Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 – Friday, 14 June 2024
Friday, 1 November 2024
Tuesday, 17 – Wednesday, 18 December 2024

Virtual Hearing

Name of Registrant:	**Gillian Maureen Lacey**
NMC PIN:	00B1658E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 9 February 2003
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Sophie Lomas (Chair, Lay member) Richard Bayly (Lay member) Simone Thorn Heathcock (Registrant member)
Legal Assessor:	Ashraf Khan (10 - 14 June, 1 November, 17 December 2024) John Donnelly (18 December 2024)
Hearings Coordinator:	Margia Patwary
Nursing and Midwifery Council:	Represented by Rosie Welsh, Case Presenter (10 - 14 June, 1 November 2024) Leesha Whawell (17 -18 December 2024)
Ms Lacey:	Not present and unrepresented at the hearing
Facts proved:	Charges 1b, 1c, 4, 5 a(i), 5a(ii), 5b, 6a, 6b, and 6c
Facts not proved:	Charges 1a, 2, 3, 7a and b
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 Ms Lacey was not in attendance and that the Notice of Hearing letter had been sent to Ms Lacey's registered email address on 9 May 2024.

Ms Welsh, 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 and, amongst other things, information about Ms Lacey's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Lacey 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 Ms Lacey

The panel next considered whether it should proceed in the absence of Ms Lacey. It had regard to Rule 21 and heard the submissions of Ms Welsh who invited the panel to continue in the absence of Ms Lacey. She submitted that Ms Lacey had voluntarily absented herself.

Ms Welsh referred the panel to the documentation concerning proceeding in absence and summarised the contact with Ms Lacey chronologically since her case was referred to the Fitness to Practice committee. She took the panel through the bundle, referred to the relevant documents, and the emails sent to Ms Lacey.

Ms Welsh submitted that there had been no engagement at all by Ms Lacey with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her 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 Ms Lacey. In reaching this decision, the panel has considered the submissions of Ms Welsh, 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 Ms Lacey;

- Ms Lacey has not engaged with the NMC and has not responded to any of the emails sent to her about this hearing;
- Ms Lacey has not provided the NMC with details of how she may be contacted other than her registered address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses had been warned to attend the hearing to give live evidence, and not proceeding would potentially inconvenience the witnesses, their employer, and for those involved in clinical practice their clients who need their professional services;
- The charges relate to events that occurred in 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Lacey in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. Ms Lacey will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her 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 Ms Lacey decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

On day four of the hearing, the panel heard an application made by Ms Welsh to amend the wording of charge 6. She told the panel that the amendment simply provides clarity and does not change the substance of the charge, but more accurately reflects the evidence. Accordingly, she submitted that the amendment could be made without injustice to Ms Lacey.

The amendment in relation to charge 6 is as follows:

> '6. On 1 May 2022 in relation to Resident F
>
> a. Refused to carry out pressure sore care.
> b. Asked Colleague A to carry out wound care.
> c. ~~Told Colleague A to "just stick a biatain on it, why do I need to do it?"~~ **"Told Colleague A that it was a waste of time coming to find you, and to "go and sort it yourself", or words to that effect.**'

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 the amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Ms Lacey and no injustice would be caused to either party by the proposed amendment being allowed. It determined that the proposed amendment would not materially alter the substance of the charge but would provide clarity and better reflect the allegation to be addressed. The panel therefore decided to allow the application for the proposed amendment to ensure clarity and accuracy.

Later that day, Ms Welsh made a further application to amend charges 1, 4 and 7.

The application was as follows (highlighted in bold):

‘That you, a registered nurse,

1. On 5 September ~~2019~~ **2021** in relation to Resident J:

a. Failed to conduct a clinical assessment and/ or neurological observations.
b. Refused to call an ambulance.
~~c. Made unprofessional comments to Colleague A.~~
d. Insisted Colleague A roll and hoist Resident J onto the bed.

2. On 22 August 2021 refused to provide care to Resident I.

3. On 2 February 2022 refused to check Resident A’s blood pressure.

4. On 16 February 2022 administered 100m**cg** Levothyroxine to Resident B without checking the MAR chart.

5. On 30 April 2022,
   a. In relation to Resident D:
      i. Refused to carry out observations because you were *“too busy”.*
      ii. Requested Colleague B and Colleague C to carry out clinical observations.
   b. Refused to carry out observations for Resident E.

6. ~~On~~ **Between 20 April 2022 and** 1 May 2022 in relation to Resident F,
   a. Refused to carry out pressure sore care.
b. Asked Colleague A to carry out wound care.
c. Told Colleague A **that it was a waste of time coming to find you, and to “go and sort it yourself”, or words to that effect.”**

7. **On an unknown date, you made unprofessional comments by stating words to the effect of:**

a. **“it doesn’t matter they will be dead soon”**
b. **“they are dying so it makes no difference”**’

Ms Welsh submitted that the amendments do not change the core of the allegations and that the substance of the concerns remain the same. She submitted that the amendments relate to corrections from hearing evidence from Colleague A.

Ms Welsh invited the panel to take into consideration that there will be no injustice to Ms Lacey as she has not provided a response. She submitted that the proposed amendments will add clarity to the charges and accurately reflect the evidence before the panel.

The panel accepted the advice of the legal assessor.

The panel was satisfied that there would be no prejudice to Ms Lacey 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 correct typographical errors and to ensure that the charges more accurately reflect the evidence.

