Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 8 – Wednesday, 31 July 2024

Virtual Hearing

Name of Registrant:	**Muhammad Iqbal Gurib**
NMC PIN	91E0138E
Part(s) of the register:	Registered Nurse - Mental Health (4 July 1994)
Relevant Location:	Barnet
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, lay member) Laura Wallbank (Registrant member) Alison Thomson (Registrant member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Anna Leathem, Case Presenter
Mr Gurib:	Present and unrepresented
No case to answer:	Charges 3a, 3b, 3c
Facts proved by admission:	Charge 1a
Facts proved:	Charges 1b, 1c, 1d, 1e, 1f, 2, 4, 5
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension order – 6 months
Interim order:	Interim suspension order – 18 months

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Leathem, on behalf of the NMC, to amend the wording of charges 1d, 2 and 3 to correct some grammatical errors.

Ms Leathem submitted that for charge 1d, there should be inclusion of the word 'be'. In charge 2, she submitted that there is an unnecessary inclusion of the word 'to' and that it should be removed. For charge 3 she submitted to amend the charge to make the dates all uniform.

Ms Leathem submitted that the amendments do not change the substance of the allegations and it would be fair and in the interest of justice for clarity, to make those amendments. She submitted that they do not cause any injustice

Proposed amendment charge 1d

> d) Allowed Resident A, who was supposed to **be** shielding, to undertake errands on behalf of Aarandale Manor;

Proposed amendment charge 2

> 2) On 30 March 2020, did not ~~to~~ complete a safeguarding allegation and/or a CQC notification in relation to Resident H.

Proposed amendment charge 3

> 3) On or around ~~0~~1 June 2020, did not address a grievance made to you by:

You indicated that you did not oppose the proposed amendments.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to correct typographical errors and ensure clarity.

Details of charge as amended

That you, a registered nurse:

1) Between 18 March 2020 and 12 June 2020:

a) Allowed one or more non-essential visitor(s) into Aarandale Manor;

b) Did not ensure that Personal Protective Equipment protocols were followed by visitors to Aarandale Manor;

c) Did not adequately complete Covid-19 risk assessments;

d) Allowed Resident A, who was supposed to be shielding, to undertake errands on behalf of Aarandale Manor;

e) Allowed Resident A to carry out Covid-19 risk assessments;

f) Allowed Resident B to leave Aarandale Manor during the day and return at night;

2) On 30 March 2020, did not complete a safeguarding allegation and/or a CQC notification in relation to Resident H.

3) On or around 1 June 2020, did not address a grievance made to you by:

a) Colleague D;

b) Colleague E;

c) Colleague F;

4) Between 30 June 2020 and 1 November 2020, when asked about a grievance raised by Colleague A against Colleague B, provided false information;

5) Your conduct as set out in Charge 4 above was dishonest in that you sought to mislead your employer.

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

Background

The charges in this case relate to your employment at Aarandale Manor which is owned by Abbey Healthcare. You were the Registered Manager of the Home from November 2019 until July 2020.

It is alleged that you put residents, staff and visitors at risk by failing to follow Government and company policies with regard to Covid-19 in that you allowed non-essential visits from relatives, failed to follow Personal Protective Equipment (PPE) protocols – visitors did not wear PPE – and failed to adequately complete risk assessments.

The Home's 'Coronavirus Assessment File' was reviewed which identified eight assessments with a number of problems in the completion of the risk assessments, including the failure to record temperatures of visitors to the Home.

It is alleged that Resident A had been to the doctor's surgery either to drop off resident samples or to collect resident medication. Resident A disclosed during a formal meeting that you had asked her to help out with running errands. This included going to various shops to get more plastic cups. It is also alleged that you disclosed during the local investigation that you allowed Resident A to carry out Covid-19 risk assessments.

It is alleged that Resident B would leave the Home during the day and return at night. Whilst he had capacity, there was concern about him leaving due to him suffering from oedema (a build-up of fluid) in his legs requiring regular dressings with the consequential risk of infection to him and given the national lockdown. Furthermore, on one occasion when Resident B had not returned home and he was found asleep in his car outside the Home with the engine still running. Resident B's care plan was checked and no risk assessment had been carried out to support the resident leaving the building although there was a risk assessment about him leaving unnoticed. There was no risk assessment regarding infection control given he was coming in and out of the Home.

On 30 March 2020, Colleague B received an e-mail from a carer stating that she had witnessed two carers abusing Resident B on 20 March 2020. She says she asked you to complete a safeguarding allegation and a CQC notification regarding this, however you sent back blank forms rather than the completed forms.

Witness 4 said that during her investigation she had a meeting with you whereby they discussed a previous grievance raised by Colleague A against Colleague B. This grievance was not upheld due to you not supporting what Colleague A had said about Colleague B. However, in the meeting on 30 June 2020, Witness 4 alleges that you described an incident that you observed which was in line with Colleague A's grievance.

Witness 4 stated that she queried your two different accounts and said that you said you had not been truthful as you did not want to lose your job.

Decision and reasons on application to admit written statements of Witness 5 and Witness 6

The panel considered an application made by Ms Leathem under Rule 31 to allow the written statement of Witness 5 and Witness 6 into evidence.

Ms Leathem provided written submissions to the panel in which she referred the panel to the principles in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), *El Karout v NMC* [2019] EWHC 28 (Admin) and *NMC v Ogbonna* [2010] EWCA Civ 1216. She also referred the panel to the NMC guidance 'Evidence' (reference DMA-6).

In respect of Witness 5's evidence Ms Leathem submitted the following:

> *"5. The panel is referred to the Evidence Matrix (Exhibit 11). [Witness 5]'s evidence concerns the following charges:*
>
> *i. Charge 1(b) – paragraphs 12-32 and 49-52*
> *ii. Charge 1(d) – paragraphs 65-77*
> *iii. Charge 1(f) – paragraphs 53-58*
>
> *6. One of the factors to be considered by the panel when determining the application is whether anything contained in the statement that is hearsay is sole and decisive to the charge.*
>
> *7. In support of charge 1(b), the panel will hear live evidence from [Witness 4] and [Colleague B] There is also a separate hearsay application in respect of [Witness 6]'s evidence on this charge. However, it is acknowledged that their evidence is not direct evidence on the charge concerning whether PPE protocols were followed.*

8. [Witness 5] is the only individual to have directly witnessed and asserted that PPE protocols were not being followed at the relevant time. [Witness 5]'s evidence is that she directly observed PPE not being worn on her visit to the Home on 4 June 2020. [Witness 6]'s evidence on this charge is based on reports provided by [Colleague B] and [Witness 5]. [Colleague B]'s evidence relies on the report prepared by [Witness 5] about what she witnessed. Finally, [Colleague B]'s evidence is that, whether or not the visitor was wearing the necessary PPE was a question on the risk assessment form. She relies upon the forms as evidence of PPE not being worn and refers to examples where entry was permitted but the visitor was not wearing PPE (Exhibit AG/02, pages 330 and 332, Exhibit 8). [Colleague B] also relies upon a disciplinary meeting with the Registrant in which he was asked about a visitor wearing PPE and responded that he would have been offered. The panel may therefore consider that [Witness 5]'s evidence is sole and decisive on this charge.

