Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 June 2024 – Friday, 14 June 2024

Virtual Hearing

Name of Registrant:	**Mary Holly Davies**
NMC PIN	12H1820E
Part(s) of the register:	Registered Nurse – (Sub part 1) Learning Disabilities (Level 1) - 26 October 2013
Relevant Location:	Gateshead
Type of case:	Misconduct
Panel members:	Melissa D'Mello (Chair, Lay member) Jillian Claire Rashid (Registrant member) Angela Kell (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Jemima Lovatt, Case Presenter
Ms Davies:	Not present and unrepresented at the hearing
Facts proved:	Charges 1a, 1b, 2a, 2b, 3 and 4
Facts not proved:	Charge 1c
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decisions and reasons on application for hearing to be held partly in private

Ms Lovatt, on behalf of the Nursing and Midwifery Council (NMC), made an application that this case should be held partly in private on the basis that proper exploration of this case involves [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel 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 accepted the advice of the legal assessor.

The panel determined to hold this hearing partly in private. It will go into private session [PRIVATE]. It will also go into private session [PRIVATE].

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Davies was not in attendance and that the Notice of Hearing letter had been sent to Ms Davies' registered address by recorded delivery and by first class post on 3 April 2024.

Ms Lovatt 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 had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was sent to Ms Davies' registered address on 3 April 2024.

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 Ms Davies' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Davies has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Davies

The panel next considered whether it should proceed in the absence of Ms Davies. It had regard to Rule 21 and heard the submissions of Ms Lovatt who invited the panel to continue in the absence of Ms Davies.

Ms Lovatt referred the panel to the emails from Ms Davies to the NMC, dated 13 June 2023 and 20 June 2023 respectively. [PRIVATE]. [PRIVATE]. [PRIVATE]. Ms Lovatt informed the panel that there had been no further evidence from Ms Davies despite several requests for such information by the NMC.

Ms Lovatt referred the panel to Rule 21 and submitted that it has been confirmed by Ms Davies and her family member in their emails to the NMC respectively, that she will not be attending the substantive hearing, nor will she be represented. She submitted that Ms Davies has voluntarily absented herself from the substantive hearing and has not requested an adjournment of this matter. Ms Lovatt submitted that there is a strong public interest in the expeditious disposal of the case as the charges relate to events that occurred in 2020. She concluded that it is therefore fair for the hearing to proceed in the absence of Ms Davies.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised

'with the utmost care and caution' as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Davies. In reaching this decision, the panel has considered the submissions of Ms Lovatt, the emails from Ms Davies to the NMC dated 13 June 2023 and 20 June 2023 respectively, [PRIVATE], and the advice of the legal assessor. It has had particular regard to the NMC Guidance on Proceeding in absence, CMT 8 and factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162. The panel also had regard to the overall interests of justice and fairness to all parties. It noted that:

- The charges relate to events that occurred in 2020 and further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- There is a strong public interest in the expeditious disposal of the case;
- Four witnesses are scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- [PRIVATE];
- [PRIVATE];
- [PRIVATE];
- [PRIVATE];
- [PRIVATE];
- Ms Davies is aware of this substantive hearing and the panel determined that, [PRIVATE], Ms Davies has voluntarily absented herself;
- No application for an adjournment has been made by Ms Davies;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- Ms Davies has provided written representations to the charges in the Registrant Response Bundle.

There is some disadvantage to Ms Davies in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, Ms Davies 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 noted that Ms Davies is not present to test the NMC's evidence by cross-examination but, the panel, of its own volition, may explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Davies' decisions to absent herself from the hearing, waive her right to attend, and/or be represented.

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

Details of charge

That you, a registered nurse, whilst working at Craigielea Care Home:

1. On or around 20th January 2020 in relation to Resident A:

    a. Threw a box of tissues at him;
    b. Told him his wife had died or words to that effect;
    c. Told him you were sick of him or words to that effect.

2. On or around 20th January 2020 you told members of staff:

    a. to wind Resident A up or words to that effect;
    b. falsify Resident A's behavioural records.

3. Your action at charge 1b was dishonest in that you knew that Resident A's wife was not dead.

4. Your actions at charges 2a and/or 2b were dishonest in that you sought to show Resident A's behaviour to be worse than it was.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Lovatt under Rule 31 to admit the handwritten statement of Colleague 1 into evidence. She highlighted that under the NMC Guidance on Evidence (DMA-6), evidence is not inadmissible on the ground that it is hearsay. However, there may be circumstances where it may not be fair to admit for example, where it is the sole and decisive evidence in respect of a serious charge, where it is not demonstrably reliable, and where it is not capable of being tested. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). She submitted that this case laid out the following factors to be considered in admitting hearsay evidence and she further stated that she would address each factor respectively:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Lovatt submitted that the handwritten statement of Colleague 1 was not the sole and decisive evidence in relation to charge 1 as there was other evidence that supported the charge. She asserted that charge 1 was also supported by the witness statements and documentary evidence of Witnesses 1, 2, 3 and 4. She submitted that the respective witnesses would be attending the hearing and there would be an opportunity for their evidence to be challenged and tested by the panel.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Lovatt highlighted that in the Registrant Response Bundle, Ms Davies had indicated that the allegations against her were fabricated and that she was subjected to bullying at the Home as a result of a complaint she had made about a medication

error made by Witness 1. Ms Lovatt submitted that Witness 1, in whose witness statement the statement of Colleague 1 was exhibited, would attend the hearing and therefore, she could be cross-examined on those issues raised by Ms Davies.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Lovatt submitted that although Ms Davies had stated that she was the subject of bullying at the Home, it is the NMC's position that she failed to provide sufficient basis for such allegation and therefore, there was insufficient evidence to suggest that Colleague 1 had any reason to fabricate her statement.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Lovatt submitted that the charges are serious and should they be found proven, the NMC's sanction bid would be a striking-off order. She submitted that an adverse finding may have a negative impact on Ms Davies' nursing career.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Lovatt submitted that Colleague 1 did not engage with the local investigation at the Home and given that she was a care assistant, she was not under a duty to engage with the NMC proceedings.

vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Lovatt submitted that the NMC investigation team did not consider Colleague 1 to be a key witness as she was not a direct witness to the incidents. Therefore, there were no concerted efforts made by the NMC to secure Colleague 1's attendance as a witness.

vii. Whether the registrant had prior notice that the witness statement would be read:

Ms Lovatt submitted that although Ms Davies did not have notice of this hearsay application prior to the hearing, a notice was sent to her on 4 June 2024 (the day in

which the hearsay application was made) by the NMC and there was yet to be any response from Ms Davies.

In conclusion, Ms Lovatt submitted that it was fair and appropriate for the handwritten statement of Colleague 1 to be admitted into evidence and the panel may then attach any weight it deems appropriate to it.

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

The panel considered the hearsay application.

The panel was of the view that the handwritten statement of Colleague 1 was potentially relevant to charge 1, however, it was ambiguous and vague as it did not specify the resident to whom the statement was referring nor the date on which the described allegation took place. Furthermore, the statement was undated, not signed and did not contain a statement of truth. The panel also noted that Colleague 1 was not a direct witness of the incident and did not identify the member of staff who informed her of the incident. The panel therefore determined that the statement of Colleague 1 amounted to double hearsay.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel noted that the statement of Colleague 1 was not the sole and decisive evidence in support of charge 1, as the NMC had adduced other evidence in support of the charge in the witness statements and documentary evidence of Witnesses 1, 2, 3 and 4.

The panel took into account that Ms Davies appeared to challenge the contents of the statement of Colleague 1 insofar as she denied the allegations. It noted that Ms Davies had stated that she was subjected to bullying at the Home by Witness 1. Ms Davies asserted that the fabricated allegations arose in response to her complaint

against Witness 1. She also asserted that other colleagues who were friends with, and part of Witness 1's clique, also fabricated their allegations against her. The panel further noted that Ms Davies had alleged that Colleague 1 may have had a reason to fabricate the allegations as she did not agree with Ms Davies' view to transfer Resident A to the hospital.

The panel considered the charges to be serious as they involved the allegation of dishonesty, and any adverse finding could have a negative impact on the nursing career of Ms Davies. It noted the submissions of Ms Lovatt that the NMC investigation team did not consider Colleague 1 to be a key witness as she was not a direct witness to the incidents and therefore, there had been no concerted effort to secure Colleague 1's attendance. However, the panel was not satisfied that there was a good reason for the non-attendance of Colleague 1, nor that the NMC had taken all reasonable steps to secure the attendance of Colleague 1 at the hearing.

The panel also noted that Ms Davies was not given notice prior to the hearing that the statement of Colleague 1 would be tendered as hearsay evidence by the NMC as notice was only given to Ms Davies on 4 June 2024 (the day in which the hearsay application was made). The panel was not satisfied that sufficient notice had been given by the NMC to Ms Davies that the statement of Colleague 1 would be tendered as hearsay evidence.

