Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 6 June 2024 – Thursday, 27 June 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Anita Clare Hovery**	
NMC PIN	92C3294E	
Part(s) of the register:	RNA: Adult nurse, level 1 (2 March 1995)	
Relevant Location:	Kent/Westminster	
Type of case:	Misconduct/Lack of competence	
Panel members:	Anthony Mole Vanessa Bailey Paul Hepworth	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Charles Conway	
Hearings Coordinator:	Max Buadi	
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter	
Miss Hovery:	Not present and not represented	
Facts proved:	Charges 1a, 1b, 2, 3, 4a, 4b, 5a, 6, 7, 8, 9, 10, 11a, 11b, 11c, 12, 13, 14, 15, 16, 17, 18, 19, 20,21, 22, 23, 24 and 25	
Facts not proved:	Charges 5b, 13 and 14	
Fitness to practise:	Impaired	
Sanction:	Striking off order	
Interim order:	Interim Suspension Order (18 months)	

Decision and reasons on service of Notice of Hearing

At the outset of the hearing, the panel noted that Miss Hovery was not present and not represented. It took account of the Notice of Hearing, dated 17 April 2024, and noted that it refers to the hearing as a '*virtual*' hearing. However, the opening paragraph of the Notice of Hearing stated *'We invite you to be there in person'* and later on, the address of the venue is clearly evident.

The panel invited submissions from Mr Kabasinskas, on behalf of the Nursing and Midwifery Council (NMC), to provide it with clarification on this matter in addition to submissions relating to service of Notice of Hearing.

Mr Kabasinskas informed the panel that the Notice of Hearing letter had been sent to Miss Hovery's registered email address by secure email on 17 April 2024.

Mr Kabasinskas submitted that it is regrettable that the wording of the Notice of Hearing stated that this hearing was virtual. However, he drew the panel's attention to part of the Notice of Hearing where it indicated the dates and the address of where the hearing was going to take place. He submitted that it is this part of the Notice of Hearing where the NMC had invited Miss Hovery to acknowledge that the hearing was going to be physical.

Mr Kabasinskas submitted that if the panel are not with him regarding the concern about the hearing being addressed as virtual and physical there are emails from Miss Hovery for the panel's consideration.

Mr Kabasinskas drew the panel's attention to two emails from Miss Hovery, dated 18 April 2024 and 22 May 2024 where she has indicated in both that she is aware that the hearing is in London. Additionally, he submitted that Miss Hovery has further indicated that the NMC should make her aware of exactly what days she needs to attend because she cannot attend every day.

In light of the above, Mr Kabasinskas submitted that the NMC had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and, amongst other things, information about Miss Hovery's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel also noted that while the Notice of Hearing also included reference that the hearing was to be held virtually, including instructions on how to join, the panel was of the view that it further stated that the hearing was to be held physically.

The panel also took account of the aforementioned emails from Miss Hovery and determined that it could infer that she Miss Hovery was aware that the hearing was to be held physically.

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

Decision and reasons on proceeding in the absence of Miss Hovery

The panel next considered whether it should proceed in the absence of Miss Hovery. It had regard to Rule 21 and heard the submissions of Mr Kabasinskas.

Mr Kabasinskas drew the panel's attention to the two aforementioned emails from Miss Hovery, dated 18 April 2024 and 22 May 2024. He submitted that no application to adjourn the hearing had been made by Miss Hovery in either email.

Mr Kabasinskas cited, within the emails, issues raised by Miss Hovery in relation to her ability to participate at this hearing. [PRIVATE]. He submitted that there is no evidence of this.

Mr Kabasinskas also cited that, within the emails, Miss Hovery referred to financial difficulties that prevented her from attending the hearing in London. He drew the panel's attention to the Notice of Hearing where the NMC have stated that financial assistance could be provided in such circumstances. He submitted that Miss Hovery had not requested any financial assistance.

Mr Kabasinskas referred the panel to an email, sent from the NMC to the Miss Hovery, dated 19 March 2024. He submitted that, within this email, Miss Hovery was informed that the hearing was due to take place on 6 June 2024 and was invited to a case management conference arranged six weeks before the start of the hearing. He informed the panel that any issues she had in relation to attendance of this hearing could have been raised. He submitted Miss Hovery had not engaged with the case management conference.

Mr Kabasinskas cited the following, within the email from Miss Hovery dated 22 May 2024, where she stated that she could not attend the hearing everyday due because she would have to leave work and miss out on her wages. Mr Kabasinskas submitted that regulatory proceedings do not allow for part time hearings. He also submitted that Miss Hovery had

stated, within the email, that she would provide the NMC with the days she could attend however she had not done this.

Mr Kabasinskas submitted that it is the NMC case that Miss Hovery had voluntarily absented herself. He also informed the panel that the NMC had three witnesses scheduled to attend today and many other witnesses are scheduled to attend within the time scheduled for this hearing.

Mr Kabasinskas submitted that Miss Hovery is disadvantaged by not attending the hearing because she cannot cross examine witnesses. He submitted that if the panel noticed any discrepancies in the evidence then it can challenge these witnesses or the NMC in this regard.

