Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 26 February – Friday, 8 March 2024

Virtual Hearing

Name of Registrant:	**David Sales Corell**
NMC PIN	08B0101C
Part(s) of the register:	RN1: Adult nurse, level 1 (26 February 2008) V300: Nurse independent / supplementary prescriber (14 June 2019)
Relevant Location:	Isle of Skye
Type of case:	Misconduct
Panel members:	Sue Heads (Chair, lay member) Pamela Campbell (Registrant member) Christine Moody (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Rim Zambour (Monday, 26 February – Monday, 4 March 2024) Franchessca Nyame (Tuesday, 5 – Friday, 8 March 2024)
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter
Mr Sales Corell:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 5a, 9, 10, 11, 12, 13, 14, 16, 17b, 17c, 18, 19, 20 (in relation to charges 9, 17b, 18a, 18d, 18f, 19), 21
Facts not proved:	Charges 5b, 6, 7, 8, 15, 17a, 20 (in relation to charges 17c, 18b, 18c, 18e)

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 Mr Sales Corell was not in attendance and that the Notice of Hearing letter had been sent to Mr Sales Corell's registered email address by secure email on 23 January 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr Sales Corell

The panel next considered whether it should proceed in the absence of Mr Sales Corell. It had regard to Rule 21 and heard the submissions of Mr Bardill who invited the panel to continue in the absence of Mr Sales Corell. He submitted that Mr Sales Corell had voluntarily absented himself.

Mr Bardill submitted that the last engagement by Mr Sales Corell with the NMC in relation to these proceedings was on 21 February 2024 where he informed the Case Coordinator that he would get back to them about his attendance at the hearing. Mr Sales Corell did not make any further contact with the NMC after this and as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

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 in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mr Sales Corell;
- Mr Sales Corell has informed the NMC that he has received the Notice of Hearing and has not responded in relation to his attendance;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A witness has attended today to give live evidence and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Sales Corell in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Sales Corell's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Sales Corell. The panel will draw no adverse inference from Mr Sales Corell's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse:

1) On or around 24 July 2019 in relation to unknown patient with a leg injury;
    a) Failed to carry out an initial assessment to see if an X-ray was required.
    b) Directed them to Broadford hospital for an X-ray without carrying out an initial assessment.
    c) Did not offer and/or provide them any pain relief.
    d) When asked by Colleague A why you did not see them stated “I don’t work well at this time on the morning” or words to that effect.
    e) Failed to record that they had attended Portree Hospital (“the Hospital”) and sought assistance for a leg injury.

2) Around June 2020:
    a) Did not follow a management instruction to leave the name of the allocated Senior Decision Maker on the whiteboard.
    b) Stated that the Senior Decision Maker concept was “bullshit” or words to that effect.

3) On 22 June 2020 refused to work with Colleague B.

4) On or around 7 July 2020 failed to record Patient B’s swab results.

5) On or around 10 July 2020:
    a) In relation to an unknown patient;
    i) Failed to handover the severity of their condition.
    ii) Did not assist Colleague C in providing care to them.
    b) Left the Hospital 40 minutes before your shift ended.

6) On 13 November 2020 in relation to Patient D:

a) Stated to an unknown member of the public you were “too busy” to assist them or words to that effect.
b) Incorrectly advised an unknown member of the public to call 111.
c) Failed to assess them.
d) Failed to assist them in an emergency.

7) On 13 November 2020 whilst catheterising Patient A;
    a) Failed to remove your jacket.
    b) Were not bare below the elbow.

8) On 20 November 2021 failed to dispose:
    a) Used rubber gloves in a clinical waste bin.
    b) A syringe and/or needle in a sharps bin.
    c) A broken glass vial in a sharps bin.

9) On 8 July 2021 sent a message to Colleague A stating “What the hell is all this RST slavery about? I thought Spain was bad but God Skye has some shite as well eh??? I don’t care what the unit need.”

10) In or around October 2021 and November 2021:
    a) On one or more occasion brought your dog into the Hospital without permission.
    b) Told others you had permission to bring your dog into the Hospital when you had not.

11) On 21 January 2022 in relation to Patient F:
    a) Incorrectly told Dr A that “She can’t come here, we [the Hospital] do not do X-ray she needs to go to Broadford” or words to that effect.
    b) Failed to advise Dr A that that the patient should attend the Hospital for an initial assessment/examination.

12) Your actions at charge 11a above were dishonest in that you knew the patient should be assessed at the Hospital first.

13) On 21 January 2022 in relation to Patient E:

a) Incorrectly told Dr A that “they [the Hospital] did not see chest pain/cardiac patients anymore, that these patients go straight to Broadford” or words to that effect.

b) Failed to triage them by phone and/or in person.

14) Your actions at charge 13a above were dishonest in that you knew the Hospital did see and/or assess chest pain/cardiac patients.

15) On 28 October 2020 in relation to Patient C;

a) Did not test their cardiac rhythm.

16) Did not follow Manager A’s requests in that you;

a) On 15 April 2021 did not attend a meeting and/or advise you were not attending.

b) Between 15 April 2021 and 17 April 2021 did not contact Manager A as requested to do so prior to attending your shift on 17 April 2021.

17) In relation to Manager A;

a) On 28 January 2021 stared at Manager A without saying anything to them during a meeting.

b) On 13 July 2020 shouted at them during a telephone conversation.

c) On 28 June 2021 stated in the presence of Colleague B in relation to organising rotas “it’s not rocket science” or words to that effect.

18) On unknown dates posted on social media:

a) “NHS Highlands. Bullying, harassment and discrimination all over Skye. Sturrock report remains as fresh as a daisy still nowadays. Terrorists.”

b) “I do have one boss, nothing to worry about, just discovered one on the computer. Many managers in this job eh?!?!?!?...”
c) “LOOK ME IN THE EYES AND TELL ME WE’RE GONNA BE FULLY STAFFED. MANAGEMENT: BEST I CAN DO IS PIZZA”.
d) An image containing the following text “Me and my co-workers listening to our boss tell us how valued we are, despite being constantly under staffed, over worked and under paid…”
e) An image containing the following text *Training the new employee at work* “So you’re not really supposed to do this, but this is what we do”.
f) An image containing the following text “Manager Company Staff who did the work”.

19) Around 8 August 2023 posted on social media an image with the following text “Fuckaccias wrapped for my former hospital colleagues and their hardwork. Please note: not for [Colleague D] (cunt) or management (useless and dangerous)”.

20) Your conduct at all or part of charges 9 and/or 17 and/or 18 and/or 19 above amounted to bullying in that your unwanted behaviour directed at Manager A and/or Colleague A and/or Colleague D and/or other colleagues was offensive and/or intimidating and/or malicious and/or insulting that undermined, humiliated, or caused physical or emotional harm to them.

21) On an unknown date shared a link on social media to an article titled “A compound in ‘magic mushrooms’ provides rapid, durable depression relief”.

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

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Bardill to amend the wording of charges 12, 13, 14, 15 and 20.

The proposed amendment in relation to charge 12 was to amend '*your actions at charge 10 above…*' to '*your actions at charge 11a above…*' It was submitted by Mr Bardill that the proposed amendment would correct the typo mistake and more accurately reflect the evidence.

The proposed amendment in relation to charge 13 was to change '*around February 2022'* to say '*on 21 January 2022'*. It was submitted by Mr Bardill that Witness 4 stated they recalled the date of the incident actually being on 21 January 2022. Mr Bardill submitted that this was supported by Witness 1's corroboration that they were told by Witness 4 the incident occurred on the same day and they were detailed in the case records for the patient.

The proposed amendment in relation to charge 14 was to correct a typographical error where instead of referring to '*actions at charge 14 above'*, it should say '*actions at charge 13a above'*. It was submitted by Mr Bardill that the proposed amendment would correct the typo mistake and more accurately reflect the evidence.

The proposed amendment in relation to charge 15 was to change '*unknown date'* to say '*on 28 October 2020'*. Mr Bardill submitted that Mr Sales Corell had been put on notice of this proposed amendment, and that it does not cause prejudice to him. Mr Bardill submitted that this amendment binds the NMC more than anyone else as they would need to prove the charge happened on this specific date.

The proposed amendment in relation to charge 20 was to change the typographical error to now list charges 9, 17, 18 and 19 in order to accurately reflect the evidence.

The proposed amendments are as follows:

‘That you, a registered nurse:

…

12) Your actions at charge ~~10~~ **11a** above were dishonest in that you knew the patient should be assessed at the Hospital first.

13) ~~Around February 2022~~ **On 21 January 2022** in relation to Patient E:

a) Incorrectly told Dr A that “they [the Hospital] did not see chest pain/cardiac patients anymore, that these patients go straight to Broadford” or words to that effect.

b) Failed to triage them by phone and/or in person.

14) Your actions at charge ~~14~~ **13a** above were dishonest in that you knew the Hospital did see and/or assess chest pain/cardiac patients.

15) On ~~an unknown date~~ **28 October 2020** in relation to Patient C;

a) Did not test their cardiac rhythm.

