the Statement of Events dated 31 January 2019 was made contemporaneously to the date of the incident by Ms Turfrey. It was of the view that Ms Turfrey was clear and consistent in her oral and documentary evidence in relation to the incident. The panel rejected your assertion that you were not on duty on that date as there was a contemporaneous record of the incident and there was evidence that you had used

your work emails on that date. In this regard, the panel had sight of your email to Mr Phiri dated 31 January 2019.

The panel considered that you were not happy with the medication/support plan and had expressed your frustration to Ms Turfrey by raising your voice. The panel also heard evidence from Ms Burns and other witnesses that you tend to raise your voice when you disagreed with a staff member. The panel also noted that this incident had occurred three days after you had demonstrated a similar behaviour to Ms Turfrey on 28 January 2019. It considered that Ms Turfrey had stated that she felt uncomfortable and intimidated by your behaviour on the day of the incident, to the extent that she expressed her concerns about your behaviour to her manager in an email. The panel therefore accepted Ms Turfrey's account of the incident and rejected your evidence that you did not raise your voice.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 31 January 2019, you intimidated Ms Turfrey, in that you raised your voice at Ms Turfrey. It therefore found charge 13c proved on the balance of probabilities.

Charge 15a and 15b

15) On 21 March 2020;
    a) Behaved in a confrontational manner towards Colleague Z [Toni Burns].
    b) Raised your voice/shouted over/at Colleague Z [Toni Burns].

These charges are found proved.

The panel took account of Ms Burns' Email to the Trust dated 23 March 2020 in which she stated that during a discussion with you on 21 March 2020:

> *'I spent about an hour with her and in the end said I would have to close the conversation down as she continued to repeat herself, was unwilling to listen, process and take on board any other view apart*

from her own. I informed her that during this conversation I found her to be abrupt, confrontational, raise her voice and try and talk over me and that this is unacceptable behaviour which I wouldn't tolerate'

The panel took into consideration that you denied the allegation in your witness statement as you stated that although the discussion had occurred with Ms Burns, you never raised your voice nor behaved in a confrontational manner against Ms Burns. You stated during your oral evidence that although you had no issues with Ms Burns as she was very supportive of your practice, you felt that she refused to believe your version of events at the time of the incident.

The panel noted that Ms Burns's Email to the Trust dated 23 March 2020 was made contemporaneously to the date of the incident. It was of the view that Ms Burns was clear and consistent in her oral and documentary evidence in relation to the incident. The panel heard evidence from Ms Turfrey and other witnesses that you tend to raise your voice when you disagreed with a staff member. The panel therefore accepted Ms Burns's account of the incident and rejected your account.

Based on the evidence before it, the panel was satisfied that it was more likely than not that, on 21 January 2020, you had behaved in a confrontational manner towards Ms Burns and raised your voice at her. It therefore found charges 15a and 15b proved on the balance of probabilities.

Charges 16d (i), 16d (ii) and 16d (iii)

16) On or around 12 April 2020, whilst restricted from holding medication keys and administering medication;

d) Following Patient F suffering an unwitnessed fall

i) Did not carry out any neurological observations of Patient F.

ii) Did not check Patient F for any injuries.

iii) Did not call the duty doctor

Charges 16d (i) and 16d (ii) are found proved. Charge 16d (iii) is found NOT proved.

The panel took account of the witness statement of Ms Wragg dated 26 September 2023 and her local statement in which she stated that, on 12 April 2020, when Patient F had suffered an unwitnessed fall, you did not carry out any neurological observations, check him for any injuries nor called the duty doctor. The panel considered that the same concerns were raised by Ms Bragger and Mr Bushell in their respective emails to the Trust dated 14 April 2020.

The panel took into account that you denied the allegation in your witness statement and oral evidence. You stated that you conducted neurological observations on Patient F throughout the course of your shift, requested staff to check for injuries and you did call the duty doctor at the time of the incident. You further stated that you completed a Datix for the incident. The panel had sight of this Datix.

The panel considered the evidence in this case. It bore in mind that the witness statement of Ms Wragg and the respective local statements of Ms Wragg, Ms Bragger and Mr Bushell are hearsay evidence, however, the panel was of the view that the respective local statements were clear and consistent with each other.

In relation to charge 16d (i), the panel noted that you had at various times in your evidence, asserted that you had not received required training/induction on various nursing competencies on the Ward and therefore refused to conduct such tasks in which you had not completed training. The panel was of the view that this position was at variance with your evidence that you had conducted neurological observations on Patient F given that you admitted during your oral evidence that you had not undergone training on neurological observations on Crofton Ward, other than an informal demonstration from an unidentified doctor. The panel noted that your knowledge about neurological

observations during your oral evidence was vague. You also criticised the duty doctor for conducting his neurological observations within a single ten-minute period. Furthermore, the panel heard from Ms Burns that there was no record of neurological observations being completed by you in the patient record.

Given the inconsistencies in your evidence, the panel rejected your account of the incident, including your assertion that you had "*gone above and beyond*" for your patient by conducting neurological observations when you had not received formal training. It therefore attached more weight to the hearsay evidence of Ms Wragg, Ms Bragger and Mr Bushell in relation to the incident. Accordingly, the panel found charge 16d (i) proved on the balance of probabilities.

With respect to charge 16d (ii), the panel noted that you stated in your witness statement that you had asked other staff members to conduct physical observations and check for physical injuries on Patient F. The panel was of the view that this demonstrated that you did not personally check Patient F for injuries. It therefore attached more weight to the hearsay evidence of Ms Wragg, Ms Bragger and Mr Bushell in relation to the incident. Accordingly, the panel found charge 16d (ii) proved on the balance of probabilities.

With regard to charge 16d (iii), the panel considered the Datix of the incident and noted that the duty doctor had responded to the incident. The panel concluded that there was insufficient evidence to demonstrate that it was not you that called the duty doctor. Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, it found charge 16d (iii) not proved.

Charge 18

18) Your actions in one or more of charges 17 a), 17 b), 17 c) & 17 d) were dishonest, in that you sought to conceal your restrictions from one or more colleagues.

This charge is found proved.

Having found charges 17a, 17b, 17c and 17d proved by way of your admissions, the panel went on to consider whether your conduct in those charges was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that you denied this allegation and stated that you had verbally informed the former Clinical Lead, of the restrictions on your nursing practice. You stated that the former Clinical Lead had told you that you could still deliver medications which was a role undertaken by care assistants. You further stated that you assumed that she would have shared the information about your restrictions with other managers and colleagues.

The panel considered that according to the written correspondence from the Trust dated 8 April 2019, you were restricted in the terms of ‘….*refrain giving medications or holding medication keys’*, and in a separate Trust letter dated 29 November 2019, *‘…not felt reasonable to restate you to full practice, inclusive of medication administration’.* You asserted that the restrictions imposed by the Trust were unclear, non-specific and did not prevent you from delivering medication to patients within the community.

The panel had regard to the IHBTT Offer Letter from the Trust dated 25 January 2021 which offered you a role in the IHBTT and confirmed that you were restricted from ‘*medication administration’* whilst working in this role. The panel also heard oral evidence from Mr Hill and Mr Oldhan that medication administration encompasses the end-to-end

process of retrieving, checking and signing out medication from the controlled drug cabinet, as well as delivery of medication to the patient.

The panel also considered the Trust Medication Management Policy and determined that the actions that you described undertaking, fell within the encompassing definition of '*medication administration*' and was not simply '*stocktaking*' nor a '*delivery service'* as you claimed.

The panel considered your assertion that you had informed the former Clinical Lead of your restrictions and assumed that she would inform other colleagues and managers. The panel took into account that both Mrs Seward (nee Drake) and Mr Hill, in their respective oral evidence, stated that it was the duty of the registered nurse to notify their colleagues and employers of any restrictions on their nursing practice. The panel also bore in mind that a registered nurse has the duty of candour to disclose any restriction on their practice at all times. The panel noted that there was no evidence that you had informed the former Clinical Lead of your restrictions, and it therefore rejected your explanations.

The panel therefore inferred that you must have been aware of the restrictions on your practice and that it restricted you from supplying/giving medication. Therefore, the panel rejected any possible explanation that you were mistaken about your duties whilst working with IHBTT.

The panel considered the context of your conduct and attitude towards your restrictions. It noted that you had expressed displeasure and frustration with the restrictions on your practice, and you never saw the necessity for such restrictions. The panel was therefore of the view that you deliberately sought to conceal your restrictions from one or more colleagues as outlined in charge 17.

In applying the second limb of the test to this case, the panel was satisfied that your conduct by not informing your supervisors and colleagues, as per charges 17a, 17b, 17c and 17d, as to the extent of your restrictions and going on to knowingly breach them by

undertaking medication administration, would be considered dishonest by ordinary decent people.

Accordingly, the panel determined that your conduct in charges 17a, 17b, 17c and 17d was dishonest and it therefore found charge 18 proved on the balance of probabilities.

Charge 19a and 19c

19) On or around 8 August 2022;
    a) Initially retrieved pregabalin from the clinic/controlled drug cupboard without signing the controlled drug book.
    c) Incorrectly placed Patient P's pregabalin, into Patient Q's medication bag.

These charges are found proved.

The panel took account of the witness statement of Ronilyn Gange dated 7 June 2023 in which they stated that on 8 August 2022, they saw you emerge from the clinic with the prescribed pregabalin for Patient P. They stated that they offered to assist you in signing the controlled drug book as a second checker, but you told them that you had not yet signed it. Ronilyn Gange stated that when they brought the controlled drugs book, you stated that you could not write in it as you did not have your glasses. Ronilyn Gange stated that when both of you had counted the medication, they gave it to you to place in the patient's medication bag whilst they filled in the controlled drugs book. Ronilyn Gange explained that there were two bags with one for Patient Q and another for Patient P.

The panel took into consideration that you denied the allegations in your witness statement as you stated that it was Ronilyn Gange who had taken the pregabalin out of the controlled drugs cupboard, but you could not recall who placed the pregabalin in the wrong patient's medication bag.

The panel had regard to the Trust Medicines Management Policy which stated that any controlled drug removal from the controlled drug cupboard should be recorded in the controlled drug book. The panel also had sight of the Controlled Drug Register for Patient P. The panel also noted that you had stated during your oral evidence that you did not have your glasses with you at the time of the incident.

The panel further had regard to the Trust Fact Finding Report dated 8 September 2022, in which it was stated that you had reported to the reviewer of the medication error incident that you did not check the medication using the IHBTT drug medication card as you assumed it was already checked by the pharmacy and already prepackaged.

The panel considered the evidence in this case, and it was of the view that Ronilyn Gange was clear and consistent in both her oral and documentary evidence in relation to the incident. The panel therefore accepted her account of the incident and rejected your account.

Based on the evidence before it, the panel therefore found charges 19a and 19c proved on the balance of probabilities.

