Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Wednesday 06 May 2026 to Tuesday 19 May 2026

Virtual Hearing

Name of Registrant:	**Claire Ann Fitzpatrick**
NMC PIN:	08A0016S
Part(s) of the register:	Sub Part 1 Registered Nurse - Mental Health RNMH: Mental health nurse, level 1 (24 January 2011)
Relevant Location:	Cumbria
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, lay member) Karen Gardiner (Registrant member) Saiqa Shaffi (Lay member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Ifeoma Okere
Nursing and Midwifery Council:	Represented by Rowena Wisniewska, Case Presenter
Mrs Fitzpatrick:	Not Present and unrepresented
Facts proved:	Charges 1(a), 1(c), 2, 3(a), 3(b), 4, 5, 6, 7, 8, 9(a), 9(b), 10, 11, 12, 13, 14, 15, 17 and 18
Facts not proved:	Charges 1 (b) and 16
Fitness to practise:	**Impaired**
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Fitzpatrick was not in attendance and that the Notice of Hearing letter had been sent to Mrs Fitzpatrick's registered email address by secure email on 2 April 2026.

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

The panel accepted the advice of the legal assessor.

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

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

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

At the outset of the hearing, Ms Wisniewska made an application for parts of this case to be held in private on the basis that a proper exploration of Mrs Fitzpatrick's case may involve reference to her private life and/or matters concerning her health. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

Ms Wisniewska indicated that she was not proposing that the entirety of the proceedings be held in private. Rather, she submitted that, in the event that reference is made to such material, those parts of the hearing should be heard in private.

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

The panel accepted the advice of the legal assessor.

The panel took into account that, pursuant to Rule 19(1) of the Rules, hearings should ordinarily be conducted in public, reflecting the principle of open justice. However, the panel also noted that Rule 19(3) provides the discretion to hold all or part of a hearing in private where this is justified by the interests of any party or otherwise in the public interest.

The panel noted Ms Wisniewska's submission that there may be references during the proceedings to Mrs Fitzpatrick's private life and/or health matters. The panel also took into account the legal assessor's advice that individuals should be able to discuss matters relating to their health and private life freely within proceedings where relevant, without concern that such matters would enter the public domain.

The panel considered that it would not be appropriate or proportionate for the entirety of the hearing to be conducted in private. However, the panel determined that, where references arise relating to Mrs Fitzpatrick's health and/or personal family matters, those parts of the hearing should be heard in private in order to protect her privacy. Equally, the panel determined that should reference be made to the personal or health related matters of any witnesses, this should also be heard in private. The panel further determined that this approach appropriately balanced the principle of open justice with the need to protect confidential and sensitive information.

Accordingly, the panel determined that the hearing would proceed in public, save for any parts of the proceedings concerning health and/or personal family matters which would be heard in private.

Decision and reasons on proceeding in the absence of Mrs Fitzpatrick

The panel next considered whether it should proceed in the absence of Mrs Fitzpatrick. It had regard to Rule 21 and heard the submissions of Ms Wisniewska who invited the panel to continue in the absence of Mrs Fitzpatrick. Ms Wisniewska submitted that the panel may proceed in Mrs Fitzpatrick's absence pursuant to the Rules, provided that it is satisfied that notice of hearing had been duly served. She referred the panel to the proceeding in absence bundle document, specifically the email dated 24 April 2026, in which Mrs Fitzpatrick stated:

"I confirm that my position remains unchanged and I will not be attending, I will not be willing to participate in the forthcoming hearing."

Ms Wisniewska submitted that, in light of this communication, Mrs Fitzpatrick had voluntarily absented herself from the proceedings. She further submitted that no application for an adjournment had been made.

Ms Wisniewska submitted that an adjournment would not be appropriate because:

- The notice of hearing had been validly served;
- There is a public interest in dealing with fitness to practise proceedings expeditiously in order to protect the public and maintain confidence in the profession and the regulator;
- Delay may affect the quality of witness evidence and recollection;
- Witnesses had already made themselves available to attend; and
- There was no indication that an adjournment would secure Mrs Fitzpatrick 's attendance at a future hearing.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised

'with the utmost care and caution' as referred to the cases of *R v Jones (Anthony William) [2002] UKHL 5, General Medical Council v Adeogba [2016] EWCA Civ 162 and Davies v HCPC [2016] EWHC 1593 (Admin*).

The panel has decided to proceed in the absence of Mrs Fitzpatrick. In reaching this decision, the panel has considered the submissions of Ms Wisniewska and the advice of the legal assessor. It has had particular regard to the factors set out in *R v Jones (Anthony William) [2002] UKHL 5, General Medical Council v Adeogba [2016] EWCA Civ 162 and Davies v Health and Care Professions Council [2016] EWHC 1593 (Admin).* The panel has also had regard to the overall interests of justice and fairness to all parties.

The panel noted that:

- No application for an adjournment has been made by Mrs Fitzpatrick;
- Mrs Fitzpatrick has informed the NMC that she would not be attending and would not be willing to participate in the hearing;
- There is no reason to suppose that adjourning would secure Mrs Fitzpatrick's attendance at some future date;
- Witnesses have attended today to give live evidence and others are due to attend;
- Not proceeding may inconvenience the witnesses and potentially affect the quality of the hearing overall;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

The panel considered that there may be some disadvantage to Mrs Fitzpatrick in proceeding in her absence. The panel noted that Mrs Fitzpatrick would not be able to challenge the evidence relied upon by the NMC in person and would not be able to

give evidence on her own behalf. However, the panel considered that this disadvantage could be mitigated. The panel was mindful that it could test the evidence presented by the NMC, explore any inconsistencies in the evidence, and exercise caution when assessing the evidence before it.

The panel further considered that any disadvantage arose as a consequence of Mrs Fitzpatrick's voluntary decision not to attend or participate in the hearing, despite having notice of the proceedings and confirming her position to the NMC.

In these circumstances, the panel determined that it was fair, appropriate and proportionate to proceed in the absence of Mrs Fitzpatrick. The panel determined that no adverse inference would be drawn from Mrs Fitzpatrick's absence when reaching its findings on the facts.

Decision and reasons on the application to admit hearsay evidence

Ms Wisniewska applied to admit the following documents as hearsay evidence pursuant to Rule 31 of the Rules:

1. Police record of interview under caution;
2. CQC inspection report dated 17 January 2022;
3. Mrs Fitzpatrick's reflective pieces;
4. Mrs Fitzpatrick's partial CV;
5. Police email dated 8 April 2024 confirming no further action; and
6. RCN letter dated 17 January 2025.

Ms Wisniewska submitted that hearsay evidence is admissible in regulatory proceedings where it is fair and appropriate. She submitted that the panel should adopt the two-stage approach identified in *El Karout v NMC [2019] EWHC 28 (Admin)*, namely first considering admissibility and thereafter determining the appropriate weight to attach to the evidence. Ms Wisniewska further referred the panel to the guidance in *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*, and invited the panel to consider the seven factors identified therein.

Ms Wisniewska submitted that none of the documents were sole or decisive evidence in relation to the charges and that each document was relevant to the issues before the panel. She further submitted that there was no evidence that the documents had been fabricated, that Mrs Fitzpatrick had prior notice of the documents, and that she had not challenged their contents.

Ms Wisniewska invited the panel to admit the documents and thereafter determine the appropriate weight to attach to each document at the conclusion of the case.

The panel accepted the advice of the legal assessor. The panel had regard to Rule 31 of the Rules, the NMC guidance entitled “Evidence” (DMA-6), *El Karout v NMC [2019] EWHC 28 (Admin),* and the principles set out in Thorneycroft.

The panel reminded itself that it must first determine admissibility and thereafter determine what weight, if any, should be attached to the evidence.

1. Police Record of Interview Under Caution

The panel determined that this document was relevant to Charges 5 to 10, as it related to the police investigation concerning the allegations before the panel.

The panel noted that the document was not a formal transcript of interview, but rather the police officer’s account and summary of the interviews. The panel considered this relevant to the issue of weight rather than admissibility.

The panel determined that the document was not sole or decisive evidence. The panel noted that there was other evidence before it, including witness evidence and documentary evidence, through which the matters contained in the document could be tested.

The panel noted there was no suggestion that the document had been fabricated. The panel further noted that Mrs Fitzpatrick had prior notice of the document and had not challenged its contents.

The panel considered that it would have been disproportionate to require the attendance of the police officer in circumstances where no further police action had been taken.

Accordingly, the panel determined that the document was admissible as hearsay evidence. The panel determined that the weight to be attached to the document would be considered when assessing it alongside other evidence during the course of the hearing.

2. CQC Inspection Report dated 17 January 2022

The panel determined that the Care Quality Commission (CQC) inspection report was relevant to Charge 1 and to the wider background and context of the care home environment during the relevant period. The panel noted that the report related to inspections conducted during November 2021, which incorporated inspection of records, policies and procedures in place at the material time of the allegations.

The panel determined that the document was not sole or decisive evidence. The panel noted that there would be oral witness evidence, documentary evidence, audits and other material available to test the matters referred to within the report.

The panel considered that the report was an official document prepared through a formal inspection process using a standard regulatory framework. The panel found no evidence or suggestion that the report had been fabricated.

The panel further considered that it would not have been proportionate to require the attendance of the author of the report, particularly given that the report assessed the care home generally rather than specifically assessing Mrs Fitzpatrick’s conduct.

The panel therefore determined that the report was admissible as hearsay evidence. The panel determined that the appropriate weight to attach to the document would be considered when assessing it alongside other evidence during the course of the hearing.

3. Mrs Fitzpatrick's Reflective Pieces

The panel determined that the reflective pieces were relevant as they constituted Mrs Fitzpatrick's response to the allegations and provided insight into her account and reflections regarding the concerns raised.

The panel determined that the documents were not sole or decisive evidence, noting that the panel would also hear the NMC's evidence relating to the allegations.

The panel noted that the reflective pieces had been included within the hearing bundle served upon Mrs Fitzpatrick and that she had not disputed authorship or challenged the contents.

The panel acknowledged that, in Mrs Fitzpatrick's absence, the panel would not have the opportunity to ask questions regarding the contents of the reflections. The panel determined that this issue was relevant to the weight to be attached to the evidence rather than admissibility. Accordingly, the panel determined that the reflective pieces were admissible as hearsay evidence.

The panel determined that the weight to be attached to the document would be considered when assessing it alongside other evidence during the course of the hearing.

4. Mrs Fitzpatrick's Partial Curriculum Vitae (CV)

The panel determined that the partial CV was relevant as it detailed Mrs Fitzpatrick's employment history, experience and roles within the care home sector during the relevant period.

The panel determined that the document was not sole or decisive evidence. The panel noted that Mrs Fitzpatrick's roles and responsibilities could also be assessed through witness evidence and other documentary material before the panel.

The panel noted that the document had been provided by Mrs Fitzpatrick and had been included within the hearing bundle served upon her. Mrs Fitzpatrick had not disputed its authenticity or contents.

