

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Hearing  
Monday, 11 May 2026 – Tuesday, 19 May 2026**

Virtual Hearing

**Name of Registrant:** Emma Elizabeth Doherty

**NMC PIN:** 18I0255N

**Part(s) of the register:** Registered Nurse – Learning Disabilities  
(October 2018)

**Relevant Location:** Manchester

**Type of case:** Misconduct

**Panel members:** David Hull (Chair, Lay member)  
Melanie Lumbers (Registrant member)  
David Newsham (Lay member)

**Legal Assessor:** Megan Ashworth

**Hearings Coordinator:** Sara Glen

**Nursing and Midwifery Council:** Represented by Mohsin Malik, Case Presenter

**Miss Doherty:** Present and represented by Karl Shadenbury,  
(UNISON)

**Facts proved (by admission):** Charges 1a, 1b, 2a, 2b, 3c, 4a, 4b, 4c, 4e

**Facts Proved:** Charges 1c

**Facts not proved:** Charge 3a, 3b, 4d

**Fitness to practise:** Impaired

**Sanction:** **Striking-off order**

**Interim order:**

**Interim suspension order (18 months)**

## **Decision and reasons on application to amend the charges 2a, 2b, 3b and 4a.**

The panel heard an application made by Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 2a, 2b, 3b and 4a.

He submitted that the proposed amendment to the wording of the charges would provide clarity and more accurately reflect the evidence. He submitted that the proposed amendments to the above charges do not alter the seriousness of the charge and are fair and just in all circumstances. He submitted that they would cause no injustice to you.

The proposed amendments would read:

'That you, a Registered Nurse

2. On 24 May 2022:

- a) ~~Said that Service User A "should be sent to jail" or words to that effect.~~  
**Agreed with a colleague that Service User A "should be sent to jail" or words to that effect.**
- b) ~~Said that Service User A had been put into seclusion "for being Service User A" or words to that effect.~~  
**Said that the reason Service User A had been put into seclusion was "Service User A being Service User A" or words to that effect.**

3. On 2 June 2022:

- b) Said that Service User A was not autistic **or words to that effect**

4. On 12 June 2022:

- a) ~~Said that Service User A "should be sent to prison" or words to that effect~~  
**Said in respect of Service User A "send her to prison" or words to that effect**

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

Mr Shadenbury submitted that he had no objection to the application to amend the wording of charges 2a, 2b, 3b and 4a.

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

The panel was of the view that such amendments to the wording of charges 2a, 2b, 3b and 4a, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It considered that the proposed amendments do not change the seriousness or amount to any material change of the charges. It also considered that the proposed amendment to the charges was not opposed by Mr Shadenbury on your behalf. The panel determined that it was appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

### **Application to offer no evidence in respect of Charge 3a**

Mr Malik referred the panel to NMC guidance DMA-3 namely ‘*Offering no evidence*’ last updated 1 September 2025 and to the relevant case law *PSA v NMC & X [2018] EWHC 70 (Admin)*.

Mr Malik submitted that there is no evidence before the panel that supports Charge 3a. He submitted that the panel have four video footage clips of Panorama BBC footage before it, and the NMC made attempts to secure further footage from the BBC that was not included in the original BBC Panorama programme. He submitted that the NMC was unsuccessful in obtaining the footage as the BBC said that there was an ongoing police investigation. He submitted that you deny the allegations of Charge 3a. He further submitted that the only mention of this allegation is contained in the Disciplinary hearing notes where you

were asked, *'Did you mimic her?'* and you said, *'I cannot remember, I recall handing over that is all, If I did I did not mean to.'* Mr Malik submitted that as there is no admission from you and there is no video footage available to support the allegation, there is not a realistic prospect that the NMC could find this charge proved. As such, the NMC offers no evidence in respect of Charge 3a.

Mr Shadenbury submitted that he had no objection to the NMC's application to offer no evidence in respect of Charge 3a.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

The panel considered the NMC's submission that there is no evidence to support the allegation in respect of Charge 3a. It considered that you have made no admissions in relation to this charge and that when the allegation was put to you in an interview closer to the material time, you were unable to recall any such incident. The panel considered that there is also no evidence before it, in the form of further video evidence nor is there any other form of evidence available to support the allegation and therefore there is not a realistic prospect that the NMC could prove this charge.

The panel accepted the NMC's application to offer no evidence in relation to Charge 3a and accordingly finds that charge not proved.

### **Details of charge (as amended)**

That you, a Registered Nurse

1. On 27 April 2022:

- a) Described Service User B as "a pain in the arse", or words to that effect

- b) In respect of Service User B, said that the Ward team “won’t be feeding into her”, or words to that effect
- c) Did not take any or adequate action when you witnessed a support worker making derogatory comments about Service User B

2. On 24 May 2022:

- a) Agreed with a colleague that Service User A “should be sent to jail” or words to that effect
- b) Said that the reason Service User A had been put into seclusion was “Service User A being Service User A” or words to that effect.

3. On 2 June 2022:

- a) Mimicked Service User A
- b) Said that Service User A was not autistic or words to that effect
- c) In respect of Service User A said “she’s not to have anything? That’s grand. That’s fine. I’m not arsed, she’ll be getting fuck all off me” or words to that effect

4. On 12 June 2022:

- a) Said in respect of Service User A “send her to prison” or words to that effect
- b) Said that Service User A would “soon be brought down a peg or two” or words to that effect
- c) Said that Service User A “needs a good thrashing” or words to that effect
- d) Said that you had previously told Service User D and/or one or more other Service Users that they “need a good beating up to bring them down” or words to that effect
- e) In respect of Service User C said “I would have gone through her”, or words to that effect”.

And, in light of the above, your Fitness To Practise is impaired by reason of your misconduct’.

## **Background**

The charges arose whilst you were employed as a registered learning disabilities nurse by Greater Manchester Mental Health Trust (the Trust). At the time of the allegations, you were working as a Band 6 Deputy Ward Manager at Prestwich Hospital (the Hospital) which is a secure psychiatric hospital. The Edenfield Centre (the Centre), which is part of the Hospital, is a service operated by the Trust which provides specialist care to adults with severe psychiatric illnesses, who are detained for their own safety or the safety of others.

You were referred to the NMC by a Deputy Chief Nurse, employed at the Trust on 21 September 2022. The NMC also made a referral about your fitness to practise under Article 22 (6) of the Nursing and Midwifery Order 2001 on 28 September 2022.

Between March and June 2022, covert filming was undertaken by a reporter for the BBC following whistleblowing allegations relating to staff behaviour and patient safety at the Hospital. The reporter worked at the Centre as a support worker and recorded a number of concerning practices. Following this, Panorama: Undercover Hospitals: Patients at Risk (the Documentary) was aired by the BBC on 28 September 2022.

You appear in the footage at 4:44;10:52; 50:35 and 51:55 minutes.

On 27 April 2022, you were identified as calling a service user a "*pain in the arse*" and saying you "*wouldn't be feeding into a service user*". On 12 June 2022, you were identified as saying a service user needed "*a good thrashing*" and should be sent to prison as "*she'll soon be brought down a peg or two*".

It was further identified that on 12 June 2022, another nurse had said she had been close to giving a service user an overdose to cause harm and you said, "*I would have gone through her*".

It was also identified that there were further occasions in May and June 2022, when you had engaged in inappropriate discussions about service users with other staff members, including an occasion on 27 April 2022, when you allegedly took no action when a support worker made derogatory comments about a service user in your presence.