9. Whilst it is acknowledged that [Witness 5]'s evidence is the direct observation of alleged failings to ensure PPE was worn by visitors, it is submitted that the evidence of [Colleague B] supports [Witness 5]'s evidence in so far as PPE was not recorded as having been worn on risk assessment forms.

10. As regards charge 1(d), [Witness 5]'s evidence is based on a conversation she had with Resident A. That conversation was followed up with a formal discussion where minutes were taken (Exhibit RY/04, pages 138-140, Exhibit 8). The evidence is also supported by [Colleague B] at paragraphs 59-61 of her statement. Whilst she confirms that [Witness 5]reported this information to her, which is in itself hearsay, she will provide evidence on a formal meeting with the Registrant in which it was accepted by the Registrant that Resident A was undertaking errands on behalf of the Home: 'IG did confirm that Res A was going out, doing shopping and errands for the home' (Exhibit AG/03, page 466, Exhibit 8). Furthermore, whilst it has not been formally admitted by the Registrant, it appears there is some

acceptance by him that Resident A undertook errands in his response to the charges:

Res A…food items from the local Waitrose and would exercise by walking a short distance of about 100 metres there and back. The GP surgery is next door to Waitrose too. She had been running errands for the home since July 2019 when her and her husband moved in the home. (page 323, Exhibit 4)

11. Charge 1(f) is in relation to an allegation that the Registrant allowed Resident B to leave the Home during the day and night. [Witness 5]'s evidence is not direct evidence but based on a conversation between her and [Witness 1] whereby [Witness 1] disclosed this information to [Witness 5] when she was interim home manager. She produces a local statement from [Witness 1] dated 22 June 2020 (Exhibit RY/04, page 137, Exhibit 8) which confirms Resident B was allowed to leave the Home in his car. At this stage, the NMC still intend to call [Witness 1] to give live evidence and are making all efforts to secure her attendance.

12. Similarly to charge 1(d), the Registrant does not appear to dispute that Resident B lei the Home in his response to the charges, 'He preferred his own company and spent time in his own car in our car park on an occasion, where he had fallen asleep' (page 26, Exhibit 4) and 'How do I stop him leaving the home, when his Social Worker is fully supportive of him coordinating the works at his flat and returning there at the earliest opportunity' (page 324, Exhibit 4).

13. It is acknowledged that hearsay evidence is not as useful to the panel as live witness evidence. However, the NMC have made efforts to secure the attendance of this witness. Unfortunately, owing to ill-health, she is not available to give evidence. [Witness 5] is not a registered nurse and therefore is not duty bound under the NMC Code to cooperate with requests to act as a witness. Obtaining a witness summons from the High Court would have been the only means of forcing her attendance. This is of course a last resort and not taken lightly. In the

circumstances of the supporting medical information, this was not an approach considered reasonable by the NMC.

14. It is submitted that this is a good reason for her non-attendance and should be considered as a factor weighing in favour of admitting the evidence.

15. Furthermore, the material is properly recorded in a witness statement, signed, dated, contains a statement of truth, and made in contemplation of NMC proceedings. It is not material that someone has taken a note of and put in an email but evidence that has been checked and signed. Furthermore, at the time of signing the statement, [Witness 5] confirmed that she would be willing to attend a hearing. Circumstances since the statement was signed on 8 March 2021 have changed. It is submitted that this is not a witness who has been uncooperative but simply unable to attend owing to ill-health.

16. The panel has the power to admit evidence, subject to relevance and fairness. It is submitted that the registrant has made plain through his response bundle what he does and does not agree with. It is submitted that it would therefore be fair to admit the evidence and then, at a secondary stage, consider what weight is to be attached to it.

17. The NMC's application is for the whole of [Witness 5]'s statement to be admitted into evidence as hearsay. In the alternative, it is submitted that the panel should consider the paragraphs individually in respect of each of the charges her evidence goes to and whether parts should be admitted if supported by other evidence and is capable of being tested through other witnesses".

In respect of Witness 6's evidence Ms Leathem provided the following written submissions:

"18. The panel is referred to the Evidence Matrix (Exhibit 11). [Witness 6]'s evidence concerns the following charges:

i. Charge 1(b) – paragraphs 30-31

ii. Charge 1(c) – paragraphs 30-33

iii. Charge 3(a) – paragraphs 38-41

iv. Charge 3(c) – paragraph 43

19. It is submitted that none of [Witness 6]'s evidence is sole and decisive on the charges. As regards charges 1(b) and 1(c), his evidence is an overview based on reports prepared by [Colleague B] and [Witness 5]. It is not direct evidence. In relation to charge 3, he provides email complaints he received from the concerned colleagues. His evidence merely describes what is contained in the emails that are exhibited. [Colleague B] also gives evidence on charge 3 (paragraphs 85 – 91).

20. Whilst his evidence cannot be challenged, it is submitted that much of his evidence is based on documentary evidence in any event. He does not have first-hand knowledge and his evidence goes to what is outlined within those documents which the panel have from his exhibits. Furthermore, any challenge by the Registrant can be explored through witness [Colleague B]. It is submitted that the panel should therefore admit [Witness 6]'s evidence and give it appropriate weight as necessary.

21. In addition, the material is properly recorded in a witness statement, signed, dated, contains a statement of truth, and made in contemplation of NMC proceedings.

22. As regards the reason for his non-attendance, this is set out in the hearsay bundle. Similarly to [Witness 5], he is also experiencing ill-health. Whilst [Witness 6] is registered with the NMC and required to cooperate with requests to act as a witness as per the NMC Code, he has provided a sick note from his GP as to why he cannot attend as a witness".

You indicated that you had no comments in relation to the application and you understood that you could outline your case to the panel at a later stage of the hearing.

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

The panel gave the application in regard to Witness 5 and Witness 6 serious consideration. The panel noted that Witness 5 and Witness 6's statements 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 were signed by them.

