Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
3-5 and 8-12 January 2024
26-28 June and 1 July 2024

Virtual Hearing

Name of Registrant:	**Dana Helen Gallagher**
NMC PIN	09I0054S
Part(s) of the register:	RNA: Adult nurse, level 1 (3 September 2012)
Relevant Location:	Moray
Type of case:	Misconduct
Panel members:	John Kelly (Chair, lay member) Nicola Dale (Lay member) Judith McCann (Registrant member)
Legal Assessor:	Charles Conway [3-12 January 2024] Juliet Gibbon [26 June 2024 onwards]
Hearings Coordinator:	Max Buadi [3-12 January 2024] Vicky Green [26 June 2024 onwards]
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Miss Gallagher:	Not present and not represented
Facts admitted:	Charges 1a, 1b, 1c, 1d, 4a, 4b(i), 4b(ii), 4c and 4d
Facts proved:	Charges 1e, 2a, 2b, 2c, 2d, 2e, 3a(i), 3a(ii), 3a(iii), 5a, 5b, 5c, 5e
Facts not proved:	Charges 3b, 5d and 6a, 6b, 6c, 6d
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 Miss Gallagher was not in attendance and that the Notice of Hearing letter had been sent to Miss Gallagher's registered email address by secure email on 23 November 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Gallagher'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 Miss Gallagher 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 Miss Gallagher

The panel next considered whether it should proceed in the absence of Miss Gallagher. It had regard to Rule 21 and heard the submissions of Mr Segovia. He drew the panel's attention to an email sent from Miss Gallagher's representative, Mr Weir, sent on 3 January 2024 which stated:

> *"I write to advise that my client has recently advised that she is not prepared to take part in the hearing.*

In the circumstances I have no option but to withdraw from acting. I will not therefore be attending on Ms Gallagher's behalf at the hearing today. Please direct future correspondence regarding this matter to Ms Gallagher directly."

Mr Segovia also informed the panel of a case conference which was held on 21 December 2023 between the NMC and Mr Weir. He submitted that it was noted in that conference that there was a risk that Miss Gallagher may decide to disengage.

Mr Segovia submitted that based on the aforementioned email, it is clear that Miss Gallagher has voluntarily absented herself. He submitted that there is no realistic possibility that, should the case be adjourned, Miss Gallagher would attend at a future date.

Mr Segovia reminded the panel that there is a public interest in the expeditious disposal of this case and allegations of misconduct should be dealt with as soon as possible. He invited the panel to continue in the absence of Miss Gallagher.

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'*.

The panel has decided to proceed in the absence of Miss Gallagher. In reaching this decision, the panel has considered the submissions of Mr Segovia, the email from Mr Weir, 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:

- Mr Weir sent the Hearings Coordinator the aforementioned email at 07:02 on the morning of the first day of the hearing;

- Miss Gallagher has deliberately and voluntarily absented herself from the hearing;
- Miss Gallagher has known for a long time that this hearing was scheduled to take place;
- Notice of service informed Miss Gallagher that the panel could proceed in her absence;
- No application for an adjournment has been made by Miss Gallagher;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 2 witnesses have attended today to give live evidence, 14 others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018;
- 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 Miss Gallagher in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person 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 Miss Gallagher's 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 Miss Gallagher.

In the meantime, it will send an email to her to inform her that she could participate at anytime during the time allocated for this hearing and ask if she has any documentation she wishes to send to the panel for its consideration.

The panel will draw no adverse inference from her absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) On 28 November 2018, having seen Resident A fall, you failed to:
   a) follow the correct procedure in relation to the moving and handling of Resident A; **[Proved by admission]**
   b) complete any physical checks and/or observations for Resident A; **[Proved by admission]**
   c) complete an incident reporting form; **[Proved by admission]**
   d) update Resident A's care records; **[Proved by admission]**
   e) provide details of the fall to colleagues during handover; **[Proved]**

2) On 28 November 2018, having been informed that Resident B had a fall, you failed to;
   a) follow the correct procedure in relation to the moving and handling of Resident B; **[Proved]**
   b) complete any physical checks and/or observations for Resident B; **[Proved]**
   c) complete an incident reporting form; **[Proved]**
   d) update Resident B's care records; **[Proved]**
   e) provide details of the fall to colleagues during handover; **[Proved]**

3) a) On 28 November 2018, told Resident C to:
      i) *"jog on"* **[Proved]**
      ii) *"go away*" **[Proved]**
      iii) "*bugger off"* or words to that effect; **[Proved]**

   b) pushed and/or shoved Resident C; **[Not proved]**

4) On 25 February 2019:
   a) gave Resident E medication that was prescribed for Resident D; **[Proved by admission]**
   b) having made the medication error at charge 4a above, you:
      i) failed to update Resident E's MAR chart to note the medication error; **[Proved by admission]**
      ii) failed to update Resident D's MAR chart to note the medication error;
   c) failed to administer any medication to Resident D; **[Proved by admission]**
   d) failed to correctly administer Temaxepam, a controlled drug, to Resident E by not having a second nurse present as required; **[Proved by admission]**

5) Between 27 July 2019 and 29 July 2019, you failed to:
   a) undertake, regularly or at all, observations for Resident F and/or make a record of observations taken; **[Proved]**
   b) escalate Resident F's deteriorating condition by failing to contact an out of hours GP and/or obtain medical assistance within a timely manner; **[Proved]**
   c) take action following an abnormal blood pressure result; **[Proved]**
   d) take appropriate action when told that Resident F was "*lifeless*" or words to that effect; **[Not Proved]**
   e) provide an adequate handover to colleagues; **[Proved]**

6) Between 27 July 2019 and 29 July 2019, you failed to:
   a) undertaking regularly or at all, observations for Resident G and/or make a record of observations taken; **[Not proved]**
   b) escalate Resident G's deteriorating condition by failing to contact an out of hours GP and/or obtain medical assistance in a timely manner; **[Not proved]**
   c) provide adequate notes to the doctor by saying Resident G was "chesty"; **[Not proved]**
   d) provide an adequate handover to colleagues; **[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 Miss Gallagher's Case Management Form, Response to the regulatory concerns and the case conference agenda

The panel heard an application made by Mr Segovia under Rule 31 to allow the Miss Gallagher's Case Management Form (CMF), her Regulatory Concerns Response Form (RCRF) and the Case Conference Agenda/minutes dated 21 December 2023 into evidence. The purpose of the application was for the panel to consider whether the RCRF, Miss Gallagher's CMF and the Case Conference Agenda containing the admissions to charges 1a to 1d and charge 4 in its entirety are admissible and should be regarded as admissions to those charges.

With regards to the RCRF, Mr Segovia informed the panel that this document is used by the NMC Case Examiners in making a decision as to whether Miss Gallagher has a case to answer and if so on what basis. He drew the panel's attention to the explanations provided by Miss Gallagher for the regulatory concerns. He reminded the panel that the RCRF was completed by or on behalf of Miss Gallagher during the early stages of the NMC's investigation process.