You last worked as a Band 6 A&E Liaison Mental Health Practitioner at the Trust before you were excluded from work on 9 September 2022. You were dismissed by the Trust on 11 October 2022.

### **Decision and reasons on facts**

At the outset of the hearing, the panel heard from Mr Shadenbury who informed the panel that you made full admissions to charges 1a, 1b, 2a, 2b, 3c, 4a, 4b, 4c, 4e.

The panel therefore finds charges 1a, 1b, 2a, 2b, 3c, 4a, 4b, 4c, 4e 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 Malik on behalf of the NMC and by Mr Shadenbury on your behalf.

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

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

- Helen Cutts: Head of Operations of the Bolton Division at the Trust. Ms Cutts carried out the Disciplinary hearing with you.

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. It considered the witness and documentary evidence provided by both the NMC and Mr Shadenbury on your behalf.

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

### **Charge 1c**

‘That you, a Registered Nurse

1. On 27 April 2022:

- c) Did not take any or adequate action when you witnessed a support worker making derogatory comments about Service User B.’

**This charge is found proved.**

In reaching this decision, the panel took into account the video footage from BBC Panorama and your documentary and oral evidence.

The panel considered the video footage evidence. It observed that at the beginning of the video footage, you appear to be leaning against the window and speaking to the Service

User. At approximately 0.05 seconds you turned away from the window toward the Support worker. At approximately 0.07 seconds, you turn and face back towards the window and appear to explain to the service user what the plan was. The panel then observed at 0.14 seconds, you turned away from the window and moved toward the door. At this point, the Support worker starts to speak and made a derogatory comment.

The panel considered in your oral evidence, you accepted that the comments made by the Support worker were derogatory and you accepted that at the time, you did not take any action, such as challenge the comment made or raise this with management. The panel also considered your explanation in your oral evidence where you said:

*“I was trying to talk to her and the intercom wasn’t working. I was up against the window listening and speaking to her. I was focussed on her, I wasn’t focussed on anything else around me.”*

The panel also considered your statement prepared for the Disciplinary hearing at the Trust dated 7 October 2022, where you said:

*‘During the first exchange I was communicating with Service User B through the seclusion window and was listening to her response. I was not actively listening to anyone in the area as I wanted to hear what Service User B was communicating with me so I knew what Service User B required from me and if I needed to gather anything from her prior to entering seclusion.’*

You further told the panel that at the time, you were not aware that the Support worker had made a derogatory comment as you were listening to the service user and not to the other staff members in the room.

The panel analysed the video footage, including how engaged you were with the service user when you were speaking to them and when you were no longer speaking to them.

The panel considered that at the point that you moved away from the window, and the Support worker made the derogatory comment, you were no longer engaged in communicating with the service user. The panel also noted that from the video footage, the derogatory comment that the Support worker made was loud to the point of shouting and the Support worker was standing directly next to you. Therefore, the panel determined that your explanation that you did not hear the comment because you were engaging with the service user and therefore did not take any action as you did not hear it, was not plausible. The panel determined that it was more likely than not that you did witness the Support worker make a derogatory comment toward the service user and took no action.

Therefore, on the balance of probabilities Charge 1c is found proved.

### **Charge 3b)**

'That you, a Registered Nurse

3. On 2 June 2022:

b) Said that Service User A was not autistic or words to that effect.'

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the Disciplinary hearing notes and your documentary and oral evidence.

The panel noted that there is no video footage of the alleged incident.

The panel considered that when asked in the disciplinary hearing if "*You have said she was not autistic,*" in reference to Service User A, you said:

*'I have not said that what I have said is things that she does or says are not in line with autism, well aware of her diagnosis but other things she*

*does are not related to her autism is all I meant, she does have mental health issues that I am well aware of but that behaviour was not in line with her diagnosis'*

The panel also considered that in your oral evidence, you said in regard to the allegation that Service User A was not autistic, *"I never said that she wasn't autistic."* You told the panel that Service User A had told another member of staff that if she escalated her behaviour, then she would get *"stuff she likes on her levels of observation"*. You told the panel that at the time this indicated to you that Service User A had insight and therefore:

*"I said that that wasn't autism, that was behaviour. I'm not denying that she has or hasn't got autism. I wouldn't deny that. It was just that moment."*

The panel determined that there is no direct evidence to support this charge. It considered that the NMC is relying exclusively on a response that you gave to the allegations during a Disciplinary hearing and there is no evidence before the panel to support that you said Service User A was not autistic. It also considered that there is no video footage, or witness evidence to support this charge. The panel determined that the NMC failed to discharge its burden of proof.

Therefore, Charge 3b is found not proved.

#### **Charge 4d)**

'That you, a Registered Nurse

4. On 12 June 2022:

- d) Said that you had previously told Service User D and/or one or more other Service Users that they "need a good beating up to bring them down" or words to that effect'

**This charge is found NOT proved.**

In reaching this decision, the panel took into account your statement prepared for the Disciplinary hearing dated 7 October 2022, summary of the concerns arising from the BBC Panorama content, the Disciplinary hearing notes and your documentary and oral evidence.

The panel noted that there is no video footage of the alleged incident.

The panel considered that during cross examination, the NMC referred you to the Disciplinary hearing notes and your response to the Trust's allegation 3 (in the summary of concerns arising from the BBC Panorama content) where you said:

*'I was angry, frustrated, let emotions get better of me, there was a support worker in office with me but can't remember who or what they said if anything'*

During the Trust's internal disciplinary hearing in response to their allegation 3, it is recorded that you said the following:

*'On 12 June, in the office of Buttermere ward, Nurse in Charge ED, discussed with junior colleagues Service User A who was in seclusion. She outlined that, in her opinion, Service User A should be sent to prison where she "soon be brought down a peg or two" and that she "needs a good thrashing", implying she needed to be punished or taught a lesson. ED also described how she used to tell the male patients on Dovedale ward that they "need a good beating up to bring them down", including a patient called Service User D.'*

The panel also considered your response in your statement dated 7 October 2022, where you said:

*'With regards to the patients on Dovedale, I have never told patients they need a good beating. I referenced this gentleman because his case was very similar to [Service User A] and felt that if we do not get the correct management plan in place she would unfortunately have the same outcome as this individual. Both displayed violence and aggression towards staff resulting in short periods of seclusion and had learning difficulties.'*

The panel also considered in your oral evidence, you said that you were referring to Service User A and not Service User D in your response at the Disciplinary hearing.

The panel determined that the evidence the NMC is relying on to prove this allegation is not sufficiently clear to satisfy the panel that it refers to Service User D as opposed to Service User A. The panel considered that your explanation in your evidence that you were referring to the similarities between the Service User A and Service User D is plausible and that you were not referring to Service User D in your response at the Disciplinary hearing. Further, the panel considered that this allegation is taken from a summary of concerns arising from the BBC Panorama video footage, of which there has been no video evidence provided to the panel. Further, the panel considered that there is no witness evidence before it relating to this allegation. Therefore, the panel determined that there is no direct evidence to support this charge and the NMC has failed to discharge its burden of proof.

Therefore, Charge 4d is found not proved.

### **Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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 safely and effectively without restriction.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

### **Submissions on misconduct**

Mr Malik invited the panel to take the view that the facts found proved amount to misconduct. He directed the panel to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Roylance*. He also referred the panel to NMC Guidance FTP-2a namely '*Misconduct*' last updated 6 May 2025.