The panel found no evidence suggesting that the document had been fabricated.

Accordingly, the panel determined that the partial CV was admissible as hearsay evidence. The panel determined that the weight to be attached to the document would be considered when assessing it alongside other evidence during the course of the hearing.

5. Police Email dated 8 April 2024

The panel considered whether the police email confirming that no further action would be taken was relevant to the regulatory proceedings.

The panel determined that the document was not relevant to the issues the panel was required to determine. The panel considered that the police investigation concerned criminal matters assessed against the criminal standard and criminal offences, whereas the panel's role was to determine regulatory concerns arising under the NMC Code of Conduct (the Code) 2015.

The panel determined that the fact that the police had taken no further action, as the panel determines matters against the civil standard, did not assist the panel in determining the regulatory allegations before it.

Accordingly, the panel determined that the police email dated 8 April 2024 was not admissible.

6. Royal College of Nursing (RCN) Letter dated 17 January 2025

The panel determined that the RCN letter was relevant as it contained Mrs Fitzpatrick's response, through her representative at the time, to the allegations and concerns raised by the NMC.

The panel determined that the document was not sole or decisive evidence and that there was other evidence available to the panel concerning the allegations.

The panel noted that the document had been formally produced by Mrs Fitzpatrick's representative and included within the hearing bundle served upon her. The panel

further noted that Mrs Fitzpatrick had not disputed the contents or authenticity of the document.

The panel considered that, in light of Mrs Fitzpatrick's absence from the proceedings, fairness required that the panel consider one of the few available accounts setting out her position in response to the allegations.

Accordingly, the panel determined that the RCN letter was admissible as hearsay evidence.

The panel determined that the weight to be attached to the document would be considered when assessing it alongside other evidence during the course of the hearing.

Details of charge

That you, while working as Home Manager at **[PRIVATE]**:

1. On a date or dates between 2019 and 2021 failed to ensure that care records for one or more of the residents listed in Schedule 1:
(a) were completed; or
(b) contained the required information; and/or
(c) were kept up to date.

2. Between mid-June 2021 and 21 June 2021, failed to investigate medication omissions in relation to Patient A as requested.

3. Failed to notify CQC of the following resident deaths:

(a) Resident PA, on or after her death on 29 April 2021;
(b) Resident DC, on or after his death on 17 May 2021.

4. On a date on or after 28 June 2021, failed to keep a SOVA record for Resident AH who had suffered a skin tear and bruising of unknown origin.

5. Between 17 June 2021 and 7 August 2021 made one or more cash withdrawals from Resident CM's Post Office account.

6. The cash withdrawals referred to at charge 5 were wholly or partly for your benefit.

7. Between 18 November 2020 and 26 February 2021 made one or more cash withdrawals from the Home's Residents' Bank Account on behalf of resident RL.

8. The cash withdrawals referred to at charge 7 were wholly or partly for your benefit.

9. Your conduct at charges 5, 6, 7 and/or 8 above was dishonest in that:
(a) in relation to Resident CM, you knew that the money in Resident CM's Post Office account did not belong to you;
(b) in relation to Resident RL, you knew that the money held in the Home's Residents' Account on his behalf did not belong to you.

10. Your conduct at charges 5, 6, 7 and/or 8 above demonstrated a lack of integrity.

11. On one or more dates between April 2016 and June 2021 borrowed and/or sought to borrow money from junior Colleague A.

12. Failed to repay around £1000 of the money you borrowed from junior Colleague A.

13. On one or more dates between 18 September 2020 and 11 March 2021 borrowed and/or sought to borrow money from junior Colleague B.

14. On a date or dates between 28 July 2021 and 20 December 2021 failed to engage in the local investigation into your alleged failings.

That you, while working at **[PRIVATE]**:

15. On a date or dates in or around December 2021 stole money from the home of Colleague C.

16. On 16 February 2023 removed a laptop from **[PRIVATE]** without authority to do so.

17. Your conduct at charges 15 and/or 16 above was dishonest in that you knew the money and/or the laptop did not belong to you.

18. Your conduct at charges 15 and/or 16 above demonstrated a lack of integrity.

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

Schedule 1

1. Resident CM
2. Resident A
3. Resident RL
4. Resident B
5. Resident C
6. Resident D
7. Resident E
8. Resident F
9. Resident G
10. Resident H
11. Resident I
12. Resident J
13. Resident K
14. Resident L
15. Resident M
16. Resident N
17. Resident O
18. Resident P
19. Resident Q
20. Resident R

21. Resident S
22. Resident T
23. Resident U
24. Resident AH
25. Resident V
26. Resident W
27. Resident X
28. Resident Y
29. Resident Z
30. Resident AA
31. Resident BB
32. Resident CC
33. Resident DD

Background

Ms Wisniewska informed the panel that, at the material time, Mrs Fitzpatrick was employed as a registered nurse and Home Manager within a care home setting.

Ms Wisniewska informed the panel that the allegations relate to concerns regarding Mrs Fitzpatrick's management and oversight of the care home, including concerns about care planning, risk assessments, governance arrangements and record keeping. The NMC alleges that there were failures to adequately maintain and oversee care records and documentation relating to residents within the home.

The panel was informed that the NMC case also includes allegations concerning financial matters involving service users' monies and borrowing monies from junior colleagues. Ms Wisniewska submitted that these allegations relate to cash withdrawals and financial transactions connected to residents of the care home. The panel was informed that these matters were subject to a police investigation and that Mrs Fitzpatrick was interviewed by the police under caution in relation to those allegations.

Ms Wisniewska submitted that, notwithstanding the outcome of the police investigation, the NMC maintains that the concerns remain capable of amounting to regulatory concerns which fall to be determined by this panel under the NMC's fitness to practise jurisdiction.

Ms Wisniewska also set out that further concerns came to light during the time Mrs Fitzpatrick was working at another care home relating to alleged theft. She stated that the regulatory concerns before the panel were wide ranging in nature.

The panel was informed that the NMC would rely upon documentary evidence, witness evidence, CQC inspection material, audits, care records, financial documentation and other records obtained during the investigation in support of the charges.

The panel was further informed that the hearing was listed for 11 days and that a number of witnesses had been scheduled to give evidence before the panel.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Fitzpatrick .

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

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

- **Ms Alyson Joyce**: Managing Director for **[PRIVATE]**; Mrs Fitzpatrick's line manager at the time of the concerns.

- **Mr Brian McCubbin:** Employee at **[PRIVATE]**; Manager at **[PRIVATE]** immediately before and after the time that Mrs Fitzpatrick was the Home manager.

- **Ms Karen Cleminson**: Employee at **[PRIVATE]**; Administrator at **[PRIVATE]**, at the time of the concerns.

- **Ms Linda Whittemore**: An Inspector employed by the Care Quality Commission ("CQC"); A CQC Inspector at the time of the concerns.

- **Ms Alison Grove**: Employee at **[PRIVATE]**; Senior Care Assistant at **[PRIVATE]** at the time of the concerns.

- **Ms Mary McInnes:** Operations Manager at a **[PRIVATE]** and **[PRIVATE]** at the time of the concerns.

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

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

Charge 1(a)

> "On a date or dates between 2019 and 2021 failed to ensure that care records for one or more of the residents listed in Schedule 1:
>
> (a) were completed"

This charge is found proved.

The panel first considered whether Mrs Fitzpatrick had a duty to ensure that care records for residents were completed.

The panel accepted the evidence of Ms Joyce and Mr McCubbin that, as Home Manager at **[PRIVATE]**, Mrs Fitzpatrick was responsible for overseeing the delivery of care to residents and for ensuring that appropriate care records were completed.

The panel had regard to Mrs Fitzpatrick's job description, which stated that she was responsible for ensuring the delivery of safe, personalised care services through *"assessment, person centred planning, monitoring and reviews."* The panel considered that this encompassed responsibility for ensuring that care records were properly completed.

The panel also considered the home action plan relating to care planning, which identified specific actions in relation to care records and named Mrs Fitzpatrick as the person responsible for implementing those actions. The panel considered this document demonstrated that Mrs Fitzpatrick had principle responsibility for the oversight and the duty to ensure that all care records for all of the residents at the home were complete.

The panel considered the meaning of *"care records*" in the context of this charge. It determined that this term was not limited to a single document. Rather, it included the range of documents necessary to provide a complete and accurate picture of a resident's needs, risks and preferences. This included care plans, risk assessments,

Do-Not-Attempt Resuscitation (DNAR) forms , Deprivation of Liberty (DOLs) documentation, Mental Capacity Act assessments (MCA), hospital transfer sheets, Malnutrition Universal Screening Tools (MUST), weight charts, wound care records and future wishes documentation.

The panel then considered the audit document described as the "*Spreadsheet of residents and missing information."* The panel found this document to be detailed and comprehensive and showed the results of an audit conducted on resident's records on 12, 15, 16 and 19 July 2021. It identified numerous examples of missing documents across residents' care files.

The panel accepted Ms Joyce's evidence that she commissioned this audit. The audit was initially compiled by Marie Forshaw, Deputy Manager, and subsequently cross-checked by Ms Joyce against the care records. The panel acknowledged that the audit was a live working document at the time, but did not consider this undermined its reliability. On the contrary, it demonstrated the breadth of the concerns identified.

In addition to missing care plans, the panel noted that most of the residents' care records which were audited were missing several key documents such as Mental Capacity Act assessments relating to resus status, nutritional assessments, oral assessments, hospital transfer sheets and Deprivation of Liberty paperwork.

This was supported in the letter to Mrs Fitzpatrick dated the 15 August 2021, when Ms Joyce highlighted the issue;

"…There are missing care plans are (sic) for 11 Service Users, and incomplete care plans for the majority of Service Users…"

The panel noted a significant number of residents' care plans completely missing including Residents I, M, X and BB.

The panel considered the context related to individual patient need and identified several omissions that created a risk of errors in care delivery, for example missing photographs which assist staff in correctly identifying service users who lack mental capacity or errors related to service users' ability to eat and drink safely.

The panel considered that these were not minor administrative oversights. They represented fundamental omissions in records essential to the safe delivery of care.

The panel reviewed the evidence in relation to each resident listed in Schedule 1.

In relation to Resident V, the panel was not satisfied that the evidence established that records were incomplete. The concerns relating to this resident were more appropriately characterised as records not being kept up to date, rather than not being completed.

In relation to all other residents listed in Schedule 1, the panel was satisfied that the documentary evidence demonstrated that required care records were missing or incomplete.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick failed to ensure that care records were completed for one or more residents listed in Schedule 1.

Charge 1(b)

> "On a date or dates between 2019 and 2021 failed to ensure that care records for one or more of the residents listed in Schedule 1:
>
> contained the required information"

This charge is found NOT proved.

The panel noted that this charge is put before it as an alternative to Charge 1a, but considered that there is some overlap between the two charges in terms of completed documentation and missing information. Given that Charge 1a was found proved for all residents except Resident V, the panel only considered charge 1b in relation to Resident V.