Details of charge (as amended)

That you, a registered nurse,

1. On 5 September 2021 in relation to Resident J: **[NOT PROVED]**
   a. Failed to conduct a clinical assessment and/ or neurological observations.
   b. Refused to call an ambulance. **[PROVED]**
   c. Insisted Colleague A roll and hoist Resident J onto the bed. **[FOND PROVED]**

2. On 22 August 2021 refused to provide care to Resident I. **[NOT PROVED]**

3. On 2 February 2022 refused to check Resident A's blood pressure. **[NOT PROVED]**

4. On 16 February 2022 administered 100mcg Levothyroxine to Resident B without checking the MAR chart. **[PROVED]**

5. On 30 April 2022,
   a. In relation to Resident D:
   i. Refused to carry out observations because you were *"too busy".* **[PROVED]**
   ii. Requested Colleague B and Colleague C to carry out clinical observations. **[PROVED]**

   b. Refused to carry out observations for Resident E. **[PROVED]**

6. Between 20 April 2022 and 1 May 2022 in relation to Resident F
   a. Refused to carry out pressure sore care. **[PROVED]**
   b. Asked Colleague A to carry out wound care. **[PROVED]**
   c. Told Colleague A that it was a waste of time coming to find you, and to "go and sort it yourself", or words to that effect." **[PROVED]**

7. On an unknown date, you made unprofessional comments by stating words to the effect of:
    a. “it doesn’t matter they will be dead soon” **[NOT PROVED]**
    b. “they are dying so it makes no difference” **[NOT PROVED]**

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Welsh under Rule 31(1) of the Nursing Midwifery Council (Fitness to Practice) Rules 2004 ('the Rules').

Ms Welsh briefly summarised her written submissions which stated:

> *'The NMC asks the panel to allow the evidence of [Witness 1], which relates to charges 1, 2, 3, 5 and 6 and seeks to adduce as hearsay the relevant statements and interview notes of witnesses who are not attending namely Colleagues B, C and D, whose evidence is exhibited within [Witness 1]'s statement.*
>
> *Colleague B and Colleague C were working as healthcare assistants, and Colleague D as a senior carer at Maypole Home at the time of the allegations.*
>
> 1. *Within [Witness 1]'s statement she:*
>   i. *At paragraph 12-15, gives evidence in relation to charge 1(a)-(d) (Resident J), exhibits the relevant incident form **RDW/3** and Bupa Falls Prevention & Management Guidance **RDW/4***
>
>   ii. *At paragraph 6-8, gives her account in relation to charge 2 (Resident I).*
>
>   iii. *At paragraph 22, gives her account in relation to charge 3 (Resident A).*
>
>   iv. *At paragraph 48 – 51, [Witness 1] gives evidence in relation to charge 5(a)(i) and (ii) (Resident D), exhibits Resident D's medical notes **RWD/24** a local statement from Colleague B and C **RDW/25**, and interview notes from Colleague B **RDW/26**, exhibits the Ms Lacey's local response as **RWD/29**.*

v. *At paragraph 56-59 and 61, [Witness 1] gives evidence in relation to charge 5(b) (Resident E), exhibits the statement of Colleague D referred to as **RWD/27** and interview notes with Colleague D referred to as **RWD/28**.*

vi. *At paragraph 62, 66 [Witness 1] gives evidence in relation to charge 6(a)(b) and (c) (Resident F) and exhibits the Ms Lacey's local response'*

Ms Welsh reminded the panel that hearsay evidence is admissible in proceedings brought before a fitness to practise committee of the NMC by virtue of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 and referred the panel to:

'<u>Evidence</u>

Rule 31 (1) – Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place).'

Ms Welsh referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 Admin, which sets out the factors the panel should take into account when deciding whether or not to admit hearsay evidence.

Ms Welsh invited the panel to admit parts of Witness 1's written statement into evidence and added, if the panel agree that the evidence is relevant, the only real consideration for the panel is whether admitting the evidence would be fair, the factors for which are set out in Thorneycroft.

Sole and decisive evidence

Ms Welsh submitted that the hearsay evidence of Witness 1 in relation to charges 2 and 3 is sole and decisive.

Ms Welsh submitted that the hearsay evidence of Colleagues B, C and D in relation to charges 5 is sole and decisive.

Ms Welsh submitted that the hearsay evidence of Witness 1 in relation to charges 1 and 6 is not sole and decisive, as it relates to incidents which Colleague A was present for, Colleague A has provided a statement and will be giving live evidence during the hearing.

Nature and Extent of the Challenge

Ms Welsh submitted that Witness 1 has exhibited an informal meeting note with Ms Lacey dated 4 May 2022 in which she was informed of some concerns about her practice which relate to charges 5 and 6, and the informal note contains her responses. She submitted that Ms Lacey has not engaged with the NMC proceedings and has not provided a response to the charges or evidence sent to her.

Suggestion of Fabrication

Ms Welsh submitted there has been no suggestion that Witness 1 has fabricated evidence, nor that she had reason to do so. There is no such suggestion that Colleagues B, C and D have fabricated evidence, they made contemporaneous statements at the time of the incidents and Colleagues B and D gave additional interviews at local level.

Seriousness of Charge

Ms Welsh submitted that if these charges went on to be proved, they would show serious attitudinal concerns that would need to be addressed with regulatory intervention.

