Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Monday, 15 July 2024 – Friday, 19 July 2024

Wednesday, 31 July 2024 – Friday, 2 August 2024

Virtual Hearing

Name of Registrant:	Shiny Thomas	
NMC PIN	10E0015O	
Part(s) of the register:	RN1: Registered Nurse – Adult (12 May 2010)	
Relevant Location:	Kent	
Type of case:	Misconduct	
Panel members:	Sue Heads Pamela Campbell Caroline Taylor	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Gaon Hart	
Hearings Coordinator:	Yewande Oluwalana (15 July – 19 July) Catherine Blake (31 July – 2 August)	
Nursing and Midwifery Council:	Represented by Scott Clair, Case Presenter	
Mrs Thomas:	Not present and not represented at the hearing	
Facts proved:	Charge 1, 3a,3b, 3c, 3d, 4a and 4b	
Facts not proved:	Charge 2	
Fitness to practise:	**Impaired**	
Sanction:	**Conditions of practice (12 months)**	
Interim order:	**Conditions of practice (18 months)**	

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Thomas was not in attendance and that the Notice of Hearing letter had been sent to Mrs Thomas' registered address by recorded delivery and by first class post on 6 June 2024.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Thomas' registered address on 8 June 2024. It was signed for against the printed name of 'THOMAS'.

Mr Clair, 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 Mrs Thomas' 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 Mrs Thomas has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34 (the Rules).

Decision and reasons on proceeding in the absence of Mrs Thomas

The panel next considered whether it should proceed in the absence of Mrs Thomas. It had regard to Rule 21 (the Rules) and heard the submissions of Mr Clair who invited the panel to continue in the absence of Mrs Thomas. He submitted that Mrs Thomas had voluntarily absented herself.

Mr Clair submitted that there had been no engagement at all by Mrs Thomas with the NMC in relation to attendance to this hearing and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Mr Clair submitted that there is a strong public interest in the expeditious disposal of this case.

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(the Rules) 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 Mrs Thomas. In reaching this decision, the panel has considered the submissions of Mr Clair and the advice of the legal assessor. It has had particular regard to relevant case law and the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Thomas;
- Mrs Thomas has not engaged with the NMC in regards to attendance at this hearing and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- There are witnesses due to attend to give live evidence, 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 2021;
- This is a joint case with another registrant, who is in attendance and represented;
- 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 Mrs Thomas in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address and she has provided some responses to the allegations, Mrs Thomas 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. The panel also has a statement from Mrs Thomas as to the allegations and can ensure that these are appropriately considered. Furthermore, the disadvantage is the consequence of Mrs Thomas' decision 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 Mrs Thomas. The panel will draw no adverse inference from Mrs Thomas' absence in its findings of fact.

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

At the outset of the hearing, Mr Clair on behalf of the NMC made an application that parts of this hearing be held in private [PRIVATE]. The application was made pursuant to Rule 19 (the Rules).

The legal assessor reminded the panel of the NMC Guidance CMT-10 and that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined that [PRIVATE] the hearing will be heard in private in order to protect her privacy.

Decision and reasons on application to amend the charge

Before the charges could be read out, the panel heard an application made by Mr Clair, to amend the wording of charge 3.

The proposed amendment was to particularise the charge to include four specific failings that Mrs Thomas is alleged to have not ensured were carried out. It was submitted by Mr Clair that the proposed amendment would not prejudice Mrs Thomas, who is not in attendance, but provide clarity and more accurately reflect the evidence.

> "That you, while a registered manager of Care 24X ("the Agency"),
>
> 3. Did not ensure staff at the Agency were adequately trained**:**
>   a. **Percutaneous Endoscopic Gastrostomy (PEG) care.**
>   b. **Catheter care.**
>   c. **PRN medication procedures.**
>   d. **End of life care."**

The panel accepted the advice of the legal assessor and had regard to Rule 28 (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 Mrs Thomas and no injustice would be caused to either party by the proposed amendment being allowed. Indeed, the panel considered that it was fairer to Mrs Thomas to have the allegations particularised. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy. The panel is satisfied that the fundamental principle of the charge had not changed, but had become more specific rather than generalised.

