Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 5 August 2024 – Wednesday, 21 August 2024

Virtual Hearing

Name of Registrant:	**Cameron Andrew Hurwood**
NMC PIN	99D0103E
Part(s) of the register:	Registered Nurse – Adult (April 2003)
Relevant Location:	Kettering Jersey Blackpool Lancaster
Type of case:	Misconduct
Panel members:	Dr Katharine Martyn (Chair, registrant member) Claire Martin (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Gaon Hart
Hearings Coordinator:	Jack Dickens
Nursing and Midwifery Council:	Represented by Dr Francis Graydon, Case Presenter
Mr Hurwood:	Present and represented by Mr John Mackell, instructed by the Royal College of Nursing
Facts proved:	2(a), 2(b), 5(a), 5(c), 6, 7, 8, 9, 10(a), 10(b), 10(c), 11
Facts not proved:	1(a), 1(b), 2(c), 3, 4, 5(b)
Fitness to practise:	Impaired
Sanction:	Striking-off Order

Interim order: Interim Suspension Order for 18 months

Details of charge

That you, a registered nurse:

Kettering General Hospital

1. When completing shifts at Kettering General Hospital between 20 and 23 December 2019, failed to provide adequate patient care in that you:

    a. did not administer one or more medications to one or more patients in a timely manner or at all;
    b. did not complete risk assessments for one or more patients in a timely manner or at all;

Jersey General Hospital, St Helier

2. Around 25 March 2020 whilst working at Jersey General Hospital, failed to provide adequate patient care in that you:

    a. did not check the blood sugar levels of a diabetic patient for the third day in a row;
    b. did not ensure that Patient A's IV drip was attached in a timely manner or at all;
    c. did not ensure that Patient A's observations were carried out and/or recorded in a timely manner or at all

Blackpool Victoria Hospital

3. On one or more occasions around January 2022 whilst working at Blackpool Victoria Hospital did not administer medications to one or more patients in a timely manner or at all

4. During a night shift commencing on 12 August 2022, did not administer Patient B's prescribed medication in a timely manner or at all

Royal Lancaster Infirmary

5. On or around 1 January 2023 whilst undertaking shifts at Royal Lancaster Infirmary:

    a. did not carry out Patient C's observations in a timely manner or at all;
    b. did not care for Patient C because you considered that she stank of fags or words to that effect;
    c. did not ensure that another colleague carried out Patient C's observations

Blackpool Victoria Hospital

6. On one or more occasions during a nightshift commencing on 2 September 2022 at Blackpool Victoria Hospital, said to Colleague A "can I put my arms between your legs like an octopus" or words to that effect

7. Your actions as specified in charge 6 amounted to sexual harassment

Royal Lancaster Infirmary

8. On an unknown date in January 2023 or February 2023, said to Colleague C that you "would like to be in-between your legs" or words to that effect

9. Your actions as specified in charge 8 amounted to sexual harassment

10. During a nightshift commencing on 24 January 2023 at Royal Lancaster Infirmary said to Colleague B:

    a. “I would rather be looked after by an IV drug user than a foreign nurse” or words to that effect;
    b. “it’s about time you earned your place to work in this country” or words to that effect;
    c. “if you’re in this country, you need to be able to understand our sense of humour” or words to that affect

11. Your conduct as specified in charges 10a) – 10c) amounted to racial harassment

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

Decision and reasons on application to amend Charge 8

The panel heard an application made by Dr Graydon, on behalf of the Nursing and Midwifery Council (‘NMC’) to amend the wording of Charge 8 to read as follows:

> 8. ~~On an unknown date in February 2023~~ **On an unknown date in January 2023 or February 2023**, said to C that you “would like to be in-between your legs” or words to that effect

Dr Graydon submitted that in light of the evidence heard by the panel, there would be no injustice or unfairness in amending the charge.

The panel heard from Mr Mackell, on your behalf. He submitted that the amendment is not opposed and, as you have already accepted using words to the effect of those that are

particularised in charge 8, there would be no material prejudice in amending the date in the charge.

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

The panel determined that it was appropriate to allow the amendment, as applied for, to more accurately reflect the evidence, specifically regarding the timing and sequence of the allegation, the panel has heard during the fact stage of this hearing. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed, as it did not substantially change the charge, nor your admissions and it aligned to evidence provided by Witness 8 and by yourself. It noted that it was in light of your evidence that this amendment was sought.

Decision and reasons on application to amend Charge 11

Dr Graydon made a further application to amend Charge 11. This application was made during the panel's deliberations, due to a question being raised by the panel into the wording of Charge 11.

> 11. Your conduct as specified in charges 10a) – 10c) **amounted to racial harassment** ~~was racially abusive~~

Dr Graydon submitted that the amendment sought does not alter the merit of the case against you. He also submitted that the words within Charges 10 are racist in nature and race is a protected characteristic under the Equality Act 2010. He submitted that the amendment would be in the interests of fairness to all parties and that no prejudice or injustice would be caused to you should the application granted. He submitted that the only unfairness would be to the NMC and the public if the application were to be rejected. He said this is because it would prevent the NMC being able to fulfil its statutory obligation under the Equality Act 2010, section 149.

Mr Mackell opposed the application. He submitted that there is a material difference between the wording of ‘abuse’ and ‘harassment’. He submitted that your case has been advanced on the basis of the charge being ‘racial abuse’, and although there is no standalone statutory definition for racial abuse, he stated that the panel can use its discretion as to what is meant by abuse and could rely on the ordinary dictionary definition of the meaning of abuse, which he provided. He submitted that to change the wording to ‘harassment’ would change the nature of the charge and, although the parties have addressed the panel on harassment and abuse, it would be unfair and unjust to amend the charge as sought as it would cause prejudice to you.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules and the relevant case law.

The panel noted that harassment had been addressed by both parties during the hearing and that witnesses had been questioned in relation to the elements of harassment in both a sexual and racial context. It considered that the change would not alter the substance of the charge or change the nature of the evidence advanced by either party. Furthermore, it noted Mr Mackell’s submission concerning the panel’s discretion on relying on the dictionary definition of abuse. The panel considered that the term ‘racial abuse’ could be considered on the ordinary meaning of the words, but as there is no single authoritative definition of this term, to rely on a dictionary definition would leave ambiguity and uncertainty.

Therefore, the panel determined that it would be appropriate to allow the amendment, as applied for, to give greater particularisation and it would ensure that the panel is able to reach a fully informed decision on this charge without any ambiguity. It was satisfied that it would not be unfair or prejudice, and no injustice would be caused to either party by the proposed amendment being allowed. The panel also considered that it would assist you to fully appreciate the extent and nature of the charges you face if the amendment was made. Furthermore, the panel concluded that to grant the amendment would be in the wider public interest as the evidence provided and examined was comprehensive and

covered the relevant aspects of harassment. By making the amendment it enabled the NMC to be able to fulfil its statutory obligations under the Equality Act 2010, section 149.

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

During witness evidence, Mr Mackell made an application for parts of this hearing to be held in private when they relate to matters of your health. The application was made pursuant to Rule 19 of the Rules.

Dr Graydon submitted that he did not object to this application.

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

The panel determined that it is your own interests of privacy to go into private session as and when matters of your health are discussed and agreed the application.