The panel first considered whether Mrs Fitzpatrick had a duty to ensure that residents' care records contained the information necessary to provide safe and effective care.

The panel accepted the evidence of Ms Joyce and Mr McCubbin that, as Home Manager, Mrs Fitzpatrick was responsible for ensuring that care records were sufficiently comprehensive to provide staff with an accurate and complete picture of each resident's needs, risks and preferences.

The panel had regard to Mrs Fitzpatrick's job description, which required her to ensure the delivery of safe, personalised care services through *"assessment, person centred planning, monitoring and reviews."* The panel was satisfied that this duty extended to ensuring that completed records contained the information required to support safe care.

The panel considered the audit document, (Spreadsheet of Residents missing information). The panel noted that the audit did not evidence any missing information for Resident V.

The panel was therefore not satisfied that in relation to Resident V, the NMC had established, on the balance of probabilities, that completed care records failed to contain the required information.

Charge 1(c)

> "On a date or dates between 2019 and 2021 failed to ensure that care records for one or more of the residents listed in Schedule 1:
>
> (c) were kept up to date"

This charge is found proved.

The panel first considered whether Mrs Fitzpatrick had a duty to ensure that residents' care records were kept up to date.

The panel accepted the evidence of Ms Joyce and Mr McCubbin that, as Home Manager at **[PRIVATE],** Mrs Fitzpatrick was responsible for ensuring that residents' care records were reviewed and updated regularly.

The panel had regard to Mrs Fitzpatrick's job description, which required her to ensure the delivery of safe, personalised care services through *"assessment, person*

centred planning, monitoring and reviews." The panel considered that this included an obligation to ensure that care records were reviewed and updated to reflect residents' current needs.

The panel also accepted Ms Joyce's evidence that care plans were expected to be reviewed at least monthly, and sooner if there was any significant change in a resident's condition or care needs.

The panel then considered the audit document, (Spreadsheet of Residents missing information). The audit identified numerous examples of care plans, assessments and related records that had not been reviewed for several months.

The panel noted that many documents had last been reviewed and/or updated in March or April 2021, despite the audit being undertaken in July 2021. The panel considered that these were not minor administrative delays, but significant lapses over a sustained period.

The panel noted the following examples from the audit:

- In relation to Resident RL, there was *"no review sheet of when formulated."*
- In relation to Resident B, a number of care plans, including falls, mobility, skin integrity and continence care plans, had not been reviewed since October 2020.
- In relation to Resident I, multiple care plans and assessments had not been reviewed since December 2020.
- In relation to Resident Q, care plans had not been reviewed since 14 March 2021.
- In relation to Resident AH, there was *"no recording in skin care plan evaluation of this wound*."

The panel considered that these examples demonstrated a widespread and consistent failure to ensure that care records were reviewed and updated as required.

The panel carefully reviewed the evidence in relation to each resident listed in Schedule 1.

The panel was not satisfied that the evidence was sufficient to establish that the care records for Residents H, K, L, X, Z and BB were not kept up to date. In relation to those residents, the documentary evidence did not clearly demonstrate overdue reviews or out of date documentation.

In relation to all other residents listed in Schedule 1, the panel was satisfied that the audit clearly demonstrated that care records, risk assessments and associated documentation had not been reviewed and updated in accordance with expected standards.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick failed to ensure that care records were kept up to date for one or more residents listed in Schedule 1, given that all but six residents did not have up to date records.

Charge 2

> "Between mid-June 2021 and 21 June 2021, failed to investigate medication omissions in relation to Patient A as requested."

This charge is found proved.

The panel first considered whether Mrs Fitzpatrick had a duty to investigate medication omissions concerning Patient A.

The panel accepted the evidence of Ms Joyce that she contacted Mrs Fitzpatrick by telephone, followed by a message, and asked her to investigate the complaint and produce a written report. In paragraph 8 of her witness statement, Ms Joyce stated:

> *"I initially contacted Claire by phone (followed up by message) to ask her to investigate this complaint and produce a written report. Claire gave verbal assurances that she would do so, saying that she had already spoken to staff about it. Claire's written investigation report never materialised."*

The panel found Ms Joyce's evidence to be clear, specific and consistent with both her oral evidence and the contemporaneous documentation.

The panel accepted that, as Home Manager, Mrs Fitzpatrick was responsible for investigating incidents and complaints relating to patient safety, including concerns regarding medication administration as set out in her job description.

The panel considered the nature of the concern. Patient A had returned to **[PRIVATE]** without the correct medication, and there were concerns that he may not have received his night-time medication whilst at **[PRIVATE]**. There was also a concern that three Lorazepam tablets were missing.

The panel accepted Ms Joyce's evidence that this was a serious issue requiring prompt investigation.

The panel also had regard to a letter dated 15 August 2021 from Ms Joyce to Mrs Fitzpatrick, which requested:

> *"a written report from you on your investigation into the failure to administer night-time medication to [Patient A] during his weekend visit 11–13.06.21. Also a written investigation is needed into the alleged missing three Lorazepam reported to you by the* **[PRIVATE]***."*

The panel considered this letter to be strong supportive evidence that the investigation remained outstanding as at the date of Ms Joyce's letter.

The panel accepted Ms Joyce's evidence that Mrs Fitzpatrick was working for three days during the relevant period and was supernumerary. The panel was satisfied that Mrs Fitzpatrick had sufficient time and opportunity to conduct the investigation.

The panel considered Mrs Fitzpatrick's explanation to Ms Joyce that she had taken a photograph of the allegedly missing medication. There was no documentary evidence that any written investigation was completed. Further, the contemporaneous correspondence clearly showed that Ms Joyce was still seeking a report.

The panel also noted that Ms Joyce later established that **[PRIVATE]** had not dispensed the Lorazepam. However, the panel determined that this did not affect the

charge. At the time Mrs Fitzpatrick was asked to investigate, the source of the discrepancy was unknown.

The panel was satisfied that Mrs Fitzpatrick was asked to investigate the medication omissions in relation to Patient A and that she failed to do so.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that between mid-June 2021 and 21 June 2021 Mrs Fitzpatrick failed to investigate medication omissions in relation to Patient A as requested.

Charge 3(a)

> "Failed to notify the Care Quality Commission ("CQC") of the following resident deaths:
>
> (a) Resident PA, on or after her death on 29 April 2021."

This charge is found proved.

The panel first considered whether Mrs Fitzpatrick was under a duty to notify the CQC of Residents' deaths.

The panel noted paragraph 5 of Home trust care limited policy procedure in the event of the death of a service user. It states:

> *"CQC notification CQC Notification of death of a Service User should be done as soon as reasonably possible. The Home Manager is responsible for maintaining all CQC notifications and for ensuring that all CQC notifications are made, as per CQC guidance."*

The panel was therefore satisfied that as the Home Manager; Mrs Fitzpatrick had the duty to notify CQC of any deaths in the Home.

The panel then went on to consider whether Ms Fitzpatrick notified the CQC of Resident PA's death.

The panel had regard to the CQC notification form (CQC – Death of a person using the service – Patient PA – dated 5 August 2021). The panel noted that the form was completed electronically and that, once submitted successfully, an acknowledgement email containing a reference number would ordinarily be generated.

The panel accepted Ms Whittemore's oral evidence that the notification process was straightforward and that, if a notification was submitted correctly, there would be an electronic confirmation.

The panel also took into account Ms Joyce's evidence that Mrs Fitzpatrick had received extensive training from Mr McCubbin before taking up the Home Manager role and was shown the relevant procedures, including the requirement to submit statutory notifications to the CQC.

The panel further accepted the evidence that Mrs Fitzpatrick had completed CQC notifications in the past and was therefore familiar with both the duty and the process.

The panel accepted Ms Joyce's evidence that she subsequently completed the notification herself on 5 August 2021. The panel considered this to be clear evidence that no valid notification had previously been submitted by Mrs Fitzpatrick. This was supported by Ms Whittemore's evidence:

> *"To clarify, the CQC did not receive any notification of the deaths of either Resident PA (who died 29 April 2021) or Resident DC (who died 17 May 2021), prior to the death notifications submitted by Alyson Joyce in August 2021."*

The panel did not have any explanation from Mrs Fitzpatrick in relation to the CQC notification in relation to Resident PA.

The panel also had regard to the evidence that, during a Quality Improvement Meeting on 29 July 2021, the CQC inspector commented that no notifications had been received from the home for approximately seven months.

The panel was satisfied that Mrs Fitzpatrick was responsible for notifying the CQC of Resident PA's death and that she failed to do so.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick failed to notify the CQC of Resident PA's death on or after 29 April 2021.

Charge 3(b)

> "Failed to notify the Care Quality Commission ("CQC") of the following resident deaths:
>
> (b) Resident DC, on or after his death on 17 May 2021."

This charge is found proved.

For the same reasons set out in Charge 3 (a) , the panel was satisfied that Mrs Fitzpatrick had a duty to notify the CQC of Resident DC's death.

The panel had regard to the CQC death notification form for Resident DC, which was completed by Ms Joyce on 6 August 2021. The panel considered this to be evidence that no valid notification had previously been submitted by Mrs Fitzpatrick.

This was supported by Ms Whittemore's evidence:

"To clarify, the CQC did not receive any notification of the deaths of either Resident PA (who died 29 April 2021) or Resident DC (who died 17 May 2021), prior to the death notifications submitted by Alyson Joyce in August 2021."

The panel accepted Ms Whittemore's evidence that the notification process was completed electronically and that a successful submission would generate an acknowledgement email containing a reference number.

The panel also accepted the evidence that Mrs Fitzpatrick had received training in the notification process from Mr McCubbin and had completed CQC notifications previously. The panel was therefore satisfied that she was fully aware of both the obligation to notify and the practical steps required to do so.

The panel considered Mrs Fitzpatrick's explanation to Ms Joyce that she believed she had submitted the notification but could not locate the electronic confirmation of submission and corresponding reference number.

The panel was not persuaded by this explanation. It considered that, if the notification had been submitted successfully, there would have been an electronic confirmation and reference number. No such evidence was produced.

The panel also took into account the evidence that, during the Quality Improvement Meeting on 29 July 2021, the CQC inspector observed that the home had not submitted notifications for approximately seven months.

The panel was satisfied that Mrs Fitzpatrick was responsible for notifying the CQC of Resident DC's death and that she failed to do so.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick failed to notify the CQC of Resident DC's death on or after 17 May 2021.

Charge 4

> "On a date on or after 28 June 2021, failed to keep a SOVA record for Resident AH who had suffered a skin tear and bruising of unknown origin."

This charge is found proved.

The panel first considered whether Mrs Fitzpatrick had a duty to ensure that a Safeguarding of Vulnerable Adults ("SOVA") record was completed in relation to Resident AH.

The panel accepted the evidence of Ms Joyce and Mr McCubbin that, as Home Manager, Mrs Fitzpatrick was responsible for ensuring that safeguarding concerns were appropriately documented and referred in accordance with the home's safeguarding procedures.