Details of charge (as amended)

That you, while a registered manager of Care 24X (“the Agency”),

1. Provided the CQC with inaccurate numbers of employees and care packages managed by the Agency. **[FOUND PROVED]**

2. Your actions at charge 1 were dishonest in that you intentionally provided inaccurate information with the intention that the CQC would believe the information to be accurate. **[FOUND NOT PROVED]**

3. Did not ensure staff at the Agency were adequately trained: **[FOUND PROVED]**

    a. Percutaneous Endoscopic Gastrostomy (PEG) care.
    b. Catheter care.
    c. PRN medication procedures.
    d. End of life care.

4. Did not have a proper system in place to ensure: **[FOUND PROVED]**

a. Safe administration and management of medication.
b. Care plans contained adequate risk assessments.

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

Background

The NMC received an anonymous referral on 17 September 2021 in respect of Mrs Thomas’ role as a registered manager at Care 24x, a domiciliary care agency (the Agency).

In addition, the NMC received a copy of a report carried out by the Care Quality Commission (CQC). The CQC received an anonymous referral relating to Care 24x

in April 2021. It carried out an inspection between the 25 June 2021 and 9 July 2021. It published its report on 11 September 2021. It found the agency to be ‘inadequate’ in answers to the questions: “Is the service safe?” and “Is the service well-led?”. In answer to the questions “is the service effective?”, “is the service caring?” and “is the service responsive?” the findings were the service “requires improvement”.

The concerns that were raised in the CQC report related to Mrs Thomas’ leadership and management. The report stated that the inspection had identified breaches in relation to safe care and treatment, good governance, and notification of incidents. The report also highlighted inadequate systems and procedures for risk assessment, medicines management and the provision of training.

The CQC report also alleged that the provider was not open and transparent during the inspection. It is alleged that inaccurate information was given to the CQC regarding the numbers of employees and care packages managed by the Agency. It was alleged by a CQC inspector that there was a lack of candour and an expert considered that the inaccuracy was a result of dishonesty on the part of both Mrs Thomas and Mr 1 who was the nominated individual of the Agency. It is also alleged that there was a failure to ensure staff were adequately trained in certain matters. There was a failure to ensure there was a proper system in place in respect of safe administration and management of medication and finally, in respect of care plans containing inadequate risk assessments.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case, together with the submissions made by Mr Clair on behalf of the NMC, the oral evidence provided by Mr 1, and Exhibit 5, Exhibit 6 and Exhibit 7, containing Mrs Thomas’ evidence.

The panel has drawn no adverse inference from the non-attendance of Mrs Thomas.

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

- Witness 1: Inspection Manager at the CQC at the time of the inspection.

- Witness 2: Expert Witness instructed by the NMC to review documents and bundles.

- Witness 3: Former inspector at the CQC who carried out the inspection at the Agency.

The panel also heard evidence from Mr 1, who was the nominated individual at the Agency.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred it to the cases of *Ivey v Genting Casinos* [2017] UKSC 67, and other cases relevant to witness demeanour, hearsay, and expert evidence.

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

Charge 1

'That you, while a registered manager of Care 24X ("the Agency"),

> *Provided the CQC with inaccurate numbers of employees and care packages managed by the Agency.'*

This charge is found proved.

In reaching this decision, the panel took into account the email exchanges between Witness 3 and Care 24x Limited and Witness 3's evidence.

The panel noted that Mrs Thomas had been the registered manager for two years, but this appeared to have been in name only with little direct involvement in the business. She had been away in Dubai for six months and upon her return to the UK, became actively involved in the day to day running of the business whereas this had previously been the domain of a former director.