Charge 20

20) Your actions in on or more of charges 19 a), 19 b), 19 c), 19 d) i), 19 d) ii), 19) d) iii) & 19 e) were outside the scope of your competence, in that you were supplying/retrieving/managing medication whilst subject to local restrictions/not deemed safe to do so.

This charge is found NOT proved.

Having found charges 19a, 19b, 19c,19d (i), 19d (ii), 19d (iii) and 19e proved, the panel went on to consider whether your actions in those charges were outside the scope of your competence. The panel considered the phrase '*scope of competence'* as such skills or

competencies which a person has acquired based on training, education or supervised practice. The panel bore in mind that it had determined that there was a case to answer with respect to this charge, however, it noted that the standard required in a case to answer decision is lower than that required in facts finding stage.

Having considered all the evidence in this case including the Second Registrant Bundle which contained various training records and supervised practice in the areas of medication administration and management, the panel was not satisfied that there was sufficient evidence for it to conclude that your actions in charges 19a, 19b, 19c,19d (i), 19d (ii), 19d (iii) and 19e were outside the scope of your competence. Accordingly, it found charge 20 not proved.

Application to adjourn the hearing (Monday, 18 August 2025)

On the morning of the resuming date of the hearing, Monday,18 August 2025. You made an application under Rule 32 of the Rules to adjourn the hearing. You explained that this application was made by you because you were notified this morning by the Royal College of Nursing (RCN) that they were no longer representing you and that you would therefore not have legal representation at this hearing today. You said that you would like the panel to grant this adjournment so that you are able to seek legal representation for the next stages of this and that it would be fair to you to allow this application.

You explained that you are not legally trained, and it would be a disadvantage to you if you did not have legal representation moving forward in your case. You explained that you have been waiting six years for this case to conclude and have had to wait a further eight months since the last sitting in December last year. You said that taking an extra couple of months until you can seek legal representation was a reasonable request.

Mr Kennedy submitted that Rule 32 (4) tells the panel about the matters that it needs to take into account when making a decision on this application. He submitted that the NMC

oppose the application for an adjournment. He submitted that this was because of the public interest in the expeditious disposal of this case. He explained that the evidence stage of this case was concluded in December last year and that this was August 2025 and any further adjournment made today would probably, depending on scheduling, take this hearing into March 2026, which was too long in the NMC's view.

Mr Kennedy submitted that assistance could be given to you if you were to move ahead without legal representation in that the legal assessor would be able to help you with the process that will be followed from this stage on. He submitted that if the panel do not agree to the application to adjourn to another set of dates in the future, it may perhaps decide to adjourn until tomorrow to allow you time to have a discussion about the process with the legal assessor and himself.

The panel accepted the advice of the legal assessor. He referred the panel to Rule 32 of the Rules in relation to adjournments and NMC guidance contained in CMT-11 last updated 13 January 2023.

The panel took account of the submissions in relation to this application. It noted the letter from the RCN sent in this morning to the Hearing Coordinator at 8:35 which stated:

> *'Please note that we are no longer acting for Dawn Ellerby. The RCN and Counsel, ..., will not be representing her at the resumed hearing this morning*
>
> *Please ensure that our name is removed from the record and that all future correspondence is sent direct to the registrant.'*

The panel noted that the basis of the opposition by the NMC to your application for an adjournment was on the ground of public interest only. The panel was made aware that your registration is currently subject to an interim suspension order which meets the requirements of the overarching objective in respect of public protection.

The panel considered that this was your first application to adjourn these proceedings and that it arose from circumstances beyond your control, when the RCN withdrew its representation of you on the morning of this resuming hearing. It considered that you had actively engaged in the proceedings to date and that it was your intention to continue in this regard.

The panel determined that you should be afforded more time to seek legal representation. Additionally, the panel noted that this case was only listed until Thursday, 21 August 2025 this week and even if it were to decide to adjourn for a short period and then return sometime this week, this case would not now be able to conclude by Thursday due to a lack of time.

The panel weighed and balanced all the factors it has identified as relevant to this application to adjourn. It noted that you recognised that if you were successful in your application to adjourn this hearing, you understood that this adjournment would likely be for several months, and you accepted this as a consequence of the application.

The panel decided to adjourn this hearing to give you more time to seek legal representation.

Fitness to practise

Lack of competence and misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and/or misconduct and, if so, whether your 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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

NMC Submissions on lack of competence and misconduct

Mr Kennedy stated that the NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Mr Kennedy stated that a lack of competence would usually involve an unacceptably low standard of professional performance. He added that unless it is exceptionally serious, a single clinical incident would usually not indicate a general lack of competence. He submitted that in order for your conduct to amount to a lack of competence, the panel should be satisfied in relation to four matters:

- Firstly, that your behaviour in relation to the proved charges in charges 1 to 8 fell below the standard that would be expected of a Band 5 nurse in an acute mental health ward.
- Secondly, that your behaviour was not an isolated incident

- Thirdly, that your behaviour relates to events which form a representative sample of your work, and
- Fourthly, the appropriate standard that was applicable to the post that you were appointed to and the work that you were carrying out.

Mr Kennedy highlighted that you had made two medication administration errors and a medication recordkeeping error within two months at the time of the incidents. He stated that you had also breached the Trust policy by taking medication keys off the ward. He submitted that these matters by themselves would be unlikely to amount to a lack of professional competence.

Mr Kennedy further highlighted that, in February 2020, you demonstrated a lack of knowledge and proficiency in relation to a number of basic tasks that a Band 5 nurse in an acute mental health ward would be expected to know. He noted that, you had been working on the acute wards and with the Trust for 15 months at that time. He stated that these matters arose in the course of a single shift and would be unlikely to amount to a lack of professional competence by themselves.

Mr Kennedy noted that you accepted that you did not complete a preceptorship programme that was imposed in January 2019 nor the support plan and an action plan put in place in January 2020. He stated that as a result of your lack of engagement, you were not allowed to administer medications for a year. He highlighted that this meant that you were not able to demonstrate competency in drug administration on a practical level although you had passed the theory assessment. Mr Kennedy reminded the panel that it had found that although you did not receive a full induction, you had received support from senior colleagues who tried to put in place measures to help you in your new role. However, you did not seem willing to accept such support.

Mr Kennedy submitted that according to the case of *Calheam v GMC* [2007] EWHC 2606 (Admin), the correct approach to take when assessing whether your failings were due to a lack of competence is not to look at each issue or incident separately, but to look at the overall picture. He asserted that the charges found

proved in charges 1 to 8 cover various aspects of nursing practice in which a competent nurse would have been expected to demonstrate competence. He submitted that your failings therefore demonstrated an unacceptably low standard of performance as a Band 5 nurse. He therefore invited the panel to find that your failings in those charges amount to a lack of competence.

In relation to misconduct, Mr Kennedy 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 medical practitioner in the particular circumstances'*

Mr Kennedy submitted that misconduct is qualified in two respects: first, it is qualified by the word '*professional*', which links the misconduct to the profession of nursing, secondly, misconduct is qualified by the word '*serious'*. He submitted that it is not any professional misconduct which will qualify, as the professional misconduct must be serious. He referred the panel to the NMC Guidance on Seriousness (FtP 3).

Mr Kennedy submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) are engaged in this case and have been breached. They are sections 1.2, 1.4, 2.1, 6.1, 8.2, 13.1, 15.2, 17.1, 18.2, 19.1, 20.1, 20.2 and 20.3

Mr Kennedy submitted that your conduct in the charges found proved in charges 9 to 21 fell below the standard expected of a registered nurse and is sufficiently serious to amount to misconduct. He asserted that this is particularly the case in relation to your repeated dishonesty. Mr Kennedy submitted that charge 11 is

particularly egregious as it had the potential to impact on Ms Turfrey's career. He therefore invited the panel to find that your actions in those charges amount to misconduct.

NMC Submissions on impairment

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Kennedy highlighted that impairment is conceptually forward looking, and therefore the question for the panel is whether your fitness to practise is currently impaired as at today's date. He 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 *Council for Healthcare Regulatory Excellence (CHRE) v NMC and Grant* [2011] EWHC 927 (Admin). He submitted that limbs a, b, c and d of the *Grant* test are engaged in this case when looking at past conduct, and also when looking forward to the future.

Mr Kennedy submitted that your conduct in relation to the medication errors placed patients at an unwarranted risk of harm. He submitted that your conduct, particularly your repeated dishonesty, had the potential to bring the nursing profession into disrepute. He asserted that you abused the position of trust which is the bedrock of the nurse and patient relationship.

In considering whether you have demonstrated sufficient insight and strengthened your practice, Mr Kennedy referred the panel to the test set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). He submitted that the clinical concerns are remediable however the dishonesty concerns are more difficult to remediate given its attitudinal nature.

In relation to insight, Mr Kennedy acknowledged that you made admissions to some charges at the outset of these proceedings and you also gave evidence in relation to the potential impact that your conduct would have on patients, colleagues and the wider public. He stated that this shows an understanding and insight on a general level.

Mr Kennedy submitted that the panel should however carefully examine whether or not you have demonstrated insight into the charges found proved but which you still denied the facts. He submitted that you have sought to blame others for your shortcomings as you had stated that they stemmed from a lack of training and support from the Trust. He asserted that you did not appear to recognise that you have a personal responsibility to ensure that you are properly equipped to carry out your duties. He referred the panel to your reflective statement and questioned whether it demonstrated full insight or that it demonstrated a denial of the matters already found proved by the panel.

Mr Kennedy submitted that a facet of insight is remorse but there was no evidence that you have been remorseful about your conduct in the charges found proved. He submitted that the thrust of your reflection amounted to a series of denials. He asserted that although you have demonstrated some insight, it was not fully developed and without full insight, there is a risk of repetition.

In respect of public protection and the wider public interest, Mr Kennedy submitted that although there was no evidence of any actual harm, patients were clearly exposed to the risk of harm. He noted that you have not been working as a registered nurse since the incidents occurred, therefore, there was no evidence of practice to demonstrate that your conduct in the charges found proved would not be repeated in the future. He therefore submitted that a finding of impairment is required on the grounds of public protection.

Mr Kennedy noted that there is a clear public interest in having competent and safe nurses to care for service users, however, your behaviour raises a question about the extent to which you could be trusted in your role as a registered nurse. He asserted that your behaviour in the charges found proved demonstrates that you could not be trusted as a

registered nurse. He submitted that the public would be appalled at your conduct in the charges found proved as this was the type of behaviour which could lead the public to be unwilling to engage with the nursing profession.

Mr Kennedy submitted that your colleagues may be unable to trust you given your repeated dishonesty and you have not made any effort to regain such trust. He submitted that the public would expect the NMC as regulator to take action to ensure that the nurse who behaved in the way that you did, would not repeat such behaviour. He therefore submitted that a finding of impairment is required on the grounds of public interest.