Good reason for non-attendance and steps taken to secure attendance

Ms Wesh submitted that it was intended that all witnesses (B, C and D) would have attended the hearing, and given evidence to the panel. She submitted that in this case, the witnesses have either not responded or engaged with the NMC or requested that the NMC no longer contact them due to feeling harassed by the NMC. She further submitted the NMC made the decision not to summons the witnesses, as they had not provided a statement to the NMC previously.

Notice

Ms Welsh submitted that the NMC provided their evidence which includes Witness 1's statement and exhibits relating to Colleagues B, C and D's evidence and that Ms Lacey has not responded.

Ms Welsh submitted that the hearsay evidence is relevant and invited the panel to consider that it would be fair to admit the evidence, or such parts of Witness 1's evidence as the panel considers to be fair.

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

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1'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 her.

The panel considered whether Ms Lacey would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 1 to that of allowing hearsay testimony into evidence.

In relation to charge 1, the panel considered the evidence before it. The panel determined that the evidence of Witness 1 in relation to charge 1 is not sole and decisive as there will be a direct witness, Colleague A, who is capable of being tested in relation to these incidents. The panel decided that it would be fair and relevant to accept Witness 1's evidence in relation to charge 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

In relation to charge 2 and 3, the panel considered the evidence before it. The panel determined that the evidence of Witness 1 in relation to charge 2 and 3 is the sole and decisive evidence in Ms Lacey's case. The panel was of the view that there was no local statement nor witness accounts before the panel to consider in relation to those charges. Further, the panel had no material that it could use to test the accuracy and the reliability of Witness 1's written statement. Therefore, the panel was of the view that it would be unfair for the hearsay evidence in relation to charge 2 and 3 to be admitted.

In relation to charge 5, the panel considered the evidence before it. The panel determined that the hearsay evidence of Colleagues B, C and D in relation to charge 5 is not sole and decisive as there are a number of documents and statements for it to consider. This included the local account given by Ms Lacey during the time of the allegations. The panel is of the view that there is evidence for the panel to assess at the fact-finding stage and it will be the matter for the panel as to what weight is placed on this evidence in due course. Further, the panel determined that the hearsay evidence in relation to this charge is fair and relevant to be admitted.

In relation to charge 6, the panel considered the evidence before it. The panel determined that the evidence of Witness 1 in relation to charge 6 is not sole and decisive as that there will be a direct witness, Colleague A, who is capable of being tested in relation to these incidents. The panel decided that it would be fair and relevant to accept the hearsay evidence in relation to charge 6 but they would decide what weight to give this evidence once all evidence had been heard and evaluated.

In all the circumstances, the panel did not accede this application in relation to Charge 2 and 3.

Background

The charges arose whilst Ms Lacey was employed as a registered nurse at Maypole Care Home (the Home), Bupa Healthcare (BUPA).

The alleged regulatory concerns were as follows:

1. Poor clinical care including in respect of
    a. clinical assessment and/or observations
    b. wound care
    c. delegation of tasks to junior members of the team

2. Poor medication practice in that you:
    a. administered medication without first taking a blood sugar reading
    b. administered the incorrect dosage of medication.
    c. failed to dispose of medication correctly

    Or, in the alternative to RC2a – poor record keeping – in that you failed to make a record of the blood sugar reading you had taken.

3. Failure to treat people in your care with dignity – in that you refused to provide care to an end- of- life resident.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Lacey.

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: Registered Nurse at the Home
- Colleague A: Band 2 Bank Healthcare Assistant at the Home

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

1. On 5 September 2021 in relation to Resident J:
    a. Failed to conduct a clinical assessment and/ or neurological observations.

This charge is found NOT proved.

In reaching its decision, the panel took account of the incident form for Resident J, dated 5 September 2021, Witness 1's witness statement, Colleague A's witness statement and BUPA Falls Prevention & Management Guidance.

The panel first considered whether Ms Lacey had a duty of care to Resident J on 5 September 2021. The panel was of the view that Ms Lacey was under a duty of care as a registered nurse on shift at the time, and had a duty to act as she was responsible for Resident J.

The panel noted that the incident form for Resident J, dated 5 September 2021 did not mention that Ms Lacey had failed to carry out a clinical assessment and/or neurological observations. Further, the panel did not have sight of any observation charts relating to Resident J. The panel noted that Ms Lacey requested a blood pressure cuff and instructed her colleagues to leave the room.

The panel also noted that whilst the local investigation found documentation was not completed effectively, it made no mention that clinical assessments or neurological observations had not been done.

During Colleague A's evidence, Colleague A told the panel that she was not suggesting Ms Lacey did not carry out clinical assessment and/or neurological observations for Resident J, but that she did not see Ms Lacey carry out carry those assessments.

The panel had no evidence before it to demonstrate that Ms Lacey failed to conduct a clinical assessment and/or neurological observations in relation to Resident J. The panel determined that this charge is found not proved.

Charge 1b

b. Refused to call an ambulance.

This charge is found proved.

In reaching its decision, the panel took account of the incident form for Resident J, dated 5 September 2021 and Colleague A's witness statement and oral evidence.
Colleague A in her witness statement stated:

> *"…We stated that an ambulance should be called to check Resident J over, and Ms Lacey refused to call an ambulance…"*

The panel was of the view that Colleague A in her oral evidence and witness statement was consistent and clear that Ms Lacey refused to call an ambulance. Therefore, the panel found this charge proved.