The panel considered that their evidence was relevant in respect of a number of the charges.

The panel considered that the NMC has made sufficient attempts to secure the attendance of Witness 5 and Witness 6 at this hearing and there was good and cogent reason for their non-attendance which related to their health and was supported by the appropriate evidence.

The panel then considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 5 and Witness 6 to that of a written statement.

In respect of Witness 5's statement, the panel considered that her evidence was not the sole and decisive evidence in respect of charges 1b, 1d and 1f. Witness 1 also gives evidence which speaks to these charges, and she is due to attend the hearing to give evidence and you will be able to cross-examine her. In addition, there were documentary pieces of evidence in the exhibits bundle which supplemented the statement of Witness 5. In these circumstances, the panel came to the view that it would be fair and relevant to

accept into evidence the written statement of Witness 5 but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

In respect of Witness 6's statement, the panel considered that his evidence was not the sole and decisive evidence in respect of charges 1b, 1c, 3a and 3c. Colleague B also gives evidence which speaks to the charges, and she is due to attend the hearing to give evidence and you will be able to cross-examine her in relation to the events. In addition, there were documentary pieces of evidence in the exhibits bundle which supplemented the statement of Witness 6. In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 6 but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Application to adjourn the hearing

After hearing from the penultimate NMC witness, the panel had sight of an email from the last NMC witness, Witness 1. Witness 1 had been scheduled to give evidence earlier on in the hearing, but the NMC had not successfully made contact with her. The email from Witness 1 stated that she would be unable to attend today due to a bereavement:

> *"My apologies I have not been in touch I was not able to recover emails… I am not available today but can be available Wednesday or Thursday this week if possible today is not convenient … I have only just received email"[sic].*

Ms Leathem invited the panel to adjourn the hearing until tomorrow when Witness 1 is able to attend to give evidence. She submitted that the reason provided is outside of anyone's control. Witness 1's evidence is important and relevant, and it is a relatively short adjournment. She submitted that Witness 1 is the last NMC witness and will not disadvantage or inconvenience any other witness. Ms Leathem also submitted that there is no injustice to the parties.

You submitted that you objected to the application because it is unfair to you that Witness 1 is delaying the process. You said you have no problem with Witness 1 attending but you would have preferred that this hearing progressed quickly.

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

The panel determined that Witness 1 provided good and cogent reasons for her non attendance and has also provided days that she is ready and available to attend to give evidence.

The panel determined that to allow this short adjournment would not cause injustice to either party and would allow the witness to attend.

The panel also determined that the adjournment would allow you further time to prepare for your case.

The panel therefore decided to grant the application to adjourn the hearing until the following day.

Decision and reasons on application of no case to answer

The panel considered an application from you, that the NMC has failed to discharge its persuasive and evidential burden and there is no case to answer in respect of charges 1b, 1c, 1d, 1e, 1f, 2, 3a, 3b, 3c and 4. This application was made under Rule 24(7). You provided written submissions.

Ms Leathem provided a written response to the application of no case to answer. She submitted that the evidence matrix is key to the panel's determination of this application. She submitted that it is unclear from your submissions which charges you suggest there is no case to answer on and so the NMC has responded on the basis that it is submitted there is no case to answer on each charge still to be determined by the panel.

In respect of charges 1b, 1c, 1d, 1e, 1f, 2, and 4, Ms Leathem referred the panel to the evidence matrix and submitted that the evidence is sufficient for a finding of a case to answer.

In relation to charges 3a, 3b and 3c, Ms Leathem submitted that the panel may consider that, taken at its highest, it could not properly result in a fact being found proved if there is no evidence that the complaints were firstly brought to your attention in order for you to deal with.

The panel took account of the submissions made and heard and accepted the oral and written advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

In respect of charge 1b, the panel considered that there is some evidence from Witness 4 and Witness 5. The panel was of the view that there is sufficient evidence to support charge 1b at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 1c, the panel considered that there is some evidence from Witness 4, Witness 6 and Colleague B. The panel was of the view that there is sufficient evidence to support charge 1c at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 1d, the panel considered that there is some evidence from Witness 5. The panel was of the view that there is sufficient evidence to support charge 1d at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 1e, the panel considered that there is some documentary evidence in the risk assessments and evidence from you. The panel therefore determined that there is sufficient evidence to support charge 1e at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 1f, the panel considered that there is some evidence from Witness 1. The panel therefore determined that there is sufficient evidence to support charge 1f at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In respect of charge 2, the panel considered that there is some documentary evidence from Colleague B and evidence from you. The panel therefore determined that there is sufficient evidence to support charge 2 at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

In relation to charge 3a, 3b and 3c, the panel saw no evidence that Colleagues D, E and F made specific grievances directly to you on or around 1 June 2020 and that you had failed to address them. The panel determined that the NMC had failed to discharge its burden of proof and therefore there was no realistic prospect that it could find the facts of charge 3a,

3b and 3c proved. The panel therefore determined there is no case to answer in respect of charges 3a, 3b and 3c.

In respect of charge 4 and 5, the panel considered that there is some evidence from Witness 4 and evidence from you. The panel therefore determined that there is sufficient evidence to support charges 4 and 5 at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel concluded that there is a case to answer in respect of charges 1b, 1c, 1d, 1e, 1f, 2, 4 and 5.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made an admission to charge 1a in respect of allowing one non-essential visitor into Aarandale Manor.

The panel therefore finds charge 1a proved, by way of your admission.

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 Leathem and by you.

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: Care Home Assistant Practitioner (CHAPS) at the Home;
- Witness 2: Quality in Care Advisor at the London Borough of Barnet Council;
- Witness 3: Adult Social Care Inspector for the Care Quality Commission (CQC);
- Witness 4: Regional Operations Director at Abbey Healthcare
- Colleague B: Regional Operations Director at Abbey Healthcare;

The panel also heard evidence from you under affirmation.

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

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

Charge 1a

1) Between 18 March 2020 and 12 June 2020:

a) Allowed one or more non-essential visitor(s) into Aarandale Manor;

This charge is found proved.

The panel took into account your admission to this charge that you allowed one non-essential visitor into the Home which was Relative A who had visited Resident C on 3

June 2020. It considered whether you had allowed other non-essential visitors into the Home.

You accepted in cross-examination that, as Home Manager, you were responsible for the Home and had oversight of who was permitted entry.

By 18 March 2020, all non-essential visits were stopped aside from in exceptional circumstances. An exceptional circumstance was when a resident was at end of life and the visit was to be agreed in advance with the Home Manager. This was supported by the evidence of Witness 1, Witness 4 Witness 5, Witness 6 and Colleague B

The panel considered that you were aware of the appropriate directives sent by email by Witness 6 at the time, in response to the frequent changes in Government guidance and adherence to company directives, policies and procedures was a specific obligation required in your job description.