With regards to the CMF, which was completed in May 2023, Mr Segovia submitted that this was sent to Miss Gallagher after the NMC's Case Examiners decided that there was a case to answer. He reminded the panel that the charges, as set out in the CMF, can change up until the Notice of Hearing is sent to the registrant. He submitted however that this is not the case here because the charges in the CMF are exactly those to be considered at this hearing. He submitted that this is important because the panel can consider the admissions Miss Gallagher has made in her response to the CMF as directly relating to the charges before it.

Mr Segovia drew the panel's attention to a section of the CMF which states that information within the form, including admissions, may be shared with the panel when it is considering the case.

Mr Segovia informed the panel that, at the case conference which took place on 23 December 2023, Mr Weir was present on behalf of Miss Gallagher. He drew the panel's

attention to a section of the case conference agenda/minutes entitled ‘Charges’. He highlighted that Mr Weir was asked by the NMC if there were any changes to her position set out in Miss Gallagher’s response to the CMF and he confirmed that there were none. He submitted that the case conference agenda/minutes also stated that should there be any changes to Miss Gallagher’s position, Mr Weir would inform the NMC. Mr Segovia informed the panel that Mr Weir has not notified the NMC of any changes. He also submitted that Mr Weir did not notify the NMC of any changes within his email sent on 3 January 2024.

Mr Segovia submitted that within the CMF, Miss Gallagher admitted charges 1a, 1b, 1c, 1d, 4a, 4b(i), 4b(ii), 4c and 4d. He also drew the panel’s attention in particular to charges 4c and 4d where red text appears to explain why the failures described in those charges occurred.

Mr Segovia submitted that the panel should consider accepting the early admissions made in the CMF.

Mr Segovia invited the panel to admit the documents into evidence and accept the admissions made by Miss Gallagher in the CMF as admissions to charges 1 and 4.

The panel heard and accepted the legal assessor’s advice on the issues it should take into consideration in respect of this application. This includes 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. He also referred the panel to the NMC guidance entitled, ‘Documents panels use when deciding cases’ (Reference: PRE-3). He particularly highlighted the following under the heading ‘The nurse, midwife or nursing associate’s documents and evidence’:

> *“The panel can then consider whether the nurse, midwife or nursing associate admits or denies any factual allegations, and may find allegations proven on the basis of the admissions which the nurse, midwife or nursing associate has made.”*

The panel considered the documents subject of the application and found them to be relevant.

With regards to fairness, the panel was of the view that the information within the documentation, namely the regulatory concerns response form and the CMF reflected Miss Gallaghers position on the charges. Additionally, the Case Conference Agenda/minutes confirmed her position as recently as 21 December 2023.

The panel also bore in mind that Mr Weir did not inform the panel of any changes to Miss Gallagher's position in his email dated 3 January 2024.

The panel also considered the comments highlighted in red within the CMF under charges 4c and 4d. It considered that these comments provided context to the charges and did not undermine the admissions made by Miss Gallagher.

In these circumstances, the panel determined that it would be fair and relevant to admit into evidence the CMF, the regulatory concerns response form and the case conference agenda/minutes and to treat what was stated in the documentation as admissions to charges 1a, 1b, 1c, 1d, 4a, 4b(i), 4b(ii), 4c and 4d proved in their entirety, by way of Miss Gallagher's admissions.

Background

In May 2019, the NMC received a referral from Spynie Care Home (the Home). The referral was in relation to Miss Gallagher administering the wrong medications to a resident and failing to record the incident, including when instructed to do so by a manager; failing to then administer those medications to the resident for whom they were prescribed; and failing to handover the medication error at the end of her shift. The Home immediately suspended Miss Gallagher in February 2019 whilst a full investigation was conducted.

Prior to her suspension from the Home, there had been concerns about Miss Gallagher's alleged failures to undertake appropriate checks on two residents after they had sustained falls and to record the incidents. The concerns also included an allegation that Miss Gallagher verbally and physically assaulted a resident saying words

to the effect of *“jog on”, “go away”, “bugger off”* and then placing her hand on the resident’s shoulders and shoving her away. These concerns occurred on the same day Miss Gallagher was mentoring a new member of staff.

Miss Gallagher resigned from the Home in March 2019 whilst she was still suspended.

Miss Gallagher then commenced employment at the Grove Care Home (the Grove).

In August 2019 the Grove informed the NMC that Miss Gallagher had been suspended following concerns raised that she had failed to provide appropriate care to two residents who were found to be unwell, over the course of three shifts between 27 and 29 July 2019. The concerns included failing to escalate deterioration in the patients’ health over the weekend or to call for medical attention, in one case even when the family requested that a doctor be called. When carers reported to Miss Gallagher that one of the residents was found to be floppy and unresponsive, it was alleged that Miss Gallagher instructed them to return her to bed. Both residents were found in poor condition by the GP during a routine visit on the morning of 30 July and one was admitted to hospital on her instructions.

Miss Gallagher who was still in her probationary period at the Home was dismissed in August 2019 with immediate effect.

Decision and reasons on application to admit Mr 6’s witness statement and accompanying exhibits as hearsay evidence

The panel heard an application made by Mr Segovia under Rule 31 to allow the written statement of Mr 6 and ‘Administration of Medicines Competency Assessments’ documents undertaken by Miss Gallagher on 14 February 2018 and 20 December 2018 into evidence.

Mr Segovia informed the panel that during case conference on 21 December 2023, Mr Weir required all witnesses to attend in person.

Mr Segovia submitted that, with regards to fairness to Miss Gallager, she is not aware of this hearsay application but is aware of the evidence it relates to.

Mr Segovia submitted that Mr 6's evidence does not go to any factual matters the panel are considering in this hearing but simply produces records held by the Home.

Mr Segovia submitted that this application is not being made due to the unavailability of Mr 6. He submitted that, due to the uncontroversial substance of Mr 6's witness statement, Mr 6 is not required by the NMC to give live evidence.

Mr Segovia submitted that Mr 6's witness statement is relevant because it exhibits the two 'Administration of Medicines Competency Assessments' undertaken by Miss Gallagher in 2018, whilst an employee at the Home. He submitted that these assessments are relevant because Miss Gallagher would've undertaken them prior to the matters described in the charges particularly those in relation to medication.

Mr Segovia invited the panel to admit Mr 6's witness statement and the two 'Administration of Medicines Competency Assessments'.

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 considered the documents and Mr 6's witness statement and concluded that they are relevant.

The panel was of the view that Mr 6's witness statement introduces two documented records of training, namely the 'Administration of Medicines Competency Assessments'. The panel was of the view that there would be no unfairness to Miss Gallagher in admitting the witness statement of Mr 6 as hearsay evidence because he did not witness any of the events subject of the charges and simply exhibits two relevant training documents.