Charge 1c

c. Insisted Colleague A roll and hoist Resident J onto the bed.

This charge is found proved.

In reaching its decision, the panel took account of the incident form for Resident J, dated 5 September 2021 and Colleague A's witness statement and oral evidence.

Colleague A in her witness statement stated:

> *"Ms Lacey came in their own time and insisted that we roll and hoist Resident J onto the bed. Ms Lacey insisted that they were capable of assessing the resident and seeing to their wound"*

Colleague A clarified this statement in her oral evidence:

> *Colleague A:*
> *"We were instructed to hoist him, which we shouldn't have done, but we hoisted him onto the bed, at which point he was just repeating that he was so sorry. He knew we were busy and he was sorry he'd been so silly…"*

The panel was of the view that Colleague A in her oral evidence and witness statement was consistent and clear that Ms Lacey had insisted that she roll and hoist Resident J onto the bed. Therefore, the panel found this charge proved.

Charges 2 and 3

In light of the panel's earlier decision that the hearsay evidence was the sole and decisive evidence in respect of these charges, the panel was of the view it had no additional evidence before it to consider. Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found 2 and 3 not proved.

Charge 4

4. On 16 February 2022 administered 100mcg Levothyroxine to Resident B without checking the MAR chart.

This charge is found proved.

In reaching its decision, the panel took account of the Incident/Near Miss Reporting Form dated 17 January 2022, Resident B's MAR chart, Witness 1's witness statement and Reflective accounts form from the Registrant Response Bundle.

Witness 1 in her witness statement stated:

‘Incident regarding Resident B - 16 February 2022

It is alleged that on 16 February 2022, Ms Lacey administered a dose of 100mg of Levothyroxine to Resident B at 08:00, after the night nurse had correctly administered the medication earlier that morning (at around 6:00). Ms Lacey's actions therefore caused Resident B to receive a double dose of Levothyroxine. Ms Lacey signed the MAR chart in the following day's slot as they could not sign in the correct day's slot as it was already given and signed for by the night nurse. I am familiar with Ms Lacey's signature and Ms Lacey admitted that they had incorrectly signed and administered the medication attach the incident form detailing this incident, dated 17 February 2022, as Exhibit RDW13. As I was the Clinical Services Manager at the time I was alerted to this incident in the morning. I attach Resident B's MAR chart as Exhibit RDW14. This shows that Resident B was administered medication in the early morning (coloured green, which was the colour used for early morning medication rounds). Ms Lacey would have been aware of this colour scheme, because it has been used in all Bupa nursing homes for a significant period of time.

…

Ms Lacey's response:

Ms Lacey was asked to complete a reflective account of the incident relating to Resident B, however I am unsure if this was ever done…

Ms Lacey was asked to complete medication training again. I recall that Ms Lacey took a long time to complete this training but completed it on 28 February 2022
I remember that Ms Lacey stated that this took a long time as they were having problems logging on. I kept asking Ms Lacey to request assistance from Boots as they were the people who were able to help Ms Lacey with this.

When I asked Ms Lacey about this medication error (I do not remember the date) | *asked her why they at first denied that it was their signature on the MAR chart. However, when Ms Lacey looked again, they stated that the signature was theirs. In discussions relating to this incident, Ms Lacey kept stating that they were 'fine' and it was just that they were not reading the charts properly'*

The panel found Witness 1's evidence to be clear and consistent. The panel noted that Ms Lacey had appeared to accept the error and agreed that the signature was hers on the document.

The panel had sight of the Resident B's MAR chart this clearly showed Ms Lacey's signature in the box for 17 February 2022. This was incorrect as Ms Lacey had wrongly administered an additional dose on 16 February 2022 but was unable to sign on the 16 February 2022 as the correct dose had already been given and signed for. The panel therefore determined that Ms Lacey administered 100mcg Levothyroxine to Resident B without checking the MAR chart. Therefore, the panel found this charge proved.

Charge 5 ai and 5aii

5. On 30 April 2022
    a. In relation to Resident D:

I. Refused to carry out observations because you were *"too busy".*

II. Requested Colleague B and Colleague C to carry out clinical observations.

This charge is found proved.

In reaching its decision, the panel took account of Witness 1's witness statement, Resident D's daily notes, Colleague B and Colleague C's statement dated 1 May 2022, Colleague B's interview dated 16 May 2022 and Registrant local responses – informal interview notes dated 4 May 2022.

Witness 1 in her witness statement stated:

‘Incidents regarding Resident D - 30 April 2022

Refusing to carry out observations:

On 30 April 2022 it is alleged that Ms Lacey refused to carry out observations on Resident D when care staff (Colleague C and Colleague D) reported them to be unwell. Allegedly, Ms Lacey was asked four times by Colleague B and Colleague C to check on Resident D, but Ms Lacey did not conduct the observations at 9:00 when they were asked, because they were 'too busy. This was concerning to me as this placed Resident D in a precarious position. Resident D could have been clinically deteriorating and Ms Lacey, as the registered nurse, would not have been aware of their condition because they did not carry out the observations on Resident D…

If a member of staff came to a registered nurse and said that someone was not well, and that they were deteriorating, then I would expect the nurse to act on this immediately and undertake a timely clinical assessment. This would involve conducting clinical observations, measuring the resident's National Early Warning Score ("NEWS") which will indicate whether the resident would need to be escalated, and/or continue to monitor the resident. NEWS would assess the resident's blood pressure, temperature, oxygen saturation, respiration and blood oxygen. Effective communication would also be required, for example, if the NEWS was high, the nurse would be expected to then call the doctor (either the GP or out of hours doctor, or even escalate to 999 depending on the score. Ms Lacey would also be expected to check the resident's care file where appropriate.