The panel had sight of the risk assessment forms that had to be completed prior to permitting entry. It determined that it was your ultimate responsibility as to which visitors could and could not enter the Home irrespective of who completed the risk assessment form. All forms should have been referred to you as per the wording of the bottom of the form*, 'This document must be completed in full and returned to the Home Manager'*. The risk assessment forms show multiple visitors being permitted entry that, in the panel's view, were not in accordance with the directives and/or policy at the time.

The panel rejected your account that you only allowed one non-essential visitor to enter the Home as it has seen evidence of multiple occasions when non-essential visits were permitted by you.

The panel therefore found charge 1a proved in that you allowed more than one non-essential visitor into the Home.

Charge 1b

1) Between 18 March 2020 and 12 June 2020:

b) Did not ensure that Personal Protective Equipment protocols were followed by visitors to Aarandale Manor;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5 and Colleague B

Witness 5 reported to Colleague B about occasions where they saw visitors at the home who were not wearing PPE.

Whilst Colleague B did not directly observe the alleged incidents that Witness 5 refers to, she confirmed in her evidence that Witness 5 spoke to her about it that day. The reason for the call was that Witness 5 had been so concerned with what she saw, that she had to clarify the visitation policy with Colleague B. Witness 5 was asked to write a statement by Colleague B.

That statement is dated 22 June 2020 and is the most contemporaneous record of the alleged event. Whilst Witness 5 did not give live evidence before the panel, Colleague B confirmed in her oral evidence that it reflected the account that had been given to her by Witness 5 over the phone.

The panel considered that the handwritten statement is consistent with Witness 5's NMC witness statement which was made in contemplation of these proceedings.

In addition, the panel had documentary evidence in risk assessments "Wearing correct PPE" was either blank or stated 'no' on the form. Further, the panel noted in your

grievance interview, confirmed by you during the course of the hearing, that you repeatedly stated PPE was provided but not that you ensured that PPE was worn.

The panel found the evidence of Witness 5 and Colleague B to be reliable and consistent. The panel therefore accepted their evidence and determined that you did not ensure that PPE protocols were followed by visitors to the Home.

The panel therefore found charge 1b proved.

Charge 1c

1) Between 18 March 2020 and 12 June 2020:

c) Did not adequately complete Covid-19 risk assessments;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B.

The panel had before it the Corona Virus Risk Assessments exhibited by Colleague B. The guidance or policy at the time was that *'All visitors should have their temperature taken with a non-touch thermometer prior to entering the main building'* and this was a policy in existence prior to the exhibited risk assessments being completed. It was also a requirement on the risk assessment forms themselves that a temperature reading was recorded.

Although you had overall responsibility for the completion of all risk assessments, the panel noted however that this charge only relates to the assessments that you completed. The panel saw evidence that on five separate occasions you had personally completed the risk assessment form for visitors entering the Home on 3 June 2020 at 10:45, 14:00,

14:15, 14:30, 15:15. On each risk assessment form, you stated ‘no thermometer’ in the section that requires ‘temperature reading’ on the form.

In your evidence you made reference to faulty thermometers. However, you accepted that there was always one working thermometer in the Home.

Colleague B also gave evidence that the thermometers were checked by the Deputy Manager on 13 June 2020 and confirmed to be working.

Having already found Colleague B’s evidence to be credible and consistent, the panel accepted her evidence and found on the balance of probabilities, in light of the evidence in respect of the availability of a working thermometer and your acceptance of that evidence, that you did not adequately complete Covid-19 risk assessments in respect of the five visitors to the Home.

The panel therefore found charge 1c proved.

Charge 1d

1) Between 18 March 2020 and 12 June 2020:

d) Allowed Resident A, who was supposed to shielding, to undertake errands on behalf of Aarandale Manor;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Resident A, Witness 5 and Colleague B.

The panel noted that Resident A was over 70 years old and should have been shielding at the relevant time. That Resident A was undertaking errands during the relevant period is

supported by Witness 5 who spoke with Resident A on 8 June 2020. This is further supported by minutes of a meeting between Resident A and Witness 5 on 1 July 2020.

Resident A confirmed that the conversation took place, that she had gone to the surgery to drop off a sample and asked the surgery about Covid testing kits. During this meeting, she also confirmed that you were aware and happy with her going out of the Home and running errands. Resident A also disclosed that you had asked her to get some plastic cups for the reception area, that she had initially gone to Waitrose and then gone on to purchase them at a convenience store.

Your evidence is that Resident A only left the Home when the Government relaxed the law and people were going out to 'stretch their legs'. However, you accepted during cross-examination that Resident A should have been shielding during the lockdown period although you said you had no power to stop Resident A from leaving the Home.

You said that Resident A described herself as an 'ambassador' to the Home. You told the panel that Resident A would show potential residents around the Home, would spend time in reception and was involved in running some errands for the Home's staff and residents when she went out to do things for herself. This arrangement predated your appointment as Home Manager. You also confirmed that this was something Colleague B had been aware of and authorised.

When Colleague B was asked in her oral evidence, she rejected the suggestion that this was an arrangement of which she was aware or authorised.

The panel determined that, irrespective of whether or not Resident A was already conducting errands and who had authorised it, you were aware of the practice and at no stage took any steps to discontinue it. Between the dates identified in the charge, Resident A should not have been carrying out errands and should have been shielding.

Further, the panel was of the view that a risk assessment should have been carried out prior to 18 March 2020 and at the start of the Covid-19 pandemic to assess the appropriateness and safety of Resident A's role of ambassador continuing, which included allowing Resident A to run errands for the Home.

The panel accepted the evidence of Witness 5 and Colleague B. The panel also took account of Resident A's most contemporaneous evidence namely the statement of Resident A to Witness 5. The panel was conscious that you continued to have a friendship with Resident A after ceasing to be the Home Manager, noted the inconsistencies in her evidence and consequently has given less weight to her evidence as opposed to that of Witness 5 and Colleague B.

The panel therefore determined, in light of all the evidence and your own acceptance of this practice, that you allowed Resident A, who was supposed to shielding, to undertake errands on behalf of the Home.

The panel therefore found charge 1d proved.

Charge 1e

1) Between 18 March 2020 and 12 June 2020:

e) Allowed Resident A to carry out Covid-19 risk assessments;

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 4 and Colleague B.