In these circumstances, the panel determined that it was not fair to admit the statement of Colleague 1 into evidence. Although, the panel considered the statement of Colleague 1 to be potentially relevant to charge 1, the statement was undated, not signed and did not contain a statement of truth. It was a double hearsay and did not clearly specify the resident to whom the statement was referring nor the date on which the described allegation took place. There was no cogent reason for the non-attendance of Colleague 1 at the hearing and insufficient notice was given to Ms Davies by the NMC that the statement of Colleague 1 would be tendered as hearsay evidence. Although Witness 1 could be questioned by the panel regarding the statement of Colleague 1, the panel concluded that this would not be sufficient to mitigate the unfairness posed to Ms Davies. Accordingly, the hearsay application was refused.

Decision and reasons on redaction of evidence

The panel heard the proposal from the legal assessor for the redaction of certain paragraphs in the documentary evidence of certain witnesses.

With respect to the handwritten statement of Witness 2 dated 10 March 2020, the legal assessor proposed the redaction of part of the sentence: *'…she was laughing at what she had done'.* He stated that the redaction was required as the sentence contains an allegation which had not been charged against Ms Davies.

The legal assessor also suggested that the first part of that sentence *'…she even told me what she had done…'* contained in the same statement, should be redacted as it amounted to an alleged admission made by Ms Davies to Witness 2. He stated that such an alleged admission was prejudicial to Ms Davies and ought to have been separately charged.

Ms Lovatt submitted that the NMC agreed with the proposal of the legal assessor for the redaction of the sentence '…*she was laughing at what she had done'* given that the allegation was not charged against Ms Davies. However, she submitted that the sentence *'…she even told me what she had done…'* should not be redacted as it was only an account of the incident by Witness 2 and did not amount to an admission by Ms Davies to the allegation. She submitted that Witness 2 would be attending the hearing and that this evidence could be tested by the panel.

In relation to the witness statement of Witness 3 dated 23 March 2023, the legal assessor proposed the redaction of the sentence in paragraph nine which stated: *'…Ms Davies told the assessors that the resident had ripped a fire door of its hinges...'.* The legal assessor stated that the redaction was required as the sentence contains an allegation of misleading the assessors, which had not been charged against Ms Davies and was not covered by charge 2b. That charge was restricted to instructions given by Ms Davies and did not include her own actions.

Ms Lovatt submitted that the sentence *'…Ms Davies told the assessors that the resident had ripped a fire door of its hinges…'* should not be redacted. She submitted that the sentence provided further context of the extent of Ms Davies' behaviour and formed part of charge 2b.

With regards to the handwritten statement of Witness 3 dated 16 March 2020, the legal assessor proposed the redaction of the sentence *'…she told me that she had told* (Resident A) *that she has killed his wife…'.* He stated that this amounted to an alleged admission made by Ms Davies to Witness 3 and that such an alleged admission was prejudicial to Ms Davies and ought to have been separately charged.

Ms Lovatt submitted that the sentence *'…she told me that she had told* (Resident A) *that she has killed his wife…'* should not be redacted as it was only an account of the incident by Witness 3 and did not amount to an admission by Ms Davies to the allegation. She submitted that Witness 3 would be attending the hearing and her evidence could be tested by the panel. She stated that it was a matter for the panel whether to accept Witness 3's account of the incident and to attach whatever weight it deemed fit to the statement.

The legal assessor further suggested the redaction of the sentence *'…she informed me she allowed the assessment team to believe that* (Resident A) *had ripped a fire door from the wall…'* contained in the handwritten statement of Witness 3 dated 16 March 2020. He stated that the sentence contained an allegation which did not form part of the charges against Ms Davies and was not covered by charge 2b. That charge was restricted to instructions given by Ms Davies and did not include her own actions.

Ms Lovatt submitted that the sentence *'…she informed me she allowed the assessment team to believe that* (Resident A) *had ripped a fire door from the wall…'* should not be redacted as it provided further context of the extent of Ms Davies' behaviour and formed part of charge 2b.

With respect to the Fact-finding Meeting Notes (fact finding meeting with Witness 3) dated 25 March 2020, the legal assessor proposed the redaction of the sentence

'…Then MHD (Ms Davies) *told me that she had just told* (Resident A) *that his wife had died…'.* He stated that it amounted to an alleged admission made by Ms Davies to Witness 3 and such an alleged admission was prejudicial to Ms Davies and ought to have been separately charged.

Ms Lovatt submitted that the sentence *'…Then MHD* (Ms Davies) *told me that she had just told* (Resident A) *that his wife had died…'* should not be redacted as it was only an account of the incident by Witness 3 and did not amount to an admission by Ms Davies to the allegation. She submitted that Witness 3 would be attending the hearing and her evidence could be tested by the panel. She stated that it was a matter for the panel whether to accept Witness 3's account of the incident and to attach whatever weight it deemed fit to the statement.

In relation to the witness statement of Witness 4 dated 10 November 2022, the legal assessor proposed the redaction of the sentence in paragraph eight which stated: *'…Holly went away downstairs to call the behavioural team (social workers) and told us to leave* (Resident A) *in his room.'* Similarly, the legal assessor also suggested the redaction of the sentence *'holly told us to leave him* (Resident A) *in his room, this made him worse.'* contained in the Record of Meeting dated 11 March 2020 (investigation meeting with Witness 4). The legal assessor stated that the respective sentences amounted to an additional allegation against Ms Davies which was not contained in the charges against her.

Ms Lovatt stated that the NMC agreed with the proposal of the legal assessor for the redaction of the respective sentences as highlighted by the legal assessor.

With regards to the witness statement of Witness 4 dated 10 November 2022, the legal assessor proposed the redaction of the sentence in paragraph nine which stated: '*Holly asked him (Resident A) to go to his room until we came upstairs, but this made him worse.'* He stated that the redaction was required as the sentence amounted to an additional allegation against Ms Davies which was not contained in the charges against her.

Ms Lovatt opposed the redaction of the sentence '*Holly asked him (Resident A) to go to his room until we came upstairs, but this made him worse.'* She submitted that the sentence was merely contextual and was not so serious as to amount to an allegation which could be charged. She submitted that Witness 4 would be attending the hearing and this provides an opportunity for her to make further clarifications on the sentence.

The panel heard the advice of the legal assessor.

With respect to the handwritten statement of Witness 2 dated 10 March 2020, the panel decided to redact part of the sentence: *'…she was laughing at what she had done'.* It was of the view that this part of the sentence contained an allegation which had not been charged against Ms Davies. However, the panel decided not to redact part of the sentence *'…she even told me what she had done…'.* It was of the view that this part of the sentence did not amount to an admission by Ms Davies but was an account of the incident by Witness 2 which could be tested during his oral evidence.

In relation to the witness statement of Witness 3 dated 23 March 2023, the panel decided not to redact the sentence in paragraph nine which stated: *'…Ms Davies told the assessors that the resident had ripped a fire door of its hinges...'.* It was of the view that this sentence provided context to the charges.

With regard to the handwritten statement of Witness 3 dated 16 March 2020, the panel decided not to redact the sentence *'…she told me that she had told* (Resident A) *that she has killed his wife…'. .* It was of the view that the sentence did not amount to an admission by Ms Davies but was an account of the incident by Witness 3 which could be tested during her oral evidence. It was a matter for the panel whether to accept Witness 3's account of the incident and to attach whatever weight it deemed fit to the statement.

The panel also decided not to redact the sentence *'…she informed me she allowed the assessment team to believe that* (Resident A) *had ripped a fire door from the wall…'* contained in the handwritten statement of Witness 3 dated 16 March 2020. It

was of the view that the sentence provided context to charge 2b and did not constitute a separate allegation.

With respect to the Fact-finding Meeting Notes (fact finding meeting with Witness 3) dated 25 March 2020, the panel decided not to redact the sentence *'…Then MHD* (Ms Davies) *told me that she had just told* (Resident A) *that his wife had died…'.* It was of the view that the sentence did not amount to an admission by Ms Davies but was an account of the incident by Witness 3 which could be tested during her oral evidence. It was a matter for the panel whether to accept Witness 3's account of the incident and to attach whatever weight it deemed fit to the statement.

In relation to the witness statement of Witness 4 dated 10 November 2022, the panel decided to redact the sentence in paragraph eight which stated: *'…Holly went away downstairs to call the behavioural team (social workers) and told us to leave* (Resident A) *in his room.'* The panel also decided to redact the sentence *'holly told us to leave him* (Resident A) *in his room, this made him worse.'* contained in the Record of Meeting dated 11 March 2020 (investigation meeting with Witness 4). It agreed with the view of the legal assessor that the respective sentences amounted to an additional allegation against Ms Davies which was not contained in the charges against her.