In conclusion, Mr Kennedy submitted that you have not been able to demonstrate that you will not resort to dishonesty in the future nor have you been able to demonstrate any remediation in relation to your misconduct. He submitted that you have not been able to demonstrate that you are now competent in areas which are at the heart of your nursing role and therefore, there is a risk of repetition. Mr Kennedy asserted that the position today is the same as it was at the time of the incidents. He invited the panel to find that your fitness to practise is impaired on both grounds of public protection and public interest.

Your submissions

You referred the panel to your response bundle for the resumed hearing on 18 August 2025, your email to the NMC containing further addendum dated 24 December 2025, the RCN response letter to the Case Examiners dated 27 May 2022, the RCN response letter to the Case Examiners dated 11 September 2023 and the RCN final grievance letter to the Trust dated 29 January 2020. Additionally, after the panel retired to consider its decision on impairment, you provided a brief email outlining some work you have undertaken over the last year for the local council.

You highlighted that you made admissions in respect of the two medication errors between November 2018 and March 2020. You submitted that when you discovered those errors, you demonstrated openness and honesty by completing a Datix in accordance with

the Trust policy. You stated that, generally, nurses make drug errors, but it is what a nurse does when they identify that drug error that is important. You stated that such nurse is expected to demonstrate honesty, duty of candour, and to ensure that the patient is not at risk. You asserted that you did all of this as at the time of the incidents, you ensured that the patient was not at risk and you contacted the on-call doctor. You stated that the doctor indicated that there was no further action required as no harm was caused to the patient. You submitted that you informed your line manager about the medication errors, you followed Trust policy and procedure, and you completed a Datix in which you reflected upon the incidents. You stated that this was assessed by the Trust and there was no further action taken against you. You asserted that you learnt from your mistakes, reflected on your practice and did everything possible to ensure that the patient was safe.

You submitted that the facts in relation to charge 3 concerning the morphine medication error were mixed up as it was not a medication error. You asserted that the issue was that you gave the morphine medication at teatime rather than at nighttime. You submitted that you completed a Datix to ensure that the patient was safe, and there was no harm caused to the patient as the drug was a slow-release medication. You highlighted that the Trust stated that you did not administer morphine to a patient however this was not true as you were not at the nightshift at the time of the incident. You stated that the nightshift staff should have seen the omission if you had failed to administer the morphine to the patient and they should have completed a Datix in accordance to Trust policy and procedures. You stated that this was one of the issues that you had complained about professionally as you were accused of things you had not done, and you were bullied. You stated that you went to the Human Resources (HR) department to make your complaint, and the Trust General Manager acknowledged your complaint.

In respect of charges 5, 6 and 7, you submitted that the Trust conducted a disciplinary hearing in relation to the medication procedural error, and you were told that you had to complete your training on medication with respect before you could administer medication. You stated that you were issued with a first written warning, you completed your training on Medication with Respect, and you were given the medication keys. You stated that

after you started to administer medication again, the Trust took the medication keys from you, and you were informed by them that you would be referred to the NMC. You highlighted that this was in contravention with Trust policy which stated that you have to be dismissed before a referral to the NMC. You therefore decided to engage the RCN.

You submitted that, during the Trust disciplinary hearing, they had alleged that training had been provided for you however there was no evidence before the panel to support such a claim. You stated that the Trust had indicated that any support that you need should be requested from your line manager however this never happened. You asserted that as a registered nurse, you are able to challenge unprofessional or unfair practice, and this is in accordance with the Code.

You submitted that, seven years prior to joining the Trust, you had an unblemished career. You referred the panel to the various positive testimonials made on your behalf and submitted that they demonstrate that you are able to carry out your duties as a registered nurse at a different Trust. You stated that when you however came to the Trust and as soon as you complained, several allegations were raised against you. You submitted that the Trust support plan should have only dealt with medication administration alone, however, the Trust included a wide range of incompetencies that you knew nothing about, and they were unrelated to the matters raised at the Trust disciplinary hearing. You highlighted that you had only worked on Stanley Ward for five months and worked for four months on Crofton Ward. You submitted that moving from Stanley Ward, which was an acute ward, to Crofton Ward, which was an elderly ward, was very difficult as you had never worked in such types of wards and there was neither any training nor induction provided on each ward. You stated that this posed a risk and this made you raise concerns.

In respect of the preceptorship programme, you stated that you had completed that programme a long time ago and it did not identify any training needs. You submitted that this made you think that you were being managed by somebody that did not want to manage you. You stated that you were concerned about patient care because you did not

get what you needed. You stated that you decided to challenge the preceptorship programme because it was not what you needed, and you whistle blew the concerns. You submitted that you refused to engage with the preceptorship programme and the action plan because it was embarrassing and it would impact patient care.

You submitted that the concerns in relation to charge 8 were never brought to your attention. You stated that if there were concerns about your moving and handling, then you should have had some supervisions, or your colleagues should have complained about you not carrying out your duties. You questioned why the concerns were not discussed with you nor were there any investigations conducted. You highlighted that Ms Burns was aware that you had not done any moving and handling training and this was as a result of circumstances beyond your control. You questioned why you were being blamed for a concern for which you had not received training. You asserted that you could not intervene when a patient is on the floor because you had not completed training in moving and handling. You stated that if you had intervened without having completed the required training, this would have amounted to a breach of the Code, and you would have been referred to the NMC.

In relation to the concerns that you failed to provide personal care, you stated that you know nothing about such concerns. You highlighted that if indeed there were such concerns, there was no evidence that supervision meetings were conducted with you to assess your re-training needs. You stated that you were surprised that you were referred to the NMC although you were still working at the Trust at that time. You questioned why you would not want to assist a patient with their personal care requirements. You submitted that you would not want such behaviour to be demonstrated to a member of your family and therefore you could not conduct yourself in such a manner as it affects the patient's dignity.

In respect of the concerns about the ward alarms, you submitted that you had responded to patients when their bed alarms went off. You stated that when a patient moves in their bed, it may trigger the bed alarms, but you always respond to such alarms. You submitted

that, at the time of the incident, you ran to attend to the patient's needs when their bed alarms went off, and you were followed by another person. You stated that the patient was fine and had not fallen off the bed.

You submitted that the only issue with the bed alarm was that you did not receive any induction on it and you had to learn by trial and error. You stated that, on several occasions, you have had to request for assistance from your colleagues to show you how to deactivate the bed alarms because you sometimes forgot how to do it. You stated that you were therefore shocked that this formed part of the charges against you. You submitted that this demonstrated that you were a subject of collusion and bullying at the Trust. You submitted that, on one occasion, you had not responded to an assistance alarm because you were on the toilet.

You submitted that you were surprised that the NMC had acted on the witness statement of one nurse who had amended it at least three times and she had made dishonest statements against you whilst under oath. You asserted that she said that you had signed a document that has now been proven to be fraudulent, and the NMC had believed it. You submitted that it was Ms Turfrey's word against your word and if you had upset her, she was not ready to discuss the issues. You stated that if a person has issues with another's supervision, such person should identify it and discuss it otherwise it could affect professional practice. You stated that it could also affect demeanour and well-being. You submitted that Ms Turfrey should have discussed the issue with you as if you have to work with her, such issues could have an impact on patients and pose a risk to them. You asserted that Ms Turfrey never raised any issue with you but you were referred to the NMC, and you only became aware of the concerns against you when you went for your grievance meeting in February 2020.

You submitted that you did not have a Medication with Respect training prior to the Trust disciplinary hearing, which should have happened. You highlighted that the NMC states that it is the employer's responsibility to have regular supervision with a nurse to identify training and learning needs to ensure effective patient care. You stated that you had

asked for supervision and support from the Trust, however, all you had were character assassinations supported by documents that you have never seen nor signed.

You highlighted that when you joined the Trust in November 2018, you had a meeting with your first supervisor the next day where he outlined all the training that you needed and supervision to be conducted. You stated that this was contained in the correct documentation, seen and signed by you. However, as highlighted by the RCN's letter to the Trust, you had worked on the wards for some time before any supervision was put in place.

You submitted that although it was also part of your responsibility to engage in relevant training, you were stopped by the action plan imposed by the Trust to engage in such training despite the grievances you had raised. You stated that your grievances were ignored and your practice was restricted by the Trust. You asserted that you were stopped from engaging with medication training because you had challenged the action plan and the Trust claimed that you had attitudinal problems for challenging it. You argued that you had not refused to engage with the action plan, but you and the RCN had challenged it because the action plan was not made in accordance with what the Trust had told you during its disciplinary hearing. You asserted that the Trust prevented you from engaging with any relevant learning or training, instead they referred you to the NMC. You asked how you could provide evidence of remediation if your practice was restricted by the Trust and you were not allowed to engage with any relevant training. You submitted that for two and a half years, the Trust stopped you from showing any remediation because you had whistle blown your grievances.

You submitted that this was a huge detriment to you and there was no reason for any reasonable employer to have any issues with you engaging in training. You stated that everybody learns differently, and you knew that you are more of a hands-on learner than learning through reading copious amount of paperwork. You stated that this was why you complained to the Speak Up Guardian and you wanted him as a witness, but this was not allowed. You stated that you could have done your training on medication alongside being

allowed to administer medication to patients. You stated that you felt that the Trust restrictions on your practice could be likened to smashing a nut with a sledgehammer.

[PRIVATE].

You submitted that you never went into the clinic room to prescribe medication as you are aware that nobody could administer medication to a patient unless it was prescribed by a doctor. You stated that you engaged with the Trust disciplinary process as per NMC standards. You asserted that you were only given a first written warning although the Trust had told the NMC that it was your final written warning. However, this was not true. You submitted that you were open and honest throughout the Trust disciplinary process and an example of your honesty was that the Trust disciplinary process did not include anything about the procyclidine and morphine medications errors. You argued that you demonstrated your honesty by completing a Datix on the two medication errors, you revealed those medication errors during the Trust disciplinary hearing and you were praised for your openness.

In relation to the concerns around your proficiency in cardio metabolic assessments, you stated that you had been transferred from an acute ward to another ward with no induction conducted. You stated that you were just expected to work on the new ward and know what to do because you have been a nurse for several years. You highlighted that you were transferred from a forensic ward where you had worked for three and half years and everything was different in the new ward. You stated that cardio metabolic assessment is about physical health, but you are not a physical health nurse. You submitted that if you did not know how to conduct a cardio metabolic assessment, it was more of a training need which the Trust was expected to identify and offer you.

You submitted that there was nothing identified in your practice that showed that you were incompetent other than the medication issue. You asserted that all the other issues identified by the Trust were more of a training need. You submitted that if you were trained on any competency, you would be able to perform your duties without any issues.