Background

On 31 January 2024 the NMC received a referral regarding your work as an agency nurse for National Locums (‘the Agency’), from ACI Training and Consultancy Ltd (‘ACI’), who provided an outsourced governance function to the Agency. You had been registered with the Agency since 5 September 2019.

The alleged concerns occurred across four different hospitals between December 2019 and January/February 2023.

Kettering General Hospital A & E Department (‘Kettering Hospital’)

Whilst working at Kettering Hospital in December 2019, it is alleged that you were having to be constantly prompted to complete tasks throughout your shift. It is alleged that you were found sitting at the nurse's station when patient care was due to be given, including, medications management and administration, risk assessments, and patient observations. It is further alleged that your record keeping, and documentation was poor.

Jersey General Hospital (‘Jersey Hospital’)

Whilst working at Jersey Hospital in March 2020, alleged concerns about your conduct and competence were raised. The allegations include that you failed to check the blood sugar levels of a diabetic patient for three days in a row, that you failed to administer medications to Patient A in a timely manner, and that you failed to complete Patient A’s notes.

Blackpool Victoria Hospital (‘Blackpool Hospital’)

Whilst working at Blackpool Hospital between January 2022 and September 2022 numerous concerns regarding your conduct and capability were raised.

It is alleged that you were unable to manage a small caseload of patients and failed to complete patient observations. It is further alleged that on one or more occasions around January 2022 you did not administer medications to one or more patients in a timely manner or at all. Further, it is also alleged that during a night shift in August 2022 you did not administer prescribed medications to Patient B, in a timely manner or at all.

Further to this, in September 2022, it is alleged that you said to Colleague A words to the effect of *"can I put my arms between your legs like an octopus"* to another nurse. It is said that this comment made Colleague A feel violated, distressed, uncomfortable and upset.

You allegedly said that this comment was ‘banter’ and a ‘play on words’ as you entered the room to get an IV octopus.

Following this incident, you were restricted from working at Blackpool Hospital.

Lancaster Royal Infirmary (‘Lancaster Hospital’)

Whilst at Lancaster Hospital between January 2023 and February 2023 further concerns were raised about your conduct and competence.

It is alleged that you did not provide patient care to Patient C and your behaviour towards Patient C was unprofessional, allegedly stating that *"she stank of fags’’* or words to that effect. It is alleged that you said this comment was a joke. It is further alleged that you did not complete a Situation, Background, Assessment, Recommendation (‘SBAR’) for this Patient.

It is further alleged that, on an unknown date in January 2023 or February 2023, you said to Colleague C you *“would like to be in-between your legs”* or words to that effect. It is alleged that this comment amounts to sexual harassment as it is an implicitly sexual comment and that it made Colleague C feel uncomfortable and uneasy.

Following this incident, in January 2023, it is alleged that you said to Colleague B (an international nurse), that *"[you] would rather be looked after by an IV drug user than a foreign nurse."* Further, and in the presence of another nurse, you allegedly said to Colleague B that *"it's about time you earned your place to work in this country"* and “*if you’re in this country, you need to be able to understand our sense of humour.”* It is alleged that you say these comments were ‘banter’.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Mackell, who informed the panel that you made partial admissions to charges 6, 8 and 10 (in its entirety), in that you admit to saying, ‘words to that effect.’

In reaching its decisions on the disputed facts, the panel took into account all the witness and documentary evidence before it, and the submissions made by Dr Graydon and Mr Mackell.

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:	Clinical Nurse Lead at ACI Training and Consultancy limited, at the time of the allegations
Witness 2:	Band 7 Sister at Kettering General Hospital, at the time of the allegations
Witness 3:	Matron at Royal Lancaster Infirmary, at the time of the allegations
Witness 4:	Grade 5 Sister at Jersey General Hospital, at the time of the allegations
Witness 5:	Band 7 Sister at Blackpool Victoria Hospital, at the time of the allegations
Witness 6:	Band 5 Nurse at Royal Lancaster Infirmary, at the

	time of the allegations
Witness 7:	Band 5 Nurse at Royal Lancaster Infirmary, at the time of the allegations
Witness 8:	Band 5 Nurse at Blackpool Victoria Hospital, at the time of the allegations
Witness 9:	Band 5 Nurse at Blackpool Victoria Hospital, at the time of the allegations
Witness 10:	Band 5 Nurse at Royal Lancaster Infirmary, at the time of the allegations
Witness 11:	Agency Band 5 Nurse at Royal Lancaster Infirmary, at the time of the allegations

The panel also heard evidence from you under affirmation.

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

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

The panel had due regard to its Public Sector Equality Duty as outlined in the Equality Act 2010, section 149, when reaching its findings on the charges. The Equality Act 2010, section 149 states that:

> *'A public authority must, in the exercise of its functions, have due regard to the need to—*
>
> *(a)eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> *(b)advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c)foster good relations between persons who share a relevant protected characteristic and persons who do not share it.'

Charge 1(a)

"That you, a registered nurse:

1. *When completing shifts at Kettering General Hospital between 20 and 23 December 2019, failed to provide adequate patient care in that you:*

    a. *did not administer one or more medications to one or more patients in a timely manner or at all;"*

This charge is found NOT proved.

The panel concluded that the NMC has not discharged their burden in proving this charge. It considered that it could not reach a determination on the meaning of 'a timely manner' as there was no evidence before it relating to what is 'timely' in this context.

The panel heard evidence that at multiple times during the shift you were sat down. However, it accepted and noted your explanation given under affirmation. You stated that at the time of these allegation you had [PRIVATE] which effected your ability to stand for long periods of time, hence why you were sat at the nurses' station or next to patients. You said in your evidence that the Agency and Kettering Hospital were aware of these issues prior to you starting the shift.

Furthermore, the panel was of the view that there was a lack of evidence and particularisation, such as corroborating patient notes and prescription charts, presented to it to be satisfied on the balance of probabilities that you did fail to provide adequate patient care as alleged. In addition, due the nature of the charge being 'failed to' the panel was not satisfied that it could determine on the evidence before it that you had a duty to the unparticularised patients in this charge.

Charge 1(b)

"That you, a registered nurse:

1. When completing shifts at Kettering General Hospital between 20 and 23 December 2019, failed to provide adequate patient care in that you:

b. did not complete risk assessments for one or more patients in a timely manner or at all;"

This charge is found NOT proved.

For similar reasons to Charge 1(a), the panel was not satisfied that there was sufficient corroborating evidence of this allegation. It had no evidence before it to show whether the risk assessments were complete and if completed, when. It was therefore not able to determine whether you had completed the risk assessment, or in the event that you did, whether this was in a timely manner.

The panel was therefore unable to find that on the balance of probabilities you had failed to carry out the risk assessments at all, or in the alternative whether you had but not within a timely manner.

Charge 2(a)

"That you, a registered nurse:

2. Around 25 March 2020 whilst working at Jersey General Hospital, failed to provide adequate patient care in that you:

a. did not check the blood sugar levels of a diabetic patient for the third day in a row;"

This charge is found proved.

Due to the wording of the charge being *'failed to'* the panel first considered whether you had a duty to this patient. Based on the evidence before it the panel were satisfied that this patient was in your care. It heard evidence from Witness 4 who stated that you were assigned to the ward and allocated four patients, one of whom was the patient particularised in this charge; therefore, you were tasked and had a duty to care for this patient. The panel also had regard to your oral evidence in which you confirmed that you were responsible for this patient. Therefore, the panel determined that you had a duty of care to this patient.