With regards to the witness statement of Witness 4 dated 10 November 2022, the panel decided not to redact the sentence in paragraph nine which stated: '*Holly asked him (Resident A) to go to his room until we came upstairs, but this made him worse.'* It was of the view that the sentence did not constitute a separate allegation against Ms Davies but was an account of the incident by Witness 4 which provided context to the charges.

Decision and reasons on legal assessor's request to ask questions on Mr 1's statements

The panel heard a request from the legal assessor to be allowed to put questions to Witness 3 with respect to Mr 1's observations of Resident A's behaviour on 20 January 2020 as contained in his statement record dated 25 March 2020. The legal

assessor stated that this was to ensure that the proceedings were fair to Ms Davies as she wanted the evidence of Mr 1 to be considered by the panel and be put to the witnesses. He stated that it would amount to prejudice to Ms Davies if Witness 3's evidence was not tested by asking her questions with respect to Mr 1's observations of Resident A's behaviour on 20 January 2020 as contained in his statement record dated 25 March 2020.

Ms Lovatt stated that she did not object to the request by the legal assessor but would suggest that any questions put to Witness 3 should be made in a general format. She submitted that it would amount to an "*overchallenge*" of Witness 3 if she was asked questions about evidence which she was not aware of and may amount to pitting witnesses against each other. She submitted that it is a matter for the panel to compare evidence from the NMC and Ms Davies and attach any weight it may deem fit. [PRIVATE].

The panel heard the advice of the legal assessor.

The panel carefully considered the request by the legal assessor. The panel considered that, in her written representations, Ms Davies was critical of the local level disciplinary managers with regard to their not taking into account Mr 1's local statement. The panel noted that Mr 1's local level statement had been requested by the legal assessor and was now before it. It noted that Ms Davies had chosen not to attend the hearing nor be represented. Therefore, she would not be able to challenge the evidence of the NMC witnesses in person. However, the panel could, within its own volition, explore any inconsistencies in the evidence before it by posing questions to NMC witnesses.

Nevertheless, the panel was of the view that, in balancing the interests of the NMC and Ms Davies, it would not stray into overcompensating for the non-attendance of Ms Davies by presenting Ms Davies' case to the NMC witnesses. The panel had before it the local level statement and the local level fact-finding investigatory meeting minutes relating to Mr 1; the panel carefully considered the nature, content and context of these documents. It bore in mind that it is a matter for the panel to compare evidence from the NMC and Ms Davies and attach any weight it may deem

fit. Therefore, the panel determined that, in this instance, it was not appropriate for the legal assessor to put questions to Witness 3 with respect to Mr 1's observations of Resident A's behaviour on 20 January 2020 as contained in his statement dated 25 March 2020. The panel was satisfied, notwithstanding the advice of the legal assessor, that this would not amount to unfairness and prejudice to Ms Davies.

Decision and reasons on application to admit additional documents

Ms Lovatt made an application for the following additional documents to be admitted into evidence:

- Extract from Ms Davies' appeal meeting minutes (the Minutes Extract)
- Pre-admission and Inpatient care plan for Resident A (the Plan)

With respect to the Minutes Extract, Ms Lovatt submitted that the panel should only focus on the highlighted parts of the Minutes Extract as they contain the comments made by the operations manager, during Ms Davies' appeal meeting, on the appropriate procedure for investigations by a care manager.

Ms Lovatt submitted that the Minutes Extract was relevant to this case as it provided context to the questions she had asked Witness 1 about the standard procedure for investigations at the Home. She stated that the Minutes Extract was obtained from the Home based on the request from the legal assessor and it was reasonable to assume that it was provided to Ms Davies as part of the appeal process at the Home.

Ms Lovatt submitted that it was fair for the Minutes Extract to be admitted into evidence as it supports the evidence of Ms Davies and would assist the panel in its decision-making process.

In relation to the Pre-admission and Inpatient care plan for Resident A, Ms Lovatt submitted that the document was obtained from the Home as a result of the question from the legal assessor as to whether there was any document with regards to the sectioning of Resident A. She submitted that the Plan contains a summary of the

reasons for Resident A's admission, his progress over time and his discharge from the hospital.

Ms Lovatt submitted that the Plan was relevant to this case as it provides context and reasons for the admission of Resident A for sectioning and his subsequent discharge in March 2020. She submitted that although the Plan does not support Ms Davies' evidence, it was fair to admit it into evidence as it would assist the panel to make its decision on facts.

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

The panel first considered whether the Minutes Extract was relevant to this case. It noted that Ms Davies had alleged that the investigation conducted by Witness 1 was biased against her and the investigation was therefore restarted by Ms 1. The panel had also heard oral evidence from Witness 1 about the standard procedure for the conduct of investigations by care managers at the Home as well as the unfavourable environment at the Home when she returned from her leave. The panel was therefore of the view that the Minutes Extract provides further context to the allegations of bias made by Ms Davies against Witness 1, and the appropriate procedure in the conduct of investigations by care managers at the Home. Accordingly, the panel determined that the Minutes Extract was relevant to this case.

The panel was satisfied that there will be no unfairness to Ms Davies in admitting the Minutes Extract into evidence given that the document supports her case, and it was reasonable to infer that she may have been provided with the Minutes Extract as part of the appeal process at the Home. Accordingly, the panel determined that it was relevant and fair to admit the Minutes Extract into evidence.

With respect to the Plan, the panel took into account that the document contains a summary of the reasons for Resident A's admission, his progress over time and his discharge from the hospital. However, the panel noted that the Plan was dated 5 March 2020 which was five weeks after the incident on 20 January 2020. The panel also noted that the Plan did not specifically reference the period of time in which some of the behaviours of Resident A were exhibited. In areas where such

information was provided, it appeared to relate to behaviours exhibited by Resident A in the forty-eight hours prior to the incidents on 20 January 2020. The panel further considered that there was no evidence provided regarding the source of the information contained in the Plan nor did it contain any original assessment which may have been completed in relation to the sectioning of Resident A.

Therefore, the panel was not satisfied that the information contained in the Plan was made with respect to the incident on 20 January 2020 and whether such behaviours, as described in the Plan, occurred within the Home. Accordingly, the panel determined the Plan was not relevant to this case, therefore, it would not be admitted into evidence.

Background

The charges arose whilst Ms Davies was employed as a registered nurse by Solehawk Limited at Craigielea Care Home (the Home). On 26 May 2020, Ms Davies was referred to the NMC by Solehawk Limited.

The referral involved a series of incidents that were alleged to have occurred in the Home on 20 January 2020. It was alleged that Ms Davies threw a box of tissues at Resident A (who lacked capacity), told him that his wife was dead and that she was sick of him.

It was further alleged that Ms Davies told other staff members to wind Resident A up before a mental health assessment and to falsify records by placing inaccurate information in Resident A's behavioural charts to suggest that his behaviour was worse than it was.

The incident was not reported to the Home's management team until March 2020, at which point an investigation began and it was found that Ms Davies demonstrated unprofessional conduct. Ms Davies submitted her resignation on 8 May 2020.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all of the oral and documentary evidence in this case together with the submissions made by Ms Lovatt and Ms Davies' Final Registrant Response Bundle.

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

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: Home manager at the Home at the time of the incidents [PRIVATE].
- Witness 2: Care assistant at the Home at the time of the incidents.
- Witness 3: Senior Carer at the Home at the time of the incidents.
- Witness 4: Care Assistant at the Home at the time of the incidents.

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

The panel first considered the contextual allegation made by Ms Davies in the Registrant Response Bundle that she was a victim of bullying and collusion against her at the Home. The panel noted that Ms Davies had specifically alleged that she

was a victim of bullying from Witness 1 and that Witness 1 and her clique (who were friends outside of work) had fabricated the allegations against her.

The panel placed weight on the oral evidence of the NMC witnesses, each of whom were asked directly and specifically if they were aware of Ms Davies being bullied at work, each having replied that they were not aware of any bullying.

The panel took into account that, when asked about Ms Davies' assertions, Witness 1 was visibly shocked and categorically denied them. Witness 1 stated that she liked Ms Davies and that they were on good terms before her [PRIVATE]; Witness 1 also explained that they had a similar professional background as they were both learning disability nurses. The panel questioned Witness 1 about Ms Davies' assertion that Witness 1 threw *'a stack of papers'* at her. Witness 1 immediately recognised the incident to which Ms Davies may have been referring and explained that her action on the day of the incident had been misconstrued by Ms Davies. Witness 1 stated that she did not throw '*a stack of papers'* at Ms Davies; rather, Witness 1 had slammed down the papers with force on her office desk and that they had slid off and landed at the feet of Ms Davies, for which Witness 1 had apologised immediately. The panel accepted Witness 1's account as she provided comprehensive context and a cogent explanation of the incident involving '*a stack of papers'*. The panel considered that it was therefore more probable that Ms Davies had misconstrued the conduct of Witness 1 on the day of the incident.