You highlighted that you were stopped from administering any medication for two and a half years and when the first referral was made to the NMC, it was risk assessed and the NMC did not find any risk. You stated that if there was any risk, the NMC would have imposed an interim order on your practice. You highlighted that given that you were not restricted by the NMC, you could have gone to another Trust and administered medication without breaching anything. You stated that the NMC had indicated that such low-risk concerns should be managed through a process of early resolution within a Trust. You submitted that you attended a meeting with the Trust management where you were told that if you withdrew your grievance claims, they would not investigate the concerns against you but manage it through early resolution. You submitted that you reached an agreement with the Trust and withdrew your grievance. You stated that you were allowed to remain on the ward for a brief time and thereafter, you were moved to the home-based treatment team. You stated that you were therefore surprised to receive the charges against you from the NMC.

You highlighted that you had worked in the community as a crisis nurse practitioner for two and a half years and there were no issues about your practice. You noted that your supervisor at that time has provided a testimonial and a professor has also provided a positive testimonial in relation to the time you spent working on Crofton ward. You invited the panel to consider the numerous positive character assessments and testimonials made on your behalf in contrast to the evidence of two nurses who had basically "*character assassinated*" you.

You submitted that in relation to the concerns in charge 8h, there was no Datix completed in relation to the incident, no supervision meeting nor did the staff members who raised the concerns attend these proceedings to give evidence. You asserted that there was no local investigation conducted nor was there any statement obtained from you by the Trust. You submitted that the concern contained in charge 8h was raised by a nurse that did not like you because you had reported an incident in which she left a patient alone in the nursing office. You stated that you completed a Datix as required by Trust policy.

In respect of the concern in charge 19, you stated that you were surprised that you were charged with breaching restrictions of administering and dispensing medication. You asserted that you never breached such restrictions. You stated that when Ronilyn Gange discovered the medication error of giving the wrong medication to a patient, they told you that they had to complete a Datix in relation to the incident because it involved a controlled drug. You highlighted that Ronilyn Gange graded the incident as green which meant that there was no patient harm. You stated that you were therefore surprised when the Trust decided to suspend you a month after the incident. You submitted that it was a one-off incident and you have never been stopped from delivering medication as it was not the same as dispensing or administering medication. You stated that you reflected on the incident and noted that the medication should have been cross-checked twice by both you and Ronilyn Gange before it was delivered to the patient. You stated that although you take responsibility for the incident, it should be a shared responsibility with Ronilyn Gange however you have only been blamed for it. You stated that you did not check the drug cards because you were told not to do anything when you deliver the medication as you expected the nurses to have already checked the drug cards. You submitted that it was the pharmacies that dispensed medication and the patients administered it themselves.

You stated that when you were working with the Home-Based Treatment Team, you were advised by the RCN to take steps to demonstrate remediation to the NMC. You submitted that you were working part time with the team and you undertook additional training in your own time in order to show remediation to the NMC. You stated that you made it clear to the manager on the ward, the Band 6 nurse and other ward nurses that you were not allowed to dispense or administer medication. You submitted that you were provided with adequate support on that ward, you passed your medication with respect in glowing colours and other relevant training concerning medication. You submitted that you had positive feedback from staff on the ward and there were no concerns with your practice.

You stated that you were told that you could deliver medication operating in the role of a healthcare assistant (HCA), but HCAs could not dispense nor administer medication. You

submitted that anybody could deliver medication even a ten-year-old child or an old lady. You stated that you apologise for not informing the service manager or the clinical lead at the Home-Based Treatment team. You submitted that you were not even aware that there was a clinical lead until they testified at these proceedings. You submitted that your failure to inform the service manager or the clinical lead was unintentional but a mistake on your part. You thought that having told the manager on the ward about your restrictions, such information would be disseminated across the team. You submitted that you were open and honest about your restrictions to everybody.

In respect of the concerns in charge 11, you stated that, despite your memory about the incident, you have previously addressed the issue about the verbal order from the doctor at the facts stage and you maintain your denial of the concerns in charge 11. You submitted that there was no statement from a doctor for two or three years. You asserted that the concerns are only based on what the doctor had been told. You submitted that Ms Turfrey was dishonest when she told the panel that Patient D was thought disordered or quite disturbed. You asserted that the doctor's notes stated the contrary as he described Patient D to be fine and did not pose a risk. You submitted that the doctor's notes were not provided to the panel, but you had seen them. You argued that based on your "*experience of forensics, PICU, learning disabilities and risk assessment in the community*", you would know when a patient posed a risk to others. You highlighted that you had been risk assessing patients for two and a half years who wanted to kill themselves. You submitted that Patient D was in seclusion and you were blamed for it because the Trust was already under intense scrutiny by Care Quality Commission (CQC) before you joined the Trust. You submitted that this was because many patients were placed under multiple seclusions unnecessarily, which indicated that there was not a proper deescalation system.

You submitted that the Trust did not inform you about any of these concerns before you were referred to the NMC. You stated that when you were suspended, you resigned and decided to take the Trust to Court. You submitted that you discovered through a subject access request that there was a fact finding conducted by the Trust "*behind your back*" and that what was written about you on file was wrong which breached the General Data

Protection Regulation (GDPR). You asserted that the facts found during that process was wrong and you submitted a robust response to the Trust. You submitted that despite the recommendation of the fact-finding that the Trust should speak to you about your [PRIVATE], this was ignored by the Trust. You stated that [PRIVATE]. You submitted that when you returned to work, you were still grieving but you had risk assessed yourself before returning to work.

Decision and reasons on lack of competence

In reaching its decision, the panel considered its findings and the evidence together with your submissions and those of Mr Kennedy. The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

> ***'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*
>
> ***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*
>
> ***Practise effectively***

6 Always practise in line with the best available evidence

To achieve this, you must:

***6.2** maintain the knowledge and skills you need for safe and effective practice*

8 Work cooperatively

To achieve this, you must:

***8.2** maintain effective communication with colleagues*

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

Preserve safety

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

***13.1** accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

***17.1** take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

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:

***18.1** prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*

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*

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*

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

The panel bore in mind, when reaching its decision in respect of the charges proved relating to a lack of competence, that you should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard.

The panel considered that both Ms Turfrey and Ms Burns addressed the concerns raised about your practice in supervision meetings with you on 22 January 2019 and 21 March 2020 respectively. The panel was therefore satisfied that you were made aware of the issues around your competence.

The panel took into account that as a result of the medication errors, the Trust restricted you from the administration and management of medication as well as not to hold medication keys for Stanley Ward. The panel noted that you were placed on a support

plan within a preceptorship style programme in order to strengthen your practice. The panel further noted that you opposed the preceptorship style programme and support plan and therefore did not fully engage with them.

You were transferred from Stanley Ward to Crofton Ward on 19th August 2019 to allow a fresh start in a different environment. However, further concerns were raised about your proficiencies as a Band 5 nurse on Crofton Ward. The panel was therefore satisfied that you were given sufficient opportunity by the Trust to strengthen your practice, but the concerns persisted.

Charges 1, 2, 3, and 4a

The panel determined that your failings in charges 2, 3 and 4a, when viewed individually, do not amount to a lack of competence. However, the panel determined that, collectively they demonstrate a pattern of behaviour in which you failed to demonstrate the required competence in the administration and management of medication over a period of two months. The panel noted that you acted outside the scope of your competency and in breach of Trust policy by attempting to write a prescription for Patient C. The panel found that your failings posed a risk of harm to patients and demonstrated a gap in applying knowledge into practice. It also showed poor practice in relation to medication management. It therefore determined that your failings in charges 2, 3 and 4a amounted to a lack of competence.

In respect of charge 1, the panel took into account that you stated that [PRIVATE], and you did not deliberately remove the medication keys off the ward. The panel accepted your explanation given that this was an isolated incident. It therefore decided that your conduct in charge 1 did not amount to a lack of competence.

Charges 5, 6 and 7

The panel took into account that you were placed on a support plan within a preceptorship style programme in order to strengthen your practice following your medication administration errors. You were also placed on an action plan at the conclusion of the Trust disciplinary hearing. The panel noted that you refused to engage with the preceptorship programme as you stated that it was generally designed for student nurses and was imposed on you to embarrass you. The panel had sight of an email to you from the Trust general manager dated 13 March 2019 where he apologised for the preceptorship programme and indicated that it was an induction style programme in response to your request for induction.

The panel found that your conduct in charges 5, 6 and 7 demonstrated an attitudinal issue towards the support offered by the Trust. However, there was no evidence to indicate that your failure to engage or complete the preceptorship programme and support plan was due to a lack of competence on your part. The panel therefore decided that your conduct in charges 5, 6 and 7 did not amount to a lack of competence.

Charge 8a

The panel took into account that Mrs Headley (nee Edmondson) and Ms Burns had showed you how to deactivate the ward alarms within six days of the incident within the allegation, but you were not still able to deactivate the ward alarms despite having worked on the ward for six months. The panel took into account that ward alarm systems are critical to maintaining the safety and security of patients, staff and visitors, particularly, in mental health or high dependency settings. The inability to operate the system promptly could compromise the safety of individuals, cause delays in emergency responses, or failure to maintain a therapeutic environment. The panel determined that this demonstrated failure in a basic skill expected from a registered nurse. The panel was satisfied that this amounted to a lack of competence.

Charge 8b

The panel took into account that you stated that you were not trained in the moving and handling of patients. It had sight of the file note containing the supervision meeting between you and Ms Burns in which you were instructed to not engage in any moving and handling of patients until you have been fully trained in such area. The panel therefore decided that your conduct in charge 8b did not amount to a lack of competence.

Charges 8c and 8d

You stated that you did not assist Patients F and H with their personal care requirements because you were not trained in moving and handling of patients. The panel rejected your explanation as the provision of personal care to patients is one of the fundamental duties of a registered nurse and you could have assisted the patients with their personal care without necessarily engaging in moving and handling. The panel concluded that leaving a patient who required personal care/assistance while you ate breakfast/toast and not supporting colleagues to provide personal care to patients demonstrated unsafe prioritisation and inadequate situational awareness. The panel was satisfied that your failings in charges 8c and 8d amounted to a lack of competence.

Charge 8f

You stated that [PRIVATE]. The panel rejected your explanation as it noted that based on the evidence of Mrs Headley (nee Edmondson), your failure to respond to assistance alarms was not an isolated incident as it had occurred on several occasions. You had worked on the ward for three months at this time and should have been able to respond adequately to assistance alarm. It is a basic requirement for a registered nurse to be ready to respond to assistance alarms at the earliest opportunity as failure to respond immediately could pose a risk of harm to patients. The panel was satisfied that your failings in charge 8f amounted to a lack of competence.

Charge 8g (i) and 8g (ii)

You stated that you were not trained in the areas of cardiometabolic assessments and mental health clusters on the ward and therefore could not demonstrate proficiencies in those areas. However, the panel had sight of the Managerial Supervision (admission process) document dated 22 January 2019 in which you were signed off for induction in the areas of cardiometabolic assessments and mental health clusters. These proficiencies are basic requirements for a Band 5 nurse working on a mental health acute ward. The panel was satisfied that your failings in charges 8g (i) and 8g (ii) amounted to a lack of competence.