Having established that you had a duty to care for this patient, the panel then went on to consider whether you had failed to check the blood sugar levels of the patient for three days in a row. In reaching its decision, the panel took into account the evidence before it. It noted that during your oral evidence you admitted to not having checked the patient's blood sugars as you were of the medical opinion that it was unnecessary given the frequency that the patient reported having their blood sugar levels taken.

Furthermore, the panel had regard to Witness 4's written statement in which they stated:

> *'I knew the registrant hadn't checked the patient's blood sugar levels for 3 days, as it came to light while doing a randomised nursing documentation check (part of my daily routine as a ward Sister).'*

In addition, the panel also noted the near contemporaneous email sent by Witness 4 on the 25 March 2020 to the Bank Office, in which they summarised this concern as you *'Failing to check blood sugar on a Diabetic patient, 3 days in a row.'*

Therefore, in light of the evidence above which it considered to be credible and consistent, the panel determined that you had failed to check the blood sugar levels of the patient for three days in a row.

Charge 2(b)

"That you, a registered nurse:

2. Around 25 March 2020 whilst working at Jersey General Hospital, failed to provide adequate patient care in that you:

b. did not ensure that Patient A's IV drip was attached in a timely manner or at all;"

This charge is found proved.

Due to the wording of the charge being *'failed to'* the panel first considered whether you had a duty to this patient. Based on the evidence before it, the panel were satisfied that this patient was in your care. It heard evidence from Witness 4 who stated that you were assigned to the ward and allocated four patients, one of whom was Patient A; therefore, the panel determined, on a balance of probabilities, that you owed a duty of care to Patient A.

Having established that you had a duty to care for this patient, the panel then went on to consider whether you had failed to attach Patient A's IV drip in a timely manner or at all. The panel considered all the evidence before it. It had regard to your oral evidence and the explanation for why you had not attached the IV drip and that you left it next to Patient A ready to be attached on completion of the 'second check' procedure by another registered nurse.

The panel also had regard to Witness 4's written and oral evidence in which it is stated that:

'Patient A was waiting for an IV drip to be attached for a couple of hours […]

Doctors round early in the morning had prescribed IVs

When I was completing a walk around of the Ward, I entered the side room and identified that the IV drip had not been started […] had not received lunch'

It noted the near contemporaneous email sent by Witness 4 on the 25 March 2020 to the Bank Office, in which they summarised this concerns as '[Patient A] *in side (sic) room not given appropriate care – IV drip waiting to be attached to patient for a couple of hours…*'

The panel considered that the described sequence of events clearly identified a time frame within which the IV drip was not attached. The panel also noted your acceptance in oral evidence that the IV drip was due to be administered but you were waiting for a colleague to complete a second check.

Therefore, in light of the evidence above which it considered to be credible and consistent, the panel determined that you had failed to attach Patient A's IV drip in a timely manner or at all.

Charge 2(c)

"That you, a registered nurse:

2. Around 25 March 2020 whilst working at Jersey General Hospital, failed to provide adequate patient care in that you:

c. did not ensure that Patient A's observations were carried out and/or recorded in a timely manner or at all"

This charge is found NOT proved.

For the reasons given at Charge 2(b) the panel was of the view that, on the balance of probabilities, you owed Patient A a duty of care.

However, the panel was of the view that there was insufficient evidence to determine whether the observations were carried out or recorded. It had regard to the contradictory evidence between you and Witness 4. Witness 4's witness statement states that

> *'Patient A […] no observations had been completed by Mr Hurwood at lunch time […] I would have most certainly expected observations to have been taken at lunch time […] I identified that Mr Hurwood had not completed any patient notes / documentation for any of his three patients.'*

Further Witness 4's near contemporaneous email sent by Witness 4 on the 25 March 2020 to the Bank Office summarised this concern as:

> *'no observations were done at lunch time No patient notes done after a Long Day'*

In your oral evidence you stated that 'you believe you did do the observations' of Patient A and that 'you did record this'.

The panel found both accounts, that of Witness 4 and yourself, credible and reliable. In the absence of any other corroborating and supporting evidence, such as Patient A's observation records or notes, the panel was of the view that it could not be satisfied, on the balance of probabilities that the notes were not completed. The panel also considered that there was insufficient evidence to assess that observation records or notes were due to be completed by 'lunchtime.'

Charge 3

"That you, a registered nurse:

3. On one or more occasions around January 2022 whilst working at Blackpool Victoria Hospital did not administer medications to one or more patients in a timely manner or at all"

This charge is found NOT proved.

The panel concluded that the NMC has not discharged their burden in proving this charge. It considered that it could not reach a determination on the meaning of 'a timely manner' as there was no evidence before it relating to what is 'timely' in this context.

Furthermore, the panel was of the view that there was a lack of evidence and particularisation, such as corroborating patient notes and prescription charts, presented to it to be satisfied on the balance of probabilities that you did not administer medications to one or more patients as alleged, or in the alternative, administered medication but not in a timely manner.

Charge 4

"That you, a registered nurse:

4. During a night shift commencing on 12 August 2022, did not administer Patient B's prescribed medication in a timely manner or at all"

This charge is found NOT proved.

The panel determined that there was insufficient evidence before it to be satisfied that one the balance of probabilities that you did not administer Patient B's prescribed medications in a timely manner or at all.

In reaching its conclusion, the panel considered the evidence before it. It considered the witness statement of Witness 5 who exhibited an email from Dr Z who had raised the concerns particularised in this Charge. It also noted that Witness 5 stated in her oral evidence that they were not involved in the conversation between yourself and Dr Z. Thus, the panel considered that Witness 5's evidence, in relation to this charge, was largely hearsay. It bore in mind the relevant Rules and case law and noted that hearsay is admissible, but less weight can be attached to hearsay statements, compared to oral evidence, as it cannot be tested.

In applying the principles of hearsay above, the panel determined that conversations and emails with Dr Z were the sole and decisive evidence in relation to this charge. As this evidence could not be challenged by you, the panel was of the view that it would be unfair to rely solely on this evidence in reaching a finding on this charge. It noted that there was insufficient corroborating evidence, such as the absence of patient notes and medication charts, to support the hearsay account. Therefore, the panel could not be satisfied on the balance of probabilities that you did not administer Patient B's medication at all, or in a timely manner.

Charge 5(a)

"That you, a registered nurse:

5) On or around 1 January 2023 whilst undertaking shifts at Royal Lancaster Infirmary:

a) did not carry out Patient C's observations in a timely manner or at all;"

This charge is found proved.

In reaching its decision on this charge, the panel considered the evidence before it, including the relevant witness statements. It also considered your oral evidence in which you stated that this specific shift was not particularly busy and that during the shift you undertook other duties in supporting colleagues by taking patients to other departments for scans. You stated in oral evidence that you were working away from the Emergency Department for four hours.

In light of all the evidence, the panel determined that on the balance of probabilities it was more likely than not that you were unaware of Patient C being in the sub-wait area and thus on a balance of probabilities did not do their observations.

Charge 5(b)

"That you, a registered nurse:

5) On or around 1 January 2023 whilst undertaking shifts at Royal Lancaster Infirmary:

b) did not care for Patient C because you considered that she stank of fags or words to that effect;"

This charge is found NOT proved.