The panel was satisfied that neither the witness statement nor the two 'Administration of Medicines Competency Assessments' were sole or decisive evidence in this case.

In these circumstances, the panel came to the view that it would be fair and relevant to accept Mr 6's witness statement and the two 'Administration of Medicines Competency Assessments' as hearsay evidence.

Decision and reasons on application to admit Ms 11's witness statement as hearsay evidence

The panel heard an application made by Mr Segovia under Rule 31 to allow the written statement of Ms 11 into evidence.

Mr Segovia reminded the panel that during case conference, Mr Weir required every witness to attend. Mr Segovia submitted that the NMC wants to return to its original position in terms of making a hearsay application for Ms 11.

Mr Segovia submitted that the application is not being made because Ms 11 is not available. He submitted that the evidence of Ms 11 is relevant because she was involved in disciplinary processes relating to Miss Gallagher whilst employed at the Home. He submitted that within Ms 11's statement, she indicated that she has worked as a personnel manager for many years, was involved in Miss Gallagher's disciplinary hearing on 20 August 2019 and provides some evidence of the attitude of Miss Gallagher during the disciplinary hearing.

With regards to fairness, Mr Segovia submitted that Ms 11's witness statement does not speak to any matter that is in dispute pertaining to the charges. He submitted that the witness statement confirms that Ms 11 cannot comment on any deficiencies or clinical matters in relation to Miss Gallagher.

Mr Segovia submitted that the witness statement is of relevance to the panel during its consideration of Miss Gallagher's misconduct.

Mr Segovia invited the panel to admit Ms 11’s witness statement as hearsay evidence.

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 considered the application and concluded that the content of Ms 11’s statement is relevant.

The panel noted that Ms 11’s statement describes Miss Gallagher’s attitude during her time working at the Home and the fact she had supervision with her mentor the week before the alleged incidents on 28 November 2018. It also bore in mind that Miss Gallagher is not present at this hearing and had required the witness to attend. Miss Gallagher was not aware of this application and the panel concluded that Ms 11’s evidence may be material in its consideration of the charges and therefore needed to be tested by her appearing in person. Therefore, in fairness to Miss Gallagher, the panel considered that it would like to hear Ms 11’s views on Miss Gallagher’s response to the allegation pertaining to poor care.

The panel also noted that the NMC have not provided the panel with a good or cogent reason for Ms 11 not to attend the hearing.

In these circumstances, the panel came to the view that while Ms 11’s witness statement is relevant, it would not be fair to accept her witness statement as hearsay evidence. It therefore rejected Mr Sergovia’s application.

[This hearing resumed on 26 June 2024]

Decision and reasons on service of notice of the resuming hearing

The panel was informed at the start of this hearing that Miss Gallagher was not in attendance and that the Notice of the resuming hearing letter had been sent to Miss Gallagher's registered email address by secure email on 24 April 2024. Mr Segovia submitted that the NMC had complied with the Rules in relation to service of notice of resuming hearings.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Gallagher has been served with the Notice of the resuming hearing in accordance with the Rules.

Decision and reasons on facts

As set out in the section entitled *'Decision and reasons on application to admit Miss Gallagher's Case Management Form, Response to the regulatory concerns and the case conference agenda'*, the panel accepted Miss Gallagher's admissions to charges 1a, 1b, 1c, 1d, 4a, 4b(i), 4b(ii), 4c and 4d.

The panel therefore found charges 1a, 1b, 1c, 1d, 4a, 4b(i), 4b(ii), 4c and 4d proved by way of Miss Gallagher's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Segovia and the written responses of Miss Gallagher contained in the RCRF, the CMF and during the local investigations.

The panel did not draw any adverse inference from the non-attendance of Miss Gallagher.

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

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

- Ms 1: Registered Manager at Milton Grange Care Home.
- Ms 2: Band 5 Staff Nurse at Spyne Care Home.
- Ms 3: Deputy Manager at Spyne Care Home.
- Ms 4: Operations Manager employed by Intobeige Care Ltd.
- Mr 5: Company Director at Intobeige Care Ltd.
- Dr 7: General Practitioner at Maryhill GP practice.
- Ms 8: Home Manager at The Grove Care Home.
- Ms 9: Adult Protection Lead at Moray West Community Care.
- Ms 11: Personnel Manager at the Grove Care Home.

- Ms 12: Bank Nurse at the Give Care Home and Weston View Care Home.
- Ms 13: Care Assistant at the Grove Care Home.
- Ms 14: Healthcare Assistant at the Grove Care Home.
- Mr 15: Healthcare Assistant at the Grove Care Home.
- Ms 16: Healthcare Assistant at the Grove Care Home.

The panel also admitted the evidence of Mr 6, the Group HR Manager at the Cairn Group, as hearsay evidence.

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

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

Charge 1e

1) On 28 November 2018, having seen Resident A fall, you failed to:
    e) provide details of the fall to colleagues during handover;

This charge is found proved.

In reaching this decision had regard to all of the evidence before it. It had particular regard to the local Post Fall Assessment Tool document (PFAT), the Home's Falls Policy and Procedure (the Policy) and the evidence of Ms 2. The PFAT is a document in

use at the Home to assist members of staff when dealing with residents who had suffered a fall.

The panel saw Ms 2's NMC witness statement dated 1 October 2019 which stated:

> *'At some point in the afternoon, I cannot remember exactly when, Resident A slipped when attempting to sit on a chair and landed on her bottom. Resident A was an elderly female resident with dementia. This happened in front of myself, Dana, and her carer. I cannot remember who the carer was. I stood behind the chair and witnessed the slip from the back.*
>
> *…*
>
> *I did not see Dana complete any documentation after this. She may have placed the incident in Resident A's daily notes but I cannot be certain.*
>
> *In this situation I believe she should have checked Resident A over for injury, filled out an incident report form, documented in Resident A's daily notes, informed the staff at handover…'*

The panel noted the following in the PFAT:

> *'Observations should be done as soon as possible after the fall, then:*
> - *Every 15 minutes for one hour*
> - *Once half an hour later*
> - *Once one hour later*
> - *Once two hours later*
> - *Every four hours until 24 hours post-fall. Wake the resident up to do the checks. Do not assume the resident is simply asleep.'*

The panel also had regard to the Policy which states:

'5.6 Record Keeping Post Fall The following records must be completed post fall in accordance with record-keeping standards and as contemporaneously as possible:

…

• Update clinical handover records if appropriate.'

The panel heard oral evidence from Ms 2 who considered that Resident A's fall should have been handed over so that the staff taking over from Miss Gallagher could have undertaken the required post fall observations for the 24 hours after the fall.

The panel had sight of Miss Gallagher's written response to this charge in the NMC RCRF. The panel noted that Miss Gallagher did not consider the fall to have been serious.