Mr Kabasinskas invited the panel to continue in the absence of Miss Hovery.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Miss Hovery. In reaching this decision, the panel has considered the submissions of Mr Kabasinskas, the representations from Miss Hovery, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- The NMC had made efforts for Miss Hovery to attend;

- Miss Hovery had mentioned [PRIVATE] but had not provided the panel with any details of this and no engagement regarding alternative arrangements in this regard;
- The NMC provided information regarding financial assistance to assist Miss Hovery in attending the hearing;
- Miss Hovery did not engage with the case management conference to highlight any issues she had with attending the hearing;
- No application for an adjournment has been made by Miss Hovery;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses have attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred from 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Hovery in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Hovery's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas to amend the wording of charge 3.

The proposed amendment was to amend the date in the charge. It was submitted by Mr Kabasinskas that the proposed amendment would provide clarity and more accurately reflect the evidence. He submitted that there can be no prejudice to Miss Hovery because the proposed amendment was not substantive. He also submitted that if the proposed amendment were not granted, it would mean that the charge could fail on a technicality.

<u>Proposed Amendment</u>

"That you, a registered nurse:

3) On ~~31 May 2019~~ **31 March 2020**, were verbally and/or physically aggressive towards healthcare professionals attempting to provide care to Patient A.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that the amendment did affect the gravamen of the charge and there would be no prejudice to Miss Hovery and no injustice would be caused to either party by the proposed amendment being allowed. It also accepted the submissions of Mr Kabasinskas whereby it noted that the charge could fail on a technicality if the amendment were not made. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) On 11 May 2019:

    a) arrived for a nursing shift c. 2.5 hours late.
    b) failed to alert your agency and/or the Trust you had been booked to work for that you would be late.

2) On 21 May 2019, were verbally aggressive towards a healthcare professional attempting to provide care to Patient A.

3) On 31 March 2020, were verbally and/or physically aggressive towards healthcare professionals attempting to provide care to Patient A.

4) On 14 April 2020:

    a) arrived for a nursing shift c. 2.5 hours late
    b) failed to alert your agency and/or the Trust you had been booked to work for that you would be late.

5) On 23 November 2020:

    a) verbally abused healthcare professionals attempting to provide care to Patient A.
    b) were physically aggressive towards healthcare professionals attempting to provide care to Patient A.

6) On one or more occasions between November 2020 and January 2021 left rude and/or offensive messages for healthcare professionals caring for Patient A in Patient A’s notes.

7) On 07 December 2020, were verbally aggressive to towards healthcare professionals attempting to provide care to Patient A and/or explain that you had been issued with a verbal warning in the light of your previous conduct.

8) On 29 December 2020, were verbally aggressive towards healthcare professionals attempting to provide care to Patient A.

9) On 16 February 2021, were verbally and/or physically aggressive towards healthcare professionals attempting to provide care to Patient A.

10) On 13 June 2021, were physically aggressive towards a healthcare professional attempting to provide care to Patient A in that you intentionally pushed into them on one or more occasions.

11) On 26 October 2021:

    a) verbally abused healthcare professionals attempting to provide care to Patient A.
    b) verbally abused Patient A.
    c) threw a cloth and bag of cleaning equipment at Patient A.

12) Between 11 May and 13 July 2021, routinely arrived late for work and/or training.

13) Between 11 May and 13 July 2021, routinely failed to alert your employer, correctly or at all, that you would be late.

14) On 01 June 2021 and 21 June 2021, failed to attend resuscitation training.

15) Between 06 and 28 May 2021 failed to follow a reasonable management instruction that you contact the NMC about fitness to practise proceedings of which you were subject.

16) Between 12 April 2021 and 29 June 2021, failed to follow a reasonable management instruction that you obtain a) a Cerner card b) access to the HealthRoster system.

17) On 5 July 2021, failed to follow a reasonable management instruction that you remove your nail varnish.

18) On 09 July 2021, failed to follow a reasonable management instruction in that you worked on bed space 3 when you had been allocated bed space 5.

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

19) Failed to pass the IV Theory Course – Drugs Calculations Assessment.

20) Routinely failed to give and/or take handover in a logical and systematic way.

21) Routinely failed to carry out the tasks listed at Schedule 1 within a reasonable timeframe.

22) Routinely failed to accurately complete A-E assessments.

23) Routinely failed to accurately take and/or record observations.

24) Routinely failed to respond appropriately to changes in patient conditions and/or requests made at ward round/by the medical team.

25) Routinely failed to observe proper hand hygiene and/or aseptic non-touch technique and/or infection control.

AND, in the light of the above, your fitness to practise is impaired by reason of your misconduct at charges 1-18 and/or your lack of competence at charges 19-25.

Schedule 1

1) Observations
2) Patient assessments
3) Medication administration
4) Nursing care
5) Record keeping
6) Safety checks

Background

On 17 October 2018, the NMC received a referral from Community Neurological Team for Miss Hovery's mother, Patient A. Miss Hovery lived at the same address as her mother.

On 21 May 2019, during a home visit by Witness 4, Occupational Therapist, it was alleged that Miss Hovery was verbally aggressive towards Witness 4, demanding that she leave.