Mr Malik identified the specific, relevant standards from 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) where your actions amounted to misconduct, namely; 1.1, 1.2, 1.5, 2.6, 8.2, 8.4, 14.1, 14.2, 14.3, 16.1, 17.1, 20.1, 20.2, 20.3, 20.5 and 20.8.

Mr Malik submitted that your conduct falls short of the standards set out in the Code and as a result, amounts to serious misconduct. He submitted that practising effectively and upholding the nursing profession is a fundamental nursing responsibility, and it was the professional duty upon you to ensure that you were acting in the appropriate manner.

He submitted the charges found proved are serious and involve the abuse of vulnerable people. The words used by you were abusive and degrading in respect of vulnerable service users on a mental health unit.

He submitted that the panel has heard evidence from you that you were frustrated at the time and that there were issues with staffing. Mr Malik submitted that this explanation does not justify you making such comments regarding vulnerable patients. He submitted that if you were truly frustrated and had to vent, then you would have directed those comments towards the trust and management, not vulnerable patients. He submitted that the comments were unacceptable.

Mr Malik submitted that the panel heard that junior staff and students were also working on the unit. He submitted that has been found proved that you said that Service User A “*needs a good thrashing*” and that by saying this, you were enticing violence against a vulnerable service user, which is deplorable. He submitted that in your evidence you gave an explanation by what you meant using the word “*thrashing*” in which you confirmed that you meant “*hit*”. He submitted that whilst it is not known how your colleagues took that comment, there was a risk that it could have led to violence towards the service user.

Mr Malik submitted that it has been found proved that you did not take any action when you witnessed a colleague making a derogatory comment about Service User B. He submitted that your explanation was that you did not hear your colleague but the fact that this charge has been found proved, indicates that you were part of the culture of the unit. He submitted that ignoring that derogatory comment was inappropriate, insensitive and clearly offensive. Mr Malik submitted that the panel heard from you that you would definitely have raised the issue, had you heard your colleague. However, he submitted that there is no evidence before the panel that you had escalated any concerns regarding the culture on the unit.

Mr Malik submitted that a key principle embedded throughout the code is that safeguarding and protecting people from harm, abuse and neglect is an integral part of providing safe and effective care. He submitted that the Code says that nurses, midwives and nursing associates must take all reasonable steps to protect people who are vulnerable or at risk of harm, from neglect or abuse. He submitted that professionals are also expected to make sure that people's physical, social and psychological needs are assessed and responded to, which includes acting as advocates for the vulnerable and challenging poor practice and behaviours related to a person's care.

He submitted that these incidents happened whilst you were working as a nurse. He submitted that the BBC Panorama documentary had a severe impact on the service users and the conduct found proved would have had an impact on the service users' ability to trust healthcare professionals and to protect them, as the comments were made by a person who was supposed to look after their care needs.

Mr Malik submitted that your behaviour and attitude found proved in this case is totally unacceptable. He submitted that your conduct falls significantly short of what would be expected of a registered nurse. He submitted that making these comments behind the backs of service users is not treating them with kindness, respect or compassion and that your actions were inappropriate. He submitted that your misconduct placed vulnerable service users at risk of emotional and psychological harm. He submitted that your misconduct is a serious departure from the Code and that fellow practitioners would consider such a departure as deplorable. As such, he submitted that the facts found proved are sufficiently serious to constitute a finding of misconduct.

Mr Shadenbury submitted that in respect of Charges 1a and 1b, both charges were admitted by you at the outset of this hearing. He submitted that these charges amount to you making derogatory comments about Service User B within the privacy of the staff room. He submitted the service user was not present at the time the comments were made and as such, there was no harm to the patient as a direct result of hearing those comments. He submitted that while other nurses would accept that whilst it is not

professional or kind, it is not uncommon for such comments to be made about service users in a private setting away from patients. He submitted that whilst he accepts your actions did fall short of the required standards of a nurse, your actions do not fall so far short that another nurse would find your conduct deplorable.

Mr Shadenbury addressed Charge 1c, which was found proved by the panel. He submitted that it is accepted by you that whilst the derogatory comment was not made by you, you should have challenged it and the service user should have been reassured if she had heard the comment. He submitted that it is accepted that your actions within this charge more than likely fell short of the required standards of a nurse and it should be expected that a nurse would challenge such a comment about a service user when it seemingly had been made directly to them. He submitted that these actions may be considered conduct that another nurse may find deplorable and that it is a matter for the panel to consider.

In respect of Charges 2a, 2b, 3c, 4a and 4b, Mr Shadenbury submitted that these charges were admitted by you at the outset of this hearing. He submitted that these charges amount to you making derogatory comments about Service User A within the privacy of the staff room. He submitted the service user was not present at the time the comments were made and as such, there was no harm to the patient as a direct result of hearing those comments. He submitted that while other nurses would accept that whilst it is not professional or kind, it is not uncommon for such comments to be made about service users in a private setting away from patients. He submitted that whilst actions in the charges did fall short of the required standards of a nurse, your actions do not fall so far short that another nurse would find your conduct deplorable.

In respect of Charge 4c, Mr Shadenbury submitted that it is accepted that this particular charge is more serious than others due to the nature of the comment made by you. He submitted that you accept that you should not have made such a comment about Service User A that incited physical harm and it is never acceptable to wish that a patient is hit, regardless of whether the comment was made in private. He submitted that it is accepted

that your actions in this charge did fall short of the required standards of a nurse and that your actions are likely to be considered conduct that another nurse would find deplorable.

In respect of Charge 4e, Mr Shadenbury submitted that this charge was admitted by you at the outset of this hearing. He submitted that this charge amounts to you making a derogatory comment about Service User C seemingly within the privacy of the staff room. He submitted that the service user was not present at the time the comment was made and did not hear the comment. He submitted that you did not intend for the comment to be an invitation to physically harm the service user, but in your evidence, you accepted that it could be interpreted in this way. He submitted that it is accepted that whilst your actions did fall short of the required standards of a nurse, your actions do not fall so far short that another nurse would find your conduct deplorable.

### **Submissions on impairment**

Mr Malik moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Yeong v General Medical Council* [2009] EWHC 1923 (Admin); [2009] WLR (D) 268. He further referred the panel to NMC guidance DMA-1 'Impairment' last updated 28 January 2026.

Mr Malik submitted that the NMC defines impairment as can the nurse practise safely and effectively without restriction.

Mr Malik submitted that in regard to the facts of this case, and in reference to the case of *Grant*, limbs a, b and c of Dame Janet Smith's "test" are engaged.

- 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'*

Mr Malik submitted that your actions have caused harm to vulnerable service users. He submitted that the BBC Panorama documentary had a huge impact on service users and their families, who witnessed what was said or being said about service users. He submitted that you did not take any action when you heard derogatory comments about Service User B and that those comments were totally unacceptable, insensitive and had the potential to cause emotional harm. Mr Malik submitted that if you had taken action, then the incident could have been addressed at the time and Service User B could have received an apology and the colleague who had made those comments disciplined.

Mr Malik submitted that the comment that Service User A *"needs a good thrashing"* would have certainly caused upset and emotional and psychological harm to the service user and their families. He submitted that these comments were made by someone who was supposed to care for that service user and they would have been appalled to discover such comments were made. He submitted that there was a possibility and a risk that your colleagues took the comment about thrashing seriously which would have led to violence toward Service User A. He submitted that the service users were vulnerable and your behaviour put service users at unwarranted risk of harm.