The panel found that Mrs Thomas provided inaccurate information to the CQC, as evidenced by the figures presented. The panel found that there was a significant discrepancy between the service users the Commissioning Support Unit (CSU) had on their system and provided to the CQC, and the numbers the Agency had given. The panel had sight of two lists of service user names, one list from the Agency contained nine names and another list from the CSU contained 21 names. The panel also had sight of the original staff list of 17 provided to the CQC and an updated version with 31 employees.

Accordingly, this charge is found proved.

Charge 2

'That you, while a registered manager of Care 24X ("the Agency"),

> *Your actions at charge 1 were dishonest in that you intentionally provided inaccurate information with the intention that the CQC would believe the information to be accurate.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 3, Mr 1, and Mrs Thomas' undated statement and evidence within her bundle, Exhibit 5.

The panel had regard to the test set out in *Ivey v Genting Casinos:*

- What was the defendant's actual state of knowledge or belief as to the facts;
- Whether that knowledge or belief was genuinely held; and

- In light of that knowledge or belief, was the conduct dishonest by the standards of ordinary decent people?

The panel noted that Mrs Thomas provided some context as to the business arrangements of the Agency. In the undated statement, Mrs Thomas stated,

> ‘*In March after returning from my holiday we noticed irregularities with the way the business was being managed, decision was made without registered manager knowledge and salary have been paid but no income for the business. On investigation we noticed that money meant for the business was being paid to personal account. Unanimous decision was made to terminate the business manager and that was the beginning of our problem.*
>
> *[PRIVATE]*
>
> *During the inspection we were open and transparent with the CQC inspector as we only presented information on what we have access to, and a business improvement plan was sent to the CQC inspector. We do not conceal information from the inspector we only provided information based on what we have access to on the day of the inspection, and we also sent more information to the inspector later.’*

At the time of the inspection, and according to the Agency’s records held, Mrs Thomas believed the Agency had only nine service users. She was not aware that the former director had continued to care for service users under the Agency’s name, and had no systems to adequately assure herself of the Agency’s service user and staff numbers.

The panel considered on the balance of possibilities that Mrs Thomas did not intentionally provide inaccurate information to the CQC. The panel found that she and Mr 1 did not have an adequate grasp on what contracts were in place for care packages, nor how many staff were employed at the Agency. Both Mrs Thomas and Mr 1 were not aware that a former director was either continuing existing care packages or accepting service users on behalf of the Agency, and running this

separately under a new business. The panel took the view that this was incompetence and not dishonesty. It was clear that Mrs Thomas did not have an adequate understanding of the running of the business or a grasp of her own responsibilities as a registered manager. The panel considered that there was an alternative explanation for the inaccurate figures apart from dishonesty.

The panel also considered the expert evidence of Witness 2. It considered that, although coherent and appropriately examined during the hearing, the expert accepted that they had limited knowledge of the background chaotic state of the business and as such, their evidence in context had reduced relevance.

It was noted that Mrs Thomas raised assertions in her bundle of discriminatory behaviour regarding the original complaints received by the CQC. The panel did not find this relevant to the charges themselves.

The panel therefore found charge 2 not proved.

Charge 3

'That you, while a registered manager of Care 24X ("the Agency"),

Did not ensure staff at the Agency were adequately trained:

- a. *Percutaneous Endoscopic Gastrostomy (PEG) care.*
- b. *Catheter care.*
- c. *PRN medication procedures.*
- d. *End of life care.'*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and their exhibits which included the CQC inspection report for the inspection visit between June 2021 and July 2021, email response from Mrs Thomas about the factual accuracy of concerns, and the training matrix for Care 24x Limited.

The panel noted the evidence from Mrs Thomas provided in her statement and exhibit bundle, Exhibit 5.