On 25 July 2019, the Kent Community Health Foundation Trust (the Trust) referred Miss Hovery following a safeguarding referral in relation to Patient A.

In 2020 and 2021, several members of staff from the community team submitted DATIX forms raising concerns regarding Miss Hovery's behaviour and actions towards them while they were visiting to provide care to Patient A.

In 2017, Miss Hovery applied to work as an Agency Nurse for Cromwell Agency ("the Agency") part of ICG Medical Ltd and completed her first shift in July 2017. In May 2019 and April 2020, complaints were made to the Agency in relation to Miss Hovery's unreliability after she failed to arrive or arrived late for her shifts.

On 30 July 2020, Miss Hovery was blocked from taking further shifts due to her unreliability.

On 12 April 2021, Miss Hovery commenced employment with Imperial College Healthcare NHS Trust as a Band 5 Nurse on the Critical Care Ward at St Mary's Hospital. Miss Hovery was placed on a performance plan as she was unable to meet the requirements for the role.

Following a 13 week supernumerary period, it was alleged that Miss Hovery was unable to achieve the required standard expected of a new Band 5 nurse in Critical Care due to the following:

- Unable to pass the IV drug calculation test;
- Unsuccessful in achieving objectives set out in her performance management plan regarding her ability to prioritise workload and manage time effectively;
- Had difficulty processing information and following instructions and escalating concerns that prevents her from being able to safely care for critically ill patients.

Decision and reasons on application to admit a letter and an email addressed to Miss Hovery from the NMC into evidence

Mr Kabasinskas drew the panel's attention to charge 15 which read:

> 15) *'Between 06 and 28 May 2021 failed to follow a reasonable management instruction that you contact the NMC about fitness to practise proceedings of which you were subject.'*

Mr Kabasinskas reminded the panel that it had heard evidence from Witness 6 about this and referenced an email about how management dealt with this.

Mr Kabasinskas drew the panel's attention to the section of the charge relating to NMC fitness to practice proceedings Miss Hovery was subject to. He reminded the panel that Miss Hovery is not present and the NMC is at a slight advantage because she cannot agree to this fact. He submitted that the burden of proof is on the NMC to prove that Miss Hovery was subject to NMC proceedings.

In light of the above, Mr Kabasinskas made an application, under Rule 31 to allow a letter from the NMC, dated 6 August 2020, and an email from the NMC, dated 29 October 2019 sent to Miss Hovery be admitted into evidence.

With regards to relevance, Mr Kabasinskas submitted that both documents are addressed to Miss Hovery and both documents pre-date the charges. He submitted that both documents go to the essence of the charge as they are sent by the NMC.

With regards to fairness, Mr Kabasinskas submitted that both documents are not new to Miss Hovery. He submitted that they have both been sent to Miss Hovery's registered email address which coincides with the email address the Notice of Hearing was sent to. He submitted that the NMC are not introducing new documentation that Miss Hovery had not been sent, therefore there can be no unfairness.

Mr Kabasinskas submitted that if the panel are not with him in regard to this application, the charge could fail on a technicality, namely the NMC may not be able to demonstrate that Miss Hovery was subject to NMC proceedings.

Mr Kabasinskas invited the panel to admit the letter from the NMC, dated 6 August 2020, and an email from the NMC, dated 29 October 2019 sent to Miss Hovery into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included 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 whether the letter from the NMC, dated 6 August 2020, and an email from the NMC, dated 29 October 2019 sent to Miss Hovery was relevant to the charges. It noted that the letters demonstrated that she was subject to NMC proceedings at the time and the panel concluded that they were relevant to the charge.

The panel determined that it was fair to admit the documents as they had been sent to Miss Hovery's registered email address.

The panel therefore determined that the material was relevant and that no unfairness or prejudice would be caused by admitting it into evidence.

Decision and reasons on consideration for panel to contact Miss Hovery and provide her with an opportunity to attend

During the course of the NMC's case on facts, Miss Hovery had sent numerous emails to the Hearings Coordinator and the NMC Case Officer.

The panel invited submissions from Mr Kabasinskas as it considered whether to provide Miss Hovery with another opportunity to attend the hearing.

Mr Kabasinskas submitted that it was the NMC's position that the panel's proposal to contact Miss Hovery was not necessary. He submitted that the FTP rules do not stipulate that the regulator or the panel should take steps to bring the registrant to the hearing during the hearing or after the panel has made the decision to proceed in the registrants absence.

Mr Kabasinskas reminded the panel that it had already sent Miss Hovery and email on day one of the hearing giving her until 14:00 that day to inform the panel if she wanted to attend physically or virtually.

Mr Kabasinskas submitted that the panel had evidence before it that Miss Hovery had voluntarily absented herself. He submitted that the panel's consideration of contacting Miss Hovery is unnecessary and would not serve any purpose.

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

The panel recognised that it had no power to require Miss Hovery to attend. It also noted that it had already determined that Miss Hovery had voluntarily absented herself and as such it proceeded in her absence.