Mr Malik submitted that in the absence of full insight and remediation, the risk of repetition and future harm remains. He submitted that your actions have brought the nursing profession into disrepute and you have breached the fundamental tenets of the nursing profession by failing to promote professionalism. As such, he submitted there is a

continuing risk to both public protection and the wider public interest due to your behaviour and conduct which occurred at your workplace.

Mr Malik submitted that the breaches of the code involve breaches of the fundamental tenets of the profession and that a finding of impairment is required to mark the unacceptability of the behaviour, to emphasise the importance of the fundamental tenet breached and to reaffirm the proper standards of behaviour. He submitted that the code divides its guidance for nurses into four categories, which can be considered as representative of the fundamental principles of nursing care, namely '*Prioritise People, Practise Effectively, Preserve Safety and Promote Professionalism and Trust*' and that you have breached these in particular, the responsibility to promote professionalism and trust.

Mr Malik submitted that in regard to remorse, reflection, insight, training and remediation, you have not submitted a reflective statement. He submitted that you have provided character references for the panel's consideration, however, he submitted that most of the references are dated in 2023 and are not signed. He submitted what weight the panel attach to the character references is a matter for the panel. Further, Mr Malik submitted that there are no up to date training certificates provided.

Mr Malik submitted that in oral evidence, you blamed the BBC for causing harm to the service users. He submitted in your oral evidence you said that you never intended for those comments to be heard by the service users and by the BBC broadcasting the documentary, the BBC had put service users at risk of harm. Mr Malik submitted that you have not fully taken responsibility for your actions and that you have failed to understand that if it was not for the BBC and covert filming, these concerns would not have come to light, and the culture within the unit would most likely have continued. Mr Malik submitted that there is no evidence that you raised any concerns about the culture and that this is something you accepted in your evidence.

Mr Malik submitted that the charges found proved indicate a deep-seated attitudinal issue and according to NMC guidance, this is not easily remediable. He submitted that you

failed to take any responsibility for your actions, blaming the BBC and staffing at the unit for your behaviour. He submitted that in evidence you maintained that staffing was the reason why you were frustrated at the time but this does not justify the comments made to vulnerable service users. He submitted that you have shown limited insight on remediation and that the concerns have not been remediated and therefore are highly likely to be repeated.

Further, Mr Malik submitted that you breached the duty of candour to be open and honest. He submitted that you have breached your position of trust as a senior member of the unit and that you failed to lead by example and be a good example to junior members and student nurses.

Mr Malik submitted that the misconduct in this case is serious and a finding of impairment is necessary on public protection grounds.

Mr Maliik submitted that a finding of impairment is also necessary on public interest grounds in this case. He submitted that your conduct has brought the nursing profession into disrepute and serves to undermine public confidence and trust in the profession.

Therefore, Mr Malik invited the panel to make a finding of impairment on both public interest and public protection grounds.

Mr Shadenbury submitted that it is accepted that three of the four limbs of the “test” in the case of *Grant* are engaged albeit you have acted this way in the past but are not liable to do so in the future.

In respect of limb a, Mr Shadenbury submitted that there is no evidence of actual harm to patients. He submitted that the NMC has not offered any evidence as to the impact of your behaviour on service users. He submitted that it is accepted that the service users were likely to have been placed at risk of unwarranted harm when these comments were aired as part of the BBC Panorama programme. As such, he submitted that this is likely to have

had a detrimental impact on how they viewed the care they received by nurses and ultimately, they would have possibly lost trust in the profession. He submitted that it is not known if the service users did view the programme, as there is no evidence that they did.

Mr Shadenbury submitted that you have not practised as a nurse since leaving the Trust in August 2022 and as such, you have been unable to demonstrate a period of practise without further concern. He submitted that your evidence to the panel and your statement have demonstrated sufficient insight and remorse into your conduct, such that the likelihood that you would repeat this conduct in the future is minimal. Therefore, he submitted that you are not liable in the future to act as to put patients at unwarranted risk of harm.

Mr Shadenbury conceded that you previously brought the profession into disrepute and that there is no doubt that confidence in the profession would have been detrimentally impacted by the public viewing the comments that you made during the BBC Panorama programme. He submitted that you are not liable to bring the profession into disrepute in the future. Further he accepted that you have in the past committed a breach of one of the fundamental tenets of the profession, namely, to prioritise people and treat them with kindness, respect and compassion. Mr Shadenbury submitted that the risk of repetition of this behaviour is minimal. As such, he submitted that you are not liable in the future to breach one of the fundamental tenets of the profession.

Mr Shadenbury submitted that you have demonstrated sufficient insight into your behaviour. He submitted that you self-referred to the NMC on 4 October 2022 and that you have made a number of early admissions to the charges in response to the Trust and to this panel. He submitted that you concede in your evidence that your conduct has and had fallen short of the required standards. Mr Shadenbury directed the panel to your statement and submitted that it demonstrates sufficient insight into how your conduct has impacted upon service users, colleagues, the Trust and on the nursing profession. Further, he submitted that you have recognised that your conduct in respect of the comments that you made about service users was poor, uncaring and callous behaviour and that you regret

this behaviour every day. He submitted that you accepted in your evidence that you did not act as a good role model for other staff members and that you have demonstrated remorse for your actions. He submitted that you did not seek to actively harm patients and you can be seen in the BBC Panorama programme clearly comforting Service User A when this was required.

Mr Shadenbury directed the panel to your positive testimonials from colleagues. He highlighted to the panel that Mr Tucci, a Senior Nursing Assistant described you as someone who has *'always shown compassion and empathy to all the patients she has nursed over the time she has been at the Edenfield Unit.'* He also highlighted to the panel that Ms Sharpley, a Registered Mental Health Nurse said that you *'had positive therapeutic relationships with service-users, always displaying empathy in her interactions.'* Further, Mr Shadenbury referred the panel to the Trust's Governance and Assurance Review dated March 2023 where it said:

*'When standards of safe staffing became problematic, they were not appropriately monitored, allowing normalisation of lower than acceptable standards, placing undue pressure on staff and reliance on temporary fixes. This was specifically prominent as a feature evident within Edenfield. There is no escaping the fact that the staffing issues at Edenfield were critically low, exposing service users, staff and the trust to undue risk. This was not acted upon as it should have been'*

Mr Shadenbury submitted that he did not seek to minimise your conduct but simply to provide context of the pressure that staff were operating under whilst working at the Centre. He submitted that in light of the above, the risk of repetition is minimal and that you have demonstrated sufficient insight into your conduct. He submitted that the panel has sufficient evidence to conclude that you are not a continuing risk to the public in relation to the charges found proved.

Mr Shadenbury submitted that in respect of the public interest, it is more than likely that the panel will find your current fitness to practise is impaired. He submitted that an informed member of the public is likely to be concerned about your conduct as seen in the BBC Panorama programme and would be concerned that you have not had a period of safe and kind practise following these incidents. Furthermore, he submitted that the impact of your conduct on the reputation of the profession is more than likely to warrant a finding of impairment in respect of public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance, Nandi, Grant, Cohen, General Medical Council v Meadow* [2007] QB 462 (Admin), *Doughty v General Dental Council* [1987] 3 All ER 843, and *R (on the application of Bevan) v General Medical Council* [2005] EWHC 174 (Admin).