Having worked at Bupa since 2019, Ms Lacey would have been aware of this well-established practice across Bupa and therefore aware of their duties regarding clinical observations. Although I do not recall any training on NEWS, it is widely

used within the care sector and in the NHS and as a nurse, you are trained to do this when you are a student nurse.

The associated risks of not carrying out clinical observations are that a resident's condition could significantly deteriorate, and we would not be aware of this. This could cause a delay in the resident receiving treatment, including administering analgesia. This can also delay providing lifesaving treatment in extreme circumstances.'

The panel determined that Witness 1's account provided in her local statement, NMC witness statement signed and dated 6 August 2023, and her oral evidence was clear and consistent. The panel also noted Witness 1's account was corroborated by Colleague B and Colleague C's statement dated 1 May 2022 and Colleague B's interview dated 16 May 2022. Furthermore, the panel noted that Colleague B and Colleague C were both present at the time of the incident.

The panel also considered Resident D's daily notes which did not show any documented observations conducted by Ms Lacey.

The panel noted that Ms Lacey in her informal discussion on 4 May 2022 stated *"I said they could do it as they were standing in the way and not moving out the way".*

The panel therefore inferred that it is more likely than not that Ms Lacey refused to carry out observations and requested Colleague B and Colleague C to carry out clinical observations. Therefore, the panel found this charge proved.

Charge 5b

b. Refused to carry out observations for Resident E.

This charge is found proved.

In reaching its decision, the panel took account of Witness 1's witness statement, Colleague D statement dated 3 May 2022, Colleague D interview dated 6 May 2022 and Registrant local responses – informal interview notes dated 4 May 2022.

Witness 1 in her witness statement stated:

> *"On 30 April 2022, it is alleged that care assistants (Colleague D and Colleague C) requested observations to be carried out on Resident E as they appeared unwell, but Ms Lacey refused to complete these.*
>
> *I was made aware of this incident because it was spoken about amongst management. I attach a statement from Colleague D, dated 3 May 2022, as Exhibit RDW27. Colleague D, a senior carer, flagged to Ms Lacey that the resident was unwell. [Registered Nurse] had directed Ms Lacey to carry out observations as they were suspended from conducting medication rounds and Ms Lacey allegedly refused to do so, sitting in the staffroom instead with [Registered Nurse]. Ms Lacey claimed they were doing dressings with [Registered Nurse], and therefore could not do the observations that Colleague D and Colleague C requested them to do. Colleague D stated that [Registered Nurse] ended up conducting the observations, despite the fact that they were in the middle of dealing with an emergency with another resident and they were giving medication (therefore they should not have been interrupted). I attach Colleague D's interview, dated 6 May 2022, as Exhibit RDW28*
>
> *Ms Lacey's duty and awareness regarding carrying out clinical observations would be the same as in paragraphs 49 to 51 above.*
>
> *If a resident is presenting to be clinically unwell, this should take priority. Nurses are trained to prioritise their care, and completing a set of observations is more important than helping another nurse with dressings. I would have expected Ms Lacey to ask someone else, who was not busy, to take over this job and to attend*

to Resident E who was presenting with illness. As above, [Registered Nurse] ended up conducting the observations, which was serious as the emergency was interrupted.

Ms Lacey's response

I understand that Ms Lacey's response to this was to refute the allegation, when discussed in a meeting with them on 5 April 2022, and Ms Lacey demonstrated no insight or awareness as a result. Ms Lacey showed no sense of urgency and did not apologise for their actions and omissions."

The panel determined that Witness 1's account provided in her local statement, NMC witness statement signed and dated 6 August 2023, and her oral evidence was clear and consistent. The panel also noted Witness 1's account corroborated with Colleague D's statement dated 3 May 2022 and interview dated 6 May 2022. Accordingly, the panel preferred this evidence.

The panel therefore inferred that it is more likely than not Ms Lacey refused to carry out observations for Resident E. Therefore, the panel found this charge proved.

Charge 6

6. Between 20 April 2022 and 1 May 2022 in relation to Resident F
    a. Refused to carry out pressure sore care
    b. Asked Colleague A to carry out wound care.
    c. Told Colleague A that it was a waste of time coming to find you, and to "go and sort it yourself", or words to that effect."

These charges were found proved.

In reaching its decision, the panel took account of Witness 1's witness statement and Colleague A's witness statement. The panel considered charges 6 a, b and c separately but will address the charges as one.

The panel considered Colleague A's witness statement as it was direct evidence.