The panel had regard to the home's Safeguarding of Vulnerable Adults policy. The policy states:

“The home manager or safeguarding lead for the home (providing they are not alleged to be implicated) will take the appropriate actions or refer the safeguarding to the local authority safeguarding team for any appropriate actions.”

The panel considered that this placed responsibility on Mrs Fitzpatrick as the Home Manager to ensure that safeguarding concerns were recorded and escalated where necessary.

The panel accepted Ms Joyce’s evidence that a skin tear and bruising of unknown origin constituted a safeguarding concern because the cause of the injury was unexplained and there was a possibility that the resident may have been subject to abuse or neglect.

The panel accepted that Resident AH sustained a skin tear and bruising of unknown origin. This was confirmed in Spreadsheet of residents and missing information. In relation to Resident AH, the audit specifically referred to “SOVA logs”. The panel accepted Ms Joyce’s evidence that this notation indicated that the relevant safeguarding documentation was missing.

The panel found Ms Joyce’s evidence to be clear, reliable and supported by both the safeguarding policy and the audit documentation.

The panel was satisfied that:

- Resident AH sustained a skin tear and bruising of unknown origin;
- the incident required safeguarding documentation;
- Mrs Fitzpatrick was responsible for ensuring that a SOVA record was completed; and
- no SOVA record was found.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that on or after 28 June 2021 Mrs Fitzpatrick failed to keep a SOVA record for Resident AH.

Charge 5

"Between 17 June 2021 and 7 August 2021 made one or more cash withdrawals from Resident CM's Post Office account."

This charge is found proved.

The panel considered whether Mrs Fitzpatrick made one or more cash withdrawals from Resident CM's Post Office account between 17 June 2021 and 7 August 2021.

The panel accepted the evidence of Ms Joyce that, as part of her investigation into concerns regarding residents' finances, she reviewed Resident CM's Post Office account statements and associated records. Those documents showed a number of cash withdrawals during the period specified in the charge.

The panel accepted that Resident CM had capacity to manage her own finances. She was able to go to the cash point to withdraw money and go to the shop supported by staff. Resident CM followed a set routine and always went to one cashpoint near to the home and had habitual spending routines.

The panel heard that only a limited number of staff supported Resident CM to go to the cash points and shops.

The panel had regard to the Post Office account statements and related financial documentation. The panel found these records to be contemporaneous and reliable evidence that a large number of cash withdrawals were made from different ATMs during the relevant period which amounted to approximately £8,000 over a two month period and far outweighed Resident CMs normal spending habits.

The panel also considered Mrs Fitzpatrick's responses in her police interview. The panel noted that she did not dispute making withdrawals from Resident CM's account. Rather, her explanation focused on what the monies were said to have been used for. The panel considered that this amounted to an acceptance that she made the withdrawals, and therefore knew the pin number.

The panel also noted that Resident CM's bank card had gone missing from the safe at the home during the period that many of the cash withdrawals were being made and therefore that no other staff had access to it to make withdrawals.

The panel found the evidence of Ms Joyce and Mr McCubbin to be credible, reliable and their accounts to be consistent with one another.

Accordingly, the panel was satisfied that the NMC had proved, on the balance of probabilities, that between 17 June 2021 and 7 August 2021 Mrs Fitzpatrick made one or more cash withdrawals from Resident CM's Post Office account.

Charge 6

> "The cash withdrawals referred to at charge 5 were wholly or partly for your benefit."

This charge is found proved.

The panel considered whether the cash withdrawals referred to in Charge 5 were used wholly or partly for Mrs Fitzpatrick's benefit.

The panel accepted the evidence of Ms Joyce that, during her investigation into Resident CM's finances, she identified a pattern of cash withdrawals which was inconsistent with Resident CM's usual spending habits.

The panel heard that Resident CM's Post Office account was used to fund small personal purchases, including cigarettes, beer, sweets and occasional treats. However, the account statements showed significantly higher and more frequent withdrawals than would ordinarily have been expected. Further, there were withdrawals from a number of different cash points on an almost daily basis, some in locations that Resident CM would not have frequented without at least the support of two staff members in order to make withdrawals.

In reaching this decision, the panel also took into account the witness evidence of Mr McCubbin and his witness statement in which he states:

> "…***RESIDENT CM*** *used her own cash card on these escorted trips. She made her own purchases on these trips and generally refused a receipt when the salesperson offered. The many and various withdrawals from all but Central Avenue were not made by in person but apparently on her behalf by*

the ex-manager Claire. No other staff seem to have knowledge of this arrangement not [sic] recall purchases being passed to.

I was informed by detective Knight that Claire did not deny making these cash withdrawals but had claimed they were all on behalf of and that the purchases were passed to by Claire even when the transactions were occurring on the days that Claire was not on duty…"

The panel also noted the account that **Mrs Fitzpatrick** gave the police on 16 March 2022 in which she; *"admitted to officers that she was* **[PRIVATE]** *but that her situation was under control. She had been* **[PRIVATE]** *."*

The panel also noted Mrs Fitzpatrick assertion that she would buy items for Resident CM whilst she was on compassionate leave. The panel considered this an implausible explanation because there were other available staff to take Resident CM out to the cash point machine and to do her shopping.

The panel further noted that Mrs Fitzpatrick in the letter sent to the NMC by the RCN on 17 January 2025 suggested that she was having a difficult time and had just suffered a *"devastating bereavement."* This makes Mrs Fitzpatrick's assertion that she was assisting the Resident at the same time even more implausible.

The panel concluded that the objective documentary evidence, the unusual pattern of expenditure, and the absence of satisfactory supporting documentation established that the monies withdrawn from Resident CM's account were used, at least in part, for Mrs Fitzpatrick's own benefit.

Accordingly, the panel was satisfied that the NMC had proved, on the balance of probabilities, that the cash withdrawals referred to at Charge 5 were wholly or partly for Mrs Fitzpatrick's benefit.

Charge 7

"Between 18 November 2020 and 26 February 2021 made one or more cash withdrawals from the Home's Residents' Bank Account on behalf of resident RL."

This charge is found proved.

The panel considered whether Mrs Fitzpatrick made one or more cash withdrawals from the Home's Residents' Bank Account on behalf of Resident RL between 18 November 2020 and 26 February 2021.

The panel accepted the evidence of Ms Joyce that Resident RL lacked capacity to manage his own finances. His funds were held within the Home's Residents' Bank Account and could only be accessed by authorised signatories.

The panel heard that Mrs Fitzpatrick was the principal authorised signatory for the account. Although another authorised signatory, Claire Potter, was also listed on the account, Ms Joyce explained that Ms Potter worked at another home and had made only one withdrawal since joining the company. The panel therefore accepted that, in practice, Mrs Fitzpatrick was the only person who routinely operated the account.

The panel accepted the evidence that, whenever money was withdrawn on behalf of Resident RL, the expenditure was required to be recorded and supported by receipts. Those records were then submitted to Client Affairs at the local authority, which was accountable to the Office of the Public Guardian.

The panel had regard to the monthly expenditure records for Resident RL, the Home's Residents' Bank Account statements and the associated financial documentation. The panel found these documents to be contemporaneous and reliable.

The panel noted that the records showed a series of cash withdrawals and purchases during the period between 18 November 2020 and 26 February 2021.

The panel also considered Mrs Fitzpatrick's police interview. It noted that she did not dispute making withdrawals from the account and accepted that she was the person who made the transactions.

Accordingly, the panel was satisfied that the NMC had proved, on the balance of probabilities, that between 18 November 2020 and 26 February 2021 Mrs Fitzpatrick

made one or more cash withdrawals from the Home's Residents' Bank Account on behalf of Resident RL.

Charge 8

> "The cash withdrawals referred to at Charge 7 were wholly or partly for Mrs Fitzpatrick's benefit."

This charge is found proved.

The panel considered whether the cash withdrawals referred to in Charge 7 were used wholly or partly for Mrs Fitzpatrick's benefit.

The panel accepted the evidence of Ms Joyce that, as part of her investigation, she compared the monthly expenditure sheets for Resident RL with the Home's Residents' Bank Account statements and the supporting receipts.

The panel heard that Resident RL was bedbound, and required full assistance with all aspects of his care. The panel also accepted the evidence that Resident RL had given up smoking when he was admitted to the home.

The panel noted that the 'summary of expenditure' provided to ASC client affairs and the CQC in respect of Resident RL's account showed that approximately 2000 cigarettes had been brought with his money over a 3 month period. The panel accepted Ms Joyce's evidence that this level of expenditure was wholly inconsistent with Resident RL's circumstances and needs.

The panel also noted that there were significant discrepancies between the sums withdrawn and the legitimate expenditure that could be evidenced on Resident RL's behalf.

The panel considered the strict controls that applied to Resident RL's finances. Expenditure was required to be recorded contemporaneously, supported by receipts, and submitted to Client Affairs at the local authority. The panel considered that these safeguards existed to protect vulnerable residents who were unable to manage their own money.

The panel accepted that Mrs Fitzpatrick was, in practice, the person operating the account and responsible for the transactions.

The panel considered Mrs Fitzpatrick's explanations during her police interview. However, it was not persuaded that her explanations satisfactorily accounted for the discrepancies.

The panel also noted the evidence from Ms Joyce which stated:

> *"…When this came to light again on 20 August 2021, by chance I had* ***Resident RL*** *audited 's care file the week before, and found that he didn't smoke. Claire had purchased 1800 cigarettes on behalf of this resident within a 6-month period. The residents at CDC are very vulnerable so for any resident who smokes, we have to have very explicit care plans for them to manage the risks associated with this. For example, we always have to time it carefully in terms of when they can smoke, as they have to have one to one care at that time. None of this was in place for* **Resident RL** *because he didn't smoke. It would have been on my radar without a doubt if he did…"*

The panel concluded that this confirmed that the cigarettes could not have been for Resident RL.

The panel found that the financial records demonstrated that monies were withdrawn from Resident RL's funds and were not properly accounted for as expenditure for his benefit.

In the absence of any credible alternative explanation, the panel determined that the most likely inference was that the monies withdrawn were used wholly or partly for Mrs Fitzpatrick's own benefit.

Accordingly, the panel was satisfied that the NMC had proved, on the balance of probabilities, that the cash withdrawals referred to at Charge 7 were wholly or partly for Mrs Fitzpatrick's benefit.

Charge 9(a)

9. Your conduct at Charges 5, 6, 7 and/or 8 above was dishonest in that:

(a) in relation to Resident CM, you knew that the money in Resident CM's Post Office account did not belong to you.

This charge is found proved.

The panel considered whether, in making the withdrawals from Resident CM's Post Office account and using the funds wholly or partly for Mrs Fitzpatrick's own benefit, she acted dishonestly.

The panel applied the test for dishonesty set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*. The panel first considered Mrs Fitzpatrick actual state of knowledge or belief as to the facts and then considered whether Mrs Fitzpatrick's conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel was satisfied that Mrs Fitzpatrick knew the money in Resident CM's Post Office account belonged to Resident CM and not to Mrs Fitzpatrick.