…

20) Your conduct at all or part of ~~charges 9 and/or 18 and/or 20 and/or 21~~ **charges 9 and/or 17 and/or 18 and/or 19** above amounted to bullying in that your unwanted behaviour directed at Manager A and/or Colleague A and/or Colleague D and/or other colleagues was offensive and/or intimidating and/or malicious and/or insulting that undermined, humiliated, or caused physical or emotional harm to them.’

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

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Sales Corell and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

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

During the hearing, Mr Bardill made a request that this case be held partly in private on the basis that proper exploration of Mr Sales Corell's case involves making reference to both the health and personal matters of Mr Sales Corell and witnesses. Mr Bardill made this application retrospectively as well as for any future mention of these matters. The application was made pursuant to Rule 19 of the Rules.

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

The panel determined to go into private session in connection with health and personal matters as and when such issues are raised in order to protect the privacy of Mr Sales Corell and any witnesses.

Decision and reasons on application to admit written statement as hearsay evidence

The panel heard an application made by Mr Bardill under Rule 31 to allow the written statement of Witness 5 into evidence. Witness 5 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they were unable to attend today [PRIVATE]. [PRIVATE]. Further, that this witness could not be cross-examined in any event as Mr Sales Corell has chosen not to attend the hearing.

Mr Bardill also submitted that there are other witnesses in this case whose evidence corroborates the points made in Witness 5's written statement and it is therefore not the sole or decisive evidence in relation to the charges.

Mr Bardill submitted that it will be a matter for the panel to decide how much weight they attach to the written statement, and that it would be fair to admit it as hearsay evidence.

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

The panel gave the application in regard to Witness 5 serious consideration. The panel noted that Witness 5's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by them.

The panel considered whether Mr Sales Corell would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 5 to that of a written statement.

The panel determined that Witness 5's statement and exhibits were relevant to the charges against Mr Sales Corell. It considered that Witness 5's evidence was not sole or decisive as it was corroborated by other witnesses. The panel considered that Mr Sales Corell had been provided with a copy of Witness 5's statement and exhibits. The panel

had already determined that Mr Sales Corell had absented himself from these proceedings and he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 5 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that the evidence was relevant and it would be fair to admit into evidence the written statement of Witness 5, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit written statement as hearsay evidence

The panel heard an application made by Mr Bardill under Rule 31 to allow the written statement of Witness 3 into evidence. Witness 3 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they were unable to attend today [PRIVATE].

Mr Bardill submitted that there is evidence in Witness 3's statement relating generally to Mr Sales Corell which is not in dispute. Further, that Witness 3 was a Staff Nurse working in the team and was therefore in a position to have some knowledge of what was expected. Mr Bardill stated that there is evidence of other witnesses in relation to Mr Sales Corell's behaviour which corroborates Witness 3's evidence. Mr Bardill submitted that Witness 3's statement is therefore not the sole or decisive evidence in relation to the charges.

Mr Bardill informed the panel that there has not been any written challenge from Mr Sales Corell in relation to the evidence in Witness 3's statement despite him being served with it. Mr Bardill submitted that Mr Sales Corell has had ample opportunity, time and notice to put forward a challenge but has not done so.

Mr Bardill also addressed the issue of whether Witness 3 would have any reason to fabricate their allegations. He informed the panel that Witness 3 is in a relationship with another witness in the case, and that this may be considered a reason why somebody may fabricate their accounts. However, Mr Bardill submitted that being in a relationship with another witness is not enough to conclude that there has been any kind of planning or fabrication.

Mr Bardill submitted that there is a good reason for Witness 3's non-attendance [PRIVATE]. Had it not been for [PRIVATE], the witness would have been available for the

hearing. Mr Bardill submitted that Witness 3 is clearly someone who is keen to engage and provide their evidence.

In the preparation of this hearing, the NMC had indicated to Mr Sales Corell that it was the NMC's intention for Witness 3 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 3, Mr Sales Corell made the decision not to attend this hearing. On this basis Mr Bardill advanced the argument that there was no lack of fairness to Mr Sales Corell in allowing Witness 3's written statement into evidence.

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

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by them.

The panel determined that the statement is directly relevant to the charges and there is a good and cogent reason why Witness 3 is not able to attend the hearing. [PRIVATE].

The panel went on to consider whether Witness 3's evidence is sole or decisive with regards to the charges. The panel first considered charge 5. It determined that there is additional evidence in relation to this charge in the form of an email sent to Witness 1. This allegation is also referred to in the investigation report. The panel therefore determined that Witness 3's evidence is not sole or decisive in relation to this charge.

In relation to charge 6, the panel determined that Witness 3's evidence directly relates to this. However, it appears there is no corroborative evidence for this charge, although it is in Witness 1's evidence it is only mentioned as something Witness 3 had informed Witness 1 of. Therefore the panel was of the view that Witness 3's evidence is sole or

decisive in relation to charge 6 and there is no way of testing its reliability. In the circumstance, the panel determined that it would not be fair to admit it.

With regards to charge 7, the panel determined that Witness 3's statement is sole or decisive as there is no corroboration in any of the other evidence and no other means of testing its reliability. The panel decided it would not be fair to admit the statement insofar as it relates to charge 7.

The panel next considered charge 8 and determined that Witness 3's evidence is not sole or decisive in relation to this charge. The panel had sight of photos and the investigation report which could corroborate Witness 3's evidence in respect of this charge. The panel therefore decided to admit it into evidence.

The panel determined the same for charge 10, which is corroborated by other witness evidence. Therefore Witness 3's statement is not sole or decisive in relation to this charge, and the panel determined to admit it into evidence.

In relation to charge 19, the panel considered that it has photographic evidence, and that this allegation is also referred to in Witness 1 and Witness 2's statements. Therefore Witness 3's evidence is not sole or decisive in relation to this charge, and the panel decided to admit it into evidence in respect of this charge.

The panel considered whether Mr Sales Corell would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of a written statement.

The panel considered that Mr Sales Corell had been provided with a copy of Witness 3's statement and, as the panel had already determined that he had absented himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness

in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 3 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that Witness 3's witness statement, supplementary witness statement and exhibits are relevant and it would be fair to accept them into evidence except in relation to charges 6 and 7. The panel determined it would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Background

Mr Sales Corell was first admitted on to the NMC Register on 26 February 2008. He commenced his employment at NHS Highlands in early 2018.

The NMC received a referral on 29 April 2022. At the time of the alleged concerns in the referral, he was working as an Advanced Nurse Practitioner in the Rural Support Team at Portree Hospital (the Hospital), which is part of NHS Grampian.

The alleged facts are as follows:

On 24 July 2019, an unscheduled patient came to the Hospital asking for help for their partner who was in the car and had a leg injury/suspected broken leg. Mr Sales Corell turned them away without assessing them first. Mr Sales Corell told them to go to Broadford, which was 40 minutes away, as the Hospital no longer carried out X-rays. It is said that he should have assessed the leg and provided stabilisation and pain relief, if required, before sending them to Broadford. Further it is also said that he failed to document that the patient arrived at the Hospital and that he turned them away. When asked about not seeing the patient by Witness 1 his response was "*I don't work well this time in the morning"* or words to that effect.

Around 17 June 2020, the Scottish Government implemented a policy that all shifts should have a named person identified as '*Senior Decision Maker'* ('SDM'). Mr Sales Corell is said to have become defensive about this and on more than one occasion wiped the name of the SDM off the board, saying "*no one is more senior*" than him. Despite being asked not to wipe the name off the board, he continued to do so.

In June 2020, he refused to work with a colleague without providing any reason/rationale or justification to do so.

On or around 7 July 2020, Mr Sales Corell is said to have failed to document Patient B's swab results on the Hospital spreadsheet, as well as on the patient's records. This meant that no other members of the team were aware of Patient B's results, or whether they required any follow up.

On or around 10 July 2020, Mr Sales Corell left his shift from the Hospital early, even though a colleague was dealing with a patient with chest pain who required assistance and Mr Sales Corell did not provide a proper handover.

These concerns were due to be discussed with Mr Sales Corell, he then went on sick leave from 14 November 2020 until 29 March 2021. He was placed on a Support Improvement Plan (SIP) on 15 April 2021.

On 8 July 2021, Mr Sales Corell is said to have engaged in inappropriate/aggressive communication over Facebook messenger when Witness 2 contacted him and asked if he could cover a shift due to sickness. Witness 2 found the communication "*out of proportion and abusive*". Mr Sales Corell sent messages to Witness 2 stating "*What the hell is all this RST slavery about? I thought Spain was bad but God Skye has some shite as well eh???*" and "*I don't care what the unit need*".

On 13 November 2020, whilst Mr Sales Corell was busy with a patient, a member of the public ran up to the Hospital claiming that their friend, Patient D, had fallen, hit their head and was not breathing. He told them that he was busy with a patient, and they should call '*111'*, when he should have told them to ring '*999'*. Witness 3 told Mr Sales Corell that Patient D needed to be attended to, but he ignored them and continued with Patient A. Witness 3 did run out of the Hospital to find Patient D, finding some paramedics on the way who said they would attend and assess Patient D. Mr Sales Corell was a qualified first responder and was expected to respond in an emergency. As a nurse he should offer help if an emergency arises.

Witness 3 returned to the Hospital. On their return, they saw Mr Sales Corell re-catheterising Patient A with his jacket on and not bare below the elbow therefore failing to undertake appropriate infection control measures.