Having regard to the PFAT and the requirement to carry out observations for 24 hours on any resident suffering a fall, the panel was satisfied that Miss Gallagher had a duty to ensure that information about Resident A's fall and the need to carry out observations was passed to colleagues through a handover at the end of her shift. The panel found the evidence of Ms 2 to be consistent, credible and reliable. Whilst the panel did not have any direct evidence from a member of staff who was present at the first handover after the fall, given Miss Gallagher's admissions to charges 1a-1d and her response to this charge that *'…she appeared to be fine after her slip…'*, the panel considered that as she had not followed procedure or considered that the fall was serious, it was more likely than not that she did not provide details of the fall to colleagues during handover. The panel therefore found this charge proved.

Charge 2a

2) On 28 November 2018, having been informed that Resident B had a fall, you failed to;

a) follow the correct procedure in relation to the moving and handling of Resident B;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the PFAT, the Policy and the evidence of Ms 2.

The panel noted the following in the Policy:

> *'5.7 Falls and the Ambulance Service The service does not operate a 'No Lift Policy'. However, there is no expectation that staff will ever physically lift a Service User, and manual handling equipment will always be used to safely assist a Service User. Risk assessments will be undertaken for all manual handling and incidents of falls. Where a Service User is injured or medically unwell, the emergency services will be contacted. If the Service User has fallen, has capacity and is not injured but cannot get up, the service will identify mechanisms to safely assist the Service User from the floor.'*

The panel had regard to the witness statement of Ms 2 in which she said:

> *'Later in the afternoon, a carer alerted the buzzer for myself and Dana after finding a resident who had fallen in his room. This was Resident B. Resident B who was an elderly man with Parkinson's. We found him lying on the floor between the chair and bathroom door.'*

Having regard to the Policy and the evidence of Ms 2 that Resident B was lying on the floor after a fall, the panel found that Miss Gallagher was under a duty to both ensure that *'mechanisms to safely assist'* were used to safely lift him from the floor and to carry out a risk assessment for manual handling.

The panel went on to consider the following in Ms 2's witness statement to the NMC:

‘When we went in Dana asked him if he was sore and he said no. Dana then asked me to help her lift Resident B from the floor and we manually lifted him. I cannot remember exactly how we lifted him but no hoists were used. I was not happy to do this but as it was my 1st day I did assist.’

The panel also heard oral evidence from Ms 2. The panel found the evidence of Ms 2 to be consistent, credible and reliable in respect of this charge. Having found that Miss Gallagher was under a duty to undertake a risk assessment and use a mechanism to safely assist Resident B from the floor and she did not, the panel found this charge proved.

Charge 2b, c and d

2) On 28 November 2018, having been informed that Resident B had a fall, you failed to;
   b) complete any physical checks and/or observations for Resident B;
   c) complete an incident reporting form;
   d) update Resident B’s care records;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the PFAT and the evidence of Ms 2.

As set out in charge 1, the panel found that Miss Gallagher was under a duty to ensure that observations were carried out on Resident B for a period of 24 hours after the fall.

The panel also had regard to the Policy which stated:

‘5.6 Record Keeping Post Fall

The following records must be completed post fall in accordance with record-keeping standards and as contemporaneously as possible:

• Accident and incident record - refer to the Accident and Incident Reporting Policy and Procedure.
• Holistic review of the Falls Action Plan for the affected Service User; the review must look at other risk factors and assessments to identify and assess possible reasons for falls.
• The post-fall incident document.
• Update the Service User's daily notes.
• Review all risk assessments.
• Complete post checklist SD 22.
• Update clinical handover records if appropriate • Where necessary, RIDDOR and regulatory reports.'

The panel determined that Miss Gallagher was under a duty to complete an incident reporting form and update Resident B's clinical records after his fall.

The panel had sight of the NMC witness statement of Ms 2 in which she stated:

> *'I also did not witness Dana fill in any documentation, conduct any checks or any further monitoring. No observations were checked either i.e. pulse, BP etc.*
>
> *Similarly to the first incident, Dana should have checked him over, filled out an incident reporting form, informed the later staff at handover and used a hoist. She also should have checked his observations and where necessary informed next of kin/a relative.*
>
> *Both these incidents caused me concern because after 12 years of being a nurse I am aware of how important record keeping and medical administration is. It is important to log everything no matter how minor.'*

The panel also had sight of Ms 1's witness statement to the NMC dated 22 October 2019 in which she stated:

> *'On arrival I reviewed the evidence that had been gathered concerning 28th November. The evidence included paperwork for Resident A and Resident B who had allegedly fallen. It showed no body maps were carried out at the time, no incident forms were completed and no family members were contacted.'*

The panel found the evidence of Ms 2 to be consistent, credible and reliable in respect of this charge and sub-charges and it was supported by the evidence of Ms 1. The panel also noted the comments made by Miss Gallagher in the RTRF where, with reference to the fall of the female resident (concluded to be Resident A by the panel) she said *'… I fully understand that it was my responsibility to fill out all of the paperwork and can only say it was a lack of judgement on my part that day… both of the residents in question were able to weight bare and needed only minimal assistance as it was not full falls that they had had…'* The panel found that Miss Gallagher minimised the seriousness of Resident B's fall.

The panel was of the view that it was more likely than not that following Resident B's fall, Miss Gallagher failed in her duty to complete any physical checks and observations, complete an incident reporting form and update Resident B's care records in the same way she had admitted to failing to do so for Resident A. Accordingly, the panel found this charge and sub-charges proved.

Charge 2e

2) On 28 November 2018, having been informed that Resident B had a fall, you failed to;
    e) provide details of the fall to colleagues during handover;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the PFAT and the evidence of Ms 2.

The panel noted that Resident B's fall occurred on the same shift as Resident A's fall and also involved Ms 2. The panel was of the view that details of Resident B's fall

should have been handed over by Miss Gallagher at the same time as details of Resident A's fall. Given the similar set out circumstances and timeframe in which these falls occurred, the panel adopted the same rationale from 1e in that Miss Gallagher minimised the seriousness of the fall and found this charge proved on that basis. The panel therefore found this charge proved.

Charge 3)a)

3) a) On 28 November 2018, told Resident C to:
  i) *"jog on"*
  ii) *"go away*"
  iii) "*bugger off"* or words to that effect;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 2 and Miss Galagher's written responses.

In her NMC written statement, Ms 2 stated:

> *'Approximately 10 hours in the shift, Dana, a carer and I were sat in the dining room having a coffee. I cannot remember who the carer was. Resident C kept coming over and grabbing us. She repeatedly said that she was "wet". This did not annoy me as it was my first day however I could see how it would eventually get draining.*
>
> *Resident C kept interrupting Dana mid conversation to grab her. At first Dana told Resident C to "jog on" and "go away. Dana then got increasingly annoyed at Resident C interrupting her. It got to the point where Dana turned round and said loudly "bugger off your doing my head in".'*

The panel also heard oral evidence from Ms 2 who had a clear recollection of this incident. She told the panel that she would not have spoken to any of her residents like that and in that tone of voice.