The panel noted that you did not deny saying that this patient "stank of fags" or words to that effect. However, as reasoned in Charge 5(a) the panel was of the view that as you were working away from the Emergency Department for four hours, on the balance of probabilities, you were unaware that Patient C was in the sub-wait area. Therefore, the panel was not satisfied that the reason you did not provide care was because Patient C 'stank of fags.'

Charge 5(c)

"That you, a registered nurse:

5) On or around 1 January 2023 whilst undertaking shifts at Royal Lancaster Infirmary:

c) did not ensure that another colleague carried out Patient C's observations"

This charge is found proved.

As reasoned in Charge 5(a) the panel was satisfied on the evidence before it that you were working away from the Emergency Department for four hours, and therefore, you should have ensured that another colleague was available to complete any observation to patients admitted to the sub-wait area. When you returned to the Emergency Department you did not check whether any patients were admitted to the sub-wait area and had observations completed. In light of this, the panel was of the view that, on a balance of probabilities, you did not ensure that another colleague carried out Patient C's observations.

Charge 6

"That you, a registered nurse:

6. On one or more occasions during a nightshift commencing on 2 September 2022 at Blackpool Victoria Hospital, said to Colleague A "can I put my arms between your legs like an octopus" or words to that effect"

This charge is found proved by admission.

The panel had regard to your admission to this charge in that you admitted saying words to this effect.

The panel was satisfied that you did say words to this effect; it reached this decision on consideration of the evidence before it. It had regard to the evidence of Witness 9 who says that you said:

‘if you don't move, I'm going to put my hands between your legs like an octopus.’

This was corroborated by the DATIX Report, dated 5 September 2022, exhibited by Witness 5, which gave a near contemporaneous account of the incident, which was agreed by Witness 8 (also Colleague A) and Witness 9 before its submission. This document states that you said:

'if you don't move, im (sic) *going to put my hands between your legs like an octopus.'*

The panel also had regard to your oral evidence in which you stated that you asked Witness 8 to move out of the way of the cupboard so you could access the IV equipment called an ‘octopus.’

The panel also considered the factual dispute on the evidence, as to whether you had included the initial words, *‘if you don’t move…’* or not. The panel considered the evidence of Witnesses 8 and 9 and the exhibits relevant to these witnesses and your testimony. On a balance of probabilities, the panel concluded that Witness 8 was busy at the time that you said the words and that Witness 9, who had opened the door for you, corroborated your version of events.

The panel therefore determined that, on a balance of probabilities, you stated words to the effect of, *‘if you don’t move, im (sic) going to put my hands between your legs like an octopus.’*

Charge 7

"That you, a registered nurse:

7. Your actions as specified in charge 6 amounted to sexual harassment"

This charge is found proved.

The panel firstly considered whether the comments made to Witness 8 (also Colleague A) were unwanted. In reaching its decision the panel took into account the evidence before it, including Witness 8 who gave evidence that it was unwanted. It also had regards to Witnesses 8 and 9's written statements and oral evidence where they stated that your actions shocked them. Further, it considered your evidence under affirmation in which you admitted the conduct was unwanted. Therefore, the panel was the view that the conduct in Charge 6 was unwanted.

Secondly, the panel considered whether the comments that were made to Witness 8 were relevant to a protected characteristic. The panel considered, and determined, that the nature of the comment and the unwanted conduct related to a relevant protected characteristic (Equality Act 2010, section 11).

The panel then considered whether your purpose in making the comments to Witness 8, was to violate their dignity or to create an intimidating, hostile, degrading, humiliating or offensive environment. The panel considered your evidence that you had no intent to abuse a protected characteristic and your purpose was to engage in 'banter' or 'humour'. The panel considered other evidence from witnesses and determined that on a balance of probabilities it cannot find that you had the purpose of violating Witness 8's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment.

It next considered whether your comments to Witness 8, had the effect of violating their dignity or had the effect of creating an intimidating, hostile, degrading, humiliating or

offensive environment. The panel considered the evidence before it, including the witness statements of Witnesses 8 and 9 and your own evidence.

In their evidence Witness 8 stated:

> *'I was shocked by what he said'*
>
> *'Taken back by it'*
>
> *'I didn't want to go in or be on shift with him'*
>
> *'Made feel very uncomfortable'*
>
> *'I was really very shocked and distressed by Mr Hurwood's comments. They were highly inappropriate.'*
>
> *'Mr Hurwood's conduct made me feel uncomfortable, violated, upset and distressed.'*
>
> *'I did not want to go into work for the next couple of night shifts. I did not feel safe or comfortable working with Mr Hurwood again.'*

Witness 9 stated in their evidence that:

> *'extremely shocked'*
>
> *'I felt very uncomfortable and shocked that Mr Hurwood had made this statement. Such a comment is completely unprofessional and inappropriate. [Witness 8] was also distressed and upset and expressed to me that she felt as if she had been violated.'*

The panel also considered your evidence under affirmation, the reflection you provided to ACI, and the DATIX report dated 3 September 2022, you stated that:

> *'*[you] *would be mortified to have made any of his colleagues feel uncomfortable but that on reflection, it was not the right thing to say, and reflects that this was an inappropriate remark to make. He states he 'didn't think'.'*
>
> *'I didn't at the time have consideration of impact but retrospectively yes'*

The panel were therefore satisfied that the actions as found proved at Charge 6 had the effect of violating the dignity of Witness 8, and that it created an intimidating, hostile, degrading, humiliating or offensive environment.

The panel determined from the evidence before it that the perception of Witness 8 was that the comments were of a sexual nature and that the comments had the effects as outlined above.

The panel also considered the other circumstances of the case, including that Witness 9 was also present and notwithstanding their presence the comments still made Witness 8 feel violated, and Witness 9 was *'uncomfortable and shocked'*. It also noted that the space in which this interaction occurred was a small room and that you were in close proximity with Witness 8. The panel acknowledge that you stated in evidence under affirmation that

> *'it was a poor choice of words but was made purely as light hearted banter'*

However, in consideration of all the evidence before it, the panel was of the view that the comments were more than trivial or transitory (*Richmond Pharmacology v Dhaliwal* (2009) ICR 724, EAT) and therefore could create a relevant environment under the Equality Act 2010. It further considered that you had no long-term professional relationship with Witnesses 8 or 9, and therefore the form of words used could not be viewed as 'banter' or

‘light-hearted’ comment between colleagues (*Dos Santos v Preview Services Ltd* ET/2700170/10).

Additionally, the panel considered, based on the evidence before it, that it was reasonable for the conduct alleged to have the impact that it did have on Witness 8 due to the nature of the inappropriate comments and that they occurred in a professional context.

For all these reasons, the panel was satisfied that on the balance of probabilities, that the action as specified at Charge 6 amounted to sexual harassment.

Charge 8

“That you, a registered nurse:

8. On an unknown date in February 2023, said to Colleague C that you “would like to be in-between your legs” or words to that effect”

This charge is found proved by admission.

The panel considered the evidence before it and were satisfied that, along with your admission to this charge, that there was sufficient reliable credible and consistent evidence before it. This evidence included your own oral evidence under affirmation, Witness 10’s (also Colleague C) witness statement and oral evidence, and the relevant exhibits.

Therefore, the panel was satisfied on the balance of probabilities that you said to Colleague C *“would like to be in-between your legs”* or words to that effect.