Charges 8h (i), 8h (ii), 8h (iii) and 8h (iv)

You stated that you did not assist Patient G with personal care requirements because you were not trained in moving and handling of patients. The panel rejected your explanation as the provision of personal care to patients is one of the fundamental duties of a registered nurse. It noted that you could have assisted Patient G by calling for assistance or by providing appropriate care without necessarily engaging in moving and handling. Leaving Patient G on the floor was a breach of your duty of care and a failure in the fundamental aspect of your nursing practice. The panel was therefore satisfied that your failings in charges 8h (i), 8h (ii), 8h (iii) and 8h (iv) amounted to a lack of competence.

Overall, the panel concluded that your failings, both individually and collectively, formed a pattern of failures in fundamental areas of nursing practice over a period of time including failures in medication administration and management, failures in patient safety and care, lack of relevant knowledge and skill. This was a sample of your work between 22 October 2018 and 2 August 2019 and demonstrated an unacceptably low standard of performance.

The panel determined that your failings in charges 2, 3, 4a, 8a, 8c, 8d,8f, 8g(i), 8g(ii), 8h(i), 8h(ii), 8h(iii) and 8h(iv) fell significantly below the standards expected of a registered Band 5 nurse and demonstrated a lack of competence.

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 found that your actions did fall significantly short of the standards expected of a registered nurse, and that your 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*
>
> ***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*
>
> ***Practise effectively***
>
> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
> ***6.2*** *maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.2*** *maintain effective communication with colleagues*

8.5 *work with colleagues to preserve the safety of those receiving care*
8.6 *share information to identify and reduce risk*

Preserve safety

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:
17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

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:
18.1 *prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*
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*

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'*

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

Charges 9a and 9b(i)

The panel determined that your conduct in charge 9a, when viewed individually, was not so serious to amount to misconduct as it was a mere request to sign off your Medication with Respect assessment. However, when viewed together with your conduct in charge 9b(i), the panel found your conduct to be inappropriate, unprofessional and wholly unacceptable in a work setting. There was no justification for your aggressive behaviour towards Ms Turfrey as you ought to have known that you could only be signed off when certain competencies have been completed. The panel found your conduct to amount to disrespect for constituted authority as Ms Turfrey was a senior nurse at the Trust. The panel therefore determined your behaviour in charges 9a and 9b(i) to be a serious breach of the fundamental standards of professional conduct and fell below the behaviour that a registered nurse is expected to maintain. Accordingly, it determined that your behaviour in charges 9a and 9b(i) was so serious that it amounted to misconduct.

Charges 9c, 9d and 9e

The panel found your conduct in charges 9c and 9d demonstrated a disregard for the local restrictions imposed on your practice by the Trust as you knew that you were restricted from holding medication keys and administering medication. Your conduct posed a risk of harm to patients as you sought to undermine the safe management of medication by attempting to hold medication keys despite being restricted. Further, your conduct in inaccurately informing Ms Turfrey that you were allowed to hold medication keys and that the action plan/support plan/preceptorship programme demonstrated an underlying attitude towards rules, colleagues and patient safety.

The panel determined that your conduct amounted to a failure to uphold the standards and values of the nursing profession. Accordingly, the panel determined that your actions in charges 9c, 9d and 9e were so serious as to amount to misconduct.

Charge 10

The panel found your dishonest conduct in charges 9c and 9d to be a deliberate attempt to circumvent the restrictions placed on your practice by the Trust. Your dishonest conduct demonstrated an abuse of your position of trust as a registered nurse in which you placed your personal interest over your duty to ensure patient safety.

The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you to have breached a fundamental tenet of the nursing profession. It found that your dishonest conduct posed a risk of harm to patients and demonstrated a lack of accountability and transparency on your part. Your dishonest behaviour was unprofessional and would be seen as deplorable by other members of the profession and the public. Therefore, the panel determined that your conduct in charge 10 as so serious as to amount to misconduct.

Charges 11a (i), 11a (ii), and 11a (iii)

Your conduct in charge 11a amounted to a failure to communicate effectively with Dr Williams about the situation surrounding Patient D. The panel found this to be serious as it posed a risk of harm to patients and to your colleagues. Had you explained the situation adequately, it was likely that the doctor would have arrived at the ward earlier and treated it as an emergency. The panel therefore determined that your conduct amounted to a serious failure in a fundamental aspect of nursing practice. The panel determined that your conduct in charges 11a (i), 11a (ii) and 11a (iii) was serious and amounted to misconduct.

Charges 11b and 11c

Your conduct in charges 11b and 11c posed a risk of harm to Patient D who could have been given an unprescribed dose of a controlled drug with its attendant health risks. Further, your conduct could have led Ms Turfey to have made a medication error if she had believed you. The panel concluded that your conduct amounted to a breach of the fundamental tenets of the nursing profession. Accordingly, the panel determined that your behaviour in charges 11b and 11c was so serious to amount to misconduct.

Charge 12

Honesty, integrity and trustworthiness is the bedrock of the nursing profession and, in being dishonest, the panel found you to have breached a fundamental tenet of the nursing profession. Your dishonest conduct posed a risk of harm to patients and demonstrated a lack of transparency. In addition, your dishonest behaviour was unprofessional and would be seen as deplorable by other members of the profession and the public. Therefore, the panel determined that your conduct in charge 12 was so serious to amount to misconduct.

Charges 13a and 13d

These charges, when viewed individually, were not so serious as to amount to misconduct, however, your conduct intimidated Ms Turfrey. Your conduct in shouting at

Ms Turfrey was unacceptable, and it demonstrated a lack of professionalism and ineffective communication in a work setting. The panel found your conduct amounted to a disrespect for Ms Turfrey who was a senior nurse at the Trust, and this formed a pattern of behaviour towards her. The panel determined that your conduct constituted a breach of standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your conduct in charges 13a and 13d was so serious as to amount to misconduct.

Charges 14a and 14b

Your conduct in working outside the scope of your competency posed a risk of harm to Patient B, to whom you administered an unprescribed dose of a controlled drug. The panel therefore found your conduct was a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your behaviour in charges 14a and 14b was so serious as to amount to misconduct.

Charges 15a and 15b

Your conduct towards Ms Burns was unacceptable, and it demonstrated a lack of professionalism and ineffective communication in a work setting. It amounted to a disrespect to Ms Burns who was a senior nurse at the Trust. This was part of a pattern of behaviour towards your managers at the Trust. The panel determined that your conduct constituted a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your conduct in charges 15a and 15b was so serious that it amounted to misconduct.

Charges 15c and 15d

The panel regarded your conduct in charge 15c as merely a response to a request to reflect on your behaviour and was not satisfied that it amounted to misconduct.

Although charge 15d, when viewed individually, was not so serious as to amount to misconduct. However, when considered in the context that you had stormed out of a meeting with Ms Burns, your conduct in leaving your work keys unattended was inappropriate and unacceptable. The panel determined that your conduct demonstrated a pattern of unprofessionalism and unsafe practice which posed a risk of harm as the keys could have been accessed by an unauthorised person or patient. The panel determined that your conduct constituted a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your conduct in charge 15d was so serious that it amounted to misconduct.

Charges 16a, 16b and 16c

Your conduct in charges 16a, 16b and 16c amounted to a disregard for the local restrictions imposed on your practice by the Trust as you knew that you were restricted from holding medication keys or administering medication. This conduct posed a risk of harm to patients as the Trust restrictions were imposed to ensure the safety of patients, and maintain a safe medication administration and management system. The panel determined that your conduct amounted to a failure to uphold the standards and values of the nursing profession. Accordingly, the panel determined that your actions in charges 16a, 16b and 16c were so serious as to amount to misconduct.

Charge 16d (i) and 16d (ii)

You were the nurse in charge of Patient F's care. Your conduct amounted to a failure to exercise your duty of care and fell significantly short of the fundamental obligations of a registered nurse.

The panel considered your rationale for your conduct in which you stated that you could not touch the patient since you were not trained in moving and handling. You also stated

that you told other staff members to check for physical injuries on Patient F. However, the panel found that even if you had told others to check for injuries, it remained your duty to ensure that such checks were carried out and then to provide the appropriate care to Patient F, which you did not do.

Although there was no evidence that any actual harm was caused to Patient F, the panel determined that checking for injuries is expected after an unwitnessed fall, as missed signs of serious injuries presents a direct patient safety risk. The panel therefore determined that your conduct fell significantly short of the standard of nursing care expected from a registered nurse and amounted to a breach of your fundamental duty of care to Patient F. Consequently, the panel determined that your failings in charges 16d (i) and 16d (ii) was so serious that it amounted to misconduct.

Charge 17

You stated that you had told the previous shift leader about your restrictions and you expected the information to be disseminated across the Home-Based Treatment Team. However, the panel determined that nurses have a responsibility for their own safe practice. It was your ongoing duty as a registered nurse to inform the appropriate persons and your colleagues about any restrictions imposed on your practice, which would compromise your ability to act safely or effectively.

Your failure to disclose your restrictions demonstrated a disregard for the safeguards imposed by the Trust to protect patients and the public. The panel found your conduct posed a risk of harm to patients. It also has the potential to undermine team morale, colleagues' trust and the wider public confidence in the nursing profession. The panel therefore found that your conduct in charge 17 amounted to a breach of the fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, your conduct was so serious as to amount to misconduct.

Charge 18

Your deliberate attempt to conceal your restrictions from your colleagues was dishonest. The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you to have breached a fundamental tenet of the nursing profession. Your dishonest conduct posed a risk of harm to patients, was unprofessional and would be considered deplorable by colleagues and undermine public confidence in the nursing profession. The panel determined that your dishonesty was so serious as to amount to misconduct.

Charges 19a, 19b, 19c, 19d (i), 19d (ii), 19d (iii) and 19e

The panel determined that whether you were working as an HCA as you believed, or as a registered nurse with local restrictions, by dealing with the controlled drugs, you were acting in breach of the local restrictions.

The Trust had imposed the restrictions to ensure the safety of patients and maintain a safe medication administration and management system. The panel determined that your conduct posed a risk of harm to Patients P and Q, given that Patient P was deprived of the prescribed controlled drug whilst Patient Q was given an unprescribed controlled drug. Your conduct was part of a pattern of behaviour in which you have shown disregard for Trust policies, procedures and restrictions.

The panel found the breach of your local restrictions to be so serious as to amount to misconduct. Further, the manner in which you dealt with the controlled drugs together with the documentation, handling and supply to the wrong patient, fell significantly short of that required of a registered nurse and was also so serious as to amount to misconduct.