However, the panel noted that case of *Adeogba* highlights the registrant’s duty to engage with the regulator. The case also highlighted fairness to the practitioner but also fairness to the regulator and the public interest.

In light of this the panel, in the interest of fairness to Miss Hovery, the NMC and the public interest, determined that it would send a final email to Miss Hovery. It was of the view that this email would make it clear that if she wanted to make representations, either physically or virtually then this would need to be done by the conclusion of the NMC’s case on facts which is scheduled to be 17 June 2024. Subsequently an email was sent to Miss Hovery, on 14 June 2024.

Decision and reasons on application on adjournment

The panel received an email dated 14 June 2024 from Miss Hovery. Within this email it appeared that Miss Hovery was potentially asking for an adjournment stating that she was

> *"not happy…I cannot attend this month your hearing should be suspended until I can be present not held when I cannot attend…I am disgusted that you are continuing to have hearings I have explained I cannot attend everyday in June as I will not get paid virtual hearings are no good as you are not present…I could attend on a couple of days but not in June at all"*.

The panel invited submissions from Mr Kabasinskas.

Mr Kabasinskas informed the panel that the NMC's position had not changed and submitted that Miss Hovery had waived her right to attend the hearing because she had voluntarily absented herself.

Mr Kabasinskas reminded the panel that fairness must be considered for both Miss Hovery and also to the NMC. He submitted that Miss Hovery would be at a disadvantage because she would not be able to present her case and there is only one NMC witness remaining at this stage.

Mr Kabasinskas submitted that in regulatory proceedings, there is no need for Miss Hovery's to give evidence as it is voluntary.

Mr Kabasinskas submitted that Miss Hovery had stated that it was not fair to proceed without her present at the hearing. He reminded the panel that Miss Hovery had sent the panel correspondence which the panel have put to the NMC witnesses on her behalf. He submitted that the aforementioned disadvantage to Miss Hovery had been mitigated.

With regards to fairness to the NMC, Mr Kabasinskas reminded the panel that the remaining NMC witness had taken time out from her work to attend the hearing and scheduled to give evidence last due to her availability. He submitted that adjourning the hearing would inconvenience the witness and the NMC do not know when she would be available again.

With regards to fairness, Mr Kabasinskas submitted that the nature and circumstances of Miss Hovery's absence have to be considered. He submitted that Miss Hovery had stated that she was working and due to financial reasons was not willing to make herself available to attend the hearing. Mr Kabasinskas submitted that this is deliberate.

Mr Kabasinskas submitted that Miss Hovery requesting an adjournment at this stage would cause a disruption of the proceedings.

Mr Kabasinskas submitted that Miss Hovery is very vague and had not provided the NMC or the panel a specific date of when she would be available. He submitted that there is no guarantee that adjourning today would secure her attendance in the future.

Mr Kabasinskas submitted that Miss Hovery had stated that she was not legally represented. He submitted that she had not provided the panel with evidence of the steps she had taken to secure representation or steps she would take if she were granted an adjournment.

Mr Kabasinskas submitted that Miss Hovery had not provided a good reason for non-attendance. He also reminded the panel that the NMC offered Miss Hovery financial assistance to attend the hearing.

Mr Kabasinskas submitted that adjourning would not serve any useful purpose and would be counter to the public interest.

Mr Kabasinskas invited the panel to reject Miss Hovery's application to have the hearing adjourned.

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

The panel had regard to all the information before it. It took account of the email from Miss Hovery and noted that she stated the panel would make "unfair judgements" because she is not present.

The panel was of the view that it had given Miss Hovery ample opportunity to attend either physically or virtually. The panel bore in mind that Miss Hovery had been invited to participate physically or virtually and she appears to have not accepted either.

The panel reminded itself that Miss Hovery had a duty to engage with her regulator and other than the emails she had sent to the panel, Miss Hovery had not engaged in a meaningful way. It also bore in mind that it had considered the correspondence she had sent and had put her case to the NMC witnesses in her absence.

The panel also noted that while Miss Hovery had mentioned representation, she had not provided the panel with evidence of the steps she had taken or would take, if the panel were to adjourn, to secure representation. It was of the view that Miss Hovery has had ample time to secure representation.

The panel also noted that Miss Hovery had not provided the NMC or the panel with a period of time she would be available. The panel was also of the view that there was no guarantee that adjourning would secure the attendance of Miss Hovery.

The panel also considered the public interest and the overarching objective to protect the public. The panel was of the view that public protection issues have been raised and there is there is a strong public interest in the expeditious disposal of the case.

The panel was of the view that adjourning today would not be fair to the NMC. It was of the view that adjourning would inconvenience the remaining NMC witness, and disrupt the NMC's case.

In light of the above, the panel determined to reject Miss Hovery's application to adjourn the hearing.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kabasinskas on behalf of the NMC and emails provided by Miss Hovery.

The panel has drawn no adverse inference from the non-attendance of Miss Hovery.