Charge 9

“That you, a registered nurse:

9. Your actions as specified in charge 8 amounted to sexual harassment”

This charge is found proved.

The panel firstly considered whether the actions found proved in Charge 8 were unwanted. In reaching its decision the panel took into account the evidence before it, including that of Witnesses 10 (also Colleague C) who stated in a communication dated 4 March 2023, that it *'made me feel uncomfortable and uneasy'*. Witness 10 in their written statement also stated that they did not speak to you through the rest of the shift, and in their oral evidence stated that they kept their distance and made sure they were with other colleagues. The panel was therefore satisfied that the actions as found proved in Charge 8 were unwanted and made and directed to Witness 10.

Secondly, the panel considered whether the comments that were made to Witness 10 were relevant to a protected characteristic. The panel considered, and determined, that the nature of the comment and the unwanted conduct related to a relevant protected characteristic (Equality Act 2010, section 11).

The panel then considered whether your purpose in making the comments to Witness 10, was to violate their dignity or to create an intimidating, hostile, degrading, humiliating or offensive environment. In its consideration the panel took into account the evidence before it. It noted that this was the second instance within a period of three months where inappropriate words had been said by you to a colleague when you had accepted on reflection, and it was reported that you had said that you *'would be mortified to have made any of his colleagues feel uncomfortable […], it was not the right thing to say, and reflects that this was an inappropriate remark to make'*. The panel considered your evidence that you had no intent to abuse a protected characteristic and your purpose was to engage in 'banter' or 'humour'. The panel considered other evidence from witnesses and determined that on a balance of probabilities it cannot find that you had the purpose of violating Witness 10's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment.

It next considered whether your comments to Witness 10, had the effect of violating their dignity or had the effect of creating an intimidating, hostile, degrading, humiliating or offensive environment. The panel considered the evidence before it, including the witness statements of Witnesses 10 and 3 and your own evidence.

In their witness statement and oral evidence, Witness 10 stated:

> *'I was shock. I pulled myself back on the stool and pushed the bloods trolley out of my way towards him.'*
>
> *'Mr Hurwood's comments had certainly taken me aback.'*
>
> *'I am very surprised that Mr Hurwood had made such inappropriate comments'*
>
> *'Feeling very uncomfortable and tried to avoid him for the rest of the night'*
>
> *'Felt uneasy after the comment'*
>
> *'it made me feel uncomfortable and uneasy'*
>
> *'When I was going on breaks I made sure I wasn't alone'*

Witness 3 stated in their witness statement that:

> '[Witness 10] *had felt extremely uncomfortable by such a statement and confided in* [another colleague].'

The panel also considered your evidence under affirmation you stated that:

> *'I didn't appreciate the impact of what I said at the time'*

‘I accept what she says how she felt didn't intend to happen’

The panel were therefore satisfied that the action as found proved at Charge 8 did have the effect of violating the dignity of Witness 10, and that it created an intimidating, hostile, degrading, humiliating or offensive environment.

The panel determined from the evidence before it that the perception of Witness 10 was that the comments were of a sexual nature and that the comments had the effects as outlined above.

The panel also considered the other circumstances of the case, including that there were other colleagues and patients close-by. Furthermore, it noted the evidence it heard was that you were in close proximity to Witness 10 when you made the comments that were found proved in Charge 8. It also noted that you were senior to the Witness in age, taller, and had no prior professional relationship.

The panel acknowledge that you stated in evidence under affirmation, that the comments were no more than ‘throw away’ remarks. However, in consideration of all the evidence before it, the panel was of the view that the comments were more than trivial or transitory (*Richmond Pharmacology v Dhaliwal* (2009) ICR 724, EAT) and therefore could create a relevant environment under the Equality Act 2010. It further considered that you had no long-term professional relationship with Witness 10, and therefore the form of words used could not be viewed as ‘throw away’ remarks comment between colleagues (*Dos Santos v Preview Services Ltd* ET/2700170/10).

Additionally, the panel considered, based on the evidence before it, that it was reasonable for the conduct alleged to have the impact that it did have on Witness 10 due to the nature of the inappropriate comments and that they occurred in a professional context. The panel noted that as there was no long-term professional relationship between you and Witness 10, and therefore it was reasonable for the comments to have the effect as outlined above.

For all these reasons, the panel were satisfied that on the balance of probabilities, that the conduct as specified at Charge 8 amounted to sexual harassment.

Charge 10(a)

"That you, a registered nurse:

10. During a nightshift commencing on 24 January 2023 at Royal Lancaster Infirmary said to Colleague B:

a. "I would rather be looked after by an IV drug user than a foreign nurse" or words to that effect;"

This charge is found proved by admission.

The panel considered the evidence before it and were satisfied that, along with your admission to this charge. It considered that your account and the accounts of Witnesses 3, 6, 7, and 11 (Colleague B) were all consistent and credible.

Therefore, the panel was of the view there was sufficient, reliable, credible, and consistent evidence before it to be satisfied on the balance of probabilities that you said *"I would rather be looked after by an IV drug user than a foreign nurse"* or words to that effect.

Charge 10(b)

"That you, a registered nurse:

10. During a nightshift commencing on 24 January 2023 at Royal Lancaster Infirmary said to Colleague B:

b. "it's about time you earned your place to work in this country" or words to that effect;"

This charge is found proved by admission.

The panel considered the evidence before it and were satisfied that, along with your admission to this charge. It considered that the accounts of Witnesses 3, 6, 7, and 11 (Colleague B) were all consistent and credible. It also noted that you stated in oral evidence that you could not recollect making this comment in the form alleged in the Charge.

However, the panel was of the view, in light of your admission and the corroborating evidence, that there was sufficient, reliable, credible, and consistent evidence before it to be satisfied on the balance of probabilities that you said *"it's about time you earned your place to work in this country"* or words to that effect.

Charge 10(c)

"That you, a registered nurse:

10. During a nightshift commencing on 24 January 2023 at Royal Lancaster Infirmary said to Colleague B:

c. "if you're in this country, you need to be able to understand our sense of humour" or words to that affect"

This charge is found proved by admission.

The panel considered the evidence before it and were satisfied that, along with your admission to this charge. It considered that the accounts of Witnesses 3, 6, 7, and 11 (Colleague B) were all consistent and credible.

The panel was of the view that, in light of your admission and the corroborating evidence, that there was sufficient, reliable, credible, and consistent evidence before it to be satisfied

on the balance of probabilities that you said *“if you’re in this country, you need to be able to understand our sense of humour”* or words to that affect.

Charge 11

“That you, a registered nurse:

11. Your conduct as specified in charges 10a) – 10c) amounted to racial harassment”

This charge is found proved.

Having found Charges 10(a), 10(b), and 10(c) proven, the panel considered this charge on the basis of all three comments contained therein.

The panel firstly considered whether the comments made to Witness 11 (Colleague B) were unwanted. In reaching its decision the panel took into account Witness 7 and Witness 11 evidence, which it considered to be reliable and corroborated each other’s consistent accounts. They stated that they had asked you to stop making these comments on numerous occasions, including that Witness 11 said *"let's just leave it there mate”* and Witness 7 saying *"it's not banter, you're being offensive."* In light of these requests for you to stop the panel was of the view that the conduct was unwanted. It also noted and accepted the reliable and coherent evidence that the conversation, in which these comments occurred, only came to an end as Witness 11 walked away to complete their other nursing duties. The panel also took into account that you accepted in oral evidence that both witnesses had asked you to stop. Therefore, the panel were of the view that the comments outlined in Charges 10(a), 10(b), and 10(c) were unwanted.