The panel accepted that, as Home Manager, Mrs Fitzpatrick was entrusted with supporting residents to safely manage their financial affairs where they had capacity to do so. Mrs Fitzpatrick was familiar with the systems and controls governing residents' finances and understood that such funds could be used only for the benefit of the relevant resident.

The panel also noted that the account was held specifically in Resident CM's name. There could be no legitimate misunderstanding that the funds were Mrs Fitzpatrick own or that she was entitled to use them for personal purposes.

The panel found that Mrs Fitzpatrick withdrew monies from Resident CM's account and that those monies were used wholly or partly for her benefit, as found proved in Charges 5 and 6.

The panel concluded that Mrs Fitzpatrick knew at all material times that the monies belonged to Resident CM and not to her.

The panel further determined that ordinary decent people would regard the use of a vulnerable resident's funds for Mrs Fitzpatrick's own benefit as plainly dishonest.

Accordingly, the panel was satisfied that the NMC had proved, on the balance of probabilities, that in relation to Resident CM, Mrs Fitzpatrick knew that the money in Resident CM's Post Office account did not belong to her.

Charge 9(b)

> "Your conduct at Charges 5, 6, 7 and/or 8 above was dishonest in that:
>
> (b) in relation to Resident RL, you knew that the money held in the Home's Residents' Account on his behalf did not belong to you."

This charge is found proved.

The panel considered whether, in relation to Resident RL, Mrs Fitzpatrick acted dishonestly.

The panel applied the test for dishonesty set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*. The panel first considered Mrs Fitzpatrick's actual state of knowledge or belief as to the facts and then considered whether her conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel had already found proved that Mrs Fitzpatrick made cash withdrawals from the Home's Residents' Bank Account on behalf of Resident RL and that those withdrawals were wholly or partly for her own benefit.

The panel was satisfied that Mrs Fitzpatrick knew that the monies held in the Home's Residents' Bank Account on behalf of Resident RL belonged to Resident RL and not to her.

The panel accepted the evidence that Resident RL lacked capacity to manage his own finances and that his funds were held by the Home for his benefit. As Home

Manager, Mrs Fitzpatrick was entrusted with administering those monies and was required to maintain accurate records and receipts for all expenditure.

The panel heard that the records relating to Resident RL's finances were submitted to Client Affairs at the local authority, which in turn was accountable to the Office of the Public Guardian. The panel considered that this process made the ownership and purpose of the monies unmistakably clear.

The panel also accepted that Mrs Fitzpatrick was, in practice, the only person who routinely operated the account. The panel was therefore satisfied that she was fully familiar with the nature of the account and the restrictions governing the use of the funds.

The panel considered Mrs Fitzpatrick's explanations in her police interview and in the Registrant's Response Bundle. However, it found no credible basis upon which she could have believed that she was entitled to use Resident RL's money for her own benefit.

The panel concluded that ordinary decent people would regard the use of money belonging to a vulnerable resident for personal purposes as dishonest.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that in relation to Resident RL, Mrs Fitzpatrick knew that the money held in the Home's Residents' Account on his behalf did not belong to her and that her conduct was dishonest.

Charge 10

> "Your conduct at Charges 5, 6, 7 and/or 8 above demonstrated a lack of integrity."

This charge is found proved.

The panel considered whether Mrs Fitzpatrick's conduct in relation to Charges 5 to 8 demonstrated a lack of integrity.

The panel reminded itself that integrity is closely associated with adherence to the ethical standards and moral principles expected of a registered nurse. It considered that, whilst dishonesty and lack of integrity are distinct concepts, conduct that is dishonest will ordinarily also amount to conduct lacking in integrity.

The panel had already found proved that:

- Mrs Fitzpatrick made cash withdrawals from Resident CM's Post Office account;
- those withdrawals were wholly or partly for her own benefit;
- Mrs Fitzpatrick made cash withdrawals from the Home's Residents' Bank Account on behalf of Resident RL;
- those withdrawals were wholly or partly for her own benefit; and
- in relation to both residents, Mrs Fitzpatrick knew that the monies did not belong to her and acted dishonestly.

The panel considered that Residents CM and RL were particularly vulnerable adults because of their underlying mental health conditions along with other vulnerabilities. As such they relied upon others to safeguard their finances and to act in their best interests.

As Home Manager, Mrs Fitzpatrick occupied a position of trust and was under a professional duty to protect those residents and their property.

The panel was of the view that rather than safeguarding the financial interests of these vulnerable residents, Mrs Fitzpatrick was more concerned with her own interests and used their money for her own benefit.

The panel considered that this conduct represented a serious abuse of Mrs Fitzpatrick's position as Home Manager and a significant departure from the standards of honesty, probity and professionalism expected of a registered nurse.

The panel further considered that Mrs Fitzpatrick's conduct demonstrated a disregard for the trust placed in her by vulnerable residents, their families, and her employer.

Having found that Mrs Fitzpatrick acted dishonestly, the panel was satisfied that her actions also demonstrated a fundamental lack of integrity.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick's conduct at Charges 5, 6, 7 and 8 demonstrated a lack of integrity.

Charge 11

> "On one or more dates between April 2016 and June 2021 borrowed and/or sought to borrow money from junior Colleague A."

This charge is found proved.

The panel considered whether, on one or more dates between April 2016 and June 2021, Mrs Fitzpatrick borrowed and/or sought to borrow money from junior Colleague A, namely Ms Karen Cleminson.

The panel accepted the evidence of Ms Cleminson, whom it found to be a credible and reliable witness. The panel noted that her oral evidence was clear and consistent with her witness statement, her local statement and the WhatsApp messages exhibited in the bundle.

The panel first considered the relationship between Mrs Fitzpatrick and Ms Cleminson.

Ms Cleminson was employed as an administrator at **[PRIVATE].** In her witness statement, she stated that Mrs Fitzpatrick was *"the registered care home manager of CDC"* and *"also my line manager."*

The panel was satisfied that Ms Cleminson was junior to Mrs Fitzpatrick and that there was a clear management relationship between them.

The panel then considered whether Mrs Fitzpatrick borrowed and/or sought to borrow money from Ms Cleminson during the period alleged.

In paragraph 4 of her witness statement, Ms Cleminson stated:

“In April 2016 Claire asked if I would loan her £500 which she would repay when she was next paid… I assumed that it was probably a one-off. I was wrong, from then on she often asked to borrow money from me.”

The panel accepted this evidence and was satisfied that the borrowing began in April 2016 and continued thereafter.

The panel also noted Ms Cleminson’s local statement, in which she said:

“Once more I was wrong and CF started asking to borrow money from me… this continued until June 2021.”

The panel considered that this evidence was consistent with the dates set out in the charge.

The panel had regard to the WhatsApp messages between Mrs Fitzpatrick and Ms Cleminson. The panel noted that the messages showed repeated requests by Mrs Fitzpatrick to borrow money over an extended period. It noted that Mrs Fitzpatrick did not dispute borrowing money from Ms Cleminson.

Having considered all of the evidence, the panel was satisfied that, on multiple occasions between April 2016 and June 2021, Mrs Fitzpatrick both borrowed money from and sought to borrow money from Ms Cleminson, who was a junior colleague.

Accordingly, the panel determined that the NMC had proved this charge on the balance of probabilities.

Charge 12

> “Failed to repay around £1000 of the money you borrowed from junior Colleague A.”

This charge is found proved.

The panel considered whether Mrs Fitzpatrick failed to repay approximately £1,000 of the money she had borrowed from junior Colleague A, Ms Karen Cleminson.

The panel accepted the evidence of Ms Cleminson, whom it found to be a credible and reliable witness. The panel noted that her oral evidence was clear and consistent with her witness statement and the documentary evidence before the panel.

In paragraph 11 of her witness statement, Ms Cleminson stated:

"Claire still owes me approximately £1000."

The panel accepted this evidence.

The panel also accepted Ms Cleminson's oral evidence that this sum remained outstanding at the time she gave evidence to the panel.

The panel had regard to the WhatsApp messages between Mrs Fitzpatrick and Ms Cleminson, which demonstrated repeated requests to borrow money and assurances that the monies would be repaid. The panel was satisfied that the monies were advanced as loans rather than gifts.

The panel also considered Ms Cleminson's local statement, in which she said that despite *"many requests and her promises and assurances that she would return the money she never did*."

The panel considered whether there was any evidence that the outstanding balance had subsequently been repaid. There was no such evidence before the panel.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick failed to repay around £1,000 of the money she borrowed from junior Colleague A.

Charge 13

> "On one or more dates between 18 September 2020 and 11 March 2021 borrowed and/or sought to borrow money from junior Colleague B."

This charge is found proved.

The panel considered whether, on one or more dates between 18 September 2020 and 11 March 2021, Mrs Fitzpatrick borrowed and/or sought to borrow money from junior Colleague B, namely Ms Alison Grove.

The panel accepted the evidence of Ms Grove, whom it found to be a credible and reliable witness. The panel noted that her oral evidence was clear and consistent with her witness statement, the WhatsApp messages exhibited in the bundle, and the contemporaneous local investigation material.

The panel first considered the relationship between Mrs Fitzpatrick and Ms Grove.

Ms Grove was employed as a Senior Care Assistant at **[PRIVATE]** and was junior to Mrs Fitzpatrick, who was the Home Manager. The panel was satisfied that there was a clear management relationship between them.

The panel then considered the documentary evidence.

The panel had regard to the WhatsApp messages. These messages showed repeated requests from Mrs Fitzpatrick for financial assistance.

The panel noted in particular that:

- on 18 September 2020, a message from a contact saved as “Clare Boss” asked to borrow £50 “until Monday”;
- on 28 September 2020, there was a further request for money; and
- on 17 October 2020, there was a request for £100.

The panel accepted Ms Grove’s evidence that she lent Mrs Fitzpatrick £80 on one occasion and that Mrs Fitzpatrick later made further requests for money, which Ms Grove declined.

The panel also considered the local investigation notes, in which Ms Grove reported that Mrs Fitzpatrick had asked her and other members of staff for money.

The panel considered the evidence as a whole and found Ms Grove’s account to be consistent, credible and supported by the documentary evidence.

The panel was satisfied that the evidence demonstrated both that Mrs Fitzpatrick borrowed money from Ms Grove and that she sought to borrow additional sums from her during the period alleged.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that on one or more dates between 18 September 2020 and 11 March 2021 Mrs Fitzpatrick borrowed and/or sought to borrow money from junior Colleague B.

Charge 14

> "On a date or dates between 28 July 2021 and 20 December 2021 failed to engage in the local investigation into her alleged failings."

This charge is found proved.

The panel considered whether, between 28 July 2021 and 20 December 2021, Mrs Fitzpatrick failed to engage in the local investigation into the concerns that had arisen regarding her practice and conduct.