### **Decision and reasons on misconduct**

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a ‘*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*’

When determining whether the facts found proved amount to misconduct, the panel also had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (the Code) in making its decision.

The panel was of the view 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:

***‘1 Treat people as individuals and uphold their dignity***

*To achieve this, you must:*

*1.1 treat people with kindness, respect and compassion*

*1.2 make sure you deliver the fundamentals of care effectively*

**2 Listen to people and respond to their preferences and concerns**

*To achieve this, you must:*

*2.6 recognise when people are anxious or in distress and respond compassionately and politely*

**8 Work 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*

**14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place**

*To achieve this, you must:*

*14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

*14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

*14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

**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*

**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*

**20.8** *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

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

In respect of Charge 1a, and you describing Service User B as “*a pain in the arse*”, the panel noted your admission at the outset of the hearing. The panel considered your work environment and acknowledged that nursing people with mental health disorders and service users who are sectioned is by its very nature, difficult and challenging. The panel considered that working in that environment requires professionalism and by you referring to Service User B as a “*pain in the arse*”, whose behaviour is clearly driven by an illness, falls far short of the standards expected of a registered nurse. The panel considered in referring Service User B as a “*pain in the arse*” to be derogatory and unkind. It also considered that in your evidence you told the panel that you said the comment in a private space in the work office. The panel accepted that this comment was not said directly to the service user but was nonetheless said to junior colleagues and that was very unprofessional. These staff may have been caring to Service User B wherein these negative words could have impacted the care they delivered. As such, the panel determined that your actions are sufficiently serious to amount to a finding of misconduct.

In respect of Charge 1b, and you saying that the ward team “*won't be feeding into her*” in regards to Service User B, the panel considered your explanation in your oral evidence that Service User B was refusing to follow her care plan and that in saying this comment you meant that you were not going to give in to Service User B's demands around her care plan and that the care plan needed to be followed. It considered that you admitted to this charge at the outset of this hearing and provided a plausible explanation in your

evidence. The panel determined that whilst your choice of language at the time that the comment was made could have been more professionally expressed and that you could have been clearer in how you conveyed what you meant, this does not amount to misconduct.

In respect of Charge 1c, and that you did not take adequate action when you witnessed a support worker making derogatory comments about Service User B, the panel considered that you were working as a Band 6 nurse and were the most senior person on shift on the day that the incident occurred. It considered at that time Service User B was already highly vulnerable. The panel considered that her vulnerability was further amplified by the fact that she was in seclusion and that you, along with the support worker were about to undertake an intimate procedure at the time the derogatory comment was made by the Support worker. The panel considered that Service User B should have been treated with courtesy, dignity and respect and that she was not, as it was evident that the Support worker said the derogatory comment in a loud manner and with the apparent intention that Service User B would hear. The panel determined that you had the opportunity in that moment to address the Support worker and to ensure that Service User B was not distressed, however you maintained in your evidence that you did not hear the Support Worker. The panel determined that as the most senior member of staff on shift, your failure to take any action at all, may be interpreted by junior staff as giving permission for that type of behaviour to continue and that this is serious. Accordingly, the panel determined that your failure to take action is sufficiently serious to amount to a finding of misconduct.

In regard to Charge 2a and that you agreed with a colleague that Service User A "*should be sent to jail*" the panel considered that in your oral evidence you confirmed that Service User A was not a prison referral. The panel considered that Service User A, who had complex mental health needs was in the most appropriate setting for her to receive the treatment she required. It considered that your comment was unkind and not compassionate towards a vulnerable patient and cannot be viewed as meaning anything other than the patient should be punished. The panel did not accept your explanation that

you said the comment out of frustration and being overwhelmed and that this is not the kind of behaviour or standards expected of a nurse. It further considered the implications of such a comment being said in front of other staff members and junior staff and that you were in a senior role. As such, the panel determined that your actions are sufficiently serious to amount to misconduct.

In regard to Charge 2b and you saying that the reason Service user A had been put in seclusion was “*Service User A being Service User A*” the panel considered that there was a very clear clinical justification for Service User A being in seclusion at that time. The panel considered that your comment was careless shorthand for the challenging and violent behaviours Service User A presented with. The panel noted that you were a senior nurse in charge and you made this comment to junior colleagues. The panel considered your evidence that you should not have said those words and that you did not intentionally mean that Service User A was in seclusion for being themselves. The panel considered that it was an ill-judged use of wording and that you should have been much clearer when discussing this information with junior colleagues. The panel determined that it does not reach the threshold for a finding of misconduct.

In regard to Charge 3c and that you said in respect of Service User A “*she’s not to have anything? That’s grand. That’s fine. I’m not arsed, she’ll be getting fuck all off me*”, the panel considered that this is highly inappropriate language that is both unkind and lacks compassion. When asked during panel questions if this was said during handover, you agreed that it was. The panel considered this to be particularly serious as you were the senior member of staff making these comments in front of other staff members. As such, it considered that you have a responsibility to set the standard that this behaviour falls far short of what is expected of a nurse in charge. The panel considered your explanation that there were staffing pressures and that you were venting, however on this occasion you had only just come on duty and it would in any event be completely inappropriate language to use regarding a vulnerable patient in a handover setting. As such, the panel determined that your behaviour was sufficiently serious to amount to misconduct.

The panel considered that Charges 4a, 4b and 4c form part of the same incident and are of a conversation where you are shown in the BBC Panorama video footage to be sitting in the nurse's office, on the floor in a relaxed position and speaking to other members of staff.

In regard to Charge 4a, and that you said in regard to Service User A "*send her to prison*" the panel considered that Service User A was a vulnerable patient with complex mental health needs. The panel considered that your comment was unkind and not compassionate towards a vulnerable patient and cannot be viewed as meaning anything other than the patient should be punished. The panel considered this to be completely inappropriate in regard to a patient who is at the Centre for appropriate medical support and treatment. The panel did not accept your explanation that you said the comment out of frustration and being overwhelmed and that this is not the kind of behaviour or standards expected of a nurse. Accordingly, the panel determined that your conduct is sufficiently serious to amount to misconduct.

In regard to Charge 4b, and that you said that Service User A would "*soon be brought down a peg or two*", the panel considered that this comment is unkind and lacking compassion for a vulnerable patient. The panel considered that as a nurse in this environment, you are supposed to be leading the nursing care to support the recovery of a vulnerable patient who is experiencing ill health due to their serious mental health condition. In making this comment you are not acting in a way that a nurse is expected. As such, the panel determined that your actions are sufficiently serious to amount to misconduct.

In regard to Charge 4c and that Service User A "*needs a good thrashing*" the panel considered that your use of terminology and language is completely unacceptable. It noted that in your evidence, when asked what you meant by this comment you said "*hit*". The panel considered that Service User A was a vulnerable patient, undergoing treatment for her mental health and your suggestion that violence should be used as a means to deal with her needs is not compassionate or kind and is completely unjustifiable. The panel

considered that as a senior nurse, saying this comment in front of junior colleagues, could encourage them to act upon your words to cause actual harm to patients. The panel determined that your conduct is sufficiently serious to amount to misconduct.

In regard to Charge 4e and that you said in respect of Service User C, “*I would have gone through her*”, when asked in panel questions what you meant by this, you told the panel that you meant you would “*verbally challenge her*”. The panel considered that your use of language and phrasing to be unacceptable, unkind and not compassionate regarding a vulnerable patient. The panel also considered that in your evidence you accepted that the terminology that you used often implies a physical challenge and that other people could have interpreted this in such a way. The panel considered that as a nurse in charge, the potential consequences of your comment being interpreted a different way is serious and that there is a risk that other members of staff may have acted upon it and caused physical harm to patients. The panel considered that this behaviour is a departure from the standards expected of a nurse and that it is sufficiently serious to amount to misconduct.