In your evidence you accepted that you allowed Resident A to carry out risk assessments and that she that completed them in your own words to 'the best of her ability'.

Witness 4's evidence is that Resident A was completing risk assessments, it was her view that under no circumstances should this practice have been allowed and undertaken by a resident of the Home.

The panel had sight of the Corona Virus Risk Assessments exhibited by Colleague B some of which have Resident A's signature. The risk assessment form requires a member of staff in charge to sign the form. The panel considered that, as a resident, Resident A was not a member of staff and as such should neither have been conducting risk assessments or signing the appropriate forms.

Further, the panel took into account that Resident A was not clinically qualified to carry out risk assessments and undertaking them also put her as a person of 70 years of age as well as the other residents in the Home at risk.

Having already found their evidence to be reliable and consistent, the panel accepted the evidence of Witness 4 and Colleague B. It also gave significant weight to your acceptance in your evidence that this was a practice which you neither stopped or sought to discontinue at any stage.

In light of the above, the panel determined that you allowed Resident A to carry out Covid-19 risk assessments.

The panel therefore found charge 1e proved.

Charge 1f

1) Between 18 March 2020 and 12 June 2020:

f) Allowed Resident B to leave Aarandale Manor during the day and return at night;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Colleague B and your evidence.

You do not dispute that Resident B left the Home in the day to go back to his property which was having work done. You said in your evidence that Resident B has full capacity and that there were no Deprivation of Liberty Safeguards (DOLS) in place or restriction under the Mental Capacity Act such that you could physically stop him from leaving the Home. You said that the discharge coordination nurse and his social worker were aware.

Witness 1's evidence is that Resident B would regularly leave the Home in the day and would sometimes return very late. On one occasion he was found asleep in his car with the engine on. This evidence is supported by her handwritten statement dated 22 June 2020.

Colleague B was specifically asked whether she knew about Resident B leaving the Home at the time and she confirmed that she did not and that she would not be involved with the care planning as it was down to the nurses in conjunction with the management of the Home.

Colleague B's evidence was that no risk assessment had been done in respect of Resident B leaving and coming back and the risk of infection. The care plan does not show any reference to a risk assessment having been carried out save for the risk of Resident B being able to leave unnoticed

The panel was of the view that, as Home Manager, you were responsible for the care of Resident B and maintaining the safety of all of the Home's residents in the pandemic. Whilst the panel accepts that you were unable to stop Resident B leaving the Home, it considered that in consequence you had an urgent responsibility to escalate your

concerns about him returning and putting the other residents and staff at risk, to the senior management team at Abbey Healthcare. The panel was of the view that consideration about the appropriateness and safety of Resident B returning to the home, with the associated infection control risks, should have been discussed as a matter of urgency with the senior managers of Abbey Healthcare and appropriate regulatory bodies. Whilst accepting you were not able to physically restrict Resident B from leaving the Home, the panel determined that you had a professional and managerial responsibility to maintain the safety of all of your residents and staff and should have put in place steps to have prevented Resident B from returning to the home.

The panel therefore found charge 1f proved.

Charge 2

> 2) On 30 March 2020, did not to complete a safeguarding allegation and/or a CQC notification in relation to Resident H.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Colleague B.

Your position is that you were never sent the details of the allegation in order to fill out the referral form. The panel noted that this is contradicted by reference within your own email to Colleague B that you had spoken with Resident H on 23 March 2020 and she had denied anyone had abused her.

In response to your email whereby you ask for more specifics to complete the safeguarding referral, Colleague B responds, *'I have sent you the allegation for your information to support with completing the referral'.* Your response to Colleague B's email was sent one minute later to confirm that you will do the notification. You then proceed to

send a blank referral form to Colleague B with the comment, *'As promised, attached is the safeguarding concern form'.*

The panel considered that by having a conversation with Resident H about an incident of abuse, you would have had enough information in order to establish what had happened. The panel further considered that in your email to Colleague B, you appeared to be more concerned with the details of the complaint made against you by the colleague who raised the allegation of abuse, rather than the potential safeguarding allegation in relation to Resident H.

Having already found Colleague B's evidence to be credible and consistent, the panel accepted her evidence of the events.

The panel determined that there was an obligation on you to complete the safeguarding allegation and/or CQC notification in relation to Resident H. The panel determined that it was part of your job description, you were specifically instructed to complete the referral by Colleague B and after saying that you would, you did not complete the referral.

The panel therefore found charge 2 proved.

Charge 4

> 4) Between 30 June 2020 and 1 November 2020, when asked about a grievance raised by Colleague A against Colleague B, provided false information;

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 4.

Your evidence is that Witness 4 had previously spoken to you about Colleague A and this had been a general conversation about how she was getting on. You stated that you were not asked about the grievance between Colleague A and Colleague B. You said you were not sent any minutes of this casual telephone call, there was no statement signed by you and you were unaware of the content or nature of the grievance raised by Colleague A.

Witness 4's evidence that as part of her investigation into a grievance raised by Colleague A about Colleague B, she spoke with you as part of her fact finding and asked you what he had witnessed. Witness 4's evidence was that you were quite clear that you had not witnessed any inappropriate behaviour by Colleague B and that this formed a key part of the reason why she did not uphold the grievance raised by Colleague A.

You subsequently said in your grievance to Abbey Healthcare on 13 June 2020 you had observed an incident where Colleague B had shouted at Colleague A on her last day of work as you had also been treated similarly by Colleague B.

At the meeting on 30 June 2020, Witness 4 recalled you referring to an incident between Colleague A and Colleague B that was in line with what you had originally asserted you did not recall. It is not disputed by you that you raised this as a concern at that point. When questioned by Witness 4 about this, she recalls you saying that you had not been truthful in the original meeting as 'you did not want to lose your job'. She remained consistent about this point in her oral evidence and further evidence is exhibited by Witness 4 in the minutes of that meeting of 30 June 2020, which she describes as 'verbatim'.

The panel considered the meeting minutes where Witness 4 stated:

> *"You mentioned earlier that [Colleague A] raised a bullying and harassment grievance against [Colleague B] and you are right, I did investigate that. This was wholly unsubstantiated. I actually spoke to you as part of the investigation. I asked you (as well as other staff) have you ever witnessed [Colleague B] speak to anyone*

inappropriately and you were very clear to me, as the registered manager of that home that there were no issues. So now, why would you change your mind".

And your response:

"The specific issue I am referring to is when [Colleague B] shut the door to the office and said to [Colleague A] 'Sit down' in a very loud, inappropriate manner".