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

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

- Witness 1: Registered Nurse at the Trust;
- Witness 2: Healthcare Assistant at the Trust;
- Witness 3: Band 3 Healthcare Assistant at the Trust, at the relevant time;
- Witness 4: Neurological Rehabilitation Occupational Therapist at the Trust;
- Witness 5: Registered Nurse who worked for Cromwell Agency;
- Witness 6: Lead Nurse/Matron at the Trust at the relevant time;

- Witness 7: Senior Clinical Educator at Imperial College Healthcare NHS Trust;

- Witness 8: Clinical Practice Educator at Imperial College Healthcare NHS Trust;

- Witness 9: Band 6 Nurse at Imperial College Healthcare NHS Trust at the relevant time;

- Witness 10: Band 6 Nurse at Imperial College Healthcare NHS Trust;

- Witness 11: Clinical Coordinator at the Trust;

- Witness 12: Band 6 Sister at Imperial College Healthcare NHS Trust.

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

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

Charge 1a

That you, a registered nurse:

1) On 11 May 2019:

a) arrived for a nursing shift c. 2.5 hours late.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 5.

Witness 5 in her witness statement stated:

> *"On 11 May 2019, Anita was scheduled to work a shift at the Stroke Unit at the North Middlesex University Hospital NHS Trust ("the NMUH Trust"). The Agency received an email from the Bank Partners at the NMUH Trust, which said that Anita had failed to attend for her shift. I exhibit a copy of the email marked as MP/05. The shift was due to start at 13:00. Anita did not arrive for her shift until 15:20.*
>
> *…*
>
> *On 13 May 2019, I spoke to Anita on the telephone and followed up with an email to Anita. I asked Anita to explain what was going on."*

The panel took account of an email, dated 11 May 2019, cited in Witness 5's witness statement from the Bank Partners at the NMUH Trust sent to the Cromwell Agency. This email stated that Miss Hovery's had not arrived for her shift on the Acute Stroke Unit due to commence at 12:00 and end at 20:00. It noted that Miss Hovery's shift was actually due to commence at 12:00 rather than at 13:00 as stated by Witness 5 in her witness statement.

The panel also took account of the email, further cited in Witness 5's witness statement, she had sent to Miss Hovery dated 13 May 2019, two days after the shift. This email stated:

> *"…Could you please advise me what happened and why you were not able to arrive on time for the shift and why you did not keep the booking team informed of the issues…"*

Miss Hovery responded to Witness 5 in an email, dated 15 May 2019, which stated:

> *"…I unfortunately arrived at the ward at 1520…" [sic]*

The panel was satisfied that the contemporaneous emails corroborate the details in Witness 5's witness statement. It found the evidence of Witness 5 to be credible, reliable and consistent.

The panel had no information before it from Miss Hovery in relation to this particular charge.

The panel therefore found that, on the balance of probabilities, on 11 May 2019 Miss Hovery, arrived for a nursing shift c. 2.5 hours late.

The panel therefore find this charge proved.

Charge 1b

That you, a registered nurse:

1) On 11 May 2019:
   b) failed to alert your agency and/or the Trust you had been booked to work for that you would be late.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 5.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to alert her agency and/or the Trust she had been booked to work for, that she would be late on 11 May 2019.

Witness 5 in her witness statement stated:

> *"If Anita knew that she was going to be late the first thing she should have done was notify the booking team at the Agency. Anita should have informed the booking team of the reason for her arriving late and what her expected time of arrival was. The Agency will then liaise with the relevant contact at the Ward or hospital and notify the relevant person such as the Ward Manager.*
>
> *…*
>
> *The process for reporting lateness is set out in the staff handbook. Anita was responsible for reading the handbook herself and she has signed the declaration to confirm that she had read it."*

The panel was therefore satisfied that Miss Hovery had a duty to alert her agency and/or the Trust that she would be late on 11 May 2019. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty to alert her agency and/or Trust that she would be late on 11 May 2019.

The panel had already accepted Witness 5's evidence, in charge 1a, that demonstrated Miss Hovery was late for her shift on 11 May 2019. It took account of an email Miss Hovery sent to Witness 5 to explain why she was late. It stated:

> *"Sorry for my delay in response to your phone call,…I ended up leaving the house and was going to buy a phone card to call and when I went to the machine my card didn't work so had to walk to the bank to use it, when the agency called it was around the time I should have started…"*

The panel took account of the fact that Miss Hovery, in the email above, apologised for her delayed response to Cromwell Agency. It noted that rather than Miss Hovery calling Cromwell Agency to explain why she was late for her shift on 11 May 2019, Crowell Agency had to call Miss Hovery.

The panel also noted that Miss Hovery in the email also stated:

> *"I made the mistake of not calling before I left as was busy with mum time passed by quickly this will not happen again."*

The panel noted that Miss Hovery acknowledged the "mistake of not calling" in an email. The panel inferred from this that she recognised that she had a duty to alert her agency and/or the Trust that she would be late on 11 May 2019.

The panel was satisfied that the contemporaneous emails corroborated the details in Witness 5's witness statement. It found the evidence of Witness 5 to be credible, reliable and consistent.

The panel had no information before it from Miss Hovery in relation to this particular charge.

The panel therefore found this charge 1b proved.