The panel found that your actions in Charges 1a, 1c, 2a, 3c, 4a, 4b, 4c and 4e did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

### **Decision and reasons on impairment**

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

In coming to its decision, the panel had regard to the NMC Guidance FTP-16 namely ‘*Insight and strengthened practice*’ last updated 14 April 2021 and DMA-1 namely ‘*Impairment*’ last Updated 28 January 2026, in which the following is stated:

*'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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.

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

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

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

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

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

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

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

d) ...'

The panel concluded that limbs a), b) and c) of Dame Janet Smith's "test" in *Grant* are engaged in this case.

The panel noted that both Mr Malik and Mr Shadenbury agreed that in the past your fitness to practise was impaired. The panel determined that in the past you put patients at unwarranted risk of psychological, emotional and physical harm through your behaviour, making derogatory comments about service users and by not challenging a derogatory comment made by a Support worker when you witnessed it. The panel considered that you were the most senior member of staff on shift and that you were working with extremely vulnerable patients with complex mental health needs. As the most senior person on shift, the panel noted that your behaviour sets the standard for that environment and in making those comments about service users, it set a permissive tone to other members of staff that they are allowed to do the same.

The panel considered that your misconduct breached the fundamental tenets of the nursing profession namely '*Prioritise People, Practise Effectively, Preserve Safety and Promote Professionalism and Trust*' and that in making those comments, you were not kind and compassionate towards the service users, nor did you act in their best interests at the time. The panel considered that these actions are not those expected of a registered nurse and therefore you brought its reputation into disrepute.

The panel next considered your insight. The panel acknowledged your explanation in your oral evidence that the environment at the Centre was toxic. In your written statement you said:

*'During my period on Buttermere Ward we were understaffed with a lack of support and resources to allow us to express our emotions. Staffing levels and burn out was discussed with management and operational management which appeared to fall on deaf ears as nothing seemed to be done about it. Staff became accepting of the low staffing levels and stopped raising it due to it being a regular occurrence... The culture on the ward was one where staff worked to get by. Morale was low and people were burnt out and frustrated.'*

In your oral evidence, you confirmed this to the panel and told it that there were staffing issues and that that in reference to the women's ward you said, "*no one wanted to work there*" and that this fluctuated depending on the level of staffing. This is supported in the Trust's Governance and Assurance Review dated March 2023. You further told the panel that there was a toxic culture in the ward, where it was permissive for staff to speak about service users in the staff room in this way. You told the panel that you were newly qualified when you started at the Centre and you were often the only Band 6 on the ward on shift and that there was no Band 7.

The panel considered that it was evident in your oral evidence that you are profoundly sorry for your actions and that you told the panel that you had let yourself, patients, their families and the profession down. It considered that your remorse is genuine. The panel considered that in both your written statement and in your oral evidence, you showed clear insight and understanding into how your actions and the airing of the BBC Panorama programme would have had a detrimental effect on service users, their families, your colleagues and on the reputation of the nursing profession. It also noted your evidence that the culture was toxic and staffing levels were short.

The panel also considered your written statement and determined it did not include sufficient understanding regarding the personal factors which led to your conduct at the time. The panel found that whilst it does include meaningful insight including remorse and apology for your actions and insight into the impact your misconduct would have had on the service users and their families and the reputation of the nursing profession, it does not address why you allowed yourself to be drawn into the toxic culture on the ward, becoming part of it, or why you personally failed to challenge the behaviour of the support worker or the wider toxic culture. Further, you do not reflect on your role as the most senior member of staff in the ward, as a leader and the way in which you should have behaved as an example to other staff members.

Therefore, the panel determined that whilst you have shown good insight into the impact of your misconduct on service users, relatives, colleagues and the profession, it was not satisfied your insight was fully developed in your understanding of why you were drawn into that culture and did not challenge it.

In regard to what you would do differently in the future, in your written statement you said:

*'My action plan to prevent this from happening again would be to immediately challenge remarks and escalate my concerns appropriately if a safeguarding concern had arisen. I will not allow the office with multiple members of staff discuss patients in a derogatory manner nor will I do the same myself. I will encourage a positive culture where staff can discuss any concerns on a 1:1 basis to prevent burn out and allowing their emotions to impact their care. If I was feeling burnt out or frustrated I would take time off the ward to reflect and think of what I can do better.'*

The panel had sight of your numerous character references and noted that whilst they are very positive, many are undated or unsigned. The panel noted that there are three dated testimonials from nearer to time of the incident in 2023 and speak about you working at the time of the allegations. In relation to strengthening your practice, the panel considered

your evidence that you have not worked as a nurse since 2022. In your evidence you told the panel that you have completed an awareness to autism training course and that you have left the nursing profession and are currently training to be a teacher. The panel determined that your misconduct is not related to your clinical skills but rather is attitudinal and behavioural in nature and that the charges also relate to a wider context. As such, the panel considered that these were transferable skills and it would have been open to you to show strengthened practice, for example drawing on your teacher training. The panel noted there is no evidence before it to show how you have actually dealt with similar situations nor how you have challenged any inappropriate behaviour. Further the panel also noted that there is no evidence before it from any other area of your life to show how you have behaved differently in similar situations and have put into practice what you have learnt.

Having considered the factors of insight and strengthened practice, the panel considered the questions posed in the case of *Cohen*, namely whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

The panel determined that whilst the matters of the charges found proved are attitudinal in nature, which may make them more difficult to remediate, in your case, given your genuine remorse and current level of insight they could be capable of remediation. However, they have not yet been fully remediated. The panel determined that you have not provided examples of how you have remediated and what steps you have taken to prevent your misconduct from happening again. The panel determined that it cannot exclude a risk of repetition, particularly in light of your incomplete insight and insufficient remediation thus far.

In all the circumstances, the panel determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered that the public expects high standards of professionalism from a registered nurse and your behaviour fell far below these standards. It considered that your misconduct was serious and breached the fundamental tenets of the nursing profession. You were in a leadership role and had a particular responsibility to set professional standards and challenge poor practice. The panel considered that the public have been made aware of your conduct through the broadcasting of the BBC Panorama documentary in 2022 and that there is a high public interest in this case. It determined that public confidence in the profession, in the NMC as its regulator and the confidence of colleagues, would be seriously undermined, if a finding of impairment were not made in this case. Therefore, the panel finds your fitness to practise also impaired on the ground of public interest.

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.

## **Sanction**

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you 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). The panel also had regard to NMC Guidance SAN-4 '*Sanctions for the highest risk cases*' last updated 28 January 2026.

## Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, dated 10 April 2026, the NMC had advised you that it would seek the imposition of a strike-off if the panel found your fitness to practise currently impaired. He submitted that a strike-off is the most appropriate and proportionate sanction in this case.

Mr Malik submitted that consideration should be given to a number of factors in this case, including aggravating and mitigating features. Mr Malik submitted that there are a number of aggravating features in this case such as;

- multiple instances of misconduct,
- the pattern over time,
- the misconduct concerned highly vulnerable service users,
- comments were made in front of junior staff,
- risk of harm to multiple service users,
- breach of position of trust,
- limited insight into failings,
- the fundamental breach of the tenets of the profession.