The panel accepted the evidence of Ms Joyce, whom it found to be a credible and reliable witness. The panel noted that her oral evidence was clear and consistent with her witness statements and the contemporaneous correspondence exhibited in the bundle.

The panel heard that, following the identification of a number of concerns, including issues relating to care records, medication omissions, CQC notifications, safeguarding documentation, residents' finances and borrowing money from junior colleagues, a formal internal investigation was commenced.

The panel first considered whether Mrs Fitzpatrick had a duty to engage in the local investigation. A letter sent to Mrs Fitzpatrick on 25 August 2021 set out this requirement as follows:

> *"…You are required to co-operate in our investigations and may be required to attend the workplace for investigative interviews or disciplinary hearings…*"

"…*you are required to be available to answer any work-related queries…"*

"…*Please read and ensure you understand our Disciplinary Policy which is enclosed. When we have completed the investigation, we will write to confirm whether you will be required to attend a disciplinary hearing…"*

The panel had regard to the documentary evidence showing that Mrs Fitzpatrick was invited to attend investigation meetings and to provide her response to the allegations.

In particular, the panel noted that:

- Ms Joyce wrote to Mrs Fitzparick on 15 August 2021 inviting her to attend an investigatory meeting on 17 August 2021;
- further correspondence was sent on 25 August 2021,13 December 2021, 17 December 2021, and 21 December 2021;
- Mrs Fitzpatrick attended one informal meeting at a local Costa Coffee to discuss the concerns at the Home on the 17 August 2021.
- Formal investigations into Mrs Fitzpatrick began on the 25 August 2021 when she was notified of her suspension pending disciplinary investigation.
- However, she did not respond to the any subsequent letters or invitations to take part in the disciplinary process.

The panel accepted Ms Joyce's evidence that she made repeated attempts to progress the local investigation but did not receive any meaningful response from Mrs Fitzpatrick.

The panel considered whether there was any evidence that Mrs Fitzpatrick attended an investigatory meeting, provided a written response, or otherwise participated in the investigation. It found no such evidence.

The panel also noted the submission made on Mrs Fitzpatrick's behalf by the RCN, which confirmed that she had chosen not to engage with the local investigation at the time.

Having considered all of the evidence, the panel was satisfied that:

- Mrs Fitzpatrick was aware of the local investigation;
- she was invited on several occasions to participate in it; and
- she failed to engage with the local investigations between 25 August 2021 and 20 December 2021.

Accordingly, the panel determined that the NMC had proved this charge on the balance of probabilities.

Charge 15

> "On a date or dates in or around December 2021 stole money from the home of Colleague C."

This charge is found proved.

The panel considered whether, in or around December 2021, Mrs Fitzpatrick stole money from the home of Colleague C, Ms Mary McInnes.

The panel accepted the evidence of Ms McInnes, whom it found to be a credible and reliable witness. The panel noted that Ms McInnes had known Mrs Fitzpatrick's family for many years and had worked with Mrs Fitzpatrick's mother in a number of care homes.

The panel accepted Ms McInnes' evidence that, after Mrs Fitzpatrick secured a new post at a Care Home in Scotland, she would stay some nights of the week at Ms McInnes' home rather than commute daily to and from Carlisle for a period of time. The panel considered that this provided Mrs Fitzpatrick with access to Ms McInnes' property.

The panel accepted Ms McInnes' evidence that she kept cash and collectable coins in two bags inside a sideboard in her lounge.

The panel heard that, after Mrs Fitzpatrick stayed at the property, Ms McInnes discovered that the money and collectable coins were missing.

The panel considered Ms McInnes' evidence that no one other than Mrs Fitzpatrick had access to her home during the relevant period. Ms McInnes explained to the

panel that she had discussed the missing items with Mrs Fitzpatrick who told her she had no knowledge of this.

The panel considered whether there was any plausible alternative explanation for the disappearance of the money and coins. It concluded that there was not.

The panel took into account that Ms McInnes did not report the matter to the police. The panel accepted her explanation that she was attempting to show compassion to Mrs Fitzpatrick, who was experiencing significant personal difficulties at the time.

The panel also considered Mrs Fitzpatrick's denial. However, the panel was not persuaded that there was any credible alternative explanation for the loss other than that Mrs Fitzpatrick took the money.

The panel reminded itself that, for this charge to be proved, it had to be satisfied that Mrs Fitzpatrick took money belonging to another person with the intention of permanently depriving that person of it.

Having considered all of the evidence, the panel was satisfied that:

- the money and collectable coins were kept in Ms McInnes' home;
- they were missing after Mrs Fitzpatrick stayed there;
- no one else had access to the property;
- there was no plausible explanation for their disappearance other than that Mrs Fitzpatrick took them; and
- there was no evidence that Mrs Fitzpatrick intended to return the money.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that in or around December 2021 Mrs Fitzpatrick stole money from the home of Colleague C.

Charge 16

> "On 16 February 2023 removed a laptop from **[PRIVATE]** without authority to do so."

This charge is found not proved.

The panel considered whether, on 16 February 2023, Mrs Fitzpatrick removed a laptop from **[PRIVATE]** without authority to do so.

The panel accepted the evidence of Ms Mary McInnes and viewed the CCTV footage from 16 February 2023. The footage showed Mrs Fitzpatrick removing a laptop from the premises. The panel was therefore satisfied that Mrs Fitzpatrick removed the laptop from the premises.

The panel then considered whether the NMC had proved that she did so without authority.

The panel noted that there was evidence suggesting that the laptop was required at another care home and that Mrs Fitzpatrick was asked to take it there.

The panel considered that the evidence on the issue of authority was unclear and inconsistent. Whilst the NMC invited the panel to infer that Mrs Fitzpatrick had no permission to remove the laptop, the panel was not satisfied that the evidence excluded the possibility that she had been authorised to do so for a legitimate work-related purpose.

The panel emphasised that this conclusion did not reflect any adverse finding regarding the credibility of Ms McInnes. Rather, the panel concluded that the evidence did not provide a sufficiently clear basis upon which it could determine, on the balance of probabilities, whether authority had not been given.

The panel reminded itself that the burden of proving the charge rests on the NMC.

Having considered all of the evidence, the panel was not satisfied that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick removed the laptop without authority.

Charge 17

> "Your conduct at charges 15 and/or 16 above was dishonest in that you knew the money and/or the laptop did not belong to you."

This charge is found proved.

The panel considered this charge only in relation to Charge 15, as Charge 16 has been found not proved.

The panel applied the test for dishonesty set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*. The panel first considered Mrs Fitzpatrick's actual state of knowledge or belief as to the facts and then considered whether her conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel had already found proved that Mrs Fitzpatrick stole money from the home of Ms McInnes.

The panel was satisfied that Mrs Fitzpatrick knew that the money and collectable coins kept in Ms McInnes' home did not belong to her.

The panel noted that the money and coins were stored in two bags inside a sideboard in the lounge. The panel considered that these items were plainly identifiable as belonging to Ms McInnes.

The panel also accepted that there was no evidence that Mrs Fitzpatrick intended to return the money.

The panel was satisfied that ordinary decent people would regard the taking of money from a colleague's home, knowing that it did not belong to Mrs Fitzpatrick, as dishonest.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick knew the money taken from the home of Ms McInnes did not belong to her and that her conduct at Charge 15 was dishonest.

Charge 18

> "Your conduct at charges 15 and/or 16 above demonstrated a lack of integrity."

This charge is found proved.

The panel considered this charge only in relation to Charge 15, as Charge 16 has been found not proved.

The panel reminded itself that integrity involves adherence to the ethical standards and moral principles expected of a registered nurse. While dishonesty and lack of integrity are distinct concepts, conduct that is found to be dishonest will ordinarily also amount to conduct lacking in integrity.

The panel had already found proved that Mrs Fitzpatrick stole money from the home of Ms Mary McInnes and that, in doing so, she acted dishonestly.

The panel considered that Ms McInnes had shown Mrs Fitzpatrick considerable kindness. Ms McInnes had known Mrs Fitzpatrick's family for many years, had worked with Mrs Fitzpatrick's mother, and allowed Mrs Fitzpatrick to stay in her home during a difficult period in Mrs Fitzpatrick's life.

The panel determined that, rather than respecting that trust, Mrs Fitzpatrick took money from Ms McInnes' home for her own benefit.

The panel considered that this conduct represented a serious abuse of trust and was fundamentally inconsistent with the standards of honesty, trustworthiness and probity expected of a registered nurse.

Accordingly, the panel determined that the NMC had proved, on the balance of probabilities, that Mrs Fitzpatrick's conduct in relation to Charge 15 demonstrated a lack of integrity.

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 Mrs Fitzpatrick's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and professionally.

The panel, in reaching its decision, 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, Mrs Fitzpatrick's fitness to practise is currently impaired as a result of that misconduct.

Submissions 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.'

Ms Wisniewska invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision, which sets out the professional standards of practice and behaviour expected of those on the NMC register. She submitted that the values and principles contained within the Code are not negotiable.

Ms Wisniewska submitted that the panel had found the majority of the charges proved, including all of the dishonesty and lack of integrity charges, with the exception of Charge 1(b) and Charge 16.

Charges 1 to 4

Ms Wisniewska submitted that Charges 1 to 4 breached paragraph 1 of the Code:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.

Ms Wisniewska submitted that the failures concerning care records, the failure to investigate the medication omissions involving Patient A, the failure to notify the CQC of two resident deaths, and the failure to complete a SOVA record for Resident AH all related to core aspects of patient care and the delivery of the fundamentals of care.

Ms Wisniewska submitted that Charges 1 to 4 also breached paragraph 10 of the Code:

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.

Ms Wisniewska submitted that these charges involved significant record-keeping failures and omissions.

Ms Wisniewska further submitted that Charges 1 to 4 breached paragraph 19 of the Code:

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

To achieve this, you must:

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

Ms Wisniewska submitted that the failures in record keeping, safeguarding and investigation created a risk of harm to residents.

In relation to Charge 2, **Ms Wisniewska** submitted that **Mrs Fitzpatrick** also breached paragraph 8.2 of the Code:

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

In relation to Charge 4, Ms Wisniewska submitted that Mrs Fitzpatrick breached paragraph 8.5 of the Code:

Ms Wisniewska submitted that Mrs Fitzpatrick failed to maintain effective communication with Ms Joyce by not carrying out the investigation she had been asked to undertake.

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

Ms Wisniewska submitted that by failing to complete the SOVA documentation, Mrs Fitzpatrick failed to communicate safeguarding concerns and failed to work collaboratively to preserve resident safety.

Charges 6, 8, 9, 10, 12, 13, 15, 17 and 18

Ms Wisniewska submitted that these charges breached paragraph 21.3 of the Code:

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care.

Ms Wisniewska submitted that Mrs Fitzpatrick abused her position as a registered nurse by withdrawing cash from vulnerable residents' bank accounts and using that money for her own benefit.