On 20 November 2021, Witness 3 found that Mr Sales Corell had left used blue medical gloves rolled up on top of the clean personal protective equipment ('PPE'). Inside the gloves was a used needle with the safety cap in place and a broken medication vial. Witness 3 disposed of this in the correct manner.

Further, in November 2021, Mr Sales Corell brought his dog to the Hospital during his shifts. He was informed by Witness 2 that this was not appropriate due to infection control. Witness 2 told him to either leave the dog at home or in the car, where he could go out to check on the dog. However, he is said to have told colleagues that Witness 2 had allowed him to bring the dog to work and continued to do so. Witness 2 emailed him on 30 November 2021, re-iterating that he was not to bring his dog on to Hospital premises. He apologised and said it was a miscommunication.

On 21 January 2022, Mr Sales Corell failed to assess Patient F following an assault. He informed Witness 4 that Patient F needed to go to Broadford for an X-ray. He should have seen Patient F first to assess and make sure they were stable for the long journey to the next hospital, as an X-ray may not have even been necessary. If there were signs of broken bones he should have completed an Xray form, given the patient pain relief, stabilised the break if possible and sent the patient in an ambulance or advised the patient to make their own way to Broadford Hospital.

Also on 21 January 2022, Witness 4 received a telephone call from Patient E explaining that they were suffering chest pain. Witness 4 called the Hospital, Mr Sales Corell answered and said that the Hospital no longer saw chest pain patients which was incorrect. Mr Sales Corell did not see Patient E. Witness 4 made enquiries and Witness 1 confirmed that the Hospital was in fact seeing patients with chest pain. Mr Sales Corell

should have seen Patient E to ensure they were stable and Mr Sales Corell had been involved with this type of situation on multiple occasions during his employment.

Other concerns were raised regarding his use of social media. One post on social media in relation to NHS Highlands stated "*Murders, terrorists and abusers*", he shared a link to an article about "*magic mushrooms*". There were posts from Mr Sales Corell criticising management at the Hospital and NHS Grampian.

On another date, Mr Sales Corell failed to monitor Patient C correctly. Patient C had a tachycardia and should have been on full cardiac monitoring. However, he only took their oxygen saturations.

Mr Sales Corell resigned from the Trust on 31 March 2022.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Bardill and the advice of the legal assessor.

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

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

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

- Witness 1: [PRIVATE].
- Witness 2: [PRIVATE].
- Witness 4: [PRIVATE].
- Witness 6: [PRIVATE].

The panel also took into consideration the written statements of the following witnesses on behalf of the NMC:

- Witness 3: [PRIVATE].
- Witness 5: [PRIVATE].

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

"That you, a registered nurse:

1) On or around 24 July 2019 in relation to unknown patient with a leg injury;
    a) Failed to carry out an initial assessment to see if an X-ray was required.
    b) Directed them to Broadford hospital for an X-ray without carrying out an initial assessment.
    c) Did not offer and/or provide them any pain relief.
    d) When asked by Colleague A why you did not see them stated "I don't work well at this time on the morning" or words to that effect.
    e) Failed to record that they had attended Portree Hospital ("the Hospital") and sought assistance for a leg injury."

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

The panel first considered whether Mr Sales Corell had a duty to carry out the initial assessment and record that the patient had attended the Hospital and sought assistance for a leg injury. The panel determined that as an ANP he had a duty to assess and treat patients before sending them anywhere else. This was further emphasised by Witness 2 in their oral evidence and Witness 1 in their written statement.

In reaching this decision, the panel also took into account the NHS Highland Primary Care Out of Hours Operational Handbook for All Clinicians ('the Handbook') which sets out the protocol for triaging walk-in patients and Mr Sales Corell's job description.

The panel also had sight of Witness 2's witness statement in which they state:

> *'On 24 July 2019, not long after Mr Corell qualified as an ANP, I was working the day shift taking over from Mr Corell who had worked the night shift in the unscheduled care unit. Mr Corell told me that someone came to the door to request assistance with their partner who was in their car and had injured their leg. Mr Corell went to the door and directed them to Broadford for an X-ray telling them that there is no X-ray available at the Hospital, which is true but Mr Corell did not examine the patient prior to doing this to see if an X-ray was required. Mr Corell also did not offer or provide any pain relief in the meantime.*
>
> *When a patient attends the unscheduled care unit and we make contact with them, we then have a duty of care to that patient. Nobody is turned away without an initial assessment as this could lead to a patient's condition deteriorating or taking themselves to Broadford (a 40 minute journey) when they should have gone via ambulance or be treated and made stable before transfer. The worst case scenario with this patient is that they could have developed compartment syndrome and lost their leg due to a fractured tibia and fibula. I asked Mr Corell why he did not see them and Mr Corell responded "I don't work well at this time in the morning" or words to this effect. The patient went to Broadford and was told that they had broken their tibia and fibula. However, there was no record of the patient turning up at the Hospital as Mr Corell had not recorded this. By not recording an attendance, Mr Corell failed to follow NHS Highland Primary Care Out of Hours Operational Handbook for all clinicians which I attach as Exhibit JS1. In particular section 10 which states 'all patient contacts should be recorded via Adastra (patient record system). This effects workload auditing and there is no audit trail of a patient's*

attendance unless it is noted on their next contact or reported verbally. The patient was seen in Broadford by another member of the RST when they stated that they had sought attention in the Hospital prior to attending Broadford which is documented by the clinician at Broadford.

The issue of having a duty of care once you answer the door to a walk in patient was emphasised many times by our line manager, [Witness 1]. Within our professional code, it states that a nurse should make sure that any treatment, assistance or care is provided without undue delay. This patient then had a 40 minute journey with a broken leg when they could have been offered pain relief and been assessed to make sure they had adequate blood supply below the fractures and an ambulance could have been arranged in order for the limb to be elevated and for them to be as comfortable as possible.'

The panel therefore determined that this charge is proven on the balance of probabilities in its entirety.

Charge 2

"That you, a registered nurse:

2) Around June 2020:
    a) Did not follow a management instruction to leave the name of the allocated Senior Decision Maker on the whiteboard.
    b) Stated that the Senior Decision Maker concept was "*bullshit*" or words to that effect."

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the two sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account Witnesses 1, 2, 3 and 6's statements as well as contemporaneous documentary evidence.

The panel first considered Witness 1's written evidence in which they state the following:

> *'Mr Corell starting working shifts at the Hospital again on 17 June 2020 and there seemed to be a change in his attitude and mannerisms. Mr Corell seemed very combative and defensive. An example of this is when they became defensive about the title of Senior Decision Maker. This was implemented by the Scottish Government during covid to ensure there was a final decision maker to decide what happens to unwell patients (i.e. go home or transfer to palliative/acute care). On shift, we would write the name of the allocated Senior Decision Maker for that day on the whiteboard in the reception area so everyone was aware who this was. When Mr Corell returned to Portree, they disagreed with approach claiming it is 'bullshit' and said 'no one is more senior than me' then proceeded to continually wipe off the Senior Decision Maker from the whiteboard despite being asked not to by myself and various members of the team…'*

The panel also had sight of Witness 3's statement in which they corroborate this account and state the following:

> *'When the Covid centre was disbanded, Mr Corell returned to Portree and I noticed that their attitude and behaviour had changed. An example of this is his attitude towards the Government's decision to implement a ("SDM") during the Covid pandemic…Mr Corell stated that the SDM concept was 'bullshit' and on an occasion when … ANP was assigned SDM, Mr Corell said 'he thinks he's better than me' and then proceeded to wipe [the SDM'S] name off the board. I told Mr Corell that the SDM name needed to be written on the board and proceeded to write [the SDM's] name back on the board. Mr Corell proceeded to wipe it off again and I told them to*

speak to a manager if they were not happy. I am not aware whether Mr Corell spoke to a manager about their concerns about the SDM.'

The panel also considered Witness 2's oral evidence in which they confirmed that Mr Sales Corell would wipe the name of the SDM off the board. This allegation is therefore corroborated by multiple witnesses.

The panel determined that this charge is proved on the balance of probabilities.

Charge 3

"That you, a registered nurse:

3) On 22 June 2020 refused to work with Colleague B."

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 1's statement and oral evidence.

The panel had sight of Witness 1's written statement in which they state the following:

'Another concern when Mr Corell returned from Broadford in June 2020, was that they did not want to work with [Colleague B], ANP. [Colleague B] had been Mr Corell's buddy/mentor during their training to become a qualified ANP and they seemed to get on well throughout Mr Corell's training. However, when Mr Corell returned to Portree, they no longer wanted to work with [Colleague B] and on 22 June 2020, I received a call from Mr Corell who hysterically stated they could not come into work as they did not want to work with [Colleague B] who they were due to work with that night. Mr Corell did not provide me with a rationale as to why they did not want to work with this colleague and stated they were not being bullied by

[Colleague B]. This was 30 minutes before Mr Corell's shift was due to begin which put pressure on me and the team to find a replacement at short notice.'