Further, Mr Malik submitted that the mitigating feature in this case, is that you made admissions at the start of this hearing.

In respect of sanctions, Mr Malik submitted that taking the NMC guidance SAN-2a '*Taking no further action*' last updated 28 January 2026 and SAN-2b '*Caution order*' last updated 28 January 2026 into consideration, this case is too serious for taking no action or a caution order due to the abuse of vulnerable patients. He submitted that this case is not at the lower end of the spectrum of impaired fitness to practice and there is no evidence before the panel of any retraining. He further submitted that you have limited insight and that repetition of the behaviour is highly likely. He submitted that the panel determined that

it could not exclude a risk of repetition, particularly in light of incomplete insight and insufficient remediation thus far. As such, he submitted that taking no action, or a caution order would not be proportionate or in the public interest.

In respect of a conditions of practice order, Mr Malik submitted that this would not be appropriate as there are no areas of practise in need of assessment or training as these are not clinical concerns but attitudinal. He submitted that the issue in this case is more fundamental as it is someone who has made inappropriate comments and failed to act when others made inappropriate comments in relation to highly vulnerable service users. He submitted that the NMC guidance SAN- 2c '*Conditions of practice order*' last updated 28 January 2026 indicates that conditions should be relevant, proportionate, workable and measurable and that as the matter in this case is too serious, there are no workable or measurable conditions that could be formulated to deal with these regulatory concerns.

In respect of a suspension order, Mr Malik referred the panel to NMC Guidance SAN-2d '*Suspension order*' last updated 28 January 2026. He submitted that the charges found proved are at the most serious end of the spectrum and that they call into question your suitability to continue practising. He submitted that the concerns are extremely serious, and that the abuse of highly vulnerable service users is at the higher end of the spectrum. He submitted that your insight is limited and there is a risk to the safety of people using services if you were allowed to continue to practise even with conditions. He submitted that the concerns are not easily remediable and the panel determined that the misconduct is not related to clinical skills and is attitudinal and behavioural in nature. He submitted that the panel determined that your statement did not include sufficient understanding regarding the personal factors which led to the conduct at the time. Mr Malik submitted that this is a serious concern as there is no evidence to address why you allowed yourself to be drawn into the toxic culture on the ward and why you failed to challenge the behaviour of the support worker or the wider toxic culture. He submitted that you were the most senior member of staff on the ward and that you should have led by example. He submitted that a temporary removal from the Register would be insufficient to maintain

public confidence and professional standards and therefore a suspension order is not appropriate as the conduct in this case is incompatible with continued registration.

In regard to a striking off order, Mr Malik referred the panel to NMC Guidance SAN-2e '*Striking – off order*' last updated 28 January 2026. He submitted that the nature and seriousness of your misconduct, calls into question your integrity and professionalism. He submitted that any allegation involving the abuse or neglect of vulnerable adults should always be treated seriously and it can have a severe impact on public confidence, the professional's ability to uphold the standards set out in the code and the safety of people receiving care. Mr Malik submitted that you put patients at unwarranted risk of psychological, emotional and physical harm through your behaviour. He submitted that you were the most senior nurse on shift that the panel were not satisfied that your insight is fully developed in the understanding of why you were drawn into the culture and did not challenge it. He submitted that your actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. He submitted that trust and confidence in the nursing profession and in the NMC as its regulator can only be maintained by the imposition of a striking off order and that in all the circumstances this is the only appropriate and proportionate order.

The panel also bore in mind Mr Shadenbury's submissions on your behalf.

Mr Shadenbury submitted that there are no universal or inflexible rules and that the individual circumstances in this case should be a factor.

Mr Shadenbury submitted that in respect of the mitigating factors in this case, there is no evidence of actual harm to service users, you have made early admission to the charges and you have provided to the panel positive character references from your colleagues. He further submitted that you have demonstrated great genuine remorse and you have demonstrated meaningful insight. Mr Shadenbury submitted that personal mitigation may be found in Exhibit 3 of your Registrants bundle, but that you have not sought to use this as an excuse for your behaviour and that you have accepted the panel's decision that your

conduct contributed toward the culture of the staff. He submitted that you also accepted that you were a senior member of staff at the time you made the comments about service users.

Mr Shadenbury accepted that in respect of the sanctions available to the panel, it is likely to determine that taking no further action would be inappropriate in the view of the seriousness of the case. He also accepted that this would be the case for a caution order as well. In respect of conditions of practice, Mr Shadenbury conceded that there are no practical or workable conditions that could be formulated given the misconduct identified in this case and it is not something that can be easily addressed through conditions. He accepted that the panel's choice in this matter is determining if a suspension order or a strike off order is the most appropriate sanction.

Mr Shadenbury submitted that in respect of a suspension order, it is the most appropriate and proportionate in this case. He submitted that the panel determined that based upon your genuine remorse and current level of insight, the conduct could be capable of remediation. He submitted that you have engaged in this fitness to practise process since the beginning and that you have cooperated with the NMC at all times. He submitted that the panel should give you an opportunity to change positively and address the concerns within its decision during a period of suspension. Further, he submitted that a period of suspension would demonstrate to the public the standards of the profession are to be upheld in the removal of a nurse that has damaged the reputation of the profession, whilst allowing that nurse to strengthen her practise and fully develop her insight, whilst suspended.

Mr Shadenbury accepted that you told the panel in your evidence that you did not intend to return to nursing practice in the future. He also submitted that the panel may be rightly concerned that if it determined that a suspension order is the most appropriate sanction that you will not adequately strengthen your practise because you have no intention to return to nursing practice. Mr Shadenbury submitted that whilst it may be true that today, you do not wish to return to nursing practice, he asked the panel to give you time to fully

consider whether, after a period of suspension, if you do want to continue working in the nursing profession and address the concerns identified by the panel.

In respect of a striking off order, Mr Shadenbury submitted that it is not appropriate or proportionate in this case as the incidents of misconduct are not fundamentally incompatible with you remaining on the NMC's register.

Mr Shadenbury submitted that a 12 month suspension order would be the most appropriate sanction in this case.

### **Decision and reasons on sanction**

The panel accepted the advice of the legal assessor who referred the panel to the relevant case law of *Atkinson v General Medical Council* [2009] EWHC 3636 (Admin), *Giele v General Medical Council* [2005] EWHC 2143 (Admin), *Bolton v Law Society* [1994] 1 WLR 512, *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, *Bijl v GMC* [2001] UKPC 42 and *O v Nursing and Midwifery Council* [2015] EWHC 2949 (Admin).

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 to be the aggravating features:

- You were working in a leadership position, as Deputy Ward Manager at the time of your misconduct,
- Conduct which put highly vulnerable service users at real risk of physical, psychological and emotional harm,

- Deliberate breaches of the Code - The panel considered that the comments you made were not in direct response to any trigger event or made in the heat of the moment. It considered that as a registered nurse, you were aware of the Code and you would have known that your conduct in making derogatory comments and not intervening when a support worker made a derogatory comment about a service user was wrong.
- A pattern of misconduct over a period of time- The panel considered that your misconduct occurred over a number of dates and involved a number of different vulnerable service users. It considered that your conduct was not an isolated incident and that there was a pattern of language, with similar thematic characteristics used over a period of time to various junior staff members.
- Vulnerability of the person receiving care – The panel considered that patients with complex mental health needs, being cared for in a secure mental health unit are particularly vulnerable.