Colleague A stated:

> *"I recall that on this particular date, I noticed that one of Resident F's undressed wounds had deteriorated. For context, this resident had 18 complex wounds, dementia, cancer, a low body mass index ("BMI"), and a low oral intake and was being nursed in bed. Resident F was on hourly checks because they were covered in sores with multiple skin conditions. At approximately mid-afternoon, I had conducted a check when I noticed that there was a wound that needed dressing and documenting. I went to the nurse's station on the ground floor to escalate this to a registered nurse, as they would have been responsible for addressing any deterioration that a HCA reported to them. I recall that Ms Lacey was sat in there with another nurse, , and I knocked and said "sorry to bother you, but [Resident FJ has got another pressure area, it looks nasty and needs dressing." Ms Lacey's response was to rip my head off. Ms Lacey said words to the effect of "and you have spent time coming to find me because? What a waste. There are dressings in his cupboard, go and sort it yourself' . I reminded Ms Lacey that they were the nurse and this needed dressing and documenting. When I asked Ms Lacey to do their job, they refused and told me to do it myself as I was clearly not busy.*
>
> *My first concern was that Ms Lacey refused to carry out their duty of pressure care when I asked them to do so - My second concern here was that Ms Lacey asked me to dress the wound. My response was to report this, because I was in no position to dress a wound that was so infected and so poorly. I immediately reported this incident to (Manager of the Home) who dealt with this straight away."*

The panel noted Colleague A's account corroborated with Witness 1's statement. Witness 1 stated:

"Incident regarding Resident F - 1 May 2022
Refusing to carry out pressure care

It is alleged that on 1 May 2022, Ms Lacey refused to carry out pressure care to Resident F when a care assistant, [Colleague A], reported that an undressed wound had deteriorated. I did not witness this incident directly. I was made aware of this incident verbally by Ms Bray. I do not recall the exact date of this.

I note that none of the care staff at Bupa would have been trained in wound management, including dressings. It is therefore the responsibility of the registered nurse to clinically assess and dress a wound appropriately and in this instance, Ms Lacey held this responsibility.

This was standard practice within the Home, therefore Ms Lacey would have been aware of their responsibility to conduct wound care and management on Resident F.

There is also pressure area training during a nurse's induction at the Home, which Ms Lacey would have completed.

Resident F had 17+ complex wounds due to vascular problems, therefore they were incredibly frail and high risk. Resident F's wound dressings would keep coming off, therefore it was the responsibility of the staff to monitor Resident F closely. To leave an open wound is dangerous, as this could become infected quickly, and as Resident F was very weak, they also could have succumbed to sepsis.

Delegation of tasks to junior staff

It was also alleged by Ms Fry in an informal meeting (I am not aware of the exact date of this meeting), that Ms Lacey asked them to carry out the wound care on Resident F, after they refused to do it. Care assistants cannot be asked to do a dressing because a wound must be clinically assessed by a nurse beforehand. Ms Lacey was required to assess whether the wound was deteriorating, whether the dressing needed to be changed, whether there was an infection or whether the doctor needed to be alerted. If a carer was asked to do this, the resident may be put at risk as the carer would not know what to look for.

Ms Lacey's response

I do not recall that there was a formal response given by Ms Lacey in relation to the incident involving Resident F but at the time I remember that Ms Lacey kept saying to Ms Fry, "just stick a biatain (a commonly used silicone dressing for wounds) on it, why do I need to do it?" I cannot recall how I am aware of this, I was possibly told this by Ms Bray at the time but I cannot be sure. This is a concerning response from a registered nurse because, as mentioned above, the care staff are not trained in wound management.

I attach the notes from an informal meeting with Ms Lacey, dated 4 May 2022, as Exhibit RDW29. There appears to be a lack of insight and remorse from Ms Lacey with regards to the potential seriousness of all of these incidents. Ms Lacey offers excuses as to why they did not conduct themselves in a professional manner. Ms Lacey stated that she was busy at the time and that she was not the ground floor nurse that day."

The panel considered it more likely than not, given the situation described by Colleague A, that Ms Lacey refused to carry out pressure sore care, asked Colleague A to carry out wound care and did use the words alleged, or words to the same effect. For the reasons previously stated, the panel found Witness 1 to be consistent and given the additional supporting evidence provided by Colleague A, found charges 6 a, b and c proved.

Charge 7

7. an unknown date, you made unprofessional comments by stating words to the effect of:
    a. “it doesn’t matter they will be dead soon”
    b. “they are dying so it makes no difference”

These charges are found NOT proved.

In reaching its decision, the panel took account of Witness 1’s witness statement and Colleague A’s witness statement. The panel considered charge 7 a and b separately but will address the charges as one.

Witness 1 in her witness statement stated:

> *This allegation is very serious, as this was an incredibly poor attitude to have regarding an end of life resident. Ms Lacey was known to make comments such as "oh it doesn't matter they will be dead soon" or "they are dying so it makes no difference". I heard Ms Lacey say this on at least two separate occasions although I cannot recall the dates.*

During oral evidence, Ms Walsh asked Witness 1 how she knew if Ms Lacey made those unprofessional comments in charge 7, Witness 1 stated:

> *“I don't. I didn't hear it being said myself”… And I can't remember the exact circumstances of hearing out what had been said. But being in management at that time, I'd imagine it would have been discussed within clinical meetings because we would discuss state taxes and incidents within meetings.”*

The panel noted there were inconsistencies between Witness 1's written statement and her oral evidence.