Secondly, the panel considered whether the comments that were made to Witness 11 were relevant to a protected characteristic. The panel determined that the nature of the comments related to the race of Witness 11 and were made directly to Witness 11. As

race is a protected characteristic (Equality Act 2010, section 9), the panel were satisfied that the comments were relevant to a protected characteristic.

The panel then considered whether your purpose in making the comments to Witness 11, was to violate their dignity or to create an intimidating, hostile, degrading, humiliating or offensive environment. In its consideration the panel took into account the evidence before it. It acknowledged that in your oral evidence you said that you made these comments as light-hearted banter and that you were playfully teasing Witness 11. The panel also took into account that Witnesses 7 and 11 asked you on multiple occasions to stop with the comments and despite this you continued to do so. The panel acknowledge that you stated that these comments were banter, however it was of the view that the comments were more than trivial or transitory (*Richmond Pharmacology v Dhaliwal* (2009) ICR 724, EAT). The panel was of the view that by you continuing making these racially derogatory and offensive comments, despite being asked to stop on multiple occasions, it is more likely that not that you had the purpose of violating Witness 11's dignity and creating a humiliating, intimidating and degrading environment for Witness 11.

It next considered whether your comments to Witness 11, had the effect of violating their dignity or had the effect of creating an intimidating, hostile, degrading, humiliating or offensive environment. The panel considered the evidence before it, including Witness 7's witness statement and their local statement, made by on 11 February 2023, stating:

> *'I was extremely surprised that Mr Hurwood had made such a comment which was racist and offensive.'*
>
> *'I was extremely taken aback by Mr Hurwood's conduct. Mr Hurwood believed that his conduct was a joke, however, it was simply not acceptable behaviour. The comments were extremely direct and completely unnecessary.'*
>
> *'Cameron was being racist and that I was offended by the remarks which were made.'*

It also took into account the evidence given by Witness 11 in their oral evidence, written statement, and exhibit of their local statement, dated 6 February 2023, stating:

> *'Made me feel not good it was a racist comment'*
>
> *'It did upset me - and I don't think I should have gone through all this'*
>
> *'I can confirm that such a comment is certainly not nice and I believe that if I was an overseas nurse who had recently started working in the country, the comment would have affected me more.'*
>
> *'Nurse in charge […] came to me and ask me if I am ok'*

It also took into account that you said in your oral evidence that you '*would accept* [the comments you made] *made a difficult environment.'*

The panel determined from the evidence before it that the perception of Witness 11 was that the comments were racist. The panel also considered the other circumstances of the case and that despite being told to stop you carried on making the racist comments to Witness 11, whom you had not had a long-term professional relationship and therefore could not therefore be viewed as a joke between colleagues (*Dos Santos v Preview Services Ltd* ET/2700170/10). Additionally, the panel considered, based on the evidence before it, that it was reasonable for the conduct alleged to have the impact that it did have on Witness 11 due to the serious and repetitive nature of the comments; furthermore, the conduct was perceived to be racist by other colleagues and not just the recipient.

For all these reasons, the panel were satisfied that on the balance of probabilities, it was more like than not, that the conduct as specified in charges 10a) – 10c) amounted to racial harassment.

Fitness to practise

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

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.

Submissions on misconduct

Dr Graydon drew the panels attention to the following case law

- *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.'*
- *Remedy UK v GMC* [2010] EWHC 1245 (Admin)
- *Calhaem v GMC* [2007] EWHC 2606 (Admin)

Dr Graydon invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms following parts of The Code: Professional standards of practice and behaviour for nurses and midwives 2015 ('the Code'):

'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

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

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

To achieve this, you must:

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

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

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

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.9 maintain the level of health you need to carry out your professional role
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'

Dr Graydon submitted that the breaches of the code are a serious departure from the standards expected of a registered nurse to uphold.

Mr Mackell referred the panel to the following cases:

- *Nandi v General Medical Council* [2004] EWHC 2317 (Admin)
- *Mallon v General Medical Council* [2007] ScotCS CSIH 17
- *Khan v Bar Standards Board* [2018] EWHC 2184 (Admin)

Mr Mackell submitted that misconduct is not established in relation to Charge 2 and Charge 5 as no serious, or potential, harm was caused to patients. He reminded the panel that at the time of some of the concerns, you were dealing with [PRIVATE] which may provide an explanation for why there were some clinical omissions in your practice.

Mr Mackell reminded the panel that you fully accepted Charges 6, 8, and 10. He stated that you have reflected upon Charges 6 to 11 and submitted you have demonstrated insight and acceptance into the impact of your actions in these charges.

Submissions on impairment

Dr Graydon reminded the panel that there is no statutory definition of impairment and that the NMC define it as: *'can the registrant practise safely kindly and effectively.*' He 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. He referenced the following case law:

- *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)
- *Cohen v General Medical Council* [2008] EWHC 581 (Admin)

Dr Graydon submitted that, in relation to Charges 2 and 5, you put two different patients at two different hospitals at risk of harm; and, in relation to Charge 6 to 11, you put colleagues at risk of harm. Dr Graydon submitted that your actions have brought profession into disrepute. He also submitted that your actions breached of fundamental tenets of the nursing profession.

Dr Graydon submitted that you have not adequately addressed, or sufficiently remediated, the concerns identified. He said that you have not developed sufficient insight into the conduct and the seriousness of the conduct. Dr Graydon submitted that the findings of the panel in relation to the harassment indicates deep-seated and attitudinal failings and remediation of these concerns is more difficult to address, if at all.

Dr Graydon submitted that there is a risk of repetition. He drew the panel's attention to a previous Fitness to Practise determination from November 2017, in which you before a Fitness to Practise committee for similar charges to this hearing. Dr Graydon submitted that despite the previous panel requiring you, by way of a condition of practice order, to complete a Personal Development Plan addressing effective and appropriate communication, professional boundaries, and self-awareness in your interactions, you have repeated the conduct. Thus, Dr Graydon submitted that there is a real risk of repetition should a finding of impairment not be made, which may result in harm.

Dr Graydon submitted that a finding of impairment on the ground of public interest would declare professional standards and uphold trust and confidence the public place in the profession. He said that the public expect nurses to act with integrity and professionalism, prioritising people and acting with trustworthiness. Dr Graydon also submitted that if a finding of impairment was not made it may impact on public seeking medical assistance.

Mr Mackell submitted that there is no immediate overt risk to members of the public, nor has a serious risk of harm been demonstrated. He submitted that your actions were not intended to target individuals and were a result of misjudged comments. He stated that you find social interactions challenging and that you are unable to filter comments [PRIVATE]. Nevertheless, Mr Mackell told the panel that you have been honest and candid and have provided genuine acceptance of your wrongdoing, and you accept that you have been the author of your misfortune.

Mr Mackell submitted that the risk of repetition is low. He submitted that conduct is remediable and that, as can be seen in the bundle provided to the panel, you have begun strengthening your practice by undertaking courses in professional boundaries, equality and diversity, and unconscious bias. He submitted that you are making strong efforts to remedy the deficits in your practice and reduce likelihood of repetition.