The panel identified the following to be the mitigating features:

- Early admission of the facts at the earliest possible opportunity. The panel considered that you made early admissions in the internal disciplinary hearing and you have made admissions at the outset of the NMC regulatory proceedings.
- Whilst the panel noted there was no evidence of apologies directed to the service users, the panel also noted that in the course of the hearing, and in your written statement, you apologised profusely for how your words and your actions would have affected service users, their family members, the Trust and the nursing profession.
- In your personal written statement and in your oral submissions, the panel noted that you had good insight into some areas regarding the impact your actions may have had on service users, their families, colleagues, the Trust and on the nursing profession.
- Existing culture on the ward and lack of support for staff.

The panel had sight of the many positive character references provided as evidence in this hearing but identified limitations with them in so far as many of the character references were mostly undated, unsigned and were written closer to the time of the incident. It further noted that the authors of the character references did not identify that they were aware of the allegations against you and so the panel determined that it would give the character references less weight for the reasons outlined above.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would 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*' (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

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

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on '*Conditions of practice order*' (Reference: SAN-2c Last Updated: 28/01/2026). The panel noted that both Mr

Shadenbury and Mr Malik agreed that this is not a case where the concerns are related to your clinical competence and are instead related to your attitude and behaviour. Having regard to the nature and seriousness of your conduct, and that you have not been practising as a nurse since 2022, the panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards. As such, the panel determined that a conditions of practice order would not be appropriate or proportionate in the circumstances.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on ‘*Suspension order*’ (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

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

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *‘the charges found proved are at the most serious end of the spectrum and call into question the professional’s suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*

- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel considered that the charges found proved related to your attitude and behaviour toward highly vulnerable service users who were being cared for due to a decline in their complex mental health, and that your misconduct was very serious in nature. The panel considered the charges found proved, where you said to other staff members that Service User A *'needs a good thrashing'* and that whilst she was experiencing a period of poor mental health, you said she should *'should be sent to prison'*. The panel considered that your conduct was a significant departure from the standards expected of a registered nurse.

The panel acknowledged your early admissions to the allegations. It also considered that whilst you have shown some meaningful insight including remorse and apology for your actions and insight into the impact your misconduct would have had on the service users and their families and the reputation of the nursing profession, you have not addressed why you allowed yourself to be drawn into the toxic culture on the ward, becoming part of it, or why you personally failed to challenge the behaviour of the support worker or the wider toxic culture. Accordingly, the panel concluded your insight is incomplete regarding this critical element.

The panel also considered the NMC's Guidance SAN-3 *'Deciding between suspension and strike off'* last updated 28 January 2026. It paid particular attention to the following paragraph:

- *'consider all of the relevant aggravating and mitigating factors*

- *consider that, unless the Committee directs otherwise, a suspension order will be reviewed before its expiry and may be extended. However, the Committee cannot direct that the suspension must be extended on review. As such the Committee should consider whether public confidence in the profession would be protected if the professional returned to practice after one year, or ever*
- *Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.'*

The panel considered that in the four years that have passed between the incident and this hearing, you have not made meaningful progress in reflecting on the critical element of how you allowed yourself to be drawn into the toxic culture as opposed to challenging it, nor taken any meaningful steps to remediate and demonstrate that you have strengthened your practice. Therefore, the panel considered that there is no realistic prospect that you would address the concerns to such an extent that you would be able to return to unrestricted practice. The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to protect the public.

Further, the panel considered that the public interest in this case is very high due to the nature of the charges found proved. The panel had regard to the NMC Guidance SAN-2e 'Striking-off order' last updated 28 January 2026 and SAN-4 on 'Sanctions for the highest risk cases' (Reference SAN-4 Last Updated: 28/01/2026). The panel considered the guidance regarding 'Abuse or neglect of children or vulnerable people' is engaged in this case. The panel determined that this case falls within the definition of being a 'highest risk case'.

The panel determined that public confidence in the profession and professional standards simply could not be maintained if you were able to continue practising as a nurse. It concluded that a suspension order would not be sufficient to uphold public confidence in the profession and in the NMC as its regulator due to the seriousness and nature of the facts found proved.

The panel had regard to the following considerations as set out in the NMC Guidance entitled '*Striking-off order*' (Reference: SAN-2e Last Updated; 28/01/2026):

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

The panel determined that your misconduct is very serious in nature and that your actions posed a real risk of psychological, physical and emotional harm to highly vulnerable service users. The panel considered that at the time of the incident, you were working in the ward as a Deputy Ward Manager. In your evidence you told the panel that you were often the most senior member of staff on shift. The panel considered that many of the comments in the charges found proved were said to junior staff members on the ward. You said in respect of Service User A, "*I'm not arsed, she'll be getting fuck all off me*", that Service User A "*should be sent to prison*" and that Service User A "*needs a good thrashing.*"

In your evidence, you told the panel that you made the comments as you were emotional, frustrated and venting to other staff members. Further, the panel considered your explanation that there was a toxic culture in the ward and that it was short staffed. The panel determined that as the most senior member of staff, it was completely unacceptable that you made these comments about highly vulnerable service users in front of other staff members.

The panel also determined that it was completely unacceptable that you did not challenge the behaviour of a staff member when they made a derogatory comment about a service user in your presence, and in doing so, you perpetuated and enabled the toxic culture that you said was existent in the ward. Your comments such as '*need a good thrashing*' or '*I would have gone through her*', could have been interpreted by other staff members as permission to treat the service users poorly. As such, the panel considered that your behaviour is very serious and could have led to serious harm to vulnerable service users who were ill with their complex mental health needs, as you were making these statements to the staff members who were directly responsible for providing their care. The panel considered that your misconduct gives rise to fundamental questions regarding your professionalism.

In regards to your insight and strengthening of practice, the panel noted that whilst you have shown a good level of insight into the impact that your actions had on service users, their relatives, your colleagues, the Trust and the nursing profession, there were areas in which your insight is not yet fully developed and critically you have not addressed why you allowed yourself to be drawn into the toxic culture on the ward, becoming part of it, or why you personally failed to challenge the behaviour of the support worker or the wider toxic culture. It considered that in the time between the incidents and this hearing, you have had the opportunity to demonstrate further evidence of strengthening of practice. It found that there was no evidence before it of your strengthened practice. The panel also heard in your evidence that you do not intend to practise as a nurse in the future and have begun teacher training. The panel considered that you could have used examples from this training or other areas of your life to demonstrate further insight and strengthening of

practice but there is nothing before it at this hearing. Consequently, the panel is not satisfied that you would be able to show further evidence of improved insight or strengthened practice following a period of suspension.

Having carefully weighed all the aggravating and mitigating factors when considering the sanction of strike-off, the panel have concluded that your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were very serious and any sanction less than a strike-off would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel considered the high public interest in this case and decided that the misconduct would likely undermine public trust and confidence in the nursing profession and the NMC as its regulator if you were permitted to return to practice. In light of this, the panel considered that a striking-off order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

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

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 to cover the potential appeal period. 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**

The panel took account of the submissions made by Mr Malik. He submitted that given the panel's decision on sanction, an interim suspension order for a period of 18 months is necessary to protect the public and is also otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

Mr Shadenbury made no submissions.

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

### **Decision and reasons on interim order**

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. Not to impose an interim suspension order would be inconsistent with the panel's earlier findings and determination.

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

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

That concludes this determination.