Charge 2

That you, a registered nurse:

2) On 21 May 2019, were verbally aggressive towards a healthcare professional attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 4 and the evidence of Miss Hovery.

Witness 4 in her witness statement stated:

> *"Anita then became extremely verbally aggressive to me. Anita was shouting at me, telling me that I needed to leave her house and that she would contact the police. I cannot remember if Anita was close to me at this point. I felt shocked by her reaction and overwhelmed."*

The panel noted that Witness 4 had recorded a DATIX upon her return to the office 21 May 2019, the day of the incident. Within the DATIX, Witness 4 recorded the following:

> *"[Miss Hovery] raised her voice significantly, she reported as I was an OT it was not in my job role to ask about bills or money. [Miss Hovery] opened the front door, told me to leave, that the door was open for me…[Miss Hovery] continued to speak aggressively towards me, reported that all conversations were recorded and her mother's finances were not of my concern."*

Miss Hovery in an email sent to the panel, dated 7 June 2024, stated:

> *"[Witness 4] completely has lied she was asked only to leave as she was asking for my private bills and she would not stop asking during her visit she was helped to help relative outside and measure for the rails, she was not at risk nothing happened during her visit I have no idea why she has chosen to comptely lie in her report" [sic]*

The panel was persuaded by the evidence of Witness 5 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous

DATIX corroborated the details in Witness 5's witness statement. The panel preferred the evidence of Witness 5 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 3

That you, a registered nurse:

3) On 31 May 2019, were verbally and/or physically aggressive towards healthcare professionals attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and the evidence of Miss Hovery.

Witness 2 in her witness statement detailed the incident of 31 March 2020 where she had visited Patient A with a colleague, a healthcare assistant, to administer insulin. She stated that due to the swelling on Patient A's legs, Patient A had pro pad boots to prevent her from slipping on the floor. Witness 5 stated that Patient A had said she did not want to have the pro pad boots on. Witness 5 then described Miss Hovery shouting and ranting that Patient A was slipping on the floor. She stated:

> *"I walked a couple of steps into the dining area and was stood next to the wall by the Patient. Anita then stood up and was standing nose to nose with me and was glaring at me. Anita was an inch away from my face. Anita continued to shout and rant in my face."*

The panel noted that Witness 2 had recorded a DATIX on 31 May 2020, the day of the incident. Within the DATIX, Witness 2 recorded the following:

“I went up to [PATIENT A] and asked if she was ok and [Miss Hovery] stood up and spuared up to me nose to nose. I said nothing to her and she backed down.” [sic]

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

“The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters.”

The panel was persuaded by the evidence of Witness 2 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 5’s witness statement. The panel preferred the evidence of Witness 2 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 4a

That you, a registered nurse:

4) On 14 April 2020:

    a) arrived for a nursing shift c. 2.5 hours late

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 5.

Witness 5 in her witness statement stated:

> *“On 15 April 2020, I received an email from the Clinical Lead at the RFBT Trust who raised concerns that Anita said was late arriving for her shift. The shift was due to start at 19:30 but Anita did not arrive until 22:00. The shift was then due to finish at 07:30 but Anita stayed on the AAU until 10:50.”*

The panel took account of an email Witness 5 sent to Miss Hovery on 15 April 2020, the day after the shift in question. Within this email, Witness 5 quoted a complaint from the Clinical Lead at the hospital the shift was due to take place. It stated:

> *“I am writing to inform you this is not the first time Anita had come to work late. I was informed by my team that she normally arrives for her 19:30 shift at around 22:00 hrs which happened last night as well.”*

The panel was satisfied that the contemporaneous emails corroborate the details in Witness 5’s witness statement. It found the evidence of Witness 5 to be credible, reliable and consistent.

The panel had no information before it from Miss Hovery in relation to this particular charge.

The panel therefore found that, on the balance of probabilities, on 14 April 2020 Miss Hovery, arrived for a nursing shift c. 2.5 hours late.

The panel therefore find this charge proved.

Charge 4b

That you, a registered nurse:

4) On 14 April 2020:

b) failed to alert your agency and/or the Trust you had been booked to work for that you would be late.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 5.

The panel had already established Miss Hovery had a duty to alert her agency and/or the Trust that she would be late in charge 1b. As Miss Hovery was employed by the same agency on 14 April 2020, it was satisfied that the same duty applied for this sub-charge. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty to alert her agency and/or Trust that she would be late on 14 April 2020.

The panel had already accepted Witness 5's evidence, in charge 4a, that demonstrated Miss Hovery was late for her shift on 14 April 2020.

The panel took account of an email Witness 5 sent to Miss Hovery on 15 April 2020, the day after the shift in question. Within this email, Witness 5 quoted a complaint from the Clinical Lead at the hospital the shift was due to take place. It stated:

> *"I am writing to inform you this is not the first time Anita had come to work late. I was informed by my team that she normally arrives for her 19:30 shift at around 22:00 hrs which happened last night as well.*
>
> *Just want to bring to your attention that she only just left AAU at 10:50 in the morning after finishing her night shift. She was giving medication to her patients till about 09:30 and was not ready to hand over her patients to the day nurse.*

She has very poor time management and had left few things not done from her shift. This is distracting the patient care and for this reason I would like to ask you to kindly cancel her oncoming shifts in AAU please"

Witness 5, in her witness statement continued:

"Anita told the Ward Manager that she was late because she was waiting for her brother to take care of her mother. Anita did not tell the Ward Manager she was running late until 21:04 on 14 April 2019."