Before the panel reached decisions on misconduct and impairment it heard and accepted the advice of the legal assessor. The legal assessor referenced the relevant case law, which included:

- *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311
- *Nandi v General Medical Council* [2004] EWHC 2317 (Admin)
- *General Medical Council v Meadow* [2007] QB 462 (Admin)
- *Calhaem v GMC* [2007] EWHC 2606 (Admin)
- *Mirtorabi v Nursing and Midwifery Council* [2017] EWHC 476
- *Cohen v GMC 2008* EWHC 581 (Admin)
- *Schodlok v. GMC* [2015] EWCA Civ 769

- *PSA v (1) GMC & (2) Christian Hanson* [2021] EWHC 588 (Admin)
- *Cheatle v GMC* [2009] EWHC 645 (Admin)
- *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant* [2011] EWHC 927 (Admin)
- *Martin v GMC* [2011] EWHC 3204 (Admin)
- *Yeong v General Medical Council* [2009] EWHC 1923 (Admin)

Decision and reasons on misconduct

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

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel first considered misconduct in relation to the clinical concerns (Charges 2 (a) and 2 (b), and 5(a) and 5(c).

The panel was of the view that your actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

To achieve this, you must:

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel noted the legal assessor's advice around *Calhaem v GMC [*2007] EWHC 2606 (Admin), including that mere negligence does not constitute misconduct; however, negligent acts and omissions that are particularly serious may amount to misconduct. The panel was of the view that the omissions found proved at Charges 2(a) and 2(b) were two separate instances and were individually sufficiently serious to amount to misconduct. It was of the view that these omissions were serious failures of fundamental nursing care which, as a registered nurse with 19 years of experience, you should not have failed to provide. The panel considered that your omissions created a high risk to the patients and could have had a serious impact on their care. The panel noted Mr Mackell's submission that at the time you had [PRIVATE] which may explain why omissions occurred. However, the panel noted that in your oral testimony, in response to a specific panel question during the facts stage of the hearing, [PRIVATE], your ability to undertake the actions omitted in Charges 2(a) and 2(b) was not impeded. [PRIVATE]. For these reasons, the panel

concluded that your conduct found proved at Charges 2(a) and 2(b) fell significantly short of the standards expected of a registered nurse, and thus found your conduct at these charges to be misconduct.

The panel was of the view that the conduct found proved at Charges 5(a) and 5(c) were individually sufficiently serious to amount to misconduct. It considered that your conduct was unsafe and constituted serious poor practice of fundamental nursing skills, in that you did not realise that there was a patient within your care and, therefore, did not provide care to that patient. The panel was of the view that, as an experienced Emergency Department nurse, you would have been aware that patients are admitted throughout a shift and once admitted can be moved around the department. Therefore, you should have been aware that somebody could have been admitted to the area that you were assigned to. The panel was of the view that, as you were working within an Emergency Department patients would have been acutely unwell and thus presented a higher risk and required greater observations and attention. The panel acknowledged that there was no detailed induction to the department but were of the view that as an experienced Emergency Department nurse, you were expected to be able to complete the fundamental skills of nursing that are required. For these reasons, the panel found that your conduct found proved at Charges 5(a) and 5(c) fell significantly short of the standards expected of a registered nurse, and thus found your conduct at these charges to be misconduct.

The panel then went on to consider misconduct in relation to Charges 6 to 11.

The panel was of the view that your actions amounted to a breach of the Code. Specifically:

'8 Work cooperatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

20.5 *treat people in a way that does not […] or cause them upset or distress*

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

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.2 *use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice ‘*

The panel determined that your conduct in Charges 6 to 11 were individually sufficiently serious to constitute a breach of the code and amount to misconduct. It considered that sexual harassment and racial harassment are serious by nature and that your conduct made colleagues feel unsafe at work, violated their dignity and that your actions had the effect of creating a degrading, hostile, intimidating, and humiliating environment. It was of the view that your conduct did not maintain professional boundaries and raised fundamental questions about your ability to uphold the standards of a registered nurse as set out in the code. For these reasons, the panel concluded that your conduct found proved at Charges 6 to 11 fell significantly short of the standards expected of a registered nurse, and thus found your conduct at these charges to be misconduct.

The panel, during the facts stage, found that your purpose in Charge 11 was to racially harass your colleague, in part due to your persistent remarks despite being asked to stop

and after being informed the comments were offensive. As such, the panel found your conduct at Charge 11 was deplorable and amounted to particularly serious misconduct.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, 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.'*

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

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

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

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

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

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

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

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

d) *[…].'*

The panel first considered impairment in relation to Charges 2(a) and 2(b), and 5(a) and 5(c).

The panel was of the view that, although no actual harm was caused to the patients in these charges, you put patients at a risk of unwarranted harm by omitting to carry out the fundamental nursing tasks required, breaching fundamental tenets of the nursing profession in caring for patients. It considered that these concerns were not isolated and occurred over multiple occasions, in multiple locations and at multiple times. The panel considered that these concerns were capable of remediation but, based on the information before it, there was insufficient evidence of strengthening of your practise in relation to these clinical concerns to satisfy the panel that you are unlikely to repeat the conduct and that you are able to practise safely and professionally. The panel acknowledged your reflection, dated 7 August 2024, but was of the view that it lacked insight into the clinical concerns, as found proved, and it primarily addressed the harassment charges. Therefore, the panel was of the view that a risk of repetition remains, and consequently significant harm may be caused. For these reasons, the panel concluded that your fitness to practise is currently impaired, as it considered you cannot practise safely and professionally, and such a finding was necessary to protect the public.

The panel considered that members of the public expect a high level of care, delivered safely and professionally, when attending hospital; and colleagues also expect to be able to trust fellow professionals to carry out assigned clinical tasks. For these reasons, the panel concluded that your fitness to practise is impaired on the ground of public interest and such a finding would uphold the public's confidence in the profession.

The panel then considered whether your fitness to practise is currently impaired by reason of the harassment found proved at Charges 6 to 11.

The panel considered that harassment has the ability to cause psychological harm to the recipient and those in close proximity. It concluded that your misconduct did cause harm to colleagues, left them feeling as though their dignity had been violated, and created an intimidating, hostile, degrading, humiliating and offensive environment for them to work in. It concluded that your conduct put colleagues, and possibly indirectly patients, at risk of unwarranted harm. The panel noted your reflection, dated 7 August 2024, and your

apology letter to your colleagues. However, it was of the view that these documents failed to appreciate the impact of your actions on others and the potential for harm that making such comments may have. It considered that your reflection focussed on the impact to yourself, and your explanation as to why this misconduct occurred. [PRIVATE] The panel also noted the certificates that you have provided to show a strengthening of your practise; but it was of the view that these certificates demonstrated a short period of training and are only a starting point that begins to address the fundamental and attitudinal concerns raised by the misconduct. The panel were of the view that the reflective piece does not demonstrate your learning and how you will apply this to your practice. It was of the view that there was limited evidence as to how your behaviour will change in the future.

Furthermore, the panel noted that in 2017 you were before a fitness to practise committee for similar conduct. At that hearing you were given a Conditions of Practice order for 12 months and were required to develop a Personal Development Plan; however shortly after the expiry of that order, the conduct in this case occurred. It also noted that the misconduct in this case occurred over two different locations and to three different colleagues and despite being informed at the time of the first incident that your conduct was unacceptable you repeated similar language again. The panel was of the view that this demonstrates a persistent pattern of behaviour, which may be deep-seated and attitudinal and could be difficult to remediate.