[PRIVATE]. The panel noted that Ms Davies had reported the medication error of Witness 1 directly to a consultant rather than pointing it out to her in the first instance as was usual practice. The panel noted that the consultant had asked Ms Davies whether if she wanted to make a formal report regarding the medication error and Ms Davies chose not to do so. However, Witness 1 had stated during her oral evidence that she did not hold any bad feelings over the reporting of the medication error and was candid with the panel about the error and the need for it to be reported.

The panel took into consideration that Witness 2 had stated during his oral evidence that he delayed reporting Ms Davies' conduct on 20 January 2020 because he was afraid for himself and the residents due to Ms Davies' position as a nurse and

because she was popular among staff at the Home. Additionally, Witnesses 3 and 4 respectively denied during their oral evidence that they were personal friends with Witness 1 or with any other witnesses involved in this hearing. In Ms Davies' initial investigation meeting with Witness 1, Ms Davies did not raise any incident of bullying or collusion by staff against her. The panel noted that, while Ms Davies had raised in the second local investigation meeting at the Home about '*a stack of papers'* being thrown at her and asserted that she had complained about the way the home manager was treating her, she did not raise any specific details of bullying or collusion by staff against her. The panel further noted that in her investigation meeting with Ms 1, as contained in the Investigation meeting notes dated 3 April 2020, Ms Davies had stated that she had a good support network at the Home prior to the incidents on 20 January 2020. In response to Ms 1's question during Ms Davies' local investigation meeting, *'do you have a good working relationship with all staff at Craigielea?'* , Ms Davies responded: '*Yes, before this, there is a good support network it's just really hard before this happened I was managing a lot of stuff at the home, I am just really struggling.'*

In these circumstances, the panel was not satisfied that there had been any bullying of Ms Davies at the Home by any of the witnesses individually or collectively. It was of the view that although the incidents on 20 January 2020 were talked about by staff subsequently, this did not amount to collusion among staff members against Ms Davies.

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

Charge 1a

1. On or around 20th January 2020 in relation to Resident A:
    a. Threw a box of tissues at him;

This charge is found proved.

The panel took account of the witness statement of Witness 4 dated 10 November 2022, in which she stated:

> *'I think I was walking back from the kitchen on the unit towards the lounge (they were joined up at that point) and I saw Holly chuck a box of tissues at* (Resident A). *I said to her that she couldn't do that, but by then* (Resident A) *was now in one of his moods. The tissues did land on him, and I remember him shouting, although I can't remember what he said now. He was upset. After* (Resident A) *started shouting, Holly went away downstairs to call the behavioural team (social workers) and told us to leave* (Resident A) *in his room. She had said that* (Resident A) *threw the tissues at her first, but I did not see throw anything at Holly.'*

The panel took into consideration that Witness 4 was clear and consistent in her account of the incident in her handwritten statement dated 11 March 2020, the record of meeting dated 11 March 2020 and the record of meeting dated 31 March 2020 respectively. The panel noted that these records, though not contemporaneous, were made closer to the time of the incident. The panel therefore attached more weight to them.

The panel further considered that Witness 4 provided a vivid description of the incident during her oral evidence, sketched a layout of the area in which the incident occurred including the locations of Resident A and Ms Davies at the time of the incident, how the box of tissues hit Resident A's chest before rolling down his belly and falling to the floor and also described the box of tissues and the aftermath of the incident.

The panel also took into account the witness statement of Witness 2 dated 3 March 2022 in which he stated:

> *'Later that same day, 20 January 2020, I was walking past the lounge/dining room.* (Resident A) *was sat near the door and I saw a box of tissues fly past. Holly was the only other person in the room and the box came from her direction which led me to believe that she had thrown them at him, although I did not see her throw the box.'*

The panel considered that Witness 2 had given a similar account in his handwritten statement dated 10 March 2020. He also provided a vivid description of the incident during his oral evidence, sketched a layout of the area in which the incident occurred including the locations of Resident A and Ms Davies at the time of the incident, described the box of tissues thrown at Resident A and where it landed on the floor.

The panel took into account that Ms Davies had denied the allegation in her investigation meeting with Witness 1, as contained in the Investigation Meeting Notes dated 11 March 2020, as well as in her investigation meeting with Ms 1, as contained in the Investigation Meeting Notes dated 3 April 2020. The panel noted Witness 4's evidence that Ms Davies had asserted on 20 January 2020 that Resident A had thrown a box of tissues at her first. The panel then noted that Ms Davies was inconsistent in her local level fact-finding meeting evidence as to whether Resident A had or had not thrown a box of tissues at her. In the first meeting, Ms Davies stated that Resident A may have thrown a box of tissues at her as this was within Resident A's reach; in the second meeting, Ms Davies stated that Resident A did not throw a box of tissues at her as it was not within his reach. The panel considered that the phrase '*threw box of tissues'* was recorded in Resident A's Behavioural Record. However, the panel bore in mind that both Witnesses 1 and 3 asserted in their oral evidence respectively that the phrase '*threw box of tissues'* was not originally included in Resident A's Behavioural Record at the time they had first seen it. Also, Witnesses 2 and 4 stated during their oral evidence respectively that they could not recognised the handwriting of the phrase '*threw box of tissues'.* The panel therefore concluded that the phrase '*threw box of tissues'* was not recorded contemporaneously on Resident A's Behavioural Record and the record was thus altered. Furthermore, the panel found that, whether or not Resident A threw a box of tissues, it did not alter the charge against Ms Davies.

The panel was of the view that, although Witnesses 2 and 4's accounts differed in terms of the precise position of Resident A and Ms Davies in the lounge at the time of the incident and in where the box of tissues had landed. They were also both clear and consistent in their oral and documentary evidence that Ms Davies threw a box of tissues at Resident A on or around 20 January 2020. The panel accepted the evidence

of both Witnesses 2 and 4 which it considered to be cogent and compelling and found that it was more likely than not that there was more than one incident in which Ms Davies had thrown a box of tissues at Resident A and that the witnesses had observed them separately.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on or around 20 January 2020, Ms Davies threw a box of tissues at Resident A. Accordingly, the panel determined that charge 1a is found proved.

Charge 1b

1. On or around 20th January 2020 in relation to Resident A:

    b. Told him his wife had died or words to that effect;

This charge is found proved.

The panel took into account the handwritten statement of Witness 2 dated 10 March 2020 in which he stated:

> *'…just after tea the nurse told* (Resident A) *that she had killed his wife…she even told me what she had done'.*

The panel also considered the witness statement of Witness 2 dated 3 March 2022 in which he stated:

> *'…I also overheard Holly tell* (Resident A) *that his wife was dead, or words to that effect.'*

The panel noted an inconsistency between Witness 2's handwritten statement and witness statement in the manner he heard about the incident. However, Witness 2 confirmed during his oral evidence that he did not directly witness the incident but Ms Davies had only told him about the incident and that she seemed to be bragging about it to him. The panel therefore attached more weight to the handwritten

statement of Witness 2 as it was made closer to the time of the incident than his witness statement.

The panel also took into consideration that Witness 3 had given a similar account in her handwritten statement dated 16 March 2020 and in the fact-finding meeting notes dated 25 March 2020 respectively that Ms Davies had informed her that she told Resident A that his wife had died.

The panel noted that Witness 4 had stated in her witness statement dated 10 November 2022 that:

> '*…He* (Resident A) *tended to have issues when couldn't remember where his wife was; she didn't live at the home and used to come and visit.*'

The panel noted that in her oral evidence, Witness 4 stated that Resident A's behaviour would be escalated by mention of his wife.

The panel took into account that in the investigation meeting with Ms 1, as contained in the Investigation Meeting Notes dated 3 April 2020, Ms Davies denied the allegation where she stated:

> *'I wouldn't say that, I always say she* (Resident A's wife) *has gone to the shop, that is a reasonable thing to say.'*

The panel considered the evidence before it. It was of the view that Witnesses 2 and 3 were both clear and consistent in their oral and documentary evidence that Ms Davies had informed them respectively that she had told Resident A that his wife had died. The panel accepted their accounts of the incident. It was therefore satisfied that it was more likely than not, that on or around 20 January 2020, Ms Davies told Resident A that his wife had died or words to that effect. Accordingly, the panel determined that charge 1b is found proved on the balance of probabilities.

Charge 1c

1. On or around 20th January 2020 in relation to Resident A:

    c. Told him you were sick of him or words to that effect;

This charge is found NOT proved.

The panel took into account that the NMC had offered no evidence in support of this charge.

Therefore, in the absence of any evidence to support this charge, the panel determined that charge 1c is found not proved.

Charge 2a

2. On or around 20th January 2020 you told members of staff:

    a. to wind Resident A up or words to that effect;

This charge is found proved.