In Witness 1's oral evidence, they reiterated that Colleague B and Mr Sales Corell got on well before COVID and that after Mr Sales Corell came back he refused to work with Colleague B 30 minutes before the start of the shift. Witness 1 also stated that Mr Sales Corell had said he found Colleague B "*loud and obnoxious*". Witness 1 also informed the panel that whilst others found Colleague B difficult to work with sometimes, no one else refused to work with them.

Witness 6 also confirmed the position that Mr Sales Corell and Colleague B did not get on in both their witness statement and in oral evidence.

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

Charge 4

"That you, a registered nurse:

4) On or around 7 July 2020 failed to record Patient B's swab results.

This charge is found proved.

The panel first considered that the duty in this charge arises from the Handbook which states there is a duty to record on the ADASTRA system and Mr Sales Corell's job description.

In reaching this decision, the panel took into account Witness 1's evidence as well as the contemporaneous emails supplied by Witness 1.

The panel had sight of Witness 1's statement in which they state the following:

'There was a concern that on 10 July 2020, Patient B was informed of their swab result but their results were not entered on the spreadsheet. The spreadsheet is used to document what swabs were needed, when they were completed, what the results were and who and when the patient was advised of the results. There was also no entry on Adastra, the Clinical record management software to confirm Patient B's results and that they had been given their results. This meant that no one else in the team were aware of any of the actions taken such as whether the patient had been advised or not, whether we had the results back. This process was part of the induction that, those who had not been working at the hospital, underwent on their return. As part of the reorientation I advised all the practitioners of the process in an email dated 25 May 2020 which I attach as ***Exhibit CS10.*** *A follow up email to discuss 'our new normal' on 3 June 2020 which I attach as* ***Exhibit CS11,*** *and then another email on the 13 July 2020 with a handover crib sheet attached which I attach as* ***Exhibit CS12 and CS13*** *respectively.'*

The panel also had sight of Mr Sales Corell's response to the email from Witness 1 dated 23 July 2020 in which he stated that he had a busy shift, but not giving any real explanation. He also responded that it had *'never been a problem something not written whilst there was team work and team players'.*

The panel determined that there is credible evidence to support this charge and therefore it was found proved on the balance of probabilities.

Charge 5a

"That you, a registered nurse:

5) On or around 10 July 2020:

a) In relation to an unknown patient;

i) Failed to handover the severity of their condition.

ii) Did not assist Colleague C in providing care to them.

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account the witness evidence of Witnesses 1 and 3.

In relation to charge 5(a)(i) the panel had sight of Witness 1's written statement in which they state the following:

> '*Additionally, I was made aware that Mr Corell left [Colleague C] with a patient who was experiencing cardiac issues and awaiting an ambulance…Although staff are allowed to leave after the handover at 20:00 if there is nothing to do, I have never said that it was alright to leave earlier than this. I have been told that Mr Corell reported there was nothing to handover to the night staff but this was not the case as [Colleague C] was left alone, attending to the cardiac patient who was unwell. It is part of Mr Corell's job description* ***(Exhibit CS2}*** *to communicate effectively with members of the team and the crib sheet for handovers* ***(Exhibit CS13)*** *details what information should be shared at the handover of every shift. Additionally, as a qualified nurse, Mr Corell should be fully aware of their responsibilities to ensure colleagues are informed when sharing the care of individuals with other staff. The risks associated were exactly what happened in that a practitioner was left alone with an acutely unwell patient and two colleagues who could have helped facilitate the care and contact ambulance services were completely unaware of the situation. Thankfully as soon as they became aware the situation de-escalated quickly and the patient was transferred to a more appropriate area.'*

The panel also had sight of the email from Colleague B dated 11 July 2020 which stated the following:

'It's definitely not a team and it is unacceptable that a practitioner left his colleague with what would appear to be an evolving STEMI [ST Elevation Myocardial Infarction] *and went home (early) without even informing the oncoming staff of the situation'.*

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

Charge 5b

"That you, a registered nurse:

5) On or around 10 July 2020:
    b) Left the Hospital 40 minutes before your shift ended."

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence and contemporaneous email from Mr Sales Corell.

The panel considered the statement of Witness 3 in which they state the following:

'I arrived for my night shift at 19:30 and Mr Corell was already out of their scrubs and in their own clothes waiting whilst on their laptop. Mr Corell left Portree around 19:40 without a handover except a brief note that [Colleague C], ANP was in the clinical area with a patient and would be out soon. [Colleague B] and I phoned through to [Colleague C] to check they were alright and they stated that they were waiting for an ambulance for a patient who was having a heart attack and asked for assistance in calling to check how long the ambulance would be. [Colleague B] called the ambulance then went into the clinical area to support [Colleague C].'

However, the panel also had sight of Colleague B's email dated 11 July 2020 in which they state that Mr Sales Corell left at 20:00. Mr Sales Corell himself states in his email to Witness 1 dated 23 July 2020 that he left at 20:05 and that Colleague C was aware of this. Witness 1 stated that the shift finishes at 20:30, but that it was common practice for practitioners to leave at 20:00 if the workload permits.

The panel determined that there is conflicting evidence in relation to this charge and therefore did not find this charge proved.

Charge 6

"That you, a registered nurse:

6) On 13 November 2020 in relation to Patient D:
    a) Stated to an unknown member of the public you were "too busy" to assist them or words to that effect.
    b) Incorrectly advised an unknown member of the public to call 111.
    c) Failed to assess them.
    d) Failed to assist them in an emergency.

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel having excluded Witness 3's evidence in relation to this charge due to its earlier finding on hearsay, had only the statement of Witness 1. This statement was based on Witness 3's report of the incident. The panel determined that there is no direct evidence in relation to this charge and that it would be unsafe to rely upon the uncorroborated evidence in Witness 1's statement.

The panel therefore determined that the NMC had not discharged its burden of proof in relation to this charge and therefore it is found not proved in its entirety.

Charge 7

"That you, a registered nurse:

7) On 13 November 2020 whilst catheterising Patient A;
    a) Failed to remove your jacket.
    b) Were not bare below the elbow."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel having excluded Witness 3's evidence in relation to this charge due to its earlier finding on hearsay, was therefore left only with the evidence of Witness 1 and the patient records which make no reference to this. There is therefore no direct evidence in relation to this charge and the panel considered that it would be unsafe to rely upon the uncorroborated hearsay evidence in Witness 1's statement.

The panel therefore determined that the NMC had not discharged its burden of proof in relation to this charge and therefore it is found not proved in its entirety.

Charge 8

"That you, a registered nurse:

8) On 20 November 2021 failed to dispose:
    a) Used rubber gloves in a clinical waste bin.

b) A syringe and/or needle in a sharps bin.
c) A broken glass vial in a sharps bin.

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account Witnesses 1, 3 and 6's statements as well as the photographic evidence.

The panel considered that this incident was referred to in both Witness 1 and Witness 3's written statements. It also had sight of photographs which show that someone had left the items in the incorrect place. Therefore, whilst there is evidence that all three items were left in an unsafe location, there is no evidence to clearly indicate that it was Mr Sales Corell who had failed to dispose of them correctly.

The panel took account of the investigation report which stated that Colleague B had '*presumed it was David as he was on shift before and had given medication to a patient that day'*.

The panel determined that there is no evidence to show whether Mr Sales Corell had been the only practitioner on duty at that time and therefore it was not necessarily him who had failed to dispose of the gloves and other items. Therefore the panel did not find this charge proved.

Charge 9

"That you, a registered nurse:

9) On 8 July 2021 sent a message to Colleague A stating "Wh*at the hell is all this RST slavery about? I thought Spain was bad but God Skye has some shite as well eh??? I don't care what the unit need.*"

This charge is found proved.

In reaching this decision, the panel took into account a screenshot of Facebook Messenger conversations dated 8 July 2021 which clearly showed that Mr Sales Corell sent this message at 21:15 in response to Witness 2/Colleague A's request for him to swap shifts. Witness 2 confirmed this in their oral evidence.

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

Charge 10

"That you, a registered nurse:

10) In or around October 2021 and November 2021:
    a) On one or more occasion brought your dog into the Hospital without permission.
    b) Told others you had permission to bring your dog into the Hospital when you had not.

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from similar facts.

In reaching this decision, the panel took into account the written statements from Witness1, Witness 2 and Witness 6 and their live oral evidence together with the email from Witness 2 to Mr Sales Corell dated 30 November 2021.

The witnesses stated that they directly witnessed Mr Sales Corell being at the Hospital with the dog. The panel also had sight of the email from Witness 2 to Mr Sales Corell dated 30 November 2021 in which they stated the following:

> *'It has come to my attention that you have informed various members of the team that I have given permission for you to bring Ripper into the UCC. I am therefore making it very clear to everyone that you did not ask my permission as associate lead to bring Ripper into the hospital nor did I give my permission for this. We discussed keeping him outside in the van as [Colleague C] did with his dog and I did acknowledge how hard it must be now there is nobody else at home but at no time did I give permission for this to happen. If for any reason you feel this is necessary, I suggest you discuss this with your District manager … or line manager [Witness 1].*
>
> *If this was misunderstood at any time, I hope it is now very clear.'*

Mr Sales Corell sent the following response on 30 November 2021:

> *'Misunderstanding*
>
> *it won't happen again'*

The panel determined that this correspondence indicates that Mr Sales Corell did bring the dog into the Hospital and did not have permission to do so.