For these reasons, the panel was of the view that a risk of repetition remains and therefore a potential for significant harm to the public, which includes colleagues, is likely. Therefore, it concluded a finding that your fitness to practise is impaired, as you cannot practise kindly, safely, and professionally, was necessary for the protection of the public.

The panel concluded that members of the public may be less willing to attend hospital and seek medical intervention if they were to learn that a nurse with such findings as these was not found to have their fitness to practise impaired. The panel considered that the public expect the regulator to uphold the standards of nursing and also have due regard to eliminating harassment and discrimination. It concluded that your misconduct has brought

the nursing profession into disrepute and breaches fundamental tenets of the nursing profession. Furthermore, it concluded that the public, which includes colleagues, expect to be treated kindly and professionally when attending hospital, or work. For these reasons, the panel concluded that a finding of impairment was also in the public interest, as you are not able to practise kindly, safely, and professionally. It also concluded that such a finding would mark the gravity of this misconduct and uphold the public confidence in the profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the relevant Guidance published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Dr Graydon invited the panel to impose a sanction of striking-off; he stated that this sanction would uphold the overriding objective of the NMC. Dr Graydon submitted this sanction is the appropriate and proportionate sanction to impose. He submitted that there is a pattern of repeated misconduct over a significant period of time which caused actual harm to colleagues, and there is clear evidence of the issues being deep-seated and attitudinal. He also submitted that you lack insight into the conduct found by the panel. He submitted that the serious misconduct found by the panel in this case is incompatible with remaining on the register and allowing you to continue to practice would undermine the

confidence in the profession and the NMC as its regulator. He stated that any lesser sanction would not offer the public the appropriate protection nor would conditions of practise be practical or workable considering the misconduct found by the panel.

Mr Mackell referenced the following case law:

- *Giele v General Medical Council* [2005] EWHC 2143 (Admin)
- *de Freitas v The Permanent Secretary of Ministry of Agriculture, Fisheries, Lands and Housing and Others (Antigua and Barbuda)* [1999] 1 AC 69

Notwithstanding the findings of this panel and your regulatory history, Mr Mackell submitted that you are an experienced, and broadly competent, practitioner who was first registered in 2003. Mr Mackell reminded the panel of the comprehensive reflective piece and the forthright, candid and honest apology provided by you to this panel, which, he submitted, demonstrates genuine insight and remorse into the comments and the impact of these on your colleagues. He reminded the panel that you took responsibility for your conduct and that you have never denied making the comments outlined in the charges. Mr Mackell drew the panels attention to the references from employers, including your most recent employer. He submitted that there is a public interest in allowing a nurse who has the capacity to work diligently and competently, which is evidenced through the documentation before the panel, to continue to practice. He submitted that the misconduct and impairment that has been found by the panel is capable of being remedied, and that if you are given the opportunity you will engage in additional training to address the concerns. He outlined that you have always faced challenges with communication and professional boundaries [PRIVATE], the result of which may assist in reducing the likelihood of this type of conduct occurring again.

Mr Mackell submitted that the appropriate and proportionate sanction, in light of the full context and relevant factors of this case, including the interim order that has prevented you from working for the last 18 months, could be one of a suspension order. He submitted that it could reflect the seriousness of charges found proved and maintain confidence in the profession and protect the public. Mr Mackell further submitted that a

conditions of practice order may be appropriate and proportionate. He further submitted that you would be willing to undertake any conditions that are imposed, reiterating that you have already taken steps to address the deficiencies in your practice and that you are working on your communication skills. He submitted that to impose a striking-off order would be disproportionate and would have a devastating personal impact as well as a significant financial impact.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the relevant Guidance, including the Sanction Guidance ('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:

- Serious failings of fundamental nursing care
- The serious clinical failings put patients at risk of potential harm
- Limited insight into how your behaviour impacted your clinical practice
- Your conduct contravened the Equality Act 2010, in that:
    - findings of serious and repeated sexual harassment which had the effect of violating colleagues' dignity, and creating an intimidating, hostile, degrading, humiliating or offensive environment for them to work in, and
    - findings of serious racial harassment which had the purpose and effect of violating colleagues' dignity, and creating an intimidating, hostile, degrading, humiliating or offensive environment for them to work in

- Actual harm was caused to colleagues by the harassment, which occurred on multiple occasions, in multiple locations and at multiple times
- Limited insight into your behavioural failings
- A pattern of repeated and persistent, unacceptable and harassing behaviour in September 2022, and despite critical feedback, repeated in January/February 2023
- The omissions and behavioural failings, in this case, are similar in nature to those addressed by a conditions of practice order in a previous regulatory concern in 2017

The panel also took into account the following mitigating features:

- Admissions to some charges
- There was an immediate apology to your colleague at the time of the racial harassment
- Proffered a later written apology to the colleagues whom your comments effected
- Wrote a reflective piece
- [PRIVATE]
- Personal mitigation [PRIVATE] at the time

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 misconduct, and the public protection issues identified, an order that does not restrict your 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 your 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 your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the wide-ranging, period of time, and seriousness of the charges found proved in this case. The panel was of the view that the specific misconduct identified in this case was not something that can be easily addressed. It noted that your knowledge in clinical practice was not the foundation of the charges and therefore retraining would have no effect in mitigating the risks identified. It also noted that, in 2017, you were subject to a conditions of practice order, however this had no effect in creating a sustained change in your practise and behaviour and did not prevent this conduct occurring some two years later. The concerns were closely intertwined with deep-seated, attitudinal and behavioural issues which cannot be remedied through a conditions of practice order. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel noted that there were multiple breaches and omissions between September 2022 and January/February 2023. The panel also noted the previous incidents in 2017,

were of a similar nature. It was of the view that there was sufficient evidence of a pattern of behaviour that had been and is likely to be repeated in the future. It determined that there was evidenced of a deep-seated and attitudinal problem. Furthermore, it considered that some of the conduct was significantly serious in that it caused actual harm to colleagues. The panel was also of the view that you had limited insight into your misconduct which increased the likelihood of repetition.

The conduct, as highlighted by the facts found proved, were a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

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?*

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the misconduct in this case raises fundamental questions about your professionalism. It also determined that public confidence in the profession would not be maintained if you were to remain on the register and there was a potential for harm to be caused to the public. The panel was of the view that the findings in this particular case

demonstrate that your misconduct was serious and to allow you 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 during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your misconduct in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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 you in writing.

Interim order

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

Submissions on interim order

Dr Graydon submitted that given the panel's decision to impose a striking-off order, the most appropriate interim order would be an interim suspension order for 18 months. He

submitted this would protect the public and would be in the wider public interest to cover the appeal period of 28-days before the striking-off order can take effect.

Mr Mackell submitted that, given the panel's findings, there is no objection to the interim order application made by Dr Graydon.

The panel heard and accepted the advice of the legal assessor. He referred to the following case law:

- *NMC v Persand* [2023] EWHC 3356 (Admin)
- *MXM v GMC* [2022] EWHC 817 (Admin)

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the available evidence, the seriousness of the facts found proved, the risk of repetition, and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.