The panel determined that if Witness 4 had not spoken to you about Colleague B's behaviour towards Colleague A prior to this meeting you would have been highly unlikely to respond as you did above but would have denied that the previous conversation took place.

The panel saw no documentary evidence in relation to the original grievance. However, having had the advantage of hearing Witness 4 in evidence, the panel found her evidence to be credible and found her evidence particularly cogent in respect of her specific recollection which resulted in Colleague A's grievance not being upheld by her. The panel could find no reason why Witness 4 would misrepresent her recollection of these events or was part of any conspiracy by Abbey Healthcare senior management team directed at you, as you have suggested in your cross-examination of her.

The panel noted that you first raised your concerns regarding Colleague B's conduct towards Colleague A once you had been suspended at which time you were raising a grievance with Abbey Healthcare using this as an example to validate your own experience of Colleague B's behaviour towards you. You also told the panel in your evidence that you did not report this incident at the time firstly because there was no Human Resources (HR) department at Abbey Healthcare and subsequently it did not occur to you to raise this with more senior management.

In light of the above, the panel preferred the evidence from Witness 4 as opposed to your own evidence.

The panel determined that on the balance of probabilities, that when asked about a grievance raised by Colleague A against Colleague B you chose to provide false information by saying that you were not aware of anything taking place when you were in fact fully aware of the grievance.

The panel therefore found charge 4 proved.

Charge 5

> 5) Your conduct as set out in Charge 4 above was dishonest in that you sought to mislead your employer.

This charge is found proved.

In reaching this decision, the panel took into account its finding at charge 4.

The panel considered your state of mind at the time when you denied witnessing any inappropriate behaviour by Colleague B towards Colleague A in the telephone conversation with Witness 4. In making it's decision, the panel gave appropriate weight to the agreed position of your good character and the fact that you had no previous regulatory findings against you.

The panel took into account that it accepted Witness 4's recollection in that conversation in which you had said that you were not aware of any issues between Colleague A and Colleague B. You do not accept you were formally asked about any issues in Colleague B's behaviour towards Colleague A in that initial telephone call. Your evidence was that it was a general conversation about Colleague A's performance.

The panel accepted Witness 4's evidence that at the grievance meeting on 30 June 2020, you said that you had not mentioned the incident where Colleague B shouted at Colleague A because you did not want to lose your job. Having already accepted Witness 4's

evidence, the panel considered that you were aware of the incident and consequently by the standards of ordinary decent people, you were dishonest when you chose to provide false information when asked about Colleague A's grievance.

The panel noted that you denied saying to Witness 4 that you were fearful of losing your job and. However, the panel saw no other explanation as to why you would have provided false information to Witness 4.

The panel therefore found charge 5 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct and impairment

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.'*

Misconduct denotes the same concept as "serious professional misconduct" and the threshold for intervention is the same (Calhaem v GMC [2007] EWHC 2606 Admin).

Ms Leathem 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. She identified the specific, relevant standards where the NMC say your actions amounted to misconduct.

Ms Leathem submitted that you were aware of the appropriate directives in respect of Covid-19. As home manager, you should have been ensuring that directives and policies were followed and set a clear example for staff. As a nurse you also should have been aware of the risk of the possibility of passing on an extremely contagious virus by letting visitors into the Home where it was not considered to be an exceptional circumstance, not ensuring PPE was always worn by visitors, allowing a resident to leave the Home and return without risk assessing the risk of infection and in allowing a vulnerable resident to conduct Covid-19 risk assessments which involved interacting with visitors as well as conducting errands for the Home during the lockdown period.

Ms Leathem submitted that you were working in unprecedented times and in a very stressful situation but nonetheless, your behaviour fell below the standards expected of a registered nurse.

In respect of failing to raise a safeguarding referral or CQC notification, despite being asked to do so by your manager, Ms Leathem submitted that this is serious

misconduct. As home manager, you were expected to escalate potential safeguarding issues to the appropriate authority for proper investigation.

In respect of charges 4 and 5, by making a false statement and then providing information that contradicted your earlier statement, you lacked a duty of candour. This ultimately led to a grievance not being upheld and undermined the trust and confidence that colleagues placed in you. Ms Leathem submitted that this is serious misconduct.

Ms Leathem then 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 Leathem submitted that the misconduct in this case is very serious and relates to basic and fundamental principles of nursing practice. Your actions placed residents and staff at serious risk of serious harm. She submitted that the contextual factors put forward by you do not sufficiently explain your conduct.

Your conduct in respect of charges 4 and 5 also breached the professional duty of candour with no or minimal connection to the Covid-19 pandemic at the time or the working environment.

Mr Leathem submitted that you have shown insufficient insight into the seriousness of your conduct and the impact this had on residents, colleagues and the public confidence in the profession. She submitted that you do not take responsibility for your actions or demonstrate any understanding into why the concerns have arisen. She referred the panel to the evidence you provided: an infection control audit prevention tool and improvement plan for one of the homes you worked at following on from Aarandale Manor. She submitted that the improvement plan is not a recent document. She also referred to a

reference from a Regional Quality Director of the Home where you have been working as home manager but that is dated 16 August 2021.

Ms Leathem therefore submitted that the panel may find that there remains a risk of repetition in the absence of any current information about your practice and a finding of current impairment is necessary on the grounds of public protection.

Ms Leathem submitted that a finding of impairment is also necessary in the wider public interest, to promote and maintain public confidence in the nursing profession and to promote and maintain proper professional standards and conduct for members of the profession.

You provided detailed written submissions to the panel. You stated that your conduct at the Home does not constitute misconduct. You informed the panel of your 33 years unblemished career in nursing. You stated that after a month of working at the Home, Abbey Healthcare brought up a whole array of issues about your post there after you had uncovered financial irregularities and you were then targeted with an indirect smear campaign.

You stated you were abiding with all Covid-19 restrictions up to around the end of May 2020 when the government relaxed the lockdown rules. You informed the panel in your written submissions that no staff or residents were infected with Covid-19 during May-June 2020 and you did you best to protect your most vulnerable residents.

You submitted that you worked tirelessly in unprecedented times and were very stressed with no support from Abbey Healthcare or necessary equipment. You stated that Abbey Healthcare placed you in such a difficult position where you made mistakes and you had been crying out for help. You stated you raised several emails to his line Manager and also to the Group Operation Director with no response. You submitted that since leaving Abbey Healthcare, you have worked current post for the last three years at Appletree

Court without issues. You provided testimonials from your time at Abbey Healthcare. You also provided reviews from your current employment and evidence of training certificates.