The panel took account of the witness statement of Witness 2 dated 3 March 2022 in which he stated:

> *'Holly asked staff members to 'wind up'* (Resident A) *in order to have him become more agitated and if his condition escalated she could have him admitted to hospital. I did not want to participate in this and simply walked aaway* (sic) *….'*

The panel considered that Witness 2 had given a similar account in his handwritten statement dated 10 March 2020. Witness 2 further confirmed in his oral evidence that Ms Davies had asked staff members to escalate Resident A's behaviour. He clarified that '*escalate*' was the word used to describe making Resident A's behaviour worse than it was on 20 January 2020.

The panel took into account the witness statement of Witness 3 dated 23 March 2023 in which she stated:

'During the shift Miss Davies informed that the resident was going to be assessed later that day and that we should "wind him up". I ignored Miss Davies and returned to my duties on another floor of the Home.'

The panel noted that Witness 3 was clear and consistent in her account of the incident in her handwritten statement dated 16 March 2020, fact-finding meeting notes dated 25 March 2020 and her local statement dated 25 March 2020 respectively. Witness 3 further confirmed in her oral evidence that Resident A's behaviour on 20 January 2020 was quite calm compared to his behaviour on other days and Ms Davies had told staff members to wind him up in order to ensure that Resident A was sectioned by the mental health assessment team.

The panel took into consideration the witness statement of Witness 4 dated 10 November 2022 in which she stated:

'I remember that someone, social workers I think, was coming in to assess (Resident A) *that day. They'd been meant to arrive at a certain time but hadn't arrived yet. Holly had said to provoke* (Resident A) *to me and Billy (another care assistant), but we said no, as* (Resident A) *was settled that day.*

The panel took into consideration that Witness 4 was clear and consistent in her account of the incident in her handwritten statement dated 11 March 2020, the record of meeting dated 11 March 2020 and the record of meeting dated 31 March 2020 respectively. Witness 4 further explained that the phrase *'get him up a height'* as used in the record of meeting dated 11 March 2020, meant that Ms Davies wanted staff members to agitate Resident A and provoke him given that he was calm and collected at the time.

The panel took into account that Ms Davies had denied the allegation in her investigation meeting with Ms 1, as contained in the Investigation Meeting Notes dated 3 April 2020 as well as in her statement in the Registrant Response Bundle.

The panel considered the evidence before it. It was of the view that Witnesses 2, 3 and 4 were clear and consistent in their oral and documentary evidence that Ms Davies had told members of staff to wind up Resident A. They also confirmed that Resident A's behaviour was not as bad that day as it had been on other days and that they could effectively manage Resident A's behaviour at the Home. The panel accepted their accounts of the incident.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on or around 20 January 2020, Ms Davies told members of staff to wind Resident A up or words to that effect. Accordingly, it found charge 2a proved.

Charge 2b

2. On or around 20th January 2020 you told members of staff:

    b. to falsify Resident A's behavioural records;

This charge is found proved.

The panel took into account the witness statement of Witness 3 dated 23 March 2023 in which she stated:

> *'Miss Davies later came up to the second (2nd) floor where I was working and asked myself and two other carers,* …(Witnesses 2 and 4)…, *to falsify the resident's records to state that his behaviours were far worse than they actually were.'*
>
> *'Once Miss Davies had left, I explained to the other staff that they should not falsify any records and they should not lie to any professionals who would be assessing the resident. During the shift, I recall that the resident had presented well and was not aggravated.'*

The panel took into consideration that Ms Davies had denied the allegation in her statement in the Registrant Response Bundle.

The panel noted that Witness 3 was clear and consistent in her account of the incident in her handwritten statement dated 16 March 2020, fact-finding meeting notes dated 25 March 2020 and her local statement dated 25 March 2020 respectively. The panel further noted that Witness 3 provided a vivid description of the incident during her oral evidence and Witnesses 2 and 4 confirmed her account of the incident during their respective oral evidence. The panel therefore accepted Witness 3's account of the incident.

The panel took each witness to Resident A's Behavioural Records for 20 January 2020 and asked them to identify their own entries and whether they recognised other entries made by others on the same day. Each witness that was on duty on 20 January 2020 indicated they did not recognise the content of some of the entries and that some of the entries did not represent Resident A's behaviour on that day.

The panel carefully considered Resident A's Behavioural Records dated 5-20 January 2020. It noted that Witnesses 2, 3 and 4, who were working at the Home on 20 January 2020, had stated that Resident A's behaviour was calm as compared to other days. Also, none of them recognised some of the entries on Resident A's Behaviour Record dated 20 January 2020. For example, Witness 2 stated that he could not recognise the entry *'throwing dishes at wall'* made in the box after his signed entry between 5pm and 6pm on 20 January 2020. Furthermore, Witness 3 stated that she had been working in the dining room/kitchen area at this time on 20 January 2020 and would have known if Resident A had thrown dishes at the wall but the incident had not occurred as she had not witnessed it nor had it been reported to her as senior carer. Witness 3 stated that had dishes been thrown at the wall by Resident A, she would have been aware of the need to clear up any associated mess and ensure the safety of other residents and this had not been the case on this date.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on or around 20 January 2020, Ms Davies told members of staff to falsify Resident A's behavioural records. Accordingly, it found charge 2b proved.

Charge 3

3. Your action at charge 1b was dishonest in that you knew that Resident A's wife was not dead.

This charge is found proved.

Having found charge 1b proved, the panel went on to consider whether Ms Davies' conduct in charge 1b was dishonest. In considering whether Ms Davies' action was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel took into account that Witness 4 had stated in her witness statement dated 10 November 2022 that:

> '*…He* (Resident A) *tended to have issues when couldn't remember where his wife was; she didn't live at the home and used to come and visit.*'

The panel also noted that in the investigation meeting with Ms 1, as contained in the Investigation Meeting Notes dated 3 April 2020, Ms Davies, in response to the allegation in charge 1b, had stated:

> *'I wouldn't say that, I always say she* (Resident A's wife) *has gone to the shop, that is a reasonable thing to say.'*

The panel was of the view that, based on the response of Ms Davies in the investigation meeting with Ms 1, it was reasonable to infer that at the time of the

incident in charge 1b, Ms Davies was fully aware that Resident A's wife was not dead.

In applying the second limb of the test to this case, the panel was of the view that as the nurse in charge at the time of the incident, Ms Davies would know that the mention of Resident A's wife was a trigger for him and she would have known his wife was alive. Therefore, the panel was satisfied that Ms Davies' conduct in charge 1b would be considered dishonest by ordinary decent people.

Accordingly, the panel determined that Ms Davies' action in charge 1b was dishonest, therefore, charge 3 is found proved on the balance of probabilities.

Charge 4

4. Your actions at charges 2a and/or 2b were dishonest in that you sought to show Resident A's behaviour to be worse than it was.

This charge is found proved.

The panel first considered whether Ms Davies' action in charge 2a was dishonest, given that it had found charge 2a proved. In considering whether Ms Davies' action was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this charge, the panel noted that Solehawk Employee Handbook dated January 2019, provides that the *'Honesty, integrity and the needs of our residents are paramount.'*

The panel had regard to Resident A's Behavioural Record dated 5-20 January 2020. It noted that on 20 January 2020, Resident A's behaviour was not as bad as it had been on other days. The panel accepted Witnesses 2's, 3's, and 4's oral and documentary evidence that although Resident A's behaviour was variable, it was calmer on 20 January 2020 than it was on other days.

The panel considered the evidence of Mr 1 in relation to the incidents that occurred on 20 January 2020. It took into account that the evidence of Mr 1 supports Ms Davies' claim that Resident A's behaviour was very challenging on 20 January 2020. However, the panel noted that Mr 1 did not record any of his observations of Resident A's behaviour in Resident A's Behavioural Record nor was there any objective documentary record made by Mr 1 to demonstrate that Resident A's behaviour was very challenging on 20 January 2020. Furthermore, Mr 1 had stated that no member of staff had reported the incidents on 20 January 2020 to him. However, the panel noted that Witness 2 had confirmed in both his witness statement and oral evidence that he had reported the incidents of 20 January 2020 to Mr 1. Witness 1 was also clear and consistent in her written and oral evidence that two other members of staff had informed her that they had also reported the incidents of 20 January 2020 to Mr 1. The panel therefore considered it implausible that Mr 1 was unaware of these incidents.

Given the absence of evidence to support Mr 1's claim that Resident A's behaviour was very challenging on 20 January 2020, the panel did not attach weight to his evidence on this matter.

Consequently, on the basis of all the evidence before it, the panel was satisfied that, as the nurse in charge of the shift on 20 January 2020, Ms Davies knew that Resident A's behaviour was not as bad as it had been on other days and therefore sought to show Resident A's behaviour to be worse than it was, by her instructions to staff in charge 2a.

In applying the second limb of the test to this case, the panel was satisfied that Ms Davies' conduct in charge 2a would be considered dishonest by ordinary decent people.

Accordingly, on the balance of probabilities, the panel determined that Ms Davies' conduct in charge 2a was dishonest.