The panel also heard live evidence from Witness 6 who stated that Mr Sales Corell did inform them that he had permission to bring the dog in. The panel also had sight of Witness 6's statement in which they state the following:

> *'On 31 October 2021, I attended Portree Hospital (the 'Hospital') for a day shift…As I was about to attend the handover meeting, I could see that Mr Corell's dog was in the hospital. I was quite shocked by Mr Corell having his dog in the hospital, as I was sure this was not allowed.*
>
> *At the time this incident occurred, it did not raise it directly with Mr Corell as there were other people around and in ear-shot. I recall [Witness 3] also being present for this incident as he was scheduled to do the day shift with me. After Danny had left the incident I sent Mr Correll a message informing him that he could not bring his dog into the hospital because of infection control, and from a hygiene point of view this was bad. Mr Corell responded to me stating that [Witness 2] had informed him that he was allowed to bring his dog into work. I recall thinking that this was strange...'*

The panel determined that there is credible and cogent evidence to support this charge, and it is corroborated by multiple witnesses. The panel therefore found this charge proved in its entirety.

Charge 11

> "That you, a registered nurse:
>
> 11) On 21 January 2022 in relation to Patient F:
>
> a) Incorrectly told Dr A that "She can't come here, we [the Hospital] do not do X-ray she needs to go to Broadford" or words to that effect."

b) Failed to advise Dr A that that the patient should attend the Hospital for an initial assessment/examination.

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account written and oral evidence from Witness 1 and Witness 4. In their statement, Witness 4 stated:

> *'Once I had finished the telephone conversation with Patient F, I called the Minor Injuries unit at the Hospital to ask if Patient F could come in (out of courtesy as I could have just told them to contact the Hospital directly). Mr Corell picked up the phone. I could tell it was Mr Corell on the telephone as they introduced themselves and I recognised their accent (I am not sure what accent Mr Corell has but it was recognisable). I explained to Mr Corell what Patient F had told me and asked if I could send them to the hospital from their friend's home to be seen. Mr Corell responded "She can't come here, we do not do X-rays. If she needs an X-ray she needs to go to Broadford" or words to the effect. I do not recall what I responded to Mr Corell exactly but I'm sure that I mentioned that the patient might not need an X-ray, and that it's a long way to go to Broadford to be seen if she doesn't need an X-ray. From memory, Mr Corell did not really take this on board and still advised me to send Patient F to Broadford.'*

In their oral evidence, Witness 4 reaffirmed that Mr Sales Corell did not ask any questions about the patient and told them to just go to Broadford. Witness 4 said that they had never had this response before where an ANP was refusing to assess a patient first.

The panel noted that Witness 1 stated:

'…*Mr Corell should have done an initial assessment on the patient even if the patient had a broken bone. Whilst we are unable to X-ray at Portree, it would have been appropriate to have seen and completed a full clinical examination of the patient and their injuries to determine if there were any signs or symptoms of broken bones. If unsure, Mr Correll should have completed an x-ray form, given the patient pain relief, stabilized the break if possible and either sent the patient in an ambulance or advised the patient to make their own way (if they had someone to take them and it was clinically safe) to Broadford Hospital which is 40 minutes away. This was the normal process for the urgent care centre at this time. Mr Corell's approach was unreasonable and could have resulted in potential harm to the patient in that they suffered prolonged and unnecessary pain and distress during the journey to Broadford*.'

The panel considered that this evidence clearly establishes that Mr Sales Corell incorrectly told Witness 4 that the patient needed to go to Broadford (without being assessed at Portree first).

The panel also had sight of Patient F's contemporaneous medical record dated 21 January 2022 which confirmed Witness 4's account.

In relation to charge 11b, the panel considered whether Mr Sales Corell was under a duty to assess the patient. The panel heard evidence from Witness 4 that it was custom and practice for a patient to attend the Hospital for an initial assessment/examination. Witness 4 stated that the GP surgery was next door and did not receive funding for minor injuries so it was not their job to deal with patients in this way. Witness 4 considered that Mr Sales Corell had a duty to see the patient for an initial assessment.

The panel accepted the evidence of Witness 4 and Witness 1 that it was custom and practice for the patient to attend Portree Hospital (Urgent Care Centre ('UCC')) for an initial assessment, and that Mr Sales Corell had failed to advise accordingly.

The panel decided that this charge is proved on the balance of probabilities.

Charge 12

"That you, a registered nurse:

12) Your actions at charge 11a above were dishonest in that you knew the patient should be assessed at the Hospital first.

This charge is found proved.

In reaching this decision, the panel first considered whether Mr Sales Corell knew that what he was saying to the doctor was incorrect. The panel concluded that Mr Sales Corell did know that the patient should be assessed at the UCC because there was a duty on him to assess the patient (as detailed in charge 11 above). In saying the patient '*can't come here*', Mr Sales Corell knew this was factually incorrect as the patient could have gone to the UCC to be assessed. By the standards of ordinary, decent people, his conduct would be considered dishonest.

The panel therefore found this charge proved.

Charge 13

"That you, a registered nurse:

13) On 21 January 2022 in relation to Patient E:

a) Incorrectly told Dr A that "*they [the Hospital] did not see chest pain/cardiac patients anymore, that these patients go straight to Broadford*" or words to that effect."

b) Failed to triage them by phone and/or in person.

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 1 and Witness 4, and patient GP records.

In their statement, Witness 4 stated:

> '*I explained that Patient E will be coming in as they were experiencing chest pains (query cardiac) and Mr Corell responded say that they did not see chest pain/ cardiac patients anymore, that these patients go straight to Broadford. Mr Corell did not provide any further explanation.*'

The panel noted that the evidence above was reflected in the patient GP record.

The panel had sight of Witness 4's written statement in which they state the following:

> *I spoke with [Witness 1] (I do not recall the method of communication), Lead Advanced Practitioner for the Rural Support Team to clarify whether the Minor Injuries unit were seeing patients with chest pain and explained what Mr Corell had told me.*
> *[Witness 1] confirmed that they were still seeing patients with chest pain.*

The panel also heard oral evidence from Witness 4 which confirmed their position, where they stated they were '*stunned'* and '*lost for words'*. This account is also corroborated by the investigation notes and in the witness statement of Witness 1.

The panel first considered that the duty in charge 13b arises from Mr Sales Corell's job description, the Handbook and Witness 1's evidence that he should have triaged the patient by phone and/or in person. He had a duty to at least assess whether it was appropriate or necessary for the patient to go to Broadford as it was a 40 minute drive away.

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

Charge 14

"That you, a registered nurse:

14) Your actions at charge 13a above were dishonest in that you knew the Hospital did see and/or assess chest pain/cardiac patients.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence it relied on in charge 13. Witness 1 stated that Mr Sales Corell had seen these types of patients before on multiple occasions so he knew this was incorrect. The panel determined that Mr Sales Corell knew that the UCC saw patients with chest pain/cardiac issues, and that what he was saying to Witness 4 was untrue. By the standards of ordinary, decent people, his conduct would be considered dishonest.

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

Charge 15

"That you, a registered nurse:

15) On 28 October 2020 in relation to Patient C;

a) Did not test their cardiac rhythm."

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence and patient records.

> *'An incident occurred on an unknown date involving Mr Corell and Patient C. This incident was raised by [Witness 5]. Patient C was presenting with Tachycardia which is a rapid beating of the heard with an irregular electrical signal. Mr Corell only completed sats observations to confirm their oxygen levels in their blood. Patient C should have been on a cardiac monitor and had full observations taken including blood pressure, pulse and respirations. It would be difficult to diagnose Patient C with a sats probe alone therefore Mr Corell should have obtained all observations available.*
>
> *…*
>
> *Mr Corell had a duty to practice in line with the best available evidence as noted at Section 6 of the NMC Code of Conduct. I do not believe Mr Corell met this duty by only completing sats observations as there was further evidence that could be obtained to ensure they were providing the most appropriate care. Although Patient C did not come to any harm, there was potential for harm therefore this is a serious concern.'*

The panel also had sight of an ECG printout dated 28 October 2020 which states that it was completed at Portree Hospital. However, the printout does not say who did the test.

There was a suggestion by Witness 1 that there should have been continuous monitoring, however this charge relates to testing the cardiac rhythm and does not specify whether this is continuous monitoring or initial testing. As there is evidence indicating that the

patient's cardiac rhythm was tested at Portree Hospital, although it is not clear who did the test, the NMC has not discharged its burden of proof in relation to this charge.

Charge 16a

"That you, a registered nurse:

16) Did not follow Manager A's requests in that you;

a) On 15 April 2021 did not attend a meeting and/or advise you were not attending.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's statement and contemporaneous emails from them to Mr Sales Corell.