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 found that your actions at charge 1 and 2 amounted to a breach of the Code. Specifically:

> *"16 Act without delay if you believe that there is a risk to patient safety or public protection*
> *To achieve this, you must:*
> *16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices*
> *16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*
>
> *19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
> *To achieve this, you must:*
> *19.3 keep to and promote recommended practice in relation to controlling and preventing infection*
>
> *20 Uphold the reputation of your profession at all times*

To achieve this, you must:
20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers"

In respect of charge 1 which related to clinical concerns and your management of the risks of the Covid- 19 pandemic at the Home, the panel was of the view that despite the extraordinary circumstances, as a nurse and home manager, you did not take adequate precautions to minimise the potential spread of Covid-19 within the Home. You made decisions on multiple occasions that were not in accordance with Abbey Healthcare directives or national guidance at that time, exposed other colleagues and residents to risk of harm, did not escalate your concerns appropriately and left staff confused as to the guidance to follow at that time.

The panel considered that you were fully aware, as manager, of the appropriate directives sent by senior management and should have been ensuring that policies were followed and set a clear example for staff. You should have been aware of the risks of the possibility of passing on an extremely contagious virus by allowing visitors into the Home where it was not considered to be an exceptional circumstance, not ensuring PPE was always worn by visitors, allowing a resident to leave the Home and return without risk assessing the risk of infection and in allowing a vulnerable resident to conduct risk assessments which involved interacting with visitors as well as conducting errands for the Home during the lockdown period.

The panel also had regard to the NMC Guidance 'How we determine seriousness' FTP-3 which stated:

"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"*

The panel was of the view that your approach to enforcing the Covid-19 restrictions in place at the time was informed by the fact that you considered you were managing a 'superior' care home, which justified a laissez faire (casual) attitude to honouring the restrictions in place and your reluctance to escalate the management of residents to senior management and other professional bodies. The panel determined that your approach to management was particularly serious as it put residents and staff at increased risk.

In also considered the NMC guidance 'Serious concerns which are more difficult to put right' FTP- 3a which states that a small number of concerns are so serious that it may be less easy for the nurse to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening for example:

> *"Being directly responsible (such as through management of a service or setting) for exposing people receiving care to harm or neglect, especially where the evidence shows the nurse, midwife or nursing associate putting their own priorities, or those of the organisation they work for, before their professional duty to ensure the safety and dignity of people receiving care".*

Consequently, the panel was of the view that your actions in charge 1 both jointly and severally (excluding charge 1a) fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In respect of charge 2 the panel determined that as home manager, you were expected to escalate potential safeguarding issues to the appropriate authority for proper investigation. An allegation of abuse against a resident would require a timely referral and whilst this was eventually completed by senior management there was a delay in the referral being completed as a result of you sending Colleague B a blank referral form. However, the panel accepted that there was potential for miscommunication in this instance. It noted no

actual patient harm was caused although there was a risk of harm. The panel considered that although your conduct had amounted to a breach of the Code, it was not sufficiently serious in isolation to amount to misconduct.

In respect of charge 4 and 5 relating to your dishonesty, the panel found that your actions amounted to a breach of the Code. Specifically:

> *"Promote professionalism and trust*
> *You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.*
>
> > *20 Uphold the reputation of your profession at all times*
> > *To achieve this, you must:*
> > *20.1 keep to and uphold the standards and values set out in the Code*
> > *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment"*

The panel also considered the NMC guidance 'Serious concerns which are more difficult to put right' FTP- 3a which states that a small number of concerns are so serious that it may be less easy for the nurse to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening for example:

> *"Breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of the public who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care".*

It also considered NMC Guidance ‘Making decisions on dishonesty charges and the professional duty of candour’ DMA-8 which states that:

“To comply with the professional duty, nurses, midwives or nursing associates must:

- *Be honest, open and truthful in all their dealings with patients and the public.*
- *Never allow organisational or personal interests to outweigh the duty to be honest, open and truthful”.*

The panel determined that you did not comply with your professional duty of candour set against the criteria above in NMC Guidance DMA-8. It determined that by making a false statement and then providing information that contradicted your earlier conversation, you failed in your duty of candour. Having accepted the evidence of Witness 4 that you stated that the reason you did not tell the truth when you were first asked, was because you did not want to lose your job, the panel considered your actions frustrated the grievance process raised by Colleague A. Your actions would ultimately lead to the grievance not being upheld and undermined the trust and confidence that colleagues placed in you. The panel therefore found that your dishonesty falls seriously short of the conduct and standards expected of a nurse and amounts to misconduct.

The panel found misconduct in respect of charges 1, 4 and 5

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired with regard to charges 1, 4 and 5.

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. Honesty is the bedrock of the nursing profession. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel found that limbs a, b, c and d are engaged in the *Grant* test. The panel found that whilst there is no evidence that residents were harmed as a result of your misconduct, your actions placed residents and staff at serious risk of serious harm. At the time of the concerns, Covid-19 was a very contagious virus, and you were responsible for the care of vulnerable residents. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. It considered that acting with honesty and integrity at all times is a fundamental principle of the nursing profession and you knowingly provided false information with regards to an employee grievance.

The panel took into account the contextual factors which you have raised. However, it had been provided with evidence of support in place at the time (i.e. regular phone calls to

discuss the policies) and clear directives and guidance in place to ensure the safety of residents and staff members.

Regarding insight, the panel considered that you have not provided any evidence of reflection, nor have you demonstrated any significant insight into the seriousness of your conduct and the impact this had on residents, colleagues and the public confidence in the profession. Further, the panel considered that you have not taken responsibility for your actions nor have you demonstrated any understanding into why the concerns about your practice have arisen. Instead, you have sought to deflect blame on others and have maintained that the allegations were the result of a malicious campaign by the care home group management team in response to you having raised a grievance and case in the Employment Tribunal which may be suggestive of an attitudinal issue. You have not provided sufficient evidence of how you would act different in the future if placed in similar circumstances.

The panel was satisfied that the clinical misconduct in this case is capable of being addressed. However, the panel remained concerned that your failure in respect of the duty of candour on the evidence currently presented is harder for you to address. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

In respect of the clinical and managerial concerns. The panel had evidence of some training certificates which demonstrate that you have continued to work since these incidents without concern and you have kept your knowledge and skills up to date. It also had before it, evidence of testimonials from your more recent employment although the most recent was dated 2021.

Currently, the panel have yet to see evidence and therefore be reassured that placed in a similar situation you would not repeat the types of failures identified in charge 1.

In relation to your dishonesty, the panel noted your current position that you do not accept that you were dishonest.