The panel had no information before it from Miss Hovery in relation to this particular charge. It took account of Witness 5's witness statement, and noted that Miss Hovery did inform the Ward Manager that she would be late, however this was not until 21:04 – 1 hour and 34 minutes after her shift was due to begin.

The panel was satisfied that the contemporaneous emails corroborate the details in Witness 5's witness statement. It found the evidence of Witness 5 to be credible, reliable and consistent.

The panel acknowledged that Miss Hovery had called the ward at 21:04 that she would be late for her shift that had already started at 19:30. However, the panel determined that this was not sufficient notice as the shift had already started when she called.

The panel therefore found that, on the balance of probabilities, Miss Hovery failed to alert her agency and/or the Trust she had been booked to work for, that she would be late on 14 April 2020.

The panel therefore find this charge proved.

Charge 5a

That you, a registered nurse:

5) On 23 November 2020:
   a) verbally abused healthcare professionals attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and the evidence of Miss Hovery.

Witness 1 in her witness statement described the incident that took place on 23 November 2020 where she visited Patient A with a healthcare assistant ("the HCA") to administer insulin. Witness 1 stated that Patient A had recently been prescribed a new insulin pen but it was not there when they visited. Witness 1 stated that she called upstairs to ask if Miss Hovery could collect the insulin pen from the pharmacy. Witness 1 in her witness statement stated:

> *"Anita was stood at the top of the stairs and started shouting at me. Anita said, "The nurses can get the fucking insulin if they want to change it." Anita then told [the HCA] and I to "Fuck off out of her fucking house" and called us "Fucking bitches."*

Witness 1 in her oral evidence stated that Miss Hovery's behaviour made her feel frightened and she, along with the healthcare assistant, ran out of the house.

The panel noted that Witness 1 had recorded a DATIX on 23 November 2020, the day of the incident. Within the DATIX, Witness 1 recorded the following:

> *"She Told [the HCA] and I to Fuck off out of Her Fucking house. Called us Fucking Bitches. Patients daughter would not listen to why her mother needed the new insulin. She ran down the stairs to [the healthcare assistant] and I sticking her 2*

fingers up and trying to record on her mobile phone. [The HCA] and I got out the door quickly."

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

"The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters."

The panel was persuaded by the evidence of Witness 1 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 1's witness statement. The panel preferred the evidence of Witness 1 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 5b

That you, a registered nurse:

5) On 23 November 2020:
    b) were physically aggressive towards healthcare professionals attempting to provide care to Patient A.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 1.

Witness 1 in her witness statement stated:

“I told Anita that there was no need to shout at us. Anita ran down the stairs where [the healthcare assistant] and I were standing, and was sticking her two fingers up at us. [The HCA] and I quickly left the Patient’s house out of the front door.”

The panel bore in mind that to find this particular charge proved, it had to be satisfied that the actions of Miss Hovery were physically aggressive. It noted the effect of Miss Hovery sticking her two fingers up at Witness 1 and the HCA, telling them to leave and running towards them made Witness 1 feel frightened.

Nevertheless, the panel noted that the evidence before the panel demonstrated that Miss Hovery’s actions were verbally aggressive towards Witness 1 and the HCA. However, there was no evidence of physical contact nor any explicit physical threat of violence.

The panel determined that the NMC, on the balance of probabilities, had failed to meet the evidential burden in relation to this charge.

The panel therefore find this charge not proved.

Charge 6

That you, a registered nurse:

6) On one or more occasions between November 2020 and January 2021 left rude and/or offensive messages for healthcare professionals caring for Patient A in Patient A’s notes.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 3, Witness 11 and the evidence of Miss Hovery.

Witness 11 in her witness statement stated:

> *"One of the cocnerns that was raised included Anita defacing the Patient's records and leaving rude notes for the district nurses." [sic]*

The panel took account of the evidence provided by Witness 11. In oral evidence she stated that she recognised that it was Miss Hovery's handwriting that was on the patient's notes.

The panel also took into account the handwritten content on Patient A's Community Medicines Referral (CMR) forms dated 19 November 2020 and 25 January 2021. On the form dated 19 November 2020 refers to staff not allowed to "give mums meds unsupervised". Additionally, on the form dated 25 January 2021 the handwriting on the form refers to insulin pen's not belonging to "mum" and the panel therefore inferred from this that is was Miss Hovery's handwriting.

The panel also noted that Witness 11 in her witness statement described a time she visited Miss Hovery at Patient A's home on 7 December 2020 to issue her with a verbal warning. It took account of the notes Witness 11 prepared for the visit, dated 7 December 2020, which stated:

> *"I turned to [her colleague] and advised that we are leaving now and this is why we are following our process, and then I turned to Anita and advised that we are leaving now and again reiterated that this is a verbal warning about her verbal abuse and behaviour, and also asked her to stop writing defacing Patient A's record."*

The panel was of the view that the writing on Patient A's records had been raised directly with Miss Hovery during the above visit.