Charge 21

Accurate record-keeping is one of the fundamental tenets of the nursing profession. Your conduct could have prevented your colleagues, the Trust and the appropriate health

professionals from being appraised with the relevant information pertaining to Patient Q's' care. The panel determined that this could have had a consequent impact on the patient's' continuity of care and posed to the patient a potential risk of harm. The panel therefore determined that your actions amounted to a serious failure in a fundamental aspect of nursing practice. The panel concluded that your conduct in charge 21 was serious and amounted to misconduct.

Consequently, having considered the proven charges individually and in totality, the panel determined that your actions in the charges found proved save for charge 15c, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

Lack of competence

The panel next considered whether, as a result of the lack of competence, your fitness to practise is currently impaired.

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 especially the question which states:

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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 in the past. The panel determined that your significant level of general incompetence in fundamental areas of nursing practice placed patients and the public at unwarranted risk of harm.

The panel also found that your lack of competence constituted a breach of fundamental tenets of the nursing profession in that you failed to practise effectively and preserve safety. It determined that you 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 your 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 your lack of competence is capable of being addressed. The panel was of the view that your lack of competence is potentially capable of being addressed through a process of insightful reflections, robust supervision and retraining in the areas of concern as well as evidence of good practice. Therefore, the panel determined that it is capable of remediation.

The panel then went on to consider whether the concerns has been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b). The panel took into account your oral evidence, your reflective statement, your further addendum, your training certificates, and the various testimonials made on your behalf.

The panel also considered the context of the failings. It noted that, at the time of the incidents, you had faced difficult personal circumstances. It also noted that you were in dispute with the Trust and had raised allegations of bullying and collusion of staff against you. You had stated that you were not provided with induction and training, and you had submitted a grievance against the Trust.

However, the panel noted that it had found that you were provided with adequate support by the Trust to strengthen your practice. It found that you were supported with supervision meetings, training, an action plan, a '*preceptorship style programme'* and support plan by the Trust but you refused to engage with them. The panel also noted that you were provided with adequate support by the Trust during the period you were facing personal difficult circumstances, and they had supported your gradual return to practice after your leave of absence. You were transferred to different wards and worked with several managers across various teams; however, the same concerns persisted. Having considered these factors, the panel determined that there were no reasonable contextual justifications for your actions.

Regarding insight, the panel considered that you made admissions to some of the charges, and you apologised for some of your actions. The panel found that although your insight is developing, it is limited in regard to the seriousness of your medication administration errors and their impact on patients, your colleagues, the nursing profession and the wider public.

The panel found that despite its findings on facts, you have continued to deflect responsibility, blame others for your actions, and provided justifications or excuses for

your failings. The panel was concerned that you failed to demonstrate sufficient understanding of the seriousness of your failings, nor did you show sufficient insight into the impact of your conduct on patients, your colleagues, the nursing profession and the wider public. You have not demonstrated sufficient insight into steps you should take to prevent the re-occurrence of such conduct.

In considering whether you have strengthened your nursing practice, the panel considered the various testimonials made on your behalf as well as the several training courses you had completed. The panel noted that whilst you have completed various training courses in the areas of concern, you had not provided any evidence of how you have implemented this learning to strengthen your nursing practice. None of the testimonials were in relation to recent practice in any setting/role. The panel was of the view that the testimonials did not specifically address the regulatory concerns.

In the light of this, the panel was not satisfied that your failings have been remedied, nor have you sufficiently strengthened your nursing practice. Accordingly, the panel determined that the competence concerns are likely to be repeated. Therefore, limbs a, b and c of the *Grant* test are engaged as to the future.

Consequently, the panel 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 your failings and the public protection issues it had identified. In the particular circumstances of this case, where there are concerns of wide-ranging failings in fundamental aspects of nursing practice involving vulnerable

patients and a lack of willingness to engage with an action plan or support plan to strengthen practice, the public would expect the regulator to take action. The panel 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 your failings, 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 your fitness to practise is currently impaired on both public protection and public interest grounds.

Decision and reasons on impairment

Misconduct

The panel next considered if, as a result of the misconduct, your fitness to practise is currently impaired.

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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel first considered whether any of the limbs of the Grant test were engaged as to your past conduct. The panel determined that although there was no evidence of actual harm caused to patients, your misconduct in acting outside the scope of your competence, your disregard for local restrictions on your practice, your failings in fundamental areas of nursing practice and your dishonest conduct placed Patients B, D, F, P and Q at unwarranted risk of harm. It was further of the view that your inappropriate and intimidating behaviour towards your colleagues may have affected staff morale and team work on the ward, which could have impacted patient care.

The panel found that your misconduct constituted a breach of fundamental tenets of the nursing profession in that you failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. It determined that you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel had also found you to have acted dishonestly.

The panel therefore concluded that limbs a, b, c and d of the Grant test are engaged in respect of your 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:

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

e. *Has it in fact been remedied?*

f. *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 your 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:*
>
> - *….*
> - *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*
>
> *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 found that your misconduct, with respect to your failings in fundamental areas of nursing practice 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 it is capable of remediation.

The panel determined that your intimidating behaviour towards your colleagues on more than one occasion, your disregard for local restrictions on your practice on several occasions and your repeated dishonesty, are suggestive of serious deep-seated attitudinal concerns, which are more difficult but not impossible to remediate.

The panel then went on to consider whether the concerns have been addressed and remedied. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b) and the NMC Guidance on Dishonesty (DMA-8). The panel reviewed your oral evidence, reflective statement, further addendum, training certificates, and the various testimonials made on your behalf.

The panel also considered the context of the misconduct. It noted that, at the time of the incidents, you had faced difficult personal circumstances. It also noted that you were in dispute with the Trust and had raised allegations of bullying and collusion of staff against you. You had stated that you were not provided with induction and training, and you had submitted a grievance against the Trust.

However, the panel noted that it had found that you were provided with adequate support by the Trust to strengthen your practice. It found that you were supported with supervision meetings, training, an action plan, a '*preceptorship style programme'* and support plan by the Trust but you refused to engage with them. The panel also noted that you were provided with adequate support by the Trust during the period you were facing personal difficult circumstances, and they had supported your gradual return to practice after your leave of absence. You were transferred to different wards and worked with several managers across various teams; however, the same concerns persisted. Having considered these factors, the panel determined that there were no reasonable contextual justifications for your actions.

Regarding insight, the panel considered that you made admissions to some of the charges, completed Datix entries at the time of some of the medication errors and you apologised for some of your actions. Also, you have demonstrated some developing but

limited insight into the seriousness of your medication administration errors and their impact on patients, your colleagues, the nursing profession and the wider public.

The panel found that despite its findings on facts, you have continued to deflect responsibility, blame others for your actions, and provided justifications or excuses for your misconduct. The panel was concerned that you failed to demonstrate sufficient understanding of the seriousness of your misconduct, nor did you show sufficient insight into the impact of your conduct on patients, your colleagues, the nursing profession and the wider public. You have not demonstrated sufficient insight into steps you should take to prevent the re-occurrence of such conduct.

Further, you have not demonstrated any insight into your repeated dishonesty and its impact on patients, your colleagues, the nursing profession and the wider public. You have not provided any reflections on your dishonest conduct or the wider impact. Instead, you have continued to assert that other witnesses themselves have lied to the panel and are therefore dishonest.

In considering whether you have strengthened your nursing practice, the panel considered the various testimonials made on your behalf as well as the several training courses you had completed. The panel noted that although you have completed various training courses in the areas of concern, other than dishonesty, you have not provided any evidence of how you have implemented this learning to strengthen your nursing practice. None of the testimonials were in relation to recent practice in any setting/role. The panel was of the view that the testimonials did not specifically address the regulatory concerns.

The panel found that your misconduct has not been remedied, nor have you sufficiently strengthened your nursing practice. Accordingly, the panel determined that your misconduct is likely to be repeated. Therefore, limbs a, b, c and d of the *Grant* test are engaged as to the future.

Consequently, the panel 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 your misconduct and the public protection issues it had identified. In this case, where there are concerns of wide-ranging failings in fundamental aspects of nursing practice involving vulnerable patients, disregard for local restrictions, intimidating behaviour towards colleagues and repeated dishonesty, the public would expect the regulator to take action. The panel determined that public confidence in the profession would be undermined if a finding of impairment were not made. 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 the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

Decision and reasons on proceeding in the absence of Mrs Ellerby at the sanction stage on 13 January 2026

Mrs Ellerby sent an email to the Hearings Coordinator at 8:34 indicating that she would want to speak to the new legal assessor at 10:00. The hearing was scheduled to commence at 9:15. The Hearings Coordinator responded to her email at 9:09 by asking her to be available at 9:20 in order to not delay the hearing as this was the last day of the hearing. Mrs Ellerby responded at 9:19 by stating:

'I [PRIVATE] *and just received your email. I would appreciate 10am and will make this as quickly as possible.'*

Mrs Ellerby sent another email at 9:24 where she requested for an adjournment on the basis of [PRIVATE]. The Hearings Coordinator sent an email to Mrs Ellerby to inform her of the NMC's intention to make an application to proceed in her absence to the sanction stage and requested for written submissions in response to such application by 11:00 or to join the hearing at that time. However, there was no response from Mrs Ellerby at 11:00. An email was received from Mrs Ellerby at 12:49 in response to the request to make submissions by 11:00. The email was received while the panel was in camera. The email contents were wide-ranging but at no stage dealt with the application to proceed in her absence. As there appeared to be nothing relevant within the email, the panel did not ask for further submissions from Mr Kennedy.

Mr Kennedy outlined the chronology of the emails between Mrs Ellerby and the Hearings Coordinator. He invited the panel to proceed in the absence of Mrs Ellerby. He highlighted that Mrs Ellerby in her initial email at 8:34 did not mention any issue of [PRIVATE] and that at 9:19, she used a past tense in stating that [PRIVATE]. He noted that it was only at 9:24 that Mrs Ellerby stated that [PRIVATE] and requested for an adjournment. [PRIVATE]

Mr Kennedy invited the panel to take into account the provisions of Rules 32(2) and 32(4) of the NMC Fitness to Practise Rules, in making its decision on the application for an adjournment. He outlined the chronology of these proceedings and highlighted that the case is in its third chronological year and if the case were to be adjourned again, it will undoubtedly not be able to resume for a period of several months. He asserted that this is against the principle of expeditious disposal of the case. He submitted that a lot of time has been lost in this case because Mrs Ellerby has been given a lot of leeway in presenting her position given that she is unrepresented. He asserted that if the case were to be adjourned, it will cause inconvenience to the NMC as it costs a considerable amount of money to organise a fitness to practise hearing. He noted that although there was no

inconvenience to witnesses, there will be inconvenience to the panel having to reconvene and reacquaint itself with this case.