Charge 14

Ms Wisniewska submitted that Charge 14 breached paragraph 23 of the Code:

23 Cooperate with all investigations and audits.

She acknowledged that paragraph 23.1 specifically refers to NMC audits but submitted that the introductory wording extends to investigations relating to organisations. She submitted that Mrs Fitzpatrick failed to cooperate with the employer's local investigation.

Charges 11 and 13

Following legal advice, Ms Wisniewska made additional submissions in relation to Charges 11 and 13.

She submitted that those charges breached paragraph 20 of the Code:

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

Ms Wisniewska submitted that Mrs Fitzpatrick borrowed money from junior colleagues, failed to repay one colleague, and applied significant pressure to obtain

the loans. She submitted that this conduct involved dishonesty, a lack of integrity, and bullying.

Conduct Outside Professional Practice

In relation to Charges 11, 13 and 15, Ms Wisniewska referred the panel to *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)* and submitted that conduct may amount to misconduct where it is morally culpable or otherwise disgraceful and prejudices the reputation of the profession.

Ms Wisniewska submitted that Mrs Fitzpatrick's conduct, although not always occurring in the direct provision of care, demonstrated serious professional misconduct.

Mrs Fitzpatrick was neither present nor represented, and no submissions were made on her behalf.

Submissions on impairment

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

Ms Wisniewska submitted that all four limbs of the Grant test were engaged.

Ms Wisniewska submitted that Mrs Fitzpatrick had in the past acted, and remained liable in the future to act, so as to put patients at unwarranted risk of harm.

Ms Wisniewska referred to:

- The widespread deficiencies in care records;
- The failure to investigate medication omissions;
- The failure to complete safeguarding documentation;

- The misappropriation of residents' money.

Ms Wisniewska submitted that Mrs Fitzpatrick had acted dishonestly in the past and remained liable to act dishonestly in the future.

Ms Wisniewska submitted that Mrs Fitzpatrick had breached the fundamental tenets of the profession, namely:

- Prioritise people;
- Practise effectively;
- Preserve safety; and
- Promote professionalism and trust.

Ms Wisniewska submitted that Mrs Fitzpatrick had brought the nursing profession into disrepute. She submitted that there was:

- No evidence of remediation;
- No evidence of meaningful insight;
- No evidence of reflection;
- Minimal engagement with the NMC; and
- No engagement with the employer's investigation.

Ms Wisniewska submitted that the misconduct demonstrates serious attitudinal concerns.

Ms Wisniewska invited the panel to find Mrs Fitzpatrick's fitness to practise currently impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311, Nandi v General Medical Council [2004] EWHC 2317 (Admin), Cheatle v General Medical Council [2009] EWHC 645 (Admin), Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin), and Cohen v General Medical Council [2008] EWHC 581 (Admin)*.

Decision and reasons on misconduct

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

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

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill **health** and meeting the changing **health** and care needs of people during all life stages

4 Act in the best interests of people at all times
To achieve this, you must:
***4.3** keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process*

8 Work co-operatively
To achieve this, you must:
***8.5** work with colleagues to preserve the safety of those receiving care*

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 *complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

10.3 *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other **health** and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 *acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so*

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*

17.2 *share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information*

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

20.4 *keep to the laws of the country in which you are practising*

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

20.6 *stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 *act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore considered misconduct with a thematic approach in relation to the charges found proved.

Charges 1, 2, 3 and 4 – Clinical Failings

The panel first considered the clinical failings concerning care records, medication investigations, CQC notifications and safeguarding documentation.

The panel was of the view that these failings were extensive and wide-ranging. They affected a significant number of residents and involved multiple omissions in relation to care plans, risk assessments, safeguarding documentation, medication investigations and statutory notifications.

The panel noted that the residents at **[PRIVATE]** were among the most vulnerable members of society. Many lacked capacity and were unable to advocate for themselves. They were entirely dependent upon staff, and in particular Mrs Fitzpatrick as Home Manager, to ensure that their care was safe, effective and appropriately documented.

The panel considered that accurate and up-to-date care records were fundamental to safe and effective care delivery. Incomplete or outdated records created a significant risk that residents could receive inappropriate or unsafe care.

The panel noted that:

- Some residents had unexplained injuries which were not properly recorded or escalated;
- Some residents experienced repeated falls without appropriate follow-up;
- Important assessments, including choking and nutritional assessments, were missing or overdue;

- Safeguarding and statutory reporting obligations were not met.

The panel considered that these failings were not isolated or minor administrative oversights. They were wide-ranging failures across the home over an extended period of time and reflected a serious failure by Mrs Fitzpatrick to discharge her responsibilities as Home Manager.

The panel found that this conduct fell far below the standards expected of a registered nurse, who was also the registered manager and amounted to misconduct.

Charges 5, 6, 7, 8, 9a, 9b and 10 – Misappropriation of Residents' Money

The panel next considered the charges relating to the misappropriation of residents' money.

The panel determined that Mrs Fitzpatrick abused her position of trust by withdrawing cash from particularly vulnerable residents' bank accounts and using it for her own benefit.

The panel considered that the residents were dependent upon Mrs Fitzpatrick to safeguard both their welfare and their finances. Further, the panel noted the impact it had on one of the residents, Resident CM and how it left her destitute and reliant on good will of others for everyday basics.

The panel found that this conduct constituted a grave abuse of trust and a serious breach of professional boundaries. In reaching this conclusion, the panel was particularly concerned to note that Mrs Fitzpatrick was accountable for the financial management for service users who lacked the mental capacity to manage their financial affairs as was the case with Resident RL.

The panel found that this conduct was dishonest, exploitative and amounted to financial abuse of particularly vulnerable individuals and as such fell far below the standards expected of a registered nurse.

The panel found that this conduct amounted to misconduct.

Charges 11, 12, and 13 – Borrowing Money from Junior Colleagues

The panel considered the charges relating to borrowing money from junior colleagues.

The panel was of the view that this conduct had the potential to undermine professional working relationships and compromise the safe delivery of care by impacting the manager-employee relationship required to ensure deliver of a safe and effective service.

The panel noted that both colleagues described feeling pressurised into lending money to Mrs Fitzpatrick. The panel noted the evidence of Ms Cleminson in which she stated that to avoid uncomfortable atmosphere at work, or potentially losing her job, she decided to continue lending Mrs Fitzpatrick money and not to pursue repayments of some monies owed by her.

The panel found that Mrs Fitzpatrick preyed on her colleague's generosity and goodwill.

The panel noted that the conduct was persistent and, in relation to one colleague, continued over a period of approximately five years. It noted that requests were made at particularly inappropriate times, including when one colleague was **[PRIVATE]**.

The panel considered that there was a clear imbalance of power, as Mrs Fitzpatrick was the manager and the colleagues were junior members of staff. It concluded that the conduct was predatory in nature.

The panel also noted the lasting personal impact upon the colleagues concerned. It found that this conduct fell far below the standards expected of a registered nurse and amounted to misconduct.

Charges 15, 17 and 18 – Theft from Mrs McInnes

The panel finally considered the theft of money from Mrs McInnes.

The panel acknowledged that this conduct occurred outside the workplace.

However, the panel had regard to the NMC's guidance on misconduct FTP- 2a last updated 6 May 2025 in particular concerns outside professional practice. The guidance states that conduct outside professional practice may amount to serious professional misconduct where it is capable of undermining trust and confidence in the profession.

The panel found that Mrs McInnes had placed trust in Mrs Fitzpatrick, welcomed her into her home and provided support. The panel determined that in taking Ms McInnes's money, Mrs Fitzpatrick exploited that trust for her own financial benefit.

The panel considered this conduct to be opportunistic, dishonest and morally culpable. The panel found that this conduct was a continuation of her dishonest behaviour exhibited at the **[PRIVATE]**.

The panel found that this amounted to misconduct. Taking all of the proved conduct together, the panel concluded that Mrs Fitzpatrick's actions demonstrated:

- Failure to deliver safe and effective care;
- Serious failures in leadership;
- Repeated dishonesty;
- A lack of integrity;
- Abuse of trust; and
- A profound disregard for the wellbeing of vulnerable residents and colleagues.

The panel found that Mrs Fitzpatrick's actions did fall far below the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on 'Impairment' (Reference: DMA-1 Last Updated:28/01/2026) 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. 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 *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

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

The panel found that the widespread deficiencies in care records, safeguarding failures and medication omissions created a significant risk of harm to residents.

The panel also found that residents suffered financial harm when Mrs Fitzpatrick misappropriated their money.

The panel was satisfied that Mrs Fitzpatrick's failures prevented safe and effective care being delivered, repeated dishonest conduct and abuse of vulnerable residents and colleagues brought the nursing profession into disrepute.

The panel determined that Mrs Fitzpatrick breached the fundamental tenets of the profession, namely:

- Prioritising people;
- Practising effectively;
- Preserving safety; and
- Promoting professionalism and trust.

The panel noted that the dishonesty findings were numerous, repeated, premeditated and carried out over an extended period of time.

Regarding insight, the panel noted that Mrs Fitzpatrick did not attend the hearing, however had provided a reflective statement earlier in the proceedings of 23 May

2024 and also made representations via the RCN on 17 January 2025. The panel were of the view that the reflective statements focused on her personal circumstances rather than demonstrating any understanding of the impact of her actions on residents, colleagues or public confidence in the profession.

Whilst Mrs Fitzpatrick's reflection expresses some limited insight regarding the impact of her behaviour in relation to borrowing money from junior colleagues, the panel considers this to be self-serving and devoid of recognition of the impact of her action on others and public confidence in the profession needs to be taken account off.

There is also no evidence that Mrs Fitzpatrick has taken accountability for her actions and the widespread impact it has had on residents, colleagues and the wider nursing profession.

The panel accepted that some of the failings in relation to Mrs Fitzpatrick's responsibilities to ensure residents care records were maintained, to ensure safe and effective care delivery viewed in isolation, were theoretically remediable.

However, the panel considered that the misconduct highlighted attitudinal concerns, particularly in light of the repeated dishonesty, exploitation of vulnerable residents, junior colleagues and abuse of professional trust.

The panel had no evidence that Mrs Fitzpatrick had undertaken any activities to strengthen her practice or any inclination to do so.

In the absence of any evidence of insight, remorse or remediation, the panel had no basis to conclude that the concerns had been addressed.

The panel concluded that there was a real risk of repetition. In reaching this conclusion, the panel took into account:

- The repeated nature of the misconduct;
- The prolonged period over which it occurred;
- The involvement of multiple victims;

- The absence of insight;
- The absence of remediation; and
- Limited engagement with the local investigations and the NMC proceedings .

The panel determined that a finding of current impairment is necessary on the grounds of public protection.

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

The panel considered that the misconduct in this case was exceptionally serious. It involved:

- Widespread failures affecting highly vulnerable residents;
- Repeated and premeditated dishonesty;
- Financial abuse of residents;
- Exploitation of junior colleagues; and
- Theft from a person who had offered personal support.

The panel also considered that a finding of impairment was required to uphold proper professional standards.