The CQC report identified what training was lacking at the time of inspection and the panel did not have sight of any other evidence that contradicted the report. The CQC report identified,

> *'The registered manager did not provide details of any training the additional 10 staff had completed identified following the site visit. Discussion with staff identified that the provider relied upon training provided by previous employers and delivered very limited training themselves…'*

The panel had sight of an email between Witness 3 and Mrs Thomas, who responded to the concerns raised at inspection. The panel also saw the training matrix supplied by the Agency, but this did not include all staff, lacked accuracy as to when training was due for renewal, and it only addressed the training in respect of basic care training, catheter care and PRN medication procedures. The training matrix did not include training for PEG care or End of Life care.

The panel noted Witness 2's comments:

> *'It is, however, worth mentioning that many of the carers employed had worked in other care settings and would have had training prior to commencing work with Care 24x.'*

However, the panel noted that there was no system in place to check what training had been undertaken previously, nor to record it.

Taking everything into consideration, the panel found that on the balance of probabilities that Mrs Thomas did not ensure that staff at the Agency were adequately trained in PEG care, catheter care, PRN medication procedures and End of Life care. The panel finds this charge proved.

Charge 4

'That you, while a registered manager of Care 24X ("the Agency"),

Did not have a proper system in place to ensure:

a. Safe administration and management of medication.
b. Care plans contained adequate risk assessments.'

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, Witness 3, Mr 1 and their exhibits which included the CQC inspection report for the inspection visit between June 2021 and July 2021. The panel also considered Mrs Thomas' statement and bundle, Exhibit 5 and Exhibit 7 respectively. The panel noted that the care plans and risk assessments stated that they had been completed by Mrs Thomas.

The panel noted that in the CQC inspection report, it was stated:

> '*The medicine policy stated that all medicines administered should be recorded and subject to stock counts and audits. There was no evidence such checks had happened. We discussed this with the provider, they acknowledged an audit had been planned but not completed.'*

The report also identified:

> *'The provider told us there had been no incidents or accidents. However an ongoing safeguarding concern contained elements which should have been recorded as an incident. The provider could not evidence any monitoring or management of incidents. An audit tool was available to the provider but had not been completed.'*

The panel also considered the evidence of Witness 2 who stated:

‘The information provided is mixed, in that continence care and skin integrity appear to be managed well, however the risk assessments fall short in providing detail of what carers should do in the event of specific needs.’

Taking everything into consideration, the panel determined that Mrs Thomas did not have a proper system in place to ensure safe administration and management of medication, nor to ensure that care plans contained adequate risk assessments. The panel finds this charge 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 Mrs Thomas’ 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 determined whether the facts found proved amount to misconduct. Secondly, to those facts found to be misconduct, the panel determined whether, in all the circumstances, Mrs Thomas’ fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Clair 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 Clair identified the specific, relevant standards where Mrs Thomas' actions amounted to misconduct, and that sections 1, 4, 6, 7, 10, 16, 17, 18, 20, and 25 of the Code are engaged.

Mr Clair submitted that, in respect of the charges found proved, Mrs Thomas' failings were not the result of mere oversight, but did amount to incompetence. Although not in a clinical role, she was responsible for how the agency was run and for the safety of its service users. Mr Clair submitted that it was Mrs Thomas' responsibility to provide the CQC with accurate numbers of employees and care packages, and that a number of staff were untrained in End of Life care, despite many of the service users being End of Life patients. Mr Clair also submitted that there was also no training in other areas of care that the staff employed by the agency were undertaking.

Submissions on impairment

Mr Clair 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Mr Clair addressed the panel regarding the test in *Grant*. He submitted that the first three limbs are engaged in this case.

Mr Clair submitted that there are significant public protection concerns as Mrs Thomas' misconduct concerned failings in fundamental areas of clinical practice.

Mr Clair then addressed the panel on the questions in *Cohen,* and whether the misconduct is remediable. He submitted that the concerns in this case do not relate solely to easily remediable concerns such as poor record keeping. He submitted that, in totality, the concerns ought to be viewed as serious. He submitted that no evidence of recent insight has been submitted by Mrs Thomas, and so the panel cannot be satisfied that she has properly reflected on the conduct found proved, nor that she has expressed remorse or regret for what happened. In these circumstances, Mr Clair submitted that there is a risk that the behaviour will be repeated. Accordingly, he invited the panel to make a finding of impairment on the ground of public protection.