The panel next considered whether Ms Davies' action in charge 2b was dishonest, given that it had found charge 2b proved. In considering whether Ms Davies' action was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

The panel noted that Solehawk Support and Care Planning Policy provides that *'Records must be factual, consistent and accurate*'. The panel further noted that Solehawk Employee Handbook dated January 2019, provides that *'Be diligent, honest and ethical in the performance of your role, duties and responsibilities'.*

In applying the first limb of the test to this charge, the panel was of the view that Ms Davies' action in telling staff to falsify Resident A's behavioural records, demonstrated that she knew that Resident A's behaviour was not as bad as it had been on other days. Accordingly, the panel was satisfied that, as the nurse in charge of the shift on 20 January 2020, Ms Davies knew that Resident A's behaviour was not as bad as it had been on other days and therefore sought to show Resident A's behaviour to be worse than it was, by her instructions to staff in charge 2b.

In applying the second limb of the test to this case, the panel was satisfied that Ms Davies' conduct in charge 2b would be considered dishonest by ordinary decent people.

Therefore, on the balance of probabilities, the panel determined that Ms Davies' conduct in charge 2b was dishonest.

In these circumstances, having determined that Ms Davies' actions in charges 2a and 2b were dishonest, the panel found charge 4 to be proved on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Davies' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Ms Lovatt stated that misconduct was defined in the case of *Roylance v General Medical Council* (No. 2) [2000] 1 AC 311 as a "*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances".*

Ms Lovatt further stated that Lord Clyde in *Roylance* case went on to identify that: *"The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a practitioner in the particular circumstances".*

Ms Lovatt submitted that Ms Davies' conduct was a serious departure from the standards expected of a registered nurse and such departure was sufficiently serious as to warrant a finding of misconduct in this case. She submitted that Ms Davies had breached the Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code) in the relevant areas as set out in the NMC Misconduct Matrix.

Ms Lovatt submitted that charge 1a breached sections 1 and 7 of the Code to treat people as individuals and uphold their dignity. She submitted that Ms Davies' conduct in throwing a box of tissues at Resident A failed to uphold his dignity and also amounted to non-verbal communication which could not necessarily be understood by Resident A. She submitted that Ms Davies did not seek to better understand and respond to Resident A's personal and health needs, but rather to neglect them.

Ms Lovatt submitted that charge 1b breached Section 1 of the Code to treat people as individuals and uphold their dignity. She submitted that Ms Davies' conduct in telling Resident A that his wife had died did not amount to treating Resident A with respect, kindness and compassion.

Ms Lovatt submitted that Ms Davies' actions in charges 2a and 2b failed to uphold section 2 of the Code. She submitted that Ms Davies failed to work in partnership with her colleagues to ensure care was effectively delivered, failed to maintain effective communication with colleagues, and failed to work with colleagues to preserve the safety of those receiving care. She further submitted that Ms Davies'

conduct breached section 8 of the Code as Ms Davies undermined effective communication with colleagues.

Ms Lovatt submitted that charge 2b breached section 3 of the Code as Ms Davies did not act in partnership with Resident A but set out to undermine Resident A's access to relevant health and social care, information and support. She further submitted that Ms Davies' conduct in charge 2b amounted to a failure to work co-operatively, by asking staff to falsify Resident A's records, she failed to maintain effective communication with colleagues and failed to work with colleagues to preserve the safety of those receiving care.

Ms Lovatt submitted that Ms Davies' conduct in charges 3 and 4 breached section 20 of the Code. She submitted that Ms Davies failed to act with honesty and integrity and treated Resident A in a way that took advantage of his vulnerability as well as caused him distress.

Ms Lovatt submitted that Ms Davies' actions in the charges found proved, breached section 14 of the Code. She submitted that Ms Davies did not identify that she had acted in a way that caused harm to Resident A and did not seek to put that right, she did not explain fully and promptly what happened, she did not apologise to the person affected and she did not document the event formally or escalate them herself.

Ms Lovatt submitted that Ms Davies' conduct further breached section 19 of the Code in that she did not take measures to reduce the likelihood of harm and the effect of harm if it takes place.

In conclusion, Ms Lovatt invited the panel to find that Ms Davies' actions in the charges found proved amounted to misconduct.

Submissions on impairment

Ms Lovatt submitted that the panel would need to consider if Ms Davies' fitness to practise is impaired as of today's date. She referred the panel to the NMC Guidance on Impairment especially the question:

'Can the nurse practice kindly, safely and professionally?'

Ms Lovatt submitted that in considering impairment, the panel should consider the test formulated By Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b, c and d of the *Grant* test are engaged in this case when looking at past conduct.

Ms Lovatt further referred the panel to the test on impairment set out in the case of *Cohen v GMC [*2008] EWHC 581 (Admin).

Ms Lovatt submitted that, with regard to whether Ms Davies' conduct can be remediated, the type of behaviour contained within these charges, in particular the dishonesty charges, are hard to remediate because they involved her behaviour and mindset. She referred the panel to the NMC Guidance FTP-14 and submitted that dishonesty is listed as one of the examples of conduct which may not be possible to address. She submitted that the other charges 1a, 1b, 2a and 2b, were not limited to issues of managing safe clinical practice which the NMC Guidance identifies as being easier to address, and whilst they do all happen on the same day, the incidents are spread out and the fundamental behaviour and attitude of undermining Resident A's care persists throughout, in a way that is not isolated. She therefore concluded that Ms Davies' conduct is difficult to remediate.

With regard to whether the concern has been remediated, Ms Lovatt submitted that there was no evidence that Ms Davies had shown any insight or remorse in relation to any of the charges and nor has she taken any step to address the concerns.

With respect to whether Ms Davies' conduct is highly likely to be repeated, Ms Lovatt referred the panel to the NMC Guidance (FTP-14c). She submitted that Ms Davies has not demonstrated any insight and has not taken any steps to address any concerns arising from the allegations. She further submitted that it could not be said

that Ms Davies' actions arose in unique circumstances and she has engaged in only a limited way with the proceedings. Ms Lovatt however noted that the NMC has no previous referrals in relation to Ms Davies and therefore, until these incidents, had a positive professional record.

Ms Lovatt submitted that the factors identified in the NMC Guidance on seriousness were not engaged in this case.

Ms Lovatt submitted that Ms Davies' past behaviour may be an indicator of future behaviour. She asserted that there is an element of repetition over the course of the 20 January 2020 and the charges found proved, showed a fundamental concern with her mindset and attitude and therefore it is highly likely that Ms Davies' actions may be repeated in future. Therefore, the limbs in the Grant test are also engaged in the future.

Ms Lovatt submitted that the panel should find Ms Davies' fitness to practise impaired on grounds of public protection because her past behaviour contained within charges 1a, 1b, 2a and 2b had placed Resident A at unwarranted risk of harm. This has breached the fundamental tenets of the nursing profession to prioritise people, practice effectively, preserve safety and promote professionalism. Furthermore, Ms Davies had acted dishonestly.

Ms Lovatt also invited the panel to find Ms Davies' fitness to practise impaired on grounds of public interest in order to uphold proper professional standards and conduct and maintaining public confidence in the profession. She submitted that Ms Davies' conduct damaged the reputation of the nursing profession and would undermine public confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> ***1.1** treat people with kindness, respect and compassion*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***1.5** respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
>
> *To achieve this, you must:*
>
> ***2.6** recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> *To achieve this, you must:*
>
> ***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*
>
> ***17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection***
>
> *To achieve this, you must:*
>
> ***17.1** take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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 profession 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*

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

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

20.8 *act as a role model of professional behaviour….*

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

To achieve this, you must:

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

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

With respect to charge 1a, the panel took into account that Resident A was an elderly vulnerable resident suffering from Alzheimer's disease and was unable to move freely of his own accord. The panel therefore found Ms Davies' conduct in charge 1a to amount to a physical abuse of a vulnerable resident in her care. It was of the view that there was no justification for Ms Davies' conduct even if Resident A had actually first thrown the box of tissues at her. The panel considered Ms Davies' conduct as a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It therefore determined that Ms Davies' action in charge 1a amounted to misconduct.

With regard to charge 1b, the panel noted it had heard evidence that Resident A was usually triggered by the mention of his wife and Ms Davies would have known of such fact. The panel was of the view that Ms Davies' conduct posed a risk of harm and caused actual harm to Resident A in terms of emotional and psychological distress. The panel therefore found Ms Davies' conduct to amount to an emotional and psychological abuse of a vulnerable resident under care. It therefore determined that Ms Davies' action in charge 1b amounted to misconduct.

In relation to charge 2a, the panel found Ms Davies' conduct to amount to an abuse of her position of authority and trust. It was concerned that Ms Davies had directed junior care staff to undertake actions directly opposed to the safe clinical care of Resident A which would have placed him at risk of harm. It was of the view that Ms Davies had set a bad example and failed to act as a good role model for junior colleagues at the Home. The panel therefore determined that Ms Davies' action in charge 2a amounted to misconduct.