Colleague A in her witness statement stated:

> *"I reported this to the Manager of the Home (via call or email on the same day. This incident occurred on a Sunday, therefore none of the management team were in so they had to be messaged. Ms Lacey's response to my concern was "they are here to die anyway". I do not have any written evidence of this. Ms Lacey did not seem phased or bothered about anything or anyone and they came across as rude, abrupt and uncaring. Ms Lacey was not the type of person that I felt comfortable confronting which is why I reported this to the Home Manager."*

Colleague A in her oral evidence stated:

> *"Yes, it's she didn't actually specifically say it on that day.*
> *…I think I'd put it read out to me that she'd said it about resident Jay, but it wasn't. But I think rereading it, it's it was just a. That was her general feeling and her general sense is on the home. That was it. It wasn't specifically about Resident J. I didn't want it to come across that she'd said it to me specifically about Resident J that day. It was just in general."*

The panel determined that were inconsistencies in Witness 1's and Colleague A's accounts. The panel noted that neither Witness 1 or Colleague A directly heard Ms Lacey making unprofessional comments as alleged in Charge 7. Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charges 7a and 7b not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Lacey'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 suitability to remain on the register unrestricted.

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, Ms Lacey's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Whawell invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015' ("the Code") in making its decision. She submitted that Ms Lacey's actions amounted to breaches of the Code and fell short of the standards expected of a registered nurse. She submitted that not only had Ms Lacey had made a mistake in relation to medication, but that on more than one occasion she had failed to act in accordance with the Code to attend to the needs of those in her care.

Ms Whawell submitted that fellow practitioners would find Ms Lacey's conduct and the lack of action to be deplorable. She invited the panel to find the charges found proved amount to misconduct.

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

Ms Whawell referred the panel to the NMC guidance titled 'Impairment', reference 'DMA-1', last updated 27 February 2024 and highlighted the following excerpt:

"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".

Ms Whawell submitted that the NMC's position on this question is that the answer is no.

Ms Whawell referred the panel to paragraph 76 of the judgement in Grant, when Mrs Justice Cox approved of the approach formulated by Dame Janet Smith. She submitted that limbs a), b) and c) of the relevant test are engaged.

Ms Whawell submitted that the first limb is engaged as a result of Ms Lacey putting patients at unwarranted risk of harm in a number of ways as set out in the charges by:

a) Refusing to call an ambulance
b) Insisting a colleague roll and hoist a resident when it was not appropriate
c) Administering medication when it was not due
d) Refusing to carry of observations
e) Telling untrained colleagues to undertake clinical observations
f) Refusing to carry out pressure sore care and directing untrained colleagues to undertake wound care

The second limb is engaged as a result of the Ms Lacey's behaviour, as found proven, plainly brings the profession into disrepute.

The third limb is engaged as a result that Ms Lacey breached fundamental tenets of the profession in numerous areas of the Code of Conduct as referred to above.

Taking the above into account, Ms Whawell submitted that Ms Lacey breached the fundamental tenets of the nursing profession, breached sections of the Code and failed to prioritise people in her care, practise effectively, preserve safety and promote

professionalism and trust. She submitted that Ms Lacey undermined the public's trust and confidence in the profession and has brought the profession into disrepute.

In regard to remediation, Ms Whawell referred the panel to the NMC Guidance entitled *'Can the concern be addressed?* (Reference FTP-15a Last Updated 27/02/2024), which states:

> *'Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> *Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*
>
> - *Medication administration errors*
> - *Poor record keeping*
> - *Failings in a discrete and easily identifiable area of clinical practice concerns about incidents that took place a significant period of time in the past, especially if the nurse, midwife or nursing associate has practised safely since they occurred.*

Ms Whawell submitted that the concerns in Ms Lacey's case were not an isolated incident and go beyond clinical practise relating to her attitude to patients in her care. She submitted that the concerns fall into a category of poor practice which indicates dangerous attitudinal issues for the safety of people for whom she is providing care, which may not be

remediable with training courses or supervision, and thus harder to address. She submitted that Ms Lacey has not engaged with the substantive proceedings and provided very little evidence in relation to her reflection and insight. She submitted that there is a clear indication that the Ms Lacey's practise is currently impaired.

Ms Whawell referred the panel to the NMC's Guidance entitled *'Serious concerns which could result in harm to patients if not put right'* reference: FTP-3b.

Ms Whawell submitted that as the concerns have not been addressed by Ms Lacey, either through a demonstration of insight and reflection, or by strengthening her practice and remediation through training and submitted that there is a high risk of repetition. She submitted that despite Ms Lacey's previous unblemished record it cannot be said that it is highly unlikely that her conduct will be repeated.

For all of the reasons mentioned above, Ms Whawell invited the panel to make a finding of misconduct and impairment on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1** Treat people with kindness, respect and compassion*
> ***1.2** Make sure you deliver the fundamentals of care effectively*
> ***1.4** Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***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*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*
> ***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*
>
> ***11 Be accountable for your decisions to delegate tasks and duties to other people***
> *To achieve this, you must:*

11.1 *Only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
11.2 *Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care.'*
11.3 *Confirm that the outcome of any task you have delegated to someone else meets the required standard*

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.2 *Arrange, wherever possible, for emergency care to be accessed and provided promptly*

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'*

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

However, the panel found that the charges found proved individually, and cumulatively, amounted to misconduct. The panel was of the view Ms Lacey did not provide vulnerable patients with the expected level of care, incorrectly administered medication, which could have caused significant consequences to patients and demonstrated deep-seated attitudinal concerns towards patients under her care. Further, the panel noted that Ms Lacey did not respond to her colleagues concerns and was dismissive towards junior staff members.

The panel found that Ms Lacey's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Lacey'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, they must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* 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 determined that that the first three limbs of the Grant test are engaged in this case.