Mr Clair submitted that the need to uphold proper professional standards and public confidence in the profession would be undermined if the panel did not make a finding of impairment in this case. Mr Clair invited the panel to make a finding of impairment on the ground of public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Calhaem v GMC [2007] EWHC 2606 (Admin)*; *Yeong v General Medical Council [2009] EWHC 1923 (Admin); Schodlok v. GMC [2015] EWCA Civ 769;* and *R v (Zygmunt) v GMC [2008] EWCH 2643 (Admin).*

Decision and reasons on misconduct

The panel considered whether the misconduct was linked to the practice of nursing, which can either be directly connected to clinical behaviours or related to clinical practice. It considered the NMC guidance in FTP 2A and determined that Mrs Thomas' role was related to clinical practice, looking at the nature and setting in the specific circumstances of a 'care' provider. The panel considered that Mrs Thomas' responsibilities, including direct responsibility for matters such as care plans for infection control in PEG or catheter care and the administration of medication, meant that her role was related to clinical behaviours, even though she was not performing a nursing role at the time.

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 Mrs Thomas' actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Thomas' actions amounted to a breach of the Code. Specifically:

6. Always practise in line with the best available evidence
6.2 *maintain the knowledge and skills you need for safe and effective practice*

8. Work cooperatively
8.4 *work with colleagues to evaluate the quality of your work and that of the team*
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
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 nee*

11. Be accountable for your decisions to delegate tasks and duties to other people

11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard*

13 Recognise and work within the limits of your competence

13.5 *complete the necessary training before carrying out a new role*

16. Act without delay if you believe that there is a risk to patient safety or public protection

16.2 *raise your concerns immediately if you are being asked to practise beyond your role, experience and training*

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

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

20. Uphold the reputation of your profession at all times

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

25. Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

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*

25.2 *support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken*

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

In relation to charge 1, the panel found this did not amount to misconduct. The panel considered the context in which this behaviour took place, particularly that Mrs Thomas was not competent in the responsibilities of the role. The panel determined that Mrs Thomas' providing inaccurate numbers of employees and care packages to the CQC was caused by her unfamiliarity with the requirements of the role, and that this amounted to negligence. The panel also considered that, while Mrs Thomas failed to meet the responsibilities and requirements of her role, service users were not put at unwarranted risk of harm as a result of the behaviour in this charge. Therefore, the panel did not consider this negligence to be so serious as to amount to misconduct.

In relation to charges 3 and 4, the panel found these charges to individually amount to misconduct. The panel determined that Mrs Thomas' failures in ensuring that Agency staff were adequately trained and ensuring that proper systems were in place to manage care plans and the safe administration and management of medication put service users at unwarranted risk of harm. Despite not being personally responsible for providing care to service users directly, the panel determined that, in her role as the registered manager, Mrs Thomas was responsible for oversight of the service. The panel considered that Mrs Thomas had been the registered manager for two years and had not in that time taken adequate steps to put in place processes that would meet the requirements of the role and ensure the safety of patients. As such, the panel determined that Mrs Thomas' conduct at both charges 3 and 4 could have led to unwarranted risk of harm to service users and could bring the profession into disrepute as it breached fundamental tenets of the Code, such that ordinary members of the public would be alarmed. Accordingly, the panel concluded that your behaviour at charge 3 and charge 4 individually was serious and amounted to misconduct. The panel found that Mrs Thomas' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Thomas' 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 finds that service users were put at risk of harm as a result of Mrs Thomas' misconduct. Mrs Thomas' misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case was capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Thomas has taken steps to strengthen her practice. To date the panel has seen no evidence of remorse or relevant remediable action taken by Mrs Thomas, nor any evidence that her insight or reflection into her behaviour is fully developed. It noted that in Mrs Thomas' reflective accounts she

sought to blame others and failed to take responsibility for her misconduct. There was no recognition of the risk posed to service users as a result of her misconduct, and no indication of how she would behave differently in future. Accordingly, the panel was of the view that there was a risk of repetition. 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.