With respect to charge 2b, the panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession and therefore found Ms Davies' conduct in directing staff to falsify records to be extremely serious and unacceptable. It was of the view that Ms Davies' conduct in charge 2b was an abuse of her position of authority and trust as she failed to act as a good role model for junior colleagues

at the Home. The panel noted that, if the care staff had carried out her instructions, it would have placed Resident A at an unwarranted risk of harm and misled appropriate health and social care professionals on the appropriate care to be provided to Resident A. The panel therefore determined that Ms Davies' action in charge 2b amounted to misconduct.

With regard to charges 3 and 4, the panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found Ms Davies to have breached a fundamental tenet of the nursing profession. It noted that Ms Davies' dishonest conduct in charges 3 and 4 respectively posed a risk of harm to Resident A as it caused emotional and psychological distress to him and would have had an impact on any future care provided to him respectively. The panel determined that to characterise Ms Davies' actions as anything other than misconduct would send the wrong message about the nursing profession.

Consequently, having considered all the charges individually and as a whole, the panel determined that Ms Davies' actions at charges 1a, 1b, 2a, 2b, 3 and 4 did fall significantly short of the conduct and standards expected of a nurse and amounted to misconduct. It concluded that Ms Davies' actions were extremely serious and unprofessional to the extent that they would be seen as deplorable by other members of the profession.

Decision and reasons on impairment

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

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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 first considered whether any of the limbs of the Grant test were engaged in the past. It was of the view that at the time of the incidents, Ms Davies' misconduct placed Resident A at an unwarranted risk of harm and caused actual harm to him in terms of emotional and psychological distress.

The panel determined that Ms Davies' misconduct constituted a serious breach of the fundamental tenets of the nursing profession as she failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel had also found two charges of dishonesty proved against Ms Davies.

The panel therefore concluded that limbs a, b, c, and d of the Grant test were engaged in the past.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel also had regard to the NMC Guidance on Serious concerns which are more difficult to put right (FTP-3a). It particularly noted that the NMC Guidance on Serious concerns which could result in harm if not put right (FTP-3b) states:

> *'We wouldn't usually need to take regulatory action for an isolated incident (for example, a clinical error) unless it suggests that there may be an attitudinal issue. Examples could include cruelty to service users or a serious failure to prioritise their safety…. Such behaviours may indicate a deep-seated problem even if there is only one reported incident which will typically be harder to address and rectify….'*

The panel had regard to the case of *Cohen v GMC* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on insight and strengthened practice (FTP-14).

In the NMC Guidance – Can the concern be addressed (FTP-14a), the panel noted the following paragraph:

> *'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *….*
> - *…..*
> - *….*
> - *….*
> - *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*
> - *incidents of violence towards, …. or abuse of people receiving care, ….or vulnerable adults.'*

The panel first considered whether Ms Davies' misconduct is capable of being addressed. It took into account that Ms Davies' actions amounted to physical, emotional and psychological abuse of an elderly vulnerable resident in her care. Ms

Davies further encouraged staff at the Home to engage in unsafe clinical conduct and to falsify records, which placed Resident A at risk of harm. The panel was of the view that her actions including her dishonest conduct were deliberate and suggestive of deep-seated attitudinal concerns. It therefore decided that the concerns are extremely difficult to remediate due to their serious and dishonest nature.

The panel then went on to consider whether the concerns had been addressed by Ms Davies. It had regard to the NMC Guidance – Has the concern been addressed (FTP-14b). Regarding insight, the panel was of the view that Ms Davies has failed to show insight into her conduct. It noted that although Ms Davies fully engaged with the local investigation process at the Home, she denied the allegations, sought to justify her conduct and failed to demonstrate remorse. The panel noted that Witness 1 stated in her witness statement dated 4 July 2023 that:

> *'I can't recall much about the investigation meeting however I can remember that when I asked Miss Davies if she had thrown a box of tissues and told the resident that his wife was dead her reply was frank and blunt, and she didn't appear to be shocked or disgusted by the allegations.'*

The panel was concerned that Ms Davies did not demonstrate any understanding of the seriousness of her actions, nor did she show any insight on the impact of her conduct on Resident A, her colleagues, the nursing profession and the wider public.

In considering whether Ms Davies had taken any step to address her misconduct, the panel noted that there was no evidence before it to indicate that Ms Davies had addressed her misconduct. Ms Davies has not provided a reflective statement nor any evidence of apology, remorse or strengthened practice to the panel.

The panel had regard to the NMC Guidance – Is it highly unlikely that the conduct will be repeated? (FTP-14c). The panel considered the full circumstances of this case. It noted that there was no evidence before it that Ms Davies has demonstrated any insight and taken any steps to address the concerns in this case. The panel was of the view that Ms Davies' conduct did not arise from any unique circumstances at the time of the incidents as people under the care of registered nurses are

vulnerable in nature. This is particularly so of people in the type of care setting that Resident A was in. It noted that Ms Lovatt had stated that Ms Davies had an otherwise positive professional record before the incidents occurred. However, the panel attached little weight to such factor given that it was considering current impairment and had found all but one of the charges proved.

In light of this, the panel determined that Ms Davies' misconduct is highly likely to be repeated and limbs a, b, c, and of the *Grant* test are engaged in the future.

The panel therefore concluded 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 had regard to the serious nature of Ms Davies' misconduct and determined that public confidence in the profession, particularly as it involved the abuse of an elderly vulnerable resident and dishonesty, would be undermined if a finding of impairment were not made in this case. It was of the view that a fully informed member of the public, aware of the proven charges in this case, would be very concerned if Ms Davies were permitted to practise as a registered nurse without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds is also required. It determined that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Ms Davies' 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 striking-off order. It directs the registrar to strike Ms Davies off the register. The effect of this order is that the NMC register will show that Ms Davies has been struck-off the register.

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

Submissions on sanction

Ms Lovatt submitted that it is the NMC's position that a striking-off order should be imposed given the findings of the panel that Ms Davies' fitness to practise is currently impaired.

Ms Lovatt submitted that the aggravating factors in this case are as follows:

- Resident A was a vulnerable resident.
- Ms Davies' behaviour was a premeditated course of conduct.
- Ms Davies' conduct encouraged the falsifying of records.
- There was psychological and emotional harm to Resident A.

Ms Lovatt submitted that the mitigating factors are:

- Ms Davies' conduct only occurred over one shift.
- Ms Davies has had some engagement with the NMC.

Ms Lovatt submitted that there are no personal mitigating factors in this case as [PRIVATE].

Ms Lovatt submitted that this case involved not just physical abuse but also mental abuse of a vulnerable resident. There was also associated dishonesty in that Ms

Davies encouraged junior staff members to falsify records to make the behaviour of Resident A look worse than it was.

Ms Lovatt submitted that Ms Davies has denied all of the allegations and therefore, she has failed to show any remorse, insight or understanding into her actions. Ms Lovatt highlighted that Ms Davies had also apportioned blame on others by alleging the allegations were fabricated by the witnesses in this case. However, the panel had found that there was no evidence of such claims by Ms Davies.

Ms Lovatt referred the panel to the NMC Guidance on Considering sanction for serious cases (SAN-2). She stated that with respect to cases involving dishonesty, the Guidance states:

> *'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register.'*

Ms Lovatt submitted that Ms Davies' misconduct involved the misuse of power and posed a direct risk of harm to a vulnerable resident under her care. She therefore invited the panel to consider Ms Davies' dishonest conduct as serious dishonesty.

Ms Lovatt further submitted that this case also involved the abuse of a vulnerable adult. She stated that the word 'abuse' was defined in NMC Guidance on Misconduct (FTP-2a) as including *'a range of acts, or failures to act which result in serious physical, sexual or emotional harm.'* She also highlighted that the NMC Guidance on Considering sanction for serious cases (SAN-2) states in its footnote that:

> *'An adult is defined as vulnerable where they have care and support needs and, as a result of this, are unable to take care of themselves or protect themselves from abuse or neglect.'*

Ms Lovatt submitted that it is the position of the NMC that Resident A falls under the definition of a vulnerable adult, and therefore, Ms Davies' misconduct amounted to an abuse of a vulnerable adult.

Ms Lovatt submitted that in making its decision on sanction, the panel should consider the full range of sanctions, starting with the least restrictive sanction.

Ms Lovatt submitted that taking no further action or a caution order would not be sufficient given the seriousness of Ms Davies' misconduct. She submitted that a conditions of practice order is not practical and workable as it would be impossible to formulate conditions to address the necessary "*mindset"* changes required to address the dishonesty.