Mr Kennedy submitted that there will be a further cost to the NMC because there is an interim order which is due to expire on 3 March 2026 and would require an application for an extension in the High Court. In terms of fairness to Mrs Ellerby, Mr Kennedy noted that although Mrs Ellerby has engaged in the process and she indicated that she would attend in future, she has been asked to provide written submissions in relation to this application, and she has not done so.

In conclusion, Mr Kennedy submitted that it is entirely a matter for the panel to weigh things in the balance on the question of fairness to Mrs Ellerby, given the seriousness of the matters that have been found proved, versus the inconvenience to the NMC and the need to complete cases in an expeditious matter. He invited the panel to refuse Mrs Ellerby's request for an adjournment of this case.

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

The panel has decided not to proceed in the absence of Mrs Ellerby. In reaching this decision, the panel has considered the submissions of Mr Kennedy, the chronology of emails between Mrs Ellerby and the Hearings Coordinator in respect of adjournment and the advice of the legal assessor. It has had particular regard to the NMC Guidance on Proceeding with hearings when the nurse, midwife or nursing associate is absent (CMT-8), the provisions of Rule 32(4) and had regard to the overall interests of justice and fairness to all parties.

The panel considered the public interest in the expeditious disposal of the case. It took into account the chronology of this case. It noted that these proceedings commenced in November 2024 where Mrs Ellerby attended the hearing with a representative. The panel handed down its determination on facts and adjourned due to insufficient time to conclude the next stage in the allotted hearing schedule. The hearing resumed in August 2025

when Mrs Ellerby was ready to proceed with the next stage however the RCN had withdrawn her legal representation leaving her unrepresented. The hearing was adjourned to January 2026 to enable her to obtain representation. On resumption in January 2026, Mrs Ellerby attended the hearing unrepresented. She participated for the first two days of the hearing, before the panel retired to consider its decision. At the conclusion of day four of the hearing, the panel handed down its determination to Mrs Ellerby via email as she had chosen to absent herself at that time. The last day of the proceedings resumed after a scheduled four-day break. However, on this day of the hearing, Mrs Ellerby emailed to indicate that she would not be able to attend the hearing due to [PRIVATE].

The panel considered the issue of public protection. It noted that Mrs Ellerby's nursing practice is currently restricted under an interim suspension order and she is currently unable to practise as a nurse until the panel reaches a decision on sanction. The panel was therefore satisfied that the public would remain protected by that order if this hearing was adjourned.

The panel considered the issue of fairness to Mrs Ellerby and the potential inconvenience caused to the NMC. The panel noted that Mrs Ellerby had earlier indicated that the amount of time these proceedings have taken, [PRIVATE] and despite this, she has requested for a further adjournment. The panel took into consideration that Mrs Ellerby has actively participated at all previous stages of these proceedings, and this was her first application for an adjournment on [PRIVATE]. [PRIVATE]

The panel noted the submissions of Mr Kennedy that such an adjournment would cause inconvenience to the NMC in terms of financial costs due to the extensive time these proceedings had taken since 2024. The panel also noted that this was the last day of the scheduled hearing, but it did not hear the application to proceed in the absence of Mrs Ellerby until 11:00. The NMC indicated that it intended to make an application for the admission of additional evidence if the panel decided to proceed in Mrs Ellerby's absence, before it proceeded to its submissions on sanction. Due to the time constraints, the panel was concerned that even if it decided to proceed in her absence, there would be

insufficient time to conclude the hearing today anyway. The panel needed sufficient time to consider and draft its decision on sanction, particularly given the serious nature of the matters found proved and the potential impact on the career of Mrs Ellerby.

In balancing all these factors set above, the panel decided to adjourn the hearing.

Decision and reasons on application to admit an additional document into evidence

At the resumption of the hearing on 15 July 2026, Mr Kennedy made an application to admit into evidence, the decision letter dated 30 April 2015, containing the decision of the Conduct and Competence Committee in a previous NMC case against you in 2015.

Mr Kennedy submitted that the NMC decision letter relates to a previous fitness to practice case brought against you. He submitted that the NMC did not seek to admit the document into evidence at the previous stages of these proceedings because the document was not relevant at that time and it would have been unfair as it could have prejudiced the panel's findings on facts and impairment. He asserted that it was appropriate to make an application for the admission of the document at the sanction stage as it was relevant and fair to admit it into evidence at this stage in accordance with Rule 31.

Mr Kennedy submitted that, in a criminal case, once a verdict has been made, previous convictions would be made known to the judge. He submitted that, although this was not a criminal proceeding, the next stage of this hearing was the sanction stage, and it was relevant that the panel was aware of your fitness to practise history with the NMC. He argued that the NMC decision letter was relevant as charges of dishonesty were found proved in that case in 2015 in the same manner as charges of dishonesty had been found proved in this case. He submitted that the panel may reach the conclusion that a previous history of dishonesty makes the dishonesty in this case more serious. He therefore invited the panel to admit the NMC decision letter dated 30 April 2015 into evidence.

You submitted that you object to the admission of the NMC decision letter into evidence. You stated that your response to the NMC application to admit this document was contained in your email dated 10 July 2026 to Mr Rees (Chief Executive Officer of the NMC). You asked the panel to take into account everything set out in that email and the associated attachments. You submitted that you declared your conviction to the NMC and to your previous employer at that time. You submitted that your previous employer did a risk assessment and that was what the University should have done but they were misled by the NMC. You stated that you were not a registered nurse in the NMC register at that time and it was found that you were naive.

You submitted that the NMC decision letter was in relation to your private life and you understood that issues in private life could be transferable to a certain extent. You asserted that it should be noted that the previous panel took into consideration the excellent testimonies in regard to your practice and that the concerns did not have an impact on patient care. You submitted that you had shown remorse, reflected on the concerns and no similar incidents had occurred. You submitted that you had learnt your lessons and you were not dishonest. You stated that you had stated in your email to Mr Rees that there were different levels of dishonesty and most of the information in that email were in relation to new evidence that had not been presented to this panel when it made its findings on the dishonesty charges. You submitted that the panel should take into consideration the mitigating circumstances at that time and that behaviour had never occurred again in your nursing career. You stated that it was a horrendous time for you and when your professional career as well as various positive testimonials made on your behalf were considered, it would be noted that there was no malice in what you did.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The panel considered all of the documentation submitted by you at this stage.

The panel first considered whether the NMC decision letter dated 30 April 2015 was relevant to this case. The panel took into account that the NMC decision letter relates to a previous fitness to practise decision against you in 2015, in which some of the concerns included dishonesty and failures to disclose a conviction. The panel noted that the misconduct in today's hearing also relates to similar concerns of dishonesty and failures to disclose restrictions, although the facts were not same with the concerns in 2015. It bore in mind that the next stage in these proceedings was to make a decision on sanction. The panel noted that the NMC Guidance - the purpose of and approach to sanctions (SAN-1) stated that, before considering sanction, the Committee must consider any aggravating factors that are present including any previous regulatory or disciplinary findings, especially if these suggest attitudinal issues or a pattern of impairment. In this regard, the panel determined that the NMC decision letter dated 30 April 2015 was relevant to this case as it relates to a previous fitness to practise decision against you with similar concerns of dishonesty and failures to disclose a restriction.

The panel next considered whether it would be fair to admit the NMC decision letter dated 30 April 2015 into evidence. The panel considered that the NMC had notified you in January 2026 that it intended to make an application to admit the NMC decision letter into evidence. The panel also considered your objections to the admission of the document into evidence that the case occurred a long time ago and the concerns were not related to today's hearing.

The panel determined that it would be fair to admit the NMC decision letter into evidence given that you were provided with reasonable notice of the NMC application and you have had sufficient time and opportunity to respond to it. The panel was satisfied that it was appropriate for the NMC to seek to admit the document into evidence at this stage in order not to prejudice the panel's findings on facts and impairment if the document had been presented at previous stages of these proceedings. The panel determined that, although the admission of the document may be prejudicial to your case, it was in the public interest and in the interest of fairness for all relevant matters to be considered that would enable the panel to reach an appropriate and proportionate decision on sanction.

Accordingly, the panel granted the application to admit the NMC decision letter dated 30 April 2015 into evidence.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

You were not present for the submissions of the NMC but stated you were content for the panel to receive them in your absence as you had confined all you had to say into the document that was received and read by the panel.

Mr Kennedy submitted that the most appropriate and proportionate sanction in this case is a striking-off order. He highlighted that the purpose of a sanction is to protect the public and satisfy the wider public interest. It is not to impose a punishment, although some sanctions may have a punitive effect. He submitted that the panel needs to balance the issue of the public interest against your right to practise as a registered nurse. He stated that the panel should act proportionately and any interference with your ability to practise must be no more than necessary for public protection and in the wider public interest.

Mr Kennedy submitted that the panel should assess the extent to which your behaviour fell below the acceptable standard of professional practice for a nurse and the aggravating

and mitigating circumstances. He submitted that the aggravating features of this case were:

- Repeated dishonesty, which is directly linked to your clinical practice.
- You demonstrated a disregard for local measures put in place to protect patients.
- Your behaviour demonstrates attitudinal issues, both in your dishonesty and in your behaviour towards your colleagues.
- You placed vulnerable patients at risk of harm.
- You lack full insight, remorse and remediation in respect of the concerns.
- There was a previous fitness to practice finding with a similar concern of dishonesty

Mr Kennedy submitted that the mitigating features of this case were:

- Your continued engagement with these proceedings.
- You made admissions to some of the charges at the outset of the hearing.
- You have shown some insight.

Mr Kennedy submitted that, in considering the available sanctions from the least restrictive order, taking no action would not be appropriate in this case in view of the public protection issues identified. He asserted that such a sanction would not mark the seriousness of the case and would be insufficient to maintain public confidence in the profession and maintain professional standards.

Mr Kennedy submitted that a caution order would not be appropriate in this case as it would not protect the public against the risks that arise from your lack of competence and misconduct. He submitted that it would not maintain public trust and confidence in the nursing profession and its regulator. He highlighted that the NMC Guidance '*Caution order'* (SAN-2b) states that such an order is only appropriate if the case is at the lower end of the spectrum of fitness to practice and where there is no risk to the public.

Mr Kennedy highlighted that the NMC Guidance '*Conditions of practice order'* (SAN-2c) states that a conditions of practice order is appropriate when the concerns can be remediated. He submitted that a number of the concerns in this case were non-clinical and

arose from deep-seated attitudinal issues which makes them more difficult to remediate. He asserted that, in light of your previous failures to engage with local restrictions, conditions would be unworkable and the imposition of a conditions of practice order would not adequately protect the public or satisfy the wider public interest.

Mr Kennedy submitted that given the lack of competence and misconduct concerns, including repeated dishonesty, in this case, a sanction which prevents you from practising is required. He submitted that the question was whether that such removal should be temporary or permanent. He referred the panel to the NMC Guidance '*Suspension order'* (SAN-2d).