Therefore, the panel was of the view that there is a risk of repetition based on the lack of evidence of insight into your dishonesty. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered that a well-informed member of the public would be seriously concerned if a finding of impairment was not made for a nurse in a managerial role who put residents and colleagues at risk of harm and acted dishonestly.

The panel therefore concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Ms Leathem informed the panel that in the Notice of Hearing, dated 6 June 2024, the NMC had advised you that it would seek the imposition of a striking-off order if the panel found your fitness to practise currently impaired. She referred the panel to the NMC Guidance on sanctions. She outlined what the NMC consider to be the aggravating and mitigating features of the case.

In terms of the sanctions that are available to the panel, Ms Leathem submitted that to take no further action or impose a caution order would be inconsistent with its reasoning on the seriousness of the misconduct and the finding of impairment on both public protection and public interest grounds. These are not concerns at the lower end of the spectrum.

In respect of a conditions of practice order, Ms Leathem submitted that whilst the misconduct surrounding the COVID-19 failings may be capable of being addressed and they would naturally fall within the remit of conditions. However, she submitted that the attitudinal context behind the COVID-19 failings goes beyond what could ordinarily be addressed by conditions. She submitted that your approach to management was particularly serious as it put residents and staff at increased risk. Furthermore, she submitted that dishonesty is not an identifiable area of practice that can ordinarily be addressed by conditions. She submitted that a conditions of practice order would not protect the public, colleagues and the reputation of the profession. She also highlighted that you have shown minimal insight and reflection.

In respect of a suspension order, Ms Leathem submitted that the COVID-19 failings occurred over a lengthy period of time that they were not a one-off instance and the

dishonesty, albeit a single instance of dishonesty, was something that you continue to deny.

Further Ms Leathem submitted that there has been no evidence of reflection nor any significant insight into the seriousness of your conduct and the impact that this had on residents, colleagues and the public confidence in the profession.

Ms Leathem submitted that whilst these may not have been harmful, deep seated personality concerns, there is perhaps an attitudinal problem, and the panel had already found that there was a casual attitude taken towards the COVID-19 pandemic and the impact that this had on the safety of residents.

Ms Leathem submitted that a striking-off order would mark the serious departures from the standards expected of a registered nurse in this case, and that cumulatively, the behaviour is fundamentally incompatible with you remaining on the register. She submitted that the lack of a duty of candour in this case raises fundamental questions about your professionalism and your trustworthiness has been undermined and falls below what is expected of a registered nurse. She further submitted that your conduct raises serious questions about the safety of the public and the maintenance of public confidence in the profession, such that it would be fundamentally incompatible for you to continue being a registered professional.

The panel also bore in mind your written submissions which you supplemented with oral submissions. You stated that have had a clear record as a nurse for the last 33 years without any issues and have worked at a management level for over 25 years. You said there has never been any issues with your previous employers until you joined Abbey Healthcare in 2019. You said your career with them was very short. You detailed what you said were the problems at the Home including management and staffing issues and that you cried out for help which never came. You said that once you raised concerns about Abbey Healthcare, you were then targeted with a vindictive campaign against you.

You said you have put your residents first in everything that you do. You said that since you left the Home you have worked solidly and turned around Moorland Lodge in Romford which was a home that required improvement which resulted in a rating of ‘good’. You said you registered it with the CQC to take Covid-19 positive residents and there was a lot of work to do in infection control and prevention which you did. You then went on to work at Seabrook Manor where you did a lot of work on infection control and prevention. You told the panel you have been in your current post for three years and that you have submitted positive references and testimonials. You said you have worked for three years without any concerns being raised about your conduct or behaviour.

You said nursing is the profession you chose because you care about people and have given your life to your patients. You said you have always been up front when you have done wrong and you have learned a lot from this. You told the panel how these proceedings have impacted you negatively. You said you do not think that a striking-off order is proportionate in your case.

The panel reminded itself of the legal advice with respect to rejected defences and made up its own mind in respect of the relevance and weight to be given in the context of deciding the appropriate sanction.

Decision and reasons on sanction

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

- Your lack of insight into your failings.
- Although you accept that the Home was ultimately your responsibility, you went on to blame senior management and deflected blame on to others. The panel saw no evidence you raised your concerns to senior management.
- As the home manager you should have been leading by example.
- A pattern of conduct over a period of time in relation to the Covid-19 charges.
- Your conduct put residents and staff at risk of suffering harm.

The panel also took into account the following mitigating features:

- Your conduct took place during an unprecedented time of the Covid-19 pandemic.
- You have kept your practice up to date.
- A number of positive testimonials.

The panel referred to the NMC guidance SAN-2 'Considering sanctions for serious cases'. When considering the seriousness of the dishonesty, the panel considered that this was a one-off, opportunistic incident related to a conversation with Witness 4. There was no misuse of power, no vulnerable victims and the dishonesty did not involve patient care or personal gain. The panel therefore determined your dishonesty to be at the lower end on the spectrum of dishonesty.

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 not protect the public nor be in the public interest to take no further action.

The panel 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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel considered that although the issues identified in respect of charge 1 could be addressed by conditions, with regards to charges 4 and 5 it was not possible to formulate conditions that would address your dishonesty.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel considered that the charges relating to your dishonesty were an isolated incident of impulsive dishonesty in the context of the challenges within the Home but the charges relating to the Covid-19 failures involved multiple failures over a period of time. It

identified possible attitudinal problems although it did not consider they were deep-seated or harmful. The panel had minimal evidence before it of any meaningful reflection or insight into any aspect of the misconduct identified.

The panel saw no evidence that you had repeated any of the behaviour. It had before it positive testimonials, including one from a previous colleague who stated that you have been working without concern up to December 2023. The panel was of the view that there was a risk of repetition of your behaviour due to your lack of insight. However, the positive testimonials go some way to mitigating the risk of repetition.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate, but in view of the panel's finding that your dishonesty was at the lower end of seriousness and taking account of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the impact such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the misconduct.

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order including striking-off.

Any future panel reviewing this case would be assisted by:

- A detailed reflection on the shortcomings identified using a reflective model with reference to the Code which identifies the importance of honesty in nursing and your professional accountability in terms of management of risk.
- Current testimonials from your line manager which attest to your professional integrity and ability to assess and manage risk.

This decision will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Leathem. She invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period. She submitted that an interim order was necessary for the protection of the public and is in

the wider public interest. If an interim order was not imposed, she submitted that this would be inconsistent with the panel's earlier findings.

You made no comment on the interim order application.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the 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 panel's 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 cover the appeal period.

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

That concludes this determination.