Ms Lovatt submitted that a suspension order may be appropriate in cases where the misconduct is not fundamentally incompatible with the nurse continuing to be a registered professional. She highlighted that the key issues to be considered are whether the seriousness of the case is satisfied by only a temporary removal from the register and whether a period of suspension will be sufficient to protect patients, public confidence in the profession and professional standards.

Ms Lovatt submitted that a suspension order would not address the seriousness in this case. She asserted that, given the panel's findings that the four limbs in the *Grant* test were engaged both in relation to Ms Davies' past and future behaviour, a temporary removal would not sufficiently protect patients nor maintain public confidence in the nursing profession.

Ms Lovatt submitted that Ms Davies' misconduct is so serious that only a striking-off order would be the most appropriate sanction in this case. She asserted that whilst Ms Davies' conduct could be considered a one-off incident, it is so serious that it is incompatible with her remaining on the register. Ms Lovatt referred the panel to the NMC Guidance on striking off order (SAN-3e). She submitted that the charges found proved raises fundamental questions about Ms Davies' professionalism and that public confidence in the nursing profession would not be maintained if Ms Davies was not removed from the register and a striking-off sanction is the only sanction

which will be sufficient to protect patients, members of the public and maintain professional standards.

In conclusion, Ms Lovatt invited the panel to impose a striking-off order as the most appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms Davies' 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 identified the following aggravating factors:

- As the registered nurse in charge of the shift, Ms Davies abused her position of trust and authority in respect of both residents and care staff.
- Resident A was in a home that cared for mentally infirm adults with dementia. He was an elderly, vulnerable resident with Alzheimer's disease, under the care of Ms Davies.
- Ms Davies' misconduct was a deliberate and sustained course of action within one shift.
- Ms Davies' misconduct caused Resident A psychological and emotional distress and as such caused him harm.
- Ms Davies placed Resident A, other residents and staff at risk of physical harm by her intention to escalate Resident A's behaviour.
- Ms Davies sought to maintain that the allegations were fabricated by her manager and colleagues.

- Ms Davies' lack of remorse or insight into her actions including its impact on Resident A, her colleagues, the nursing profession and the wider public.

The panel considered whether there were any mitigating factors in this case.

[PRIVATE]. [PRIVATE].

The panel took into account that Witness 1 stated in her witness statement dated 4 July 2023 that:

> *'Miss Davies said that while I was away on leave, she felt more pressure and thought the nursing assistants weren't doing enough. She had been working a lot of hours, sometimes doing six (6) shifts a week and* [PRIVATE] *…'*

However, in Ms Davies' investigation meeting with Ms 1, as contained in the Investigation meeting notes dated 3 April 2020, the panel noted the following questions and answers from Ms 1 and Ms Davies respectively:

> *'Ms 1: Holly, did you find your shift on 20.01.20 difficult, were you for any reason feeling more stressed?*
>
> *Ms Davies: Not really, it was quite busy….*
>
> *Ms 1: Did you feel supported by the Acting Manager?*
>
> *Ms Davies: Yes*
>
> *Ms 1: How many staff were working on that floor?*
>
> *Ms Davies: 2 Care Assistant and 1 nurse assistant*
>
> *Ms 1: For how many residents?*
>
> *Ms Davies: 8/9 residents.*

Ms 1: Not bad numbers.

Ms Davies: No, not bad at all…

Ms 1: do you have a good working relationship with all staff at Craigielea?

Ms Davies: Yes, before this, there is a good support network…'

The panel attached significant weight to the above-mentioned excerpt from the Investigation meeting notes dated 3 April 2020. The panel therefore determined that there were no mitigating factors in this case.

The panel had regard to the NMC Guidance on Considering sanctions for serious cases (SAN-2), in particular, Abuse or neglect of children or vulnerable people. The panel considered the definition of vulnerable people in the footnote of the Guidance which states:

> *'An adult is defined as vulnerable where they have care and support needs and, as a result of this, are unable to take care of themselves or protect themselves from abuse or neglect.'*

The panel considered that Resident A falls under this definition of a vulnerable adult. It found that Ms Davies' misconduct amounted to an abuse of a vulnerable adult and such behaviour can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use their services.

The panel also had regard to the NMC Guidance on Considering sanctions for serious cases, in particular, Cases involving dishonesty. The panel found that Ms Davies' misconduct was not a one-off incident nor was it a spontaneous action, but a deliberate and sustained course of action within one shift and occurred within her professional practice. The panel considered that Ms Davies' misconduct involved the

misuse of power and abuse of trust by directing care staff to falsify Resident A's records and to deliberately provoke him to make his behaviour worse than it was. The panel found that Ms Davies' conduct posed a direct risk of harm to Resident A, who was an elderly vulnerable resident under her care.

The panel therefore found the dishonesty in this case to be serious and at the higher end of the spectrum of serious cases. Additionally, had it not been for the care staff refusing to follow Ms Davies' instructions to provoke Resident A and falsify his behavioural records as they considered these instructions to be wrong, further harm may have been caused to Resident A, other residents, and staff.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that Ms Davies poses a risk of harm, had breached fundamental tenets of the nursing profession and her misconduct would undermine the public's confidence in the nursing profession if she were allowed to practise without restriction. The panel therefore determined that it would neither 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 Ms Davies' practice would not be appropriate in the circumstances. The SG (SAN-3b) states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Davies' misconduct was at the higher end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on Ms Davies' registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. The panel took into account the SG (SAN-3c), in particular:

'Conditions may be appropriate when some or all of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to 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 was of the view that the misconduct identified in this case could not be addressed through retraining and was extremely difficult to remediate. The panel had identified deep-seated attitudinal problems in this case including serious dishonesty on Ms Davies' part. It determined that given the seriousness of the concerns, the deep-seated attitudinal problems and Ms Davies' lack of insight into the severity and impact of her actions on Resident A, her colleagues, the nursing profession and the wider public, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the high risk of repetition, and this poses a risk of harm to patients' safety and the public. Consequently, the panel decided that a conditions of practice order would not protect the public nor be in the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG (SAN-3d) states that suspension order may be appropriate where some of the following factors are apparent:

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

The panel noted that this was not a single instance of misconduct but a deliberate and sustained course of misconduct within one shift at the Home. It found that Ms Davies failed to demonstrate any insight into the severity and impact of her actions on Resident A, his family, Ms Davies’ colleagues and employer, the nursing profession and the wider public. The panel noted that there was no evidence before it to indicate that Ms Davies had taken any steps to remediate her misconduct. It also found that Ms Davies’ misconduct caused actual harm to Resident A in terms of psychological and emotional distress and placed him at risk of physical harm. Ms Davies’ actions are suggestive of deep-seated attitudinal concerns which heightens the significant risk of repetition.

Therefore, the panel was not satisfied that a period of suspension would not be a sufficient, appropriate or proportionate sanction and would neither protect the public nor satisfy the public interest consideration in this case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that all of the criteria as set out above are met in this case. It noted the definition of vulnerable people in the footnote of the NMC Guidance on Considering sanctions for serious cases, in particular, Abuse or neglect of children or vulnerable people which states:

> *'An adult is defined as vulnerable where they have care and support needs and, as a result of this, are unable to take care of themselves or protect themselves from abuse or neglect.'*

The panel considered Ms Davies' conduct in the physical, emotional and psychological abuse of Resident A, who was an elderly vulnerable resident under her care, to be inherently cruel and abhorrent. Ms Davies should have shown kindness and provided compassionate care to Resident A as well as advocating honestly and appropriately for his wellbeing. She should have taken steps to minimise Resident A's distress rather than to escalate it. Furthermore, Ms Davies' conduct in directing care staff to falsify Resident A's records and to deliberately provoke him to make his behaviour worse than it was, amounted to a significant abuse of trust and authority. The panel concluded that Ms Davies had failed to practise kindly, safely and professionally as a registered nurse.

In considering sanction, the panel noted that, until these incidents, Ms Davies had an otherwise professional record. Notwithstanding, the panel concluded that the serious breach of fundamental tenets of the profession, evidenced by Ms Davies' actions and dishonest conduct, is fundamentally incompatible with her remaining on the register. To allow Ms Davies to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Davies' actions in bringing the

nursing profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

This will be confirmed to Ms Davies in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Lovatt. She submitted that, given the serious nature of the concerns and that the panel has determined that a striking-off order is appropriate and proportionate, an interim suspension order for a period of 18 months is necessary in order to protect the public and also in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. She submitted that an interim conditions of practice order would not be appropriate and proportionate in this case given the findings of the panel on misconduct, impairment, and sanction.

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

Decision and reasons on interim order

The panel had regard to the NMC Guidance, 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. It was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. It found that there were no relevant, proportionate, workable and measurable conditions that could be formulated.

The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and otherwise in the public interest, during any potential appeal period. It was of the view that the length of the order is necessary to cover any possible delays during the appeal process. The panel determined that not to impose an interim suspension order would be inconsistent with its earlier decisions.

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

That concludes this determination.