The panel had sight of Witness 1's statement in which they state the following:

'Mr Corell was invited to an early resolution initial meeting on 15 April 2021 via a letter dated 29 March 2021 which I attach as ***Exhibit CS22.*** *Mr Corell did not advise me that they would not be attending nor was any reason given as to why they did not attend. On the day of the meeting, a hand delivered letter was sent to Mr Corell asking that they contact me as soon as possible and before attending their next shift that weekend. Mr Corell did not contact me before their shift and instead sent a short email stating that they had forgotten about the early resolution initial meeting on 17 April 2021. Mr Corell did not attend this meeting so a further meeting was arranged for 10 May 2021 and Mr Corell was invited to this on 4 May 2021. I attach the letter as* ***Exhibit CS23.'***

The panel also had sight of Witness 1's emails to Mr Sales Corell inviting him to early resolution meetings. The second email dated 4 May 2021 inviting him to another meeting

on 10 May 2021 states '*following your recent non attendance'* which indicates that he did not attend the meeting on 15 April 2021.

Witness 1 referred to the failure to attend a meeting in their oral evidence when they explained that they had to make a four-hour return trip to attend this meeting, and that Mr Sales Corell would have been aware of this.

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

Charge 16b

"That you, a registered nurse:

16) Did not follow Manager A's requests in that you;
    b) Between 15 April 2021 and 17 April 2021 did not contact Manager A as requested to do so prior to attending your shift on 17 April 2021.

This charge is found proved.

In reaching this decision, the panel took into account the investigation report which states that Mr Sales Corell was failing to engage. The panel also heard from Witness 1, as quoted above, that the letter was hand delivered to Mr Sales Corell which asked him to contact the manager on as soon as possible before his shift. Witness 1 confirmed in their oral evidence that Mr Sales Corell did not contact them.

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

Charge 17a

""That you, a registered nurse:

17) In relation to Manager A;

a) On 28 January 2021 stared at Manager A without saying anything to them during a meeting.

This charge is found NOT proved.

The panel considered the statement of Witness 1 in which they stated that *'Mr Corell sat and stared at me for a long period of time (approximately 15-20 minutes) without saying anything, making me feel incredibly uncomfortable'.*

Whilst the panel recognised that Witness 1 had given oral evidence to say they felt Mr Sales Corell's behaviour was "*intimidating"* and he had been staring, there was no evidence before it to corroborate their understanding. Further, Witness 1 stated that this took place at an improvement meeting and the meeting on 28 January 2021 was related to sickness. Although Witness 6 referred to a meeting where they described Mr Sales Corell's behaviour towards Witness 1 as confrontational, Witness 6 confirmed to the panel in oral evidence that this meeting took place at a later date.

The panel determined that the evidence as to what happened at the meeting on 28 January 2021 was unclear.

The panel therefore found this charge not proved.

Charge 17b

""That you, a registered nurse:

17) In relation to Manager A;

b) On 13 July 2020 shouted at them during a telephone conversation.

This charge is found proved.

The panel heard the evidence of Witness 1 and had sight of the investigation report.

The panel also had sight of the timeline produced by Witness 1 in which they state the following:

> *'On 13th July I received a phone call at home and an email whilst I was off duty where DSC [Mr Sales Corell] proceeded to shout at me down the phone accusing me of leaving the area unsafe as he was working alone except for a HCSW (both Urgent Care and the CAC operated on an appointment system). I asked him to calm down and stop shouting at me, DSC then stated he was not shouting at me he was being firm with me. I asked him what he had done to ensure that he was working in a safe environment, ie: contacted team mates to see if anyone could come in to support him, contacted SAS to advise them to bring no ambulance patients, contacted MacKinnon Memorial (MMH) to advise the doctors, contacted any patients booked into the CAC to rebook if possible, he stated he had done none of these. I advised DSC that as a band 7 advanced practitioner I would expect that his first priority was to ensure safety rather than call and shout at me. I then told him to deal with what I had told him to do and I contacted team members and arranged for a colleague to work with him. We had another informal 1:1 meeting about this.'*

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

Charge 17c

> ""That you, a registered nurse:
>
> 17) In relation to Manager A;

c) On 28 June 2021 stated in the presence of Colleague B in relation to organising rotas “it’s not rocket science” or words to that effect.”

This charge is found proved.

The panel had sight of the contemporaneous email written by Witness 1 in which they state that Mr Sales Corell:

> *‘Advised me as his manager that completing a rota ‘isn’t rocket science’ in the presence of [Witness 6]. Yet when he was offered the opportunity to do the rota he refused saying he wouldn’t because he is no good at that sort of thing’.*

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

Charge 18

“That you, a registered nurse:

18) On unknown dates posted on social media:

a) “NHS Highlands. Bullying, harassment and discrimination all over Skye. Sturrock report remains as fresh as a daisy still nowadays. Terrorists.
b) “I do have one boss, nothing to worry about, just discovered one on the computer. Many managers in this job eh?!?!?!?...”
c) “LOOK ME IN THE EYES AND TELL ME WE’RE GONNA BE FULLY STAFFED. MANAGEMENT: BEST I CAN DO IS PIZZA”.
d) An image containing the following text “Me and my co-workers listening to our boss tell us how valued we are, despite being constantly under staffed, over worked and under paid…”
e) An image containing the following text *Training the new employee at work* “So you’re not really supposed to do this, but this is what we do”.

f) An image containing the following text “Manager Company Staff who did the work”.

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges are similar in nature.

In reaching its decision, the panel had sight of screenshots relating to each sub-charge from both Mr Sales Corell’s personal and business social media accounts. The panel heard evidence confirming that these were his accounts. The panel had no reason to dispute that he sent these posts.

The panel found this charge proved in its entirety.

Charge 19

““That you, a registered nurse:

19) Around 8 August 2023 posted on social media an image with the following text “Fuckaccias wrapped for my former hospital colleagues and their hardwork. Please note: not for [Colleague D] (cunt) or management (useless and dangerous)”.

This charge is found proved.

In reaching its decision, the panel had sight of a screenshot of this post from Mr Sales Corell’s business social media account. The panel had no reason to dispute that Mr Sales Corell had sent this post.

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

Charge 20

““That you, a registered nurse:

20) Your conduct at all or part of charges 9 and/or 17 and/or 18 and/or 19 above amounted to bullying in that your unwanted behaviour directed at Manager A and/or Colleague A and/or Colleague D and/or other colleagues was offensive and/or intimidating and/or malicious and/or insulting that undermined, humiliated, or caused physical or emotional harm to them.

This charge is found proved in the following respects.

The panel considered this charge in relation to each separate aspect.

In relation to Charge 9:

The panel considered the statement of Witness 2 in which they stated the following:

‘Mr Corell responded by swearing and complaining about the rota system. Mr Corell said "What the hell is all this RST slavery about? I thought Spain was bad but God Skye has some shite as well eh???? I don't care what the unit need." I found Mr Corell's response to be out of proportionate and abusive as I was just asking if they were available to cover a shift. I would have expected a brief message to say they are not available if this was the case.’

The panel determined that this does amount to bullying and would be seen as offensive, intimidating and undermining. Witness 2 further stated that the response made them feel anxious.

Therefore the panel found this charge proved in relation to charge 9.

In relation to Charge 17:

On the facts above, the panel found charges 17b and 17c proved and therefore only considered those sub-charges in relation to this charge.

The panel determined that Mr Sales Corell shouting on the telephone did amount to bullying and intimidating behaviour. The panel considered Witness 1's statement in the investigation report that Mr Sales Corell '*shouted at the top of his voice'*. This behaviour towards a manager clearly undermined their position.

In relation to charge 17c, the panel did not hear direct evidence on this and therefore did not know the tone which was used by Mr Sales Corell. The panel determined that whilst this may be impolite and inappropriate in the circumstances, it is not sufficiently serious to amount to bullying.

The panel therefore found this charge proved in relation to charge 17b but not in relation to 17c.

In relation to Charge 18a:

The panel took account of Witness 2's evidence that '*everyone knew'* who Mr Sales Corell's line manager was, and that the Isle of Skye is small. Therefore the panel determined that his action of posting this message directed at his line manager (Witness 1) amounted to bullying in that it was intimidating, offensive, malicious, insulting which undermined, humiliated and caused Witness 1 "*extreme distress*".

This charge is therefore proved on the balance of probabilities in relation to charge 18a.

In relation to Charge 18b:

The panel determined that Mr Sales Corell's exchange with a colleague on Facebook was inappropriate, but was not sufficiently serious to amount to bullying. Therefore, the panel found this charge not proved.

In relation to Charge 18c:

The panel determined that this does not amount to bullying. It considered that this appears to be a joke in poor taste. Although the panel considered that posting such an image in a public forum was unprofessional behaviour, it did not amount to bullying.

Therefore, the panel did not find this charge proved.

In relation to Charge 18d:

The panel considered that this is a personal post and is undermining and offensive to the person it was directed at. Further, that the community was small and others would know who was being referred to. Witness 1 found these posts, some made whilst he was on duty, to be '*professionally undermining, derogatory and professionally damaging*'. Therefore the panel determined that this does amount to bullying.

The panel found this charge proved in relation to charge 18d.

In relation to Charge 18e:

The panel considered that this post appears to be a flippant comment which was unprofessional and in poor taste. However, it was not created by Mr Sales Corell himself, but taken from another social media account called '*Funny Nurses'*. Further, this post is not directed at anyone in particular and does not amount to bullying.

The panel therefore found this charge not proved in relation to charge 18e.