In addition, due to the seriousness of the charges and lack of remediation and genuine insight, the panel 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 Mrs Thomas' fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mrs Thomas' name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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.

Submissions on sanction

Mr Clair informed the panel that in the Notice of Hearing, dated 6 June 2024, the NMC had advised Mrs Thomas that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a suspension order of 12 months with a review is more appropriate in light of the panel's findings.

Mr Clair submitted that this case is too serious for the panel to make no order or to impose a caution. He submitted that Mrs Thomas' misconduct was not at the lower end of the spectrum. He submitted that while there are clear, identifiable areas which could be addressed through conditions, there is no evidence of Mrs Thomas' current level of insight into her failings. As such, he submitted that conditions or practice are not appropriate. Mr Clair submitted that the seriousness of this case requires a temporary suspension from the Register in order to protect the public and maintain public confidence in the profession. He submitted that a striking-off order would be disproportionate.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Thomas' 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:

- That Mrs Thomas' misconduct put vulnerable service users at potential risk of harm
- That Mrs Thomas has not consistently engaged with the NMC process
- That Mrs Thomas' reflection only concerns the allegation of dishonesty, and she does not provide insight into her misconduct on the other charges, nor the potential harm that her misconduct could have caused

The panel also took into account the following mitigating features:

- That Mrs Thomas was under significant personal challenges at the time of her misconduct
- That Mrs Thomas experienced challenges with the operational management of the business at the time of the misconduct
- That Mrs Thomas did engage with the NMC at the early stages of its investigation and did submit some limited reflection to the NMC in this respect

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Thomas' 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 Mrs Thomas' 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 Mrs Thomas' registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the misconduct highlighted in this case.

The panel had regard to the fact that, other than these incidents, it has seen no information of any other regulatory concerns raised against Mrs Thomas. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Thomas should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in this case as Mrs Thomas' misconduct is identifiable and remediable with training and reflection.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Clair in relation to the sanction that the NMC was seeking in this case. However, the panel determined that conditions would protect the public and meet the public interest and still afford Mrs Thomas an opportunity to strengthen her practice and demonstrate this practically to the NMC.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post that you undertake as a nurse, midwife or nursing associate. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You may not be the ‘Registered Manager’ or ‘Nominated Individual’ (or equivalent position) in a domiciliary care agency or care/nursing home.

2. You must meet with your line manager/supervisor/mentor monthly to discuss your progress in complying with processes, procedures and regulatory requirements. A report from these meetings must be made and submitted to the NMC before any review.

3. You must undertake training in the following areas:

   a) Regulatory compliance relevant to your role
   b) Quality assurance

4. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer’s contact details.

5. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months in order to allow adequate time for the required training to be completed and demonstrate a period of safe practice and a strengthening of management capability.

Before the order expires, a panel will hold a review hearing to see how well Mrs Thomas has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of training completed
- A full reflective piece from Mrs Thomas demonstrating that she understands the importance of regulatory compliance and quality assurance, as well as insight into her misconduct
- Any relevant regulatory or independent audit reports for the setting Mrs Thomas is working in, if she was involved
- Testimonials relating to Mrs Thomas' current practice

This will be confirmed to Mrs Thomas in writing.

Interim order

As the conditions of practice 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 Mrs Thomas' own interests until the conditions of practice sanction 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 Mr Clair. He invited the panel to impose an interim conditions of practice order for a period of 18 months to allow adequate time for any appeal to be resolved.

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 the only suitable interim order would be that of a conditions of practice order, as this is appropriate due to the panel's earlier findings. The

conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow time for any appeal to be resolved.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Thomas is sent the decision of this hearing in writing.

That concludes this determination.