The panel determined that public confidence in the nursing profession and in the NMC as a regulator would be seriously undermined if a finding of impairment were not made in all the circumstances of this case. The panel considered that members of the public would be appalled if a nurse who had engaged in this level of dishonesty, abuse of trust and misconduct were permitted to practise unrestricted.

The panel therefore found Mrs Fitzpatrick's fitness to practise currently impaired on public interest grounds.

Accordingly, the panel determined that Mrs Fitzpatrick's fitness to practise is currently impaired on both public protection and public interest grounds.

Having regard to all of the above, the panel was satisfied that Mrs Fitzpatrick's fitness to practise is currently impaired by reason of her misconduct.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) last updated 28 January 2026 published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Wisniewska submitted that the appropriate and proportionate sanction in this case was a striking-off order.

Ms Wisniewska reminded the panel of its powers under Article 29 of the Nursing and Midwifery Order 2001 and referred the panel to the NMC's Sanctions Guidance, in particular SAN1, SAN2 and SAN4.

Ms Wisniewska submitted that the panel had identified a real risk of repetition, the potential for patients to be placed at risk of harm, and serious attitudinal failings. She submitted that the misconduct was exceptionally serious and involved:

- Widespread failures affecting highly vulnerable residents;
- Repeated and premeditated dishonesty;
- Financial abuse of residents;
- Exploitation of junior colleagues; and

- Theft from a person who had offered support to Mrs Fitzpatrick.

Ms Wisniewska submitted that these findings amounted to significant departures from the standards expected of a registered nurse and breaches of the fundamental tenets of the nursing profession.

In relation to dishonesty, Ms Wisniewska referred the panel to SAN-4, which identifies the types of dishonesty most likely to require consideration of striking off. She submitted that a number of those factors were present in this case, including:

- Misuse of power;
- Personal and financial gain from a breach of trust;
- Direct risk to people receiving care; and
- Premeditated, systematic and long-standing deception.

Ms Wisniewska submitted that this was not a case involving isolated or spontaneous dishonesty. Rather, the dishonest conduct was repeated and sustained over a significant period of time.

Ms Wisniewska submitted that the aggravating features included:

- Lack of proper insight, reflection and remediation;
- Serious and repeated dishonesty;
- Conduct suggesting an underlying attitudinal problem;
- Abuse of a position of trust;
- A pattern of misconduct over an extended period;
- Financial exploitation of vulnerable dementia patients, causing financial and emotional harm; and
- A lack of acknowledgement of the most serious failings.

In terms of mitigation, Ms Wisniewska submitted that the only mitigating factors were the personal circumstances Mrs Fitzpatrick described, namely Mrs Fitzpatrick husband's **[PRIVATE]** in March 2021 and Mrs Fitzpatrick **[PRIVATE]** in July 2021. She submitted that there were otherwise no significant mitigating factors.

Ms Wisniewska submitted that taking no further action and a caution order would be inappropriate given the gravity of the misconduct, the substantial breaches of the Code, and the panel's finding of a real risk of repetition.

Ms Wisniewska submitted that a conditions of practice order would not be appropriate because there were no workable, relevant, measurable and proportionate conditions that could address the misconduct. While some of the clinical failings might be remediable, conditions would not address the dishonesty concerns, which were indicative of serious attitudinal failings.

Ms Wisniewska submitted that a suspension order would also be insufficient because the case involved harmful deep-seated attitudinal problems and a significant risk of repetition.

Turning to a striking-off order, Ms Wisniewska submitted that:

- The regulatory concerns raised fundamental questions about Mrs Fitzpatrick's professionalism;
- Public confidence in the profession could not be maintained if Mrs Fitzpatrick were allowed to remain on the register; and
- Striking off was the only sanction sufficient to protect the public and maintain professional standards.

Ms Wisniewska submitted that, taking a holistic view of the case, the misconduct was so serious, and the lack of insight, remorse and remediation so stark, that the only appropriate and proportionate sanction was a striking-off order.

Decision and reasons on sanction

Having found Mrs Fitzpatrick's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance (SG), in particular SAN-1,2,3

and 4. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mrs Fitzpatrick demonstrated no meaningful insight into her misconduct.
- The dishonesty findings were serious, repeated, premeditated and long-standing.
- Mrs Fitzpatrick abused her position of trust, power and authority in relation to both residents and junior colleagues.
- Mrs Fitzpatrick financially exploited highly vulnerable residents.
- Her conduct caused emotional and financial harm to residents.
- The misconduct occurred over a significant period of time.
- Mrs Fitzpatrick's conduct placed residents at risk of harm.
- Mrs Fitzpatrick failed to engage meaningfully with the NMC proceedings and did not attend the hearing without good reason.

The panel considered it particularly aggravating that the residents involved were among the most vulnerable members of society. They were dependent on Mrs Fitzpatrick, as Home Manager and registered nurse, to advocate for them and protect their interests because they were unable to do so themselves. The panel also considered Mrs Fitzpatrick's conduct towards junior colleagues to be predatory. The panel found that she preyed on their goodwill and generosity for her own benefit.

The panel also took into account the following mitigating features:

- Mrs Fitzpatrick's **[PRIVATE]**.
- Mrs Fitzpatrick's **[PRIVATE]**.

The panel acknowledged these matters but determined that they carried very little weight. It noted that some of the misconduct pre-dated these personal circumstances and that several incidents of dishonesty occurred outside the workplace and continued after the **[PRIVATE]**.

The panel considered Mrs Fitzpatrick's limited reflective account but concluded that it was self-serving and did not demonstrate meaningful insight, remorse or understanding of the impact of her conduct on residents, colleagues or the wider nursing profession.

The panel concluded that the aggravating factors significantly outweighed the mitigating factors.

The panel first considered whether to take no further action. It concluded that this would be wholly inappropriate given the seriousness of the misconduct, the high risk of repetition, and the public protection concerns identified.

The panel determined that taking no further action would not address the regulatory concerns and would not enable the NMC to meet its overarching objectives of protecting the public and maintaining public confidence in the profession

The panel next considered whether to impose a caution order.

The panel noted that a caution order may be appropriate where the registrant has demonstrated insight, significant reflection and a low risk of repetition.

The panel found that none of those factors were present. Mrs Fitzpatrick had not demonstrated insight, there was no significant evidence of reflection, and the panel considered the risk of repetition to be high.

The panel therefore concluded that a caution order would not be sufficient to protect the public and would not satisfy the public interest.

The panel next considered whether a conditions of practice order would be appropriate.

The panel concluded that there were no relevant, proportionate, workable or measurable conditions that could adequately address the breadth and seriousness of the concerns in this case.

The panel acknowledged that some aspects of the clinical failings might ordinarily be remediable. However, it found that this was not the case here because of Mrs Fitzpatrick's persistent lack of insight and refusal to accept personal responsibility.

The panel noted Mrs Fitzpatrick's email in which she stated that she no longer wished to practise as a nurse. It therefore considered that there was no indication that she would engage with or comply with any conditions imposed.

The panel also concluded that there were no conditions of practice that could address the dishonesty and lack of integrity found proved.

Accordingly, the panel determined that a conditions of practice order would not sufficiently protect the public or maintain public confidence in the profession.

The panel then considered whether a suspension order would be appropriate.

The panel found that Mrs Fitzpatrick's misconduct was serious and suggestive of deep-seated attitudinal problems due to the repeated dishonesty, abuse of trust and financial exploitation of highly vulnerable residents.

The panel determined that Mrs Fitzpatrick's misconduct was at the most serious end of the spectrum.

The panel found that there was no realistic prospect that Mrs Fitzpatrick would develop sufficient insight, strengthen her practice, or return to safe and effective practice.

The panel concluded that a suspension order would serve no meaningful purpose. Even if a reviewing panel were to consider the matter after a period of suspension, the panel saw no realistic prospect that the underlying concerns would be resolved.

The panel also considered that members of the public would be appalled if a nurse who had financially abused vulnerable residents were permitted to return to the register after a period of suspension.

Accordingly, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel concluded that the concerns in this case raised fundamental questions about Mrs Fitzpatrick's professionalism.

The panel found that Mrs Fitzpatrick's misconduct involved repeated, premeditated and long-standing dishonesty. It involved financial abuse and exploitation of highly vulnerable residents and predatory conduct towards junior colleagues. The panel considered that her actions represented significant departures from the standards expected of a registered nurse and constituted serious breaches of the fundamental tenets of the profession.

The panel considered that this was a high-risk case involving repeated dishonesty, abuse of trust and the financial exploitation of highly vulnerable residents. The panel determined that Mrs Fitzpatrick's misconduct was fundamentally incompatible with continued registration.

The panel determined that there was no amount of reflection or retraining that Mrs Fitzpatrick could do that would be sufficient to maintain public confidence in the profession given her dishonesty and lack of integrity.

Given that the panel has found that there is no realistic prospect that Mrs Fitzpatrick could return to safe and effective practice, and in taking a holistic view of the case, the panel determined that the only appropriate and proportionate sanction was a striking-off order.

The panel concluded that nothing short of striking Mrs Fitzpatrick off the register would be sufficient to protect the public, maintain public confidence in the nursing profession, and uphold proper professional standards.

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

The panel therefore directs the Registrar to strike Mrs Fitzpatrick's name off the register.

This will be confirmed to Mrs Fitzpatrick in writing.

Interim order

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

Submissions on interim order

Ms Wisniewska submitted that, as the striking-off order would not take effect until the expiry of the 28-day appeal period, it was necessary for the panel to consider whether to impose an interim order during that period.

Ms Wisniewska reminded the panel that an interim order may be made if the panel is satisfied that it is necessary for the protection of the public, otherwise in the public interest, or in the registrant's own interests. She submitted that, in this case, an interim order was necessary on the grounds of both public protection and the wider public interest.

Ms Wisniewska applied for an interim suspension order for a period of 18 months. She submitted that such an order was necessary to protect the public and to maintain public confidence in the profession pending any appeal against the striking-off order.

In support of her application, Ms Wisniewska invited the panel to have regard to the seriousness of the facts found proved and to the reasons set out in its substantive decision. She submitted that, if no appeal were made, the interim order would fall away and would be replaced automatically by the striking-off order 28 days after Mrs Fitzpatrick was sent the written decision.

Decision and reasons on interim order

In reaching this decision, the panel had regard to its findings on impairment and sanction. The panel had found Mrs Fitzpatrick's fitness to practise impaired on both public protection and public interest grounds. The panel considered that it would undermine those findings if no interim order were imposed during the 28-day appeal period.

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. In light of the panel's findings and concerns as regards to repetition and with regard to the overarching objective of public protection and public interest, the panel imposed an interim suspension order for a period of 18 months.

The panel considered that an interim suspension order is necessary for a period of 18 months to cover the time that any appeal might take to be concluded. The panel noted that, if no appeal is lodged, the interim order will lapse automatically when the striking-off order takes effect at the end of the 28-day appeal period.

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

That concludes this determination.