Mr Kennedy submitted that it was clear from the panel's findings that your behaviour was not a single instance of misconduct, there has been no full insight demonstrated by you and there were harmful deep-seated attitudinal issues which pose a risk of harm to public safety. He highlighted that the panel had found repeated dishonesty in this case and therefore the panel should consider the NMC Guidance on Sanctions for the highest risk cases, in particular, '*cases involving dishonesty'* (SAN-4). He highlighted that you have provided your responses in relation to the panel's findings on dishonesty and it was a matter for the panel to decide whether you have accepted it and provided reassurance that it would not be repeated in future. He stated that there is no binary choice between suspending or removing a registrant from the register in cases involving dishonesty. He submitted that it was vital that the panel considers sanctions in ascending order of seriousness and work up to the next most serious sanction when necessary.

Mr Kennedy submitted that particular care was required when a nurse has denied charges of dishonesty which are found proved. He submitted that the panel must bear in mind the principle that professionals facing charges involving dishonesty should have a proper opportunity to resist very serious allegations and that this must be balanced against the necessity of protecting patients and the public. He stated that approach was echoed in the case of *Sawati v GMC* [2022] EWHC 283 (Admin), where Mrs. Justice Collins Rice stated that dishonesty of any sort whatsoever is unquestionably at least a yellow card issue for a

doctor, but whether it is a red card issue in any case, is a matter for the tribunal to evaluate.

Mr Kennedy submitted that the dishonesty in this case could not be assessed as being at the lower end of the scale as it was premeditated, multifaceted, and in respect of charge 18, longstanding. He submitted that your dishonesty was repeated, despite opportunities to reveal the true position in relation to the restrictions on unemployment and it was for personal gain. He submitted that your refusal to adhere to conditions designed to assist your practice and promote patient safety, together with your aggressive attitude towards colleagues show a harmful deep-seated attitudinal problem. Mr Kennedy submitted that when these are considered together with your lack of insight, your dishonesty shows that there is a likelihood of repetition. He submitted that your position is made worse by the decision made by a fitness to practise committee against you in 2015 involving dishonesty concerns. He therefore concluded that your conduct was fundamentally incompatible with you remaining on the register but it was a matter for the panel to decide on the appropriate and proportionate sanction.

Prior to absenting yourself from the hearing and before the submissions of the NMC, you told the panel that you have provided your submissions on sanction in your emails to the NMC dated 8 February 2026 and 10 July 2026 with the original statement of Ms Katrina Turfrey, as well as your email dated 10 July 2026 to Mr Rees with associated attachments. You stated that you had nothing further to add to those submissions.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive

in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel identified the following aggravating features:

- Your failings in basic areas of nursing practice and your misconduct placed Patients B, D, F, P and Q at unwarranted risk of harm.
- Your misconduct and lack of competence persisted over an extensive period of time.
- Your failure to demonstrate sufficient insight into the seriousness and impact of your misconduct and lack of competence on patients, your colleagues, the nursing profession and the wider public.
- You have continued to deflect responsibility, blame others for your actions, and provided justifications or excuses for your misconduct and lack of competence.
- Your failure to work collaboratively with your colleagues at the Trust, refusal to follow instructions and abide by restrictions, your inappropriate and intimidating behaviour towards your colleagues.
- Your repeated dishonesty on three separate occasions and was linked to your clinical practice.
- You have had a previous fitness to practise finding with similar concerns of dishonesty and failures to disclose a restriction.

The panel identified the following mitigating feature:

- You made early admissions to some of the charges, and you apologised for some of your actions.

The panel did not consider the several training courses you had completed and your testimonials to be mitigating factors. This was because the panel had earlier determined that you had not provided any evidence of how you have applied your training to strengthen your nursing practice. It had also noted that none of the testimonials were in

relation to recent practice in any setting/role and they did not specifically address the regulatory concerns.

Although you were facing difficult personal circumstances during the period of some of the incidents, the panel did not consider them as mitigating factors because there was evidence that the Trust had provided you with support during that period. Additionally, there was no evidence to indicate that your misconduct and lack of competence was a result of your personal difficult circumstances.

The panel had regard to the NMC Guidance on Sanctions for the highest risk cases, in particular, Cases involving dishonesty (SAN-4). The panel found that your dishonest conduct was not a one-off incident nor was it a spontaneous action, but instead a premeditated and systematic course of conduct which occurred on three occasions and directly linked to your nursing practice. Your dishonest conduct demonstrated an abuse of position of trust as a registered nurse in which you sought to mislead your colleagues which posed a potential risk of harm to patients.

The panel recognised that you are entitled to defend the allegations against you but noted that you have not accepted the panel's findings. You have continually sought to deflect responsibility and blame others for your actions. Furthermore, you have had a previous fitness to practise finding with similar concerns of dishonesty and failures to disclose a restriction. Having considered these factors, the panel found the dishonesty in this case to be serious and at the higher end of the spectrum of dishonesty. Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel first considered whether to take no action but concluded that this would be inappropriate and not proportionate in view of the seriousness of the case. It had earlier decided that there is a risk of repetition, that you breached fundamental tenets of the nursing profession, and that your misconduct and lack of competence would undermine the public confidence in the nursing profession if you were allowed to practise without

restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (SAN-2b) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel noted that it had found that your misconduct and lack of competence pose a risk of harm to patients and public safety. In view of its findings on your lack of competence, misconduct and impairment, the panel decided that your case was not at the lower end of the spectrum of impaired fitness to practise. Given the seriousness of the case, the public protection and public interest considerations identified, the panel determined that an order, that does not restrict your nursing practice, would not be appropriate nor proportionate in the circumstances. The panel therefore concluded that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether to impose a conditions of practice order on your nursing practice. The panel was mindful that any conditions imposed must be relevant, proportionate, measurable and workable. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (SAN-2c) particularly:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*

- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *……*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel was of the view that although your clinical failings could be addressed through retraining and robust supervision, there were concerns in the charges found proved that you failed to cooperate with the preceptorship programme/action plan provided by the Trust and you breached some of the restrictions imposed by the Trust. You further misrepresented and concealed the restrictions from your colleagues which posed a risk of harm to patients. Therefore, the panel was not satisfied that there was any evidence to demonstrate that you would comply with any conditions of practice order imposed on your nursing practice.

Furthermore, the panel had earlier determined that your misconduct was suggestive of deep-seated attitudinal issues which are more difficult to address. The panel therefore determined that given the seriousness of the concerns, the deep-seated attitudinal issues and your limited insight into the severity and the impact of your failings and misconduct, there were no proportionate, workable and measurable conditions that could be formulated to address the risk of repetition and the consequent risk of harm. Consequently, the panel determined that a conditions of practice order would not protect the public nor maintain professional standards and public confidence in the nursing profession.

The panel went on to consider whether a suspension order would be appropriate and proportionate in this case. The panel had regard to the NMC Guidance on *'Suspension*

order' (SAN-2d) in which the following factors on when a suspension order may be appropriate are set out:

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

The panel considered the provisions of the NMC Guidance on *'Deciding between suspension and strike off'* (SAN-3). The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension order. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel noted that the lack of competence and misconduct concerns in this case were wide-ranging and, along with your dishonest conduct, were at the higher end of the spectrum. Your repeated dishonesty on three different occasions, your disregard for local restrictions on your practice and your intimidating behaviour towards your colleagues on more than one occasion seriously calls into question your suitability to continue practising as a registered nurse.

Although you have engaged actively with these proceedings, you have rejected the panel's findings, continued to blame others and deflect responsibility for your actions. The panel noted that there has been a previous fitness to practise finding against you with similar concerns of dishonesty and failures to disclose restrictions, in which a suspension order was imposed on your nursing practice. The panel further noted that there was no evidence that you had developed further insight into your failings and misconduct since the commencement of these proceedings two years ago nor that you had further strengthened your nursing practice. The panel therefore concluded that there was no realistic prospect that you would address the concerns to such a level where you could return to practice safely if a suspension order was imposed on your nursing practice given the deep-seated attitudinal concerns and your insufficient insight.

The panel reminded itself of the mitigating feature of this case and whether it could determine that a suspension order would meet the needs of the overarching objective. The panel concluded that it did not and therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (SAN-2e):

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

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

The panel determined that the serious breach of fundamental tenets of the profession, evidenced by your lack of competence and misconduct, is fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case raise serious and significant questions about your professionalism and to allow you to continue practising would not protect the public and would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

Given the seriousness and wide-ranging nature of the concerns; the deep-seated attitudinal issues relating to your aggressive, confrontational and intimidating behaviour towards your colleagues on more than one occasion, your disregard for local restrictions on your practice on several occasions and your repeated dishonesty; and the fact there has been a previous fitness to practise finding against you with similar dishonesty concerns; the panel determined that there was no amount of insight and reflection in this case which could keep patients and the public safe, maintain public confidence in the profession, and uphold professional standards.

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

proportionate in this case and this is the only sanction which would be sufficient to protect the public.

The panel determined that this order is necessary to maintain public confidence in the nursing profession, and to uphold the professional standards of behaviour expected and required of a registered nurse.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Before the NMC's submissions on interim order, you indicated that you do not wish to be present when the application for an interim order would be made by the NMC and you were content for the panel to hear the NMC application in your absence. You indicated that you intend to appeal the substantive order and you did not have any submissions to make in response to the NMC application for an interim order.

Mr Kennedy highlighted that the substantive order would not become effective until 28 days after the panel's decision is served on you if there is no appeal against it. He noted that you have indicated your intention to appeal against the substantive order and therefore an interim order is necessary for the protection of the public and is otherwise in the public interest to cover the appeal period. He submitted that given the panel's earlier decisions, an interim suspension order for a period of 18 months is necessary to protect

the public and is otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. He submitted that not to impose an interim suspension order would be inconsistent with the panel's earlier decisions.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order.

The panel first considered whether an interim order is necessary for the protection of the public. The panel noted that it had earlier determined that there was no amount of insight and reflection in this case which could keep patients and the public safe, maintain public confidence in the profession, and uphold professional standards. Given the seriousness and wide-ranging nature of the concerns as well as the deep-seated attitudinal issues in this case, the panel determined that there remains a risk of repetition. The panel therefore determined that given the risk of repetition, there remains a real risk of harm to the public should you be permitted to practise as a registered nurse without restriction during the appeal period. Accordingly, the panel concluded that an interim order is necessary on the ground of public protection.

The panel next considered whether an interim order is in the public interest. In the particular circumstances of this case, where a substantive sanction, particularly a striking-off order, had been imposed in relation to wide-ranging lack of competence concerns and misconduct involving repeated serious dishonesty, should an interim order not be imposed, the reputation of the profession and the NMC as regulator would be undermined and seriously damaged. In these particular circumstances, the panel determined that an interim order is necessary in the public interest.

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

The panel determined that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to protect the public and maintain public confidence in the nursing profession, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.