In relation to Charge 18f:

The panel determined that this post does amount to bullying and is intimidating. It portrays Mr Sales Corell's manager as oblivious to the staff's distress, and everyone would know who the manager was in the post. The panel also determined that this was a distressing image of a child drowning, and is malicious, undermining and did cause emotional harm to his manager by suggesting that the manager did not care about any staff who were struggling.

The panel therefore found this charge proved in relation to charge 18f.

In relation to Charge 19:

The panel determined that this post does amount to bullying. It names and targets Mr Sales Corell's colleague and calls them an extremely offensive word. Mr Sales Corell has named a specific colleague and refers to management ('*useless*' and '*dangerous*'). He posted it onto his business account which has a wider reach and was read by others who referred to the post as '*shocking'*. Witness 3 stated in their statement:

> '*When this post appeared and named me personally we were both worried that things may be escalating beyond the previous posts as it seemed very personal.* [PRIVATE] [Witness 1] *was so concerned she made a call to the police for advice.'*

The panel determined that this behaviour was intimidating, malicious, insulting, undermining, humiliating, and caused emotional harm.

The panel found this charge proved on the balance of probabilities in relation to charge 19.

Charge 21

““That you, a registered nurse:

19) On an unknown date shared a link on social media to an article titled “A compound in ‘magic mushrooms’ provides rapid, durable depression relief”.

This charge is found proved.

In reaching its decision, the panel had sight of a screenshot of this post. It was clear to the panel that Mr Sales Corell shared this link on social media.

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

Fitness to practise

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

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

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

Submissions on misconduct

Mr Bardill submitted on behalf of the NMC that the actions or omissions present in the facts found proved amount to misconduct. He referenced 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.'*.

With regard to seriousness, Mr Bardill referenced the case *of R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 which held that the conduct must be '*sufficiently serious that it can properly be described as misconduct going to fitness to practise*', and that there are two kinds:

> "*First, it may involve sufficient serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession*."

Mr Bardill submitted that the conduct found proved consists of both kinds of misconduct in that some of the actions or omissions took place while on shift or carrying out clinical duties, whereas other actions relate to behaviour outside of clinical practice, but which the NMC say is still sufficiently disgraceful that it brings the profession into disrepute.

Mr Bardill submitted that the consequences of refusing care or treatment to a patient (including assessing them and giving pain relief) are that the patient's access to care is delayed, during which time they are in pain. In addition, there is the risk that potential issues with the patient are not addressed at the first opportunity and the patient is put at risk of deterioration of their health and subsequently harm.

Moreover, in addition to the direct risk of harm, and actual harm, to patients, Mr Bardill stated that there is the added factor that resources were expended elsewhere unnecessarily and inappropriately (such as the GP) which affected the delivery of service in that area, as well as the safety of patients.

Mr Bardill submitted that a failure to keep proper records of patient attendance or treatment, commensurate with trust policies, puts patients at real risk of harm because it becomes unclear what stage their treatment is at. This additionally put staff, who are part of the public, at risk of unwittingly making clinical errors and harming patients.

Mr Bardill submitted that there are clear attitudinal issues displayed by Mr Sales Corell towards staff members and colleagues, which includes dishonesty, shouting, swearing,

undermining management and policies, referring to management as '*murderers'* and '*terrorists'*. Furthermore, the posting on social media of images and memes, in a way that undermines the trust and confidence the public place in the profession, Mr Sales Corell and indeed the people or trust he is targeting in the posts, compounds this. Mr Bardill added that Mr Sales Corell's wrong advice on policy or procedure relating to treatment, was a dishonest act borne out of an attitudinal problem which increased the real risk of harm to patients and in this case patients did suffer harm in that their pain and suffering was prolonged and delayed by his actions.

Mr Bardill therefore submitted that, owing to the real risk to patient and public safety arising from the facts of this case, the actual harm suffered, and the damage to the trust and confidence of the public, accompanied with the dishonesty, Mr Sales Corell's actions amounted to 'sufficiently serious misconduct' for the purposes of these proceedings as stated above, and consist of both clinical and non-clinical misconduct.

Mr Bardill also identified a number of Mr Sales Corell's actions which amounted to a breach of **'**The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code).

Submissions on impairment

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

Mr Bardill submitted that the conduct found proved in this case was repeated on numerous occasions despite efforts from management to implement plans, communicate policies and procedures and give instructions. This repetition strongly indicates that, if Mr Sales Corell were allowed to continue to practise without restriction, the present risk to patient and public safety would remain unresolved and ongoing, increasing the risk of repetition

and also further potential misconduct. This is particularly pertinent in the context of a case with such attitudinal and honesty-related issues.

Mr Bardill further submitted that the panel has not seen any evidence of any insight or remorse at all from Mr Sales Corell, nor has there ever been any evidence of acceptance of responsibility for a single charge or allegation in this case. Mr Sales Corell has yet to provide an explanation for his conduct and has had ample opportunity to do so. He has not offered any assistance or information about the allegations or made reference to anyone or anything that can assist. This may not seem significant on its own, but given he has displayed similar conduct previously as part of the charges, and displays such deep-seated attitudinal problems, Mr Bardill submitted that it is significant to the question of ongoing risk.

Mr Bardill submitted that, not only would the above place patients at a real risk of harm, but it would also place the public at risk of harm. He added that this would undermine the trust and confidence placed in the profession, particularly where patients have been harmed or placed at risk of harm and staff put in difficult or risky situations in their own practice.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance*, *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (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 in making its decision.

The panel was of the view that Mr Sales Corell's actions fell significantly short of the standards expected of a registered nurse, and 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'

2 Keep clear and accurate records relevant to your practice

To achieve this, You must:

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

3 Uphold the reputation of your profession at all times

To achieve this, you must:

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it.

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

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

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

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

To achieve this, you must:

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

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.

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times.'

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

Although the behaviour Mr Sales Corell displayed in respect of charges 3, 4, 16, 17c, and 21 was inappropriate, unprofessional, and inadvisable in the case of charge 21, the panel found that this behaviour did not reach the threshold to amount to serious misconduct:

Charge 3

The panel determined that Mr Sales Corell refusing to work with a colleague for no good reason 30 minutes before a shift, potentially put the team under extra stress, and was very unprofessional but was not sufficiently serious to amount to serious misconduct.

Charge 4

The panel concluded that Mr Sales Corell failing to record Patient B's swab results was a one-off incident. The panel recognised that single errors such as this can occur and so determined that it was not sufficiently serious to reach the threshold of serious misconduct.

Charge 16

The panel identified Mr Sales Corell not following his manager's instructions as an attitudinal issue, however, not one at the higher end of the scale of seriousness. The panel considered Mr Sales Corell's actions to be unprofessional but a management issue rather than serious misconduct.

Charge 17c

The panel was of the view that Mr Sales Corell telling a colleague that organising rotas is "*not rocket science*", whilst inappropriate and unprofessional, did not amount to serious misconduct.

Charge 21

The panel determined that Mr Sales Corell sharing a link on social media to an article regarding 'magic mushrooms' and its supposed impact on depression was unprofessional and inadvisable. However, the panel bore in mind that Mr Sales Corell did not comment on the post and there was no suggestion that he was making any recommendations. In view of this, the panel was not satisfied that this amounted to serious misconduct.

The panel found that charges 1, 2, 5a, 9, 10,11, 12, 13, 14, 17b, 18, 19 and 20 did amount to serious misconduct:

Charge 1

The panel considered Mr Sales Corell's actions at this charge to be a clear breach of a number of nursing practice standards. It determined that his failure to carry out an assessment of the patient amounted to negligent practice, and the failure to provide them with pain relief was unkind, not least because he was advising a 40-minute journey that was likely to cause increased discomfort. The panel considered that Mr Sales Corell's flippant comment regarding not working well at that time of day to be unprofessional and unacceptable when relating to patient care. The panel was also mindful that Mr Sales Corell was an experienced nurse at the time and would have been well aware of his responsibilities, and so his actions amounted to serious misconduct.

Charge 2

The panel took into account the context of the COVID-19 pandemic and the fact that there were specific rules and regulations that health professionals were required to adhere to in order to limit the spread of disease. The panel determined that it was Mr Sales Corell's duty to follow these rules and his failure to do so put patients, colleagues and the community at risk which amounted to serious misconduct.

Charge 5a

The panel found Mr Sales Corell's failure to handover the severity of a cardiac patient's condition and not assisting a colleague with their care to be a single incident. However, the panel determined that his failure to support a colleague and to ensure appropriate care for an acutely ill patient was sufficiently serious to amount to serious misconduct.

Charge 9

The panel took charges 9 and 20 together. Having decided that the words Mr Sales Corell used amounted to bullying, the panel found that this behaviour amounted to serious misconduct.

Charge 10

The panel concluded that Mr Sales Corell bringing his dog to work, despite being told this was not permitted, was an attitudinal issue and a flagrant breach of policy as well as being an infection control risk. Mr Sales Corell was a senior nurse and should have been a role model for his more junior colleagues. Mr Sales Corell's actions were inappropriate, particularly as he did this without permission and then misled those who challenged him by saying that he had permission. The panel determined that this amounted to serious misconduct.