The panel had regard to Miss Gallagher’s written response in which she stated the following:

> *‘I was well used to said resident and had never become angry or shouted at her the whole time I worked in Spynie.’*

Whilst the panel noted Miss Gallagher’s denial of this charge, this written response has not been able to be tested through oral evidence. Nevertheless, the panel found the evidence of Ms 2 to be consistent, credible and reliable in respect of this charge. The panel found that there was no reason for Ms 2 to fabricate her evidence. The panel found that it was more likely than not that on 28 November 2018, told Resident C to *“jog on”, “go away*” and to “*bugger off”* or words to that effect. The panel therefore found this charge proved.

Charge 3)b)

> 3)
>
> b)pushed and/or shoved Resident C;

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel had sight of Ms 2’s local statement dated 6 December 2028 and noted the following:

> *‘At one point she [Miss Gallagher] placed her hands on Resident C’s shoulders and walked her away.’*

Having regard to Ms 2’s statement and confirmed in her oral evidence, the panel was of the view that Miss Gallagher’s actions could not have amounted to a push or a shove. The panel therefore found this charge not proved.

Charge 5a

5) Between 27 July 2019 and 29 July 2019, you failed to:
   a) undertake, regularly or at all, observations for Resident F and/or make a record of observations taken;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 13, Ms 14 and Mr 15.

The panel saw Ms 13’s witness statement to the NMC dated 6 December 2019 in which she stated:

> *‘During Saturday morning, I cannot remember what time, another carer [Ms 14] and I were assisting Resident F with personal care. [Ms 14] and I noted that the resident did not seen quite herself. She was not acting in the normal way she would or responding to us verbally as usual.*
>
> *We used the standaid to transfer Resident F to a wheelchair. At this point we became more concerned that Resident F may be unwell. She was slumped to the right side of the chair and was not communicating as well as normal.*
>
> *We called the nurse on duty, Dana, to the room and explained our concerns.*
>
> *Dana did not perform any checks on Resident F. She did speak to Resident F, I cannot remember exactly what was said, and Resident F communicated verbally in return to Dana and said that she wanted to go to the dining room for lunch.*

Dana instructed us to take Resident F for lunch and did not say anything else about Resident F's condition.

I went to see Dana and informed her that Resident F did not seem well and was now back in her bed. I cannot remember Dana's reaction to this. I do remember that frequently throughout the weekend I went to see Dana to give her updates like this about Resident F's condition and she never seemed that concerned…

…At this point she began to have an episode of significant spasms/jerking affecting all her limbs. At first I was not sure what was happening but then we realised it was serious.

We pressed the emergency buzzer and the nurse responded. When she [Miss Gallagher] arrived we explained what had happened and this time she did complete observations on Resident F and we completed the personal care.'

The panel also had regard to the witness statement of Ms 14 in which she stated:

'I was working a shift on the morning of Saturday 27 July 2019. Another Health Care Assistant, [Ms 13], and I were assisting Resident F with her personal care. I remember during this time we became concerned about Resident F's condition. I can't really remember why we were concerned except that she looked quite grey in the face and did not look herself.

We decided we should get the Staff Nurse to come check Resident F over. One of us, I'm not sure who, went to get Dana to check Resident F over. From what I can remember Dana did not check Resident F over, she did not write anything down and she did not carry out any observations. She just said she would check on Resident F later but she did not seem concerned at all. I can't remember ever seeing Dana go check on Resident F again during the day. I can remember that I thought this was odd as Resident F seemed genuinely ill.'

The panel also had regard to Mr 15's witness statement to the NMC dated 17 January 2023 in which he stated:

> *'She had a quick check in Resident F's eyes and said it would be best to put her back in bed. I don't remember seeing her carry out any observations or make any recordings.*
>
> *We have to do hourly checks so I continued to see and I was concerned about her condition. I did not see Dana go back to check on a at any point. I thought that Resident F was quite clearly ill and that Dana as the staff nurse should have been concerned.'*

The panel had regard to Dr 7's NMC witness statement dated 22 January 2020 in which she stated:

> *'When I checked on Resident F she was unconscious- her GCS was 10/15. (Glasgow Coma Scale) I looked at three parameters- her eyes, her voice and her movement. Resident F's eyes measured at 2. This means they open up to pain. Resident F's voice measured at 3. Meaning inappropriate words, her answers were random words unrelated to questions. Resident F's movements measured at 5. Meaning localised pain- if painful pressure is applied she would reach towards the pain. This signified that Resident F was very ill. She was slumped to the right side of the bed, had vomit in her mouth and on the pillow. She was generally very unwell. Normally when I see Resident F she was very well kept, sitting up, smiling and chatted away.*
>
> *I asked [Ms 12] if any observations had been done on Resident F during the previous few days. [Ms 12] had a look at Resident F's records and said no, nobody had checked Resident F's pulse or undertaken observations during the days before.'*

Having been informed of Resident F's condition, the panel was of the view that Miss Gallagher was under a duty to undertake regular observations on Resident F and make

a record of these. The panel found the evidence in respect of this charge to be consistent, credible and reliable across the witnesses' oral and documentary evidence and with that of Dr 7. It found that it was more likely than not that Miss Gallagher did not undertake regular observations and make a record of these. Accordingly, the panel found this charge proved.

Charge 5b

5) Between 27 July 2019 and 29 July 2019, you failed to:
   b) escalate Resident F's deteriorating condition by failing to contact an out of hours GP and/or obtain medical assistance within a timely manner;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Dr 7, Ms 13, Ms 14 ad Mr 15.

The panel had regard to the evidence of Dr 7, Ms 13, Ms 14 and Mr 15 as set out in charge 5a above to establish the background of this charge.

The panel had regard to Dr 7's witness statement in which she stated:

> *'The Grove has 24 hour access to GMEDS, in no way was it acceptable to wait until I got in on Tuesday to check on Resident F. Nobody had requested a medical practitioner review prior to my visit and I was appalled at the condition I found Resident F in.'*

The panel heard evidence that Miss Gallagher was the only nurse on duty between 27 and 29 July 2019. The panel was of the view that as the only nurse on duty, having been made aware of Resident F's condition, Miss Gallagher was under a duty to recognise and escalate Resident F's deteriorating condition by contacting an out of hours GP and/or obtain medical assistance using the GMEDS out of hours service in a timely manner. The panel found that it was more likely than not that Miss Gallagher did

not escalate Resident F’s deteriorating condition. Accordingly, the panel found this charge proved.

Charge 5c

> 5) Between 27 July 2019 and 29 July 2019, you failed to:
>   a) take action following an abnormal blood pressure result;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 13, Ms 14 and Ms 16.