The panel finds that vulnerable patients were put at a risk harm as a result of Ms Lacey’s misconduct. The panel considered that Ms Lacey did not adhere to the standards expected of a nurse. The panel determined that Ms Lacey’s misconduct breached the fundamental tenets of the nursing profession and consequently brought the profession into disrepute in that she had failed to provide proper care for vulnerable patients and behaved wholly inappropriately towards junior members of staff.

The panel went on to consider whether there is a risk of repetition and in doing so it assessed Ms Lacey’s current insight, remorse and remediation.

The panel considered whether Ms Lacey misconduct is capable of remediation and came to the decision that her practice was remediable. However, the panel had no evidence that Ms Lacey had strengthened her practice, reflected on her conduct, shown remorse or taken steps to remediate her practice. Ms Lacey had not provided sufficient evidence of reflection to demonstrate her understanding of the impact her actions had on patients or her colleagues. Further, the panel also note that attitudinal and behavioural issues are more difficult to remediate. Therefore, the panel considered that there is a real risk of repetition and decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. It considered that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Lacey's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Lacey's 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 Ms Lacey off the register. The effect of this order is that the NMC register will show that Ms Lacey has been struck-off the register.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

The panel noted that in the Notice of Hearing, dated 10 September 2024, the NMC would seek the imposition of a striking-off order if it found Ms Lacey's fitness to practise currently impaired.

Ms Whawell submitted the appropriate sanction for Ms Lacey's case is a striking-off order.

Ms Whawell outlined the aggravating features. She stated there were no mitigating features to outline in Ms Lacey's case.

Ms Whawell submitted that Ms Lacey has not provided any evidence of insight or that she has followed good practice since the concerns were raised. She submitted that Ms Lacey has not provided any details in relation to personal mitigation.

Ms Whawell referred the panel to the NMC guidance *titled 'Considering sanctions for serious cases'* reference 'SAN-2'. She invited the panel to have regard to the guidance as it will assist the panel in determining the seriousness of the facts that it found proved as this case involves neglect of vulnerable people.

Ms Whawell submitted that taking no action would be inappropriate given the seriousness of the case. She submitted that it would be neither proportionate nor in the public interest to take no further action. She further submitted that the imposition of a caution order would not be appropriate in these circumstances.

Ms Whawell submitted that the deep-seated attitudinal and behavioural concerns identified cannot be addressed by a conditions of practice order. She submitted that there was no willingness from Ms Lacey to respond positively through retraining nor has she demonstrated any engagement with these proceedings. As such, she submitted that the panel may take the view that a conditions of practice order would not be appropriate.

Ms Whawell submitted that a suspension order would not be appropriate or proportionate to the risks identified in this case. She submitted that a temporary removal from the register would not be sufficient to protect the public, as this is not a single incident of misconduct. She submitted that there are attitudinal concerns and no evidence of insight to mitigate the risk of repetition. Further, the conduct in this case is fundamentally incompatible with ongoing registration and gravely undermines the public trust and confidence in nurses, given the nature and seriousness of the behaviour a suspension order would fail to address the significant public interest in this case.

Ms Whawell submitted that Ms Lacey's behaviour demonstrates a fundamental breach of the public's trust in nurses and raises fundamental questions about her professionalism. Public confidence in the nursing and midwifery professions can only be maintained if Ms Lacey is permanently removed from the register.

Ms Whawell submitted that the most appropriate order in this case is a striking off order based on the nature and seriousness of the charges found proved. She submitted that the only proportionate order in this case which would protect the public and satisfy the public interest considerations is a striking off order.

Ms Whawell invited the panel to impose a striking-off order.

Decision and reasons on sanction

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

- Pattern of misconduct over a period of time relating to both patients and colleagues
- Lack of insight
- Putting vulnerable patients at risk of harm

The panel did not identify any mitigating features.

The panel noted that Ms Lacey had no previous regulatory findings, but determined this was of limited relevance in the context of the seriousness of the case which involved deep-seated attitudinal issues which Ms Lacey has not addressed.

The panel had regard to the NMC Guidance *'Considering sanctions for serious cases'* reference: SAN-2. The panel noted that allegations involving neglect of vulnerable people will always be treated seriously and that such behaviour can have a particularly severe impact on public confidence and the safety of those who use services.

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 Ms Lacey'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 Ms Lacey'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 Ms Lacey's 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 nature of the charges and the panel's finding of deep-seated attitudinal concerns. The panel also have no information whether Ms Lacey is working in the healthcare sector. The panel has taken into account that Ms Lacey has not been able to demonstrate any meaningful engagement with these proceedings and therefore concluded that it would be unlikely that she would engage with any conditions imposed on her practice. Furthermore, the panel concluded that the placing of conditions on Ms Lacey's 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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that this was not a single instance of misconduct, it was for a period of time involving both patients and colleagues. The panel determined that there is evidence of harmful deep-seated attitudinal issues. The panel had no evidence as to Ms Lacey's insight and it has determined there is a significant risk of repeating this behaviour.

The panel concluded that the serious breach of the fundamental tenets of the profession evidenced by Ms Lacey's actions is fundamentally incompatible with her 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?*

Ms Lacey's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Lacey's actions were serious and to allow her 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 Ms Lacey's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of 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 Ms Lacey 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 Ms Lacey's own interests until the striking-off sanction takes effect.

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

Decision and reasons on interim order

The panel of its own volition determined that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.