Charge 11

The panel concluded that Mr Sales Corell failing to inform a doctor that a patient could come to the UCC for an initial assessment and instead them telling that they "*can't come here*' constituted serious misconduct as he gave incorrect advice whilst knowing it was untrue. The panel determined that Mr Sales Corell's actions put a patient at risk of harm.

Charge 12

Having decided that Mr Sales Corell's actions were dishonest, the panel considered this charge to amount to serious misconduct as he intentionally misled a doctor and potentially put a patient at risk.

Charge 13

The panel considered Mr Sales Corell failing to triage a patient and incorrectly telling them that the UCC did not take chest pain/cardiac cases to amount to serious misconduct. Mr

Sales Corell put the patient at risk as the chest pain could have been potentially life threatening so they should have been assessed before being sent on a 40-minute journey.

Charge 14

Having decided that Mr Sales Corell's actions were dishonest, the panel found that this behaviour amounted to serious misconduct as he intentionally misled a doctor and put a patient at risk.

Charge 17b

The panel took charges 17b and 20 together. Having decided that Mr Sales Corell's actions constituted bullying, the panel considered this behaviour amounted to serious misconduct.

Charge 18

The panel concluded that Mr Sales Corell's social media posts amounted to serious misconduct. The panel considered that, as a registered nurse, Mr Sales Corell would have been aware that posting derogatory comments about colleagues on social media was unprofessional and unacceptable. The panel determined that these posts were likely to have spread across the island community, bringing the profession into disrepute. The panel recognised that Mr Sales Corell's posts had a significant effect on his manager and other colleagues which was made worse by him posting it on his business account which had a large number of followers.

Charge 19

The panel considered Mr Sales Corell's social media post in which he personalised and named specific colleagues, using highly offensive language, to be wholly unacceptable. The panel determined that this amounted to serious misconduct.

Charge 20 (in relation to charges 9, 17b, 18a, 18d, 18f, 19)

The panel heard evidence that Mr Sales Corell's bullying behaviour impacted on the team dynamic which undermined the team's ability to provide a safe and proper standard of care to the community. Mr Sales Corell's colleagues described his behaviour as '*public bullying*' which caused some '*extreme distress*'. The panel had particular regard to Witness 1 detailing the effect of Mr Sales Corell's bullying behaviour:

> '*I have been made aware that there have been postings on David's Facebook pages that are professionally undermining, derogatory and professionally damaging about me. These postings, some made whilst he was on duty…have left me feeling incredibly distressed, harassed and bullied…I am now finding it a little intimidating as I fear any move by me to manage these situations will result in public humiliation.*
> …
> *'I am presently feeling quite unwell with this, I am not sleeping, I am having difficulty concentrating on anything else and seem to be on the edge of tears constantly*.'.

Further, Witness 3 stated in their witness statement:

> '*When this post appeared and named me personally we were both worried that things may be escalating beyond the previous posts as it seemed very personal. My wife was so concerned she made a call to the police for advice.*'

The panel recognised the cumulative effect of Mr Sale Corell's bullying and determined that it amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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 *Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

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

The panel considered the above test and was satisfied that all four limbs of the test were engaged in relation to Mr Sales Corell's past actions.

The panel heard reference in oral evidence that Mr Sales Corell was experiencing difficulties in his private life at the time of the events. The panel acknowledged an email from Mr Sales Corell to Witness 1 date 10 November 2020 in which he stated that he felt he was under *'a huge amount of pressure*'. This same email states that, notwithstanding the pressure he was under, he '*was able to perform* [his] *duties as an ANP with no* problems'. The panel also was told by several witnesses that his nursing practice and behaviour was fine before he went to Broadford. However, the panel had no additional information on Mr Sales Corell's personal difficulties due to his non-attendance and lack of submissions. The panel also heard in evidence that Mr Sales Corell was offered the opportunity to work elsewhere, [PRIVATE], he was moved to day shifts to support him, and a Support Improvement Plan was developed for him.

However, the panel found that patients were put at a real risk of harm, and that colleagues were caused emotional harm as a result of Mr Sales Corell's poor practice and attitudinal issues. Mr Sales Corell's unprofessional activity on his social media accounts brought the reputation of the nursing profession into disrepute. The charges in this case spanned July 2019 – August 2023. The charges found proved relating to bullying spanned July 2021 – August 2023, and the dishonesty charges both occurred on 21 January 2022. The panel found that Mr Sales Corell's misconduct breached the fundamental tenets of the nursing profession.

Regarding insight, the panel determined that Mr Sales Corell has not demonstrated remorse, an understanding of how his actions put patients at a risk of harm, or an understanding of why what he did was wrong and how this impacted negatively on his colleagues and the reputation of the nursing profession.

The panel was of the view that the clinical failings in this case are capable of being remediated. However, Mr Sales Corell has not provided the panel with any evidence demonstrating that he has taken steps to strengthen his practice such as relevant training. The panel considered the attitudinal concerns and dishonesty to be more difficult to address, particularly as Mr Sales Corell did not engage substantively with the local investigation or NMC proceedings.

The panel determined that there is a real risk of repetition based on Mr Sales Corell's lack of insight and failure to address the concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 determined that a finding of impairment on public interest grounds is required as public confidence in the profession and the NMC as a regulator would be undermined if a finding of impairment were not made in this case. The panel therefore concluded that Mr Sales Corell's fitness to practise is impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Sales Corell's fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel had regard to all the evidence that was adduced in this case and the Sanctions Guidance (SG) published by the NMC.

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

Submissions on sanction

Mr Bardill submitted that the appropriate sanction for these charges is a striking-off order.

Mr Bardill submitted that a conditions of practice order would not be appropriate in addressing the regulatory concerns or protecting the public. The panel heard evidence of improvement plans, meetings, support from staff, [PRIVATE] and much more; none of this appeared to assist Mr Sales Corell. Given the panel's findings and the lack of evidence of insight, remorse, or remediation, Mr Bardill submitted that supervising Mr Sales Corell would be unworkable. He added that the attitudinal issues are deep-seated, and the lack of evidence from Mr Sales Corell means that the panel could not be satisfied that a conditions of practice order would eliminate the risks in this case. Moreover, it would not address the dishonesty nor reflect the seriousness of a dishonesty case where patients were put at risk of harm.

Mr Bardill submitted that a suspension order would not suffice in addressing the regulatory concerns in this case.

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Mr Bardill submitted that a striking-off order is the appropriate sanction in this case. He stated that the lack of demonstrated remediation, insight, or remorse, coupled with the aggravating features that the panel may think outweigh the mitigation features significantly, means that the regulatory concerns cannot be sufficiently addressed without a striking-off order. Additionally, a striking-off order is the only order which would adequately meet the public interest and properly reflect the seriousness of a case where patients and the public were put in harm's way. This is compounded by the fact there is no evidence from Mr Sales Corell that he has addressed any of this. Mr Bardill therefore submitted that the only order which will adequately, proportionately and fairly meet the objectives of upholding proper standards, protecting the public, and patient safety, is to strike Mr Sales Corell off the register.

Mr Bardill informed the panel that an interim suspension order has been in place from 30 May 2022.

Decision and reasons on sanction

Having found Mr Sales Corell's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Sales Corell's wide-ranging misconduct some of which put patients at risk of harm
- His pattern of misconduct from July 2019 – August 2023.
- His lack of insight into his failings
- That he breached the trust of patients and his colleagues

The panel also took into account the following mitigating features:

- Good record prior to these concerns raised
- Mr Sales Corell's personal mitigation including an extended period of [PRIVATE] and [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Sales Corell's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Sales Corell's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Sales Corell's registration would be a sufficient and appropriate response. The panel determined that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining as many of the charges relate to attitudinal concerns. Furthermore, the panel concluded that the placing of conditions on Mr Sales Corell's registration would not adequately address the seriousness of this case, nor protect the public given that Mr Sales Corell has not cooperated with previous attempts made to support him to improve his performance, and that he has failed to engage with the NMC in relation to these proceedings.

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

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

The panel took into consideration that Mr Sales Corell has failed to demonstrate any insight into his actions or take steps to address both his clinical failings and deep-seated attitudinal issues. The panel was mindful that Mr Sales Corell's misconduct occurred over a number of years and was worsened by the fact that he was subject to an interim suspension order when a particularly concerning social media post was made around 8 August 2023. The panel concluded that, as there was no evidence whatsoever of any insight or remorse, a significant risk of repetition remained. This had not been reduced with the current interim suspension order, indeed Mr Sales Corell committed further misconduct in that time.

In this particular case, 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 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 found that the misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse, was wide-ranging in nature and had persisted over a number of years. The panel determined that the findings in this particular case were serious and raised fundamental questions about Mr Sales Corell's professionalism. In all the circumstances, Mr Sales Corell's actions are fundamentally incompatible with him remaining on the register.

The panel further decided that to allow Mr Sales Corell to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mr Sales Corell in writing.

Interim order

As a striking-off order cannot take effect until the end of the 28-day appeal period, the panel 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 Mr Sales Corell's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel considered the submissions from Mr Bardill that an interim suspension order should be made. He submitted that an interim order is necessary to protect the public and meet the wider public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

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

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public and is otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

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

This will be confirmed to Mr Sales Corell in writing.

That concludes this determination.