The panel had regard to the witness statement of Ms 13 in which she stated:

> *‘I remember Dana said that the blood pressure taken, using the blood pressure cuff, during her observations was either really high or really low. I cannot remember which one but I know the blood pressure was not at the level it should be. I did not see her make any note about the blood pressure observations.’*

The panel also had regard to Ms 16’s witness statement to the NMC dated 9 January 2023 in which she stated:

> *‘Later on during the same shift [Ms 13] and I were again with doing personal care when her body started jerking and moving. Again I can’t remember the exact details but one of us must have gone to get Dana or pressed the buzzer. When we told Dana what happened I don’t think that she was too concerned however she started doing a full set of observations on Resident F. I remember that the numbers on the blood cuff machine were quite high but Dana just kept saying that the machine wasn’t working properly. She did not seem too concerned or bothered about her observations. I did not see her record any of the observations she had taken. As the numbers on blood cuff machine had been quite high [Ms*

13] and I were concerned. We questioned Dana about this but she just kept saying the blood cuff machine wasn't working then left the room.'

The panel also heard evidence from Ms 14 who said that she saw Miss Gallagher testing the blood pressure machine on herself and she confirmed that it was working.

The panel was satisfied that as the only nurse on duty, Miss Gallagher had a duty to take action following an abnormal blood pressure reading. The panel found that it was more likely than not that she did not and therefore found this charge proved.

Charge 5d

5) Between 27 July 2019 and 29 July 2019, you failed to:
   d) take appropriate action when told that Resident F was "*lifeless*" or words to that effect;

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 13.

The panel noted the following in Ms 13's written statement:

'When transferring her back to bed in the standaid Resident F suddenly became floppy and unresponsive. [Mr 15] and I immediately called the nurse to attend. Dana instructed us to return the resident back to bed.'

The panel found no evidence that Miss Gallagher was told that Resident F was *"lifeless"* or words to that effect. The panel considered that the description of Resident F being *"floppy"* and *"unresponsive"* was very different to her being described as *"lifeless"*. The panel therefore found that the NMC had not discharged its evidential burden and it found this charge not proved.

Charge 5e

5) Between 27 July 2019 and 29 July 2019, you failed to:
e) provide an adequate handover to colleagues;

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 7, Ms 13, Ms 14 and Mr 15.

The panel had regard to all of the evidence so far in relation to this charge which provided a background to the incident relating to Resident F. Given the concerns raised to Miss Gallagher about Resident F, the panel was of the view that as the nurse on duty, Miss Gallagher should have been aware of Resident F's condition and provided an adequate handover to her colleagues in order to provide the correct level of care.

The panel had regard to the witness statement of Dr 7 in which she stated:

> *'I asked [Ms 12] if any observations had been done on Resident F during the previous few days. [Ms 12 had a look at Resident F's records and said no, nobody had checked Resident F's pulse or undertaken observations during the days before.*
>
> *I do not think Resident F's symptoms had been handed over from the evening shift to the daytime shift. Or, if it had been passed over, it had not been documented.'*

Having found that Miss Gallagher failed to undertake observations and document these, escalate Resident F's deteriorating condition and take action following an abnormal blood pressure result the panel determined that it was more likely than not that she did not provide an adequate handover to colleagues. The panel considered that Miss Gallagher's actions and omissions were indicative of her not appreciating the

seriousness of Resident F's deteriorating condition, and considered it unlikely that she would have handed this over. The panel therefore found this charge proved.

Charge 6

6) Between 27 July 2019 and 29 July 2019, you failed to:
   a) undertaking regularly or at all, observations for Resident G and/or make a record of observations taken;
   b) escalate Resident G's deteriorating condition by failing to contact an out of hours GP and/or obtain medical assistance in a timely manner;
   c) provide adequate notes to the doctor by saying Resident G was "chesty";
   d) provide an adequate handover to colleagues;

The panel found this charge not proved in its entirety.

After reviewing all of the evidence before it, the panel decided to consider all of the sub-charges in charge 6 together.

The panel noted that at the Grove, regular observations would only be carried out if a patient's condition was deteriorating. The panel noted that Resident G had been admitted to the Grove for palliative care and there was no evidence of them deteriorating beyond what was expected for a patient receiving end of life care whilst Miss Gallagher was on duty. None of the carers on duty that weekend could recall a deterioration in Resident G's condition and Dr 7 had given oral evidence that the resident's condition could have deteriorated rapidly. In the absence of evidence of Resident G's condition deteriorating whilst Miss Gallagher was on duty, the panel found that she had not been under a duty to undertake observations or escalate to an out of hours GP or seek medical assistance.

The only evidence the panel heard regarding Resident G's deteriorating condition was from Dr 7 who stated that the family of Resident G requested a GP visit over the weekend, but there was no evidence provided to the panel as to who the family spoke with to make this request or the reason why.

The panel had no evidence to suggest that the note provided to Dr 7 stating that Resident G was *“chesty”* was insufficient or inappropriate in the circumstances. Dr 7 gave oral evidence that simply using the word *“chesty”* may be a sufficient note to describe Resident G’s condition depending upon the circumstances. Having found that there was no evidence of Resident G’s condition deteriorating whilst Miss Gallagher was on duty, the panel found that there was no reason for this to be handed over to colleagues.

Having regard to all of the above, the panel determined that the NMC had failed to discharge its evidential burden and found this charge not proved in its entirety.

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

The panel, in reaching its decision, has recognised the need 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, Miss Gallagher's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Segovia drew the panels attention 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.'*

Mr Segovia invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Segovia identified the specific, relevant standards where in his submission, Miss Gallagher's actions and omissions amounted to misconduct. He submitted that the

charges found proved relate to a range of issues including a failure to manage falls correctly, very poor behaviour which included a verbal assault on a vulnerable resident, medication errors, record keeping errors and omissions and a failure to escalate a deteriorating resident.

Mr Segovia submitted that Miss Gallagher's failures in charges 1 and 2 are serious. He submitted that Miss Gallagher's failure to act in accordance with local policy and procedure in properly managing the falls of two vulnerable residents, resulted in her placing them at a risk of harm. Mr Segovia submitted that Miss Gallagher's actions in respect of these charges fell below the standard required of her.

In respect of charge 3, Mr Segovia submitted that Mrs Gallagher's verbal assault on a resident was very serious and falls well below the standards expected.

Mr Segovia submitted that medication administration in respect of charge 4 is a primary and basic aspect of nursing care. He submitted that giving the incorrect medication to a resident was very serious and could have resulted in serious harm. He also submitted that Miss Gallagher's failure to record the error was very serious.

In respect of charge 5, Mr Segovia submitted that Miss Gallagher's failure to seek assistance in relation to a resident's deteriorating condition was very serious.

Mr Segovia submitted that taking the charges and sub-charges found proved individually, each is sufficient to amount to serious misconduct. This also applied cumulatively.

Submissions on impairment

Mr Segovia 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. He made reference to the case of

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

Mr Segovia submitted that the concerns about Miss Gallagher were wide ranging and occurred in two different places of work. He submitted that her inaction and failure to follow the correct procedure for dealing with residents who have had a fall placed both Resident A and Resident B at a risk of harm. In mixing up medications, Mr Segovia submitted that receiving medication that was not intended for them placed Resident E at a risk of harm and there was also a risk to Resident D who did not receive their required medication. He submitted that by not escalating Resident F's deteriorating condition or providing adequate care at the right time posed a risk of causing significant harm.

Mr Segovia submitted that Miss Gallagher's misconduct breached fundamental tenets of the profession and brought the profession into disrepute as a consequence of her poor practice. He referred the panel to the witness statements of Ms 8 and Ms 11 and submitted that they both observed Miss Gallagher to lack insight and empathy when discussing the concerns. Mr Segovia submitted that Miss Gallagher appears to lack understanding of the seriousness of her actions and omissions which raises attitudinal concerns.

Mr Segovia informed the panel that Miss Gallagher has been subject to an interim suspension order since 27 September 2019 and has therefore not has the opportunity to demonstrate safe practice as a registered nurse. He submitted that whilst she has not been able to work as a registered nurse, she has not provided any other evidence of insight or remediation. Mr Segovia submitted that admissions to some of the charges are, in themselves, not sufficient to establish insight. He submitted that in the absence of any evidence of insight or remediation, there is a high risk of repetition of her misconduct and invited the panel to find Miss Gallagher's fitness to practice impaired on public protection and public interest grounds.

The panel accepted the advice of the legal assessor.

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 Miss Gallagher's actions and omissions fell significantly short of the standards expected of a registered nurse, and that her actions and omissions amounted to a breach of the Code. Specifically:

> '***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> > ***1.1*** *treat people with kindness, respect and compassion*
> > ***1.2*** *make sure you deliver the fundamentals of care effectively*
> > ***1.4*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
>
> > ***2.6*** *recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***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*
>
> ***7 Communicate clearly***
> *To achieve this, you must:*

7.2 *take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs*

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*

__13.3__ ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

__18.2__ keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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__ …, 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
__20.5__ treat people in a way that does not take advantage of their vulnerability or cause them upset or

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, having regard to the number of breaches of the Code and the seriousness of each, the panel was of the view that the charges and sub-charges found proved, individually and collectively, amount to misconduct.

In respect of charges 1 and 2, the panel considered that Miss Gallagher's actions in lifting both residents without following policy and procedure and failing to undertake checks or place them under 24 hours observations, placed them at a real risk of significant harm and was serious.

The panel found that Miss Gallagher's aggressive verbal treatment of Resident C, a vulnerable resident, fell seriously short of how a nurse should speak to residents and the standards expected, and showed a lack of respect for Resident C and an attitudinal issue on the part of Miss Gallagher.

In respect of charge 4, the panel accepted that medication errors can occasionally happen, however, it was of the view that Miss Gallagher's failure to follow procedure and take action to put the error right was serious and placed residents at a risk of harm. The panel found that having realised that she had given Resident E the medication that was prescribed for Resident D, including a prescribed controlled drug, and not subsequently giving Resident D their prescribed medication was a serious and fundamental error in basic nursing practice.

The panel found that Miss Gallagher's actions and omissions set out in charge 5 were very serious. Despite having been told that Resident F's condition was deteriorating on a number of occasions by four different carers and a friend of the resident, Miss Gallagher failed to provide the appropriate care and to escalate appropriately. The panel considered that Miss Gallagher's inaction meant that Resident F suffered unnecessarily by not receiving the appropriate and timely care. The panel also found that Miss Gallagher's colleagues involved in the care of Resident F were placed at a risk of emotional harm, they raised concerns and these concerns were not taken seriously and dismissed.

The panel found that the concerns about Miss Gallagher's practice and the facts found proved in this case are wide ranging, serious and occurred in two different homes and some arose during a probationary period. Taking all of the charges together, the panel found that there is evidence of Miss Gallagher having a lax and blase attitude towards resident care and a blatant disregard for local policy and procedure which raises significant attitudinal concerns. The panel was of the view that some of Miss Gallagher's actions and omissions would be considered as deplorable by both fellow members of the profession and fully informed members of the public as they fell seriously short of the conduct and standards expected of a nurse and amount to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Gallagher'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. 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 found limbs a, b and c are engaged in this case.

The panel found that Miss Gallagher placed a number of vulnerable residents at unwarranted risk of harm and caused actual harm to Resident F.

In not following policy and procedure by lifting Residents A and B, Miss Gallagher placed both residents at a risk of harm. She could have caused further injury and in not completing observations and ensuring observations were carried out after the falls, there was a risk that had the residents sustained an injury this would not have been identified. Furthermore, in manually lifting the residents without the assistance of appropriate mechanisms to safely assist, Miss Gallagher placed herself and colleagues at a risk of harm.

The panel determined that Miss Gallagher's treatment of Resident C risked causing emotional harm to a vulnerable resident. The panel also determined that the medication errors and subsequent failures of Miss Gallagher placed Resident E at a risk of serious harm through receiving medication not intended for them and also placed Resident D at a risk of serious harm as they did not receive their prescribed medication.

In respect of Resident F, the panel determined that there was a clear risk of harm by Miss Gallagher not responding appropriately to concerns about her deteriorating condition. The panel considered that during the period that she was deteriorating, Resident F was deprived of receiving care to reduce her suffering and was therefore caused actual harm. Having heard evidence from four carers, the panel considered that Miss Gallagher's lack of action after concerns were raised, placed her colleagues at a risk of emotional harm as they could see Resident F deteriorating and nothing was done to help her.

The panel considered that Miss Gallagher's misconduct brought the profession into disrepute and breached fundamental tenets of the profession. A nurse is expected prioritise people, practise effectively, preserve safety and promote professionalism and trust. The panel considered that Miss Gallagher had a duty, as the nurse in charge, to ensure that the residents received proper care and that staff were well supported. The panel determined that Miss Gallagher's flagrant disregard for resident safety and adherence to local policy and procedure brought the profession into disrepute and breached fundamental tenets of the profession.

The panel considered that most of the charges are clinical in nature and therefore, individually, would technically be capable of remediation. However, taking all of the charges together, the panel was of the view that the issues are compounded and indicative of a deep seated attitudinal problem. The panel noted that an attitudinal issue, although not impossible, is inherently difficult to remediate.

In considering insight, the panel had regard to all of Miss Gallagher's responses in the documentation before it. The panel had sight of a reflective statement from Miss Gallagher and found that she sought to minimise her actions by blaming external factors such as staffing levels and she lacked any meaningful insight into her failings. The panel also had regard to Miss Gallagher's responses during the local investigations and noted that she only appeared to accept that she could have done things differently when prompted and she was not forthcoming in identifying the shortfalls in her practice. The panel had no evidence of any steps that Miss Gallagher has taken to strengthen her practice.

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

In the absence of evidence of insight or remediation from Miss Gallagher, the panel determined that there is a high risk of the misconduct being repeated and consequent risk of harm to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel was of the view that a fully informed member of the public would be shocked to hear about the wide ranging and fundamental failures in this case. The panel considered that a member of the public would expect a finding of impairment in a case where a nurse persistently acted outside of local policy and procedure, placing residents and colleagues at a real risk of serious harm on multiple occasions at two different nursing homes. The panel determined that public confidence in the profession would be

undermined if a finding of impairment were not made and therefore found Miss Gallagher’s fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Gallagher’s fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

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

Submissions on sanction

Mr Segovia informed the panel that in the Notice of Hearing, dated 23 November 2023, the NMC advised Miss Gallagher that it would seek the imposition of a striking off order if it was found her fitness to practise is currently impaired.

Mr Segovia referred the panel to the relevant guidance in particular, *'How we determine seriousness'* (Reference: FTP-3 Last Updated: 27/02/2024). Mr Segovia submitted that the facts found proved are very serious, he drew the panel's attention to the section entitled *'What we mean by seriousness'* in the NMC guidance set out above (FTP-3), in particular, the following:

> *'Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*
>
> - *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care'*

Mr Segovia reminded the panel of its findings at the fitness to practise stage, namely, that Miss Gallagher has shown no insight into her misconduct or taken steps to strengthen her practice and, as a consequence, there is high a risk of repetition and a real risk of harm. Mr Segovia submitted that given the seriousness of this case and the attitudinal concerns highlighted by the panel, the most appropriate and proportionate sanction is that of a striking off order.

Decision and reasons on sanction

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.

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

The panel took into account the following aggravating features:

- A pattern of misconduct that occurred over a significant period of time and impacted on six vulnerable residents in two different homes.
- Miss Gallagher's misconduct was wide ranging and related to basic and fundamental nursing skills.
- Some of the misconduct occurred while Miss Gallagher was within a probationary period.
- Five vulnerable residents were placed at risk of suffering harm and one vulnerable resident was caused actual harm as a result of Miss Gallagher's misconduct.
- Miss Gallagher lacks insight into her failings and, in her reflective statement, she sought to deflect blame rather than taking responsibility for her actions.

The panel determined that there are no mitigating features in this case. The panel noted that in her reflective statement, Miss Gallagher put forward staffing issues as a mitigating feature. Whilst the panel accepted that staffing issues can lead to additional pressure on nurses, the panel was of the view that, as the only nurse on duty,

particularly in relation to Resident F, Miss Gallagher had a duty to ensure that care to a deteriorating resident was prioritised. The panel also noted that Miss Gallagher did raise her drug administration error when it occurred, however, as she acted in a way that placed Residents D and E at a risk of harm, any positives that could have been taken from her initial transparency were outweighed by her subsequent poor practice in failing to rectify her error and also in recording it properly.

Before considering what sanction, if any, to impose, the panel first established the seriousness of the misconduct. The panel had regard to the NMC guidance on *'How we determine seriousness'* (Reference: FTP-3 Last Updated: 27/02/2024) and the factors set out in the section entitled *'What we mean by seriousness'.* The panel found that the following factor was the most pertinent in this case:

> *'Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*
>
> - *conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care'*

Having found that Miss Gallager had a lax and blasé attitude towards the level of care she provided, the panel determined that this was dangerous and placed vulnerable residents in her care at a risk of serious harm. The panel therefore determined that the misconduct in this case is serious.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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 Miss Gallagher'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 Miss Gallagher'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 a conditions of practice order would be appropriate. The panel found that as the misconduct was so wide-ranging, relating to basic and fundamental nursing skills, a conditions of practice order would not adequately manage the risks and protect the public. Furthermore, whilst the clinical issues identified in this case are potentially capable of being addressed through retraining, given the underlying and deep-seated attitudinal concerns identified, the panel determined that workable conditions could not be formulated to address this. Miss Gallagher has not recently engaged with the NMC nor provided any evidence of insight, strengthened practice or any evidence of a willingness to address the shortcomings in her practice. Having regard to all of the above, the panel determined that a conditions of practice order would not protect the public or meet the public interest considerations of this case.

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 found that the misconduct in this case did not arise out of an isolated incident, it persisted over a significant period of time and impacted on multiple

vulnerable residents, and had the potential to affect a number of colleagues in two different homes. The panel also found that although some of the concerns appeared clinical in nature, they were all underpinned by Miss Gallagher's deep-seated attitudinal concerns evidenced in her repeated and persistent disregard for resident safety and care and local policy and procedure.

At the impairment stage, the panel determined that as a result of Miss Gallagher's lack of insight and lack of any evidence of strengthened practice, she was highly likely to repeat the misconduct. Having regard to all of the above, the panel determined that whilst temporary removal from the NMC Register would protect the public in the short term, but in the longer term it would not. Furthermore, given the seriousness and attitudinal nature of the misconduct, the panel determined that a suspension order would not satisfy the public interest in this case or maintain and uphold proper professional standards. The panel therefore concluded that a suspension order is not appropriate in these circumstances.

In considering a striking-off order, the panel had regard to the following factors set out in the SG:

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

The panel considered that the misconduct identified raises fundamental questions about Miss Gallagher's professionalism. She had a duty to preserve the safety and prioritise the needs of the vulnerable residents in her care and she failed in this duty. The panel found that her failure was not as a consequence of genuine errors or a lack of competence, it arose out of a flagrant disregard for local policy and procedure and through a lax and blasé approach to resident care. The panel found that the deep-seated attitudinal concerns and the misconduct identified in this case are significant and

serious departures from the standards expected of a registered nurse and as such, are fundamentally incompatible with Miss Gallagher remaining on the NMC Register.

Balancing all of these factors and after taking into account all the evidence before it during this case, and the seriousness of the misconduct, the panel determined that the only appropriate and proportionate sanction that will adequately protect the public is that of a striking-off order.

Furthermore, the panel determined that Miss Gallagher's actions in bringing the profession into disrepute by adversely affecting the public view of how registered nurses conduct themselves, were such that public confidence in the profession would be undermined if Miss Gallagher was not removed from the NMC Register.

The panel also found that public confidence in the NMC as a regulator would be undermined if a striking-order was not imposed in these circumstances. The panel considered that a striking-off order was necessary to maintain public confidence in the profession, and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

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 Miss Gallagher's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Segovia who invited the panel to impose an interim suspension order for a period of 18 months to cover any appeal period. He submitted that an interim suspension order is necessary on public protection and public interest grounds for the reasons as set out in the panel's reasons for finding current impairment and imposing a striking off order.

The panel accepted the advice of the legal assessor.

Decision and reasons on 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. Having already determined that a striking off order is necessary to protect the public and to satisfy the public interest in this case, to not impose an interim suspension order to cover the appeal period would be inconsistent with its earlier findings. The panel therefore imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to Miss Gallagher in writing.

That concludes this determination.