Witness 3 in her witness statement described an incident during a visit to Patient A's house to administer insulin and change bandages. She stated:

> *"Every insulin patient, including the Patient, has a set of notes kept in the patient's home which includes a paper CMR. We use the Paper CMR to record what insulin we have administered during the visit. Anita would take out the CMR and write insults and scribbles on it. This meant that we were no longer able to record the insulin administered on that CMR and had to write on a new one. We took any defaced CMR out of the Patient's notes and took them back to base so they could be scanned and stored electronically."*

The panel therefore concluded that the handwriting of "mum" on the patient records, the information from Witness 3 and Witness 11's contemporaneous notes supported Witness 11's oral evidence that the handwriting belonged to Miss Hovery.

The panel went on to examine if the notes left by Miss Hovery were rude and/or offensive for healthcare professionals caring for Patient A. It took account of the notes left by Miss Hovery, provided by Witness 11, stated:

> *"To all the dumb nurses where is insulin usually kept take a look !! not in the drawers" [sic]*

The panel noted that this note was addressed to healthcare professionals caring for Patient A. It was satisfied that referring to the nurses as "dumb" amounted to being rude and offensive.

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

"The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters."

In response to the charge Miss Hovery, within the aforementioned email stated:

"There notes have not been changed"

The panel was persuaded by the evidence of both Witness 11 and Witness 3 which it deemed to be credible, reliable and consistent. It was also satisfied that the contemporaneous notes from Witness 11 corroborated the details in her witness statement. The panel preferred the evidence of Witness 11 and Witness 3 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 7

That you, a registered nurse:

7) On 07 December 2020, were verbally aggressive to towards healthcare professionals attempting to provide care to Patient A and/or explain that you had been issued with a verbal warning in the light of your previous conduct.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 11 and the evidence of Miss Hovery.

Witness 11 in her witness statement described an incident on 7 December 2020 where she and a colleague visited Miss Hovery at Patient A's home. She stated:

“During the meeting, we explained that the team were afraid of coming to see the Patient due to Anita's vernal abuse [sic] and aggressive behaviour. We informed Anita that if the abuse continued then one possible option was to withdraw the care provided to the Patient.”

Witness 11 clearly described, both in her witness statement and in her oral evidence, the behaviour of Miss Hovery. Witness 11 described it as verbal and abusive and stated at one point Miss Hovery started shouting. Witness 11 in her witness statement stated:

“I asked Anita to stop shouting numerous times during the visit. After asking on one occasion, Anita said this is shouting, and proceed to raise her voice and screamed at us loudly.”

The panel took account of the notes Witness 11 prepared for the visit, dated 7 December 2020, which stated:

“Throughout the visit I have asked Anita to stop shouting numerous times, again asked her to stop shouting, she then said this shouting, and screamed at us.”

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

“The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters.”

Miss Hovery also stated, within the aforementioned email:

“There nurse in charge visited one day on entering the property started to order me around when I was busy doing chores, u have no idea why there nurse in charge

would treat people like this, she told me to go and sit where she wanted but she had no right to order me around for no reason." [sic]

The panel was persuaded by the evidence of Witness 11 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous notes taken by Witness 11 corroborated the details in her witness statement. The panel preferred the evidence of Witness 11 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 8

That you, a registered nurse:

8) On 29 December 2020, were verbally aggressive towards healthcare professionals attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 3, Witness 11 and the evidence of Miss Hovery.

Witness 3 in her witness statement stated:

"On 29 December 2020, I visited the Patient at her home to administer her insulin. I was accompanied by a registered nurse whose name I do not recall."

During this time, Witness 3 in her witness statement described how Miss Hovery asked her why bloods had not been taken that day. Witness 3 in her witness statement continued:

“I informed Anita that bloods had not been requesed during this visit but that we would check on our system later that day. Anita did not find my responise acceptable and then continued to speak to me rudely…Anita stated that her mother was pale and tired and that we did not have basic observation skills. Anita then called me 'cocky' and 'confident'. Anita accused me of always being rude to her and saying things about her to the District Nurses.” [sic]

In response to panel questions Witness 3 clarified the conversation pertaining to this incident. She stated that this was not a normal conversation as Miss Hovery was shouting and doors were being slammed. She stated that Miss Hovery was getting in her face in an aggressive way and also stated that she was crying and was “red faced”. She stated she needed a time out due to the verbal aggression which delayed her ability to see other patients.

The panel noted that Witness 3 had recorded a DATIX on 29 December 2020, the day of the incident. Within the DATIX, Witness 3 described the verbal abuse and the panel particularly noted she recorded the following:

“Staff member shaken by personal comments made. Took a bit of time out to calm down before continuing to visit patients.” [sic]

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

“The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters.”

The panel was persuaded by the evidence of Witness 3 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous

DATIX corroborated the details in Witness 3's witness statement. The panel preferred the evidence of Witness 3 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 9

That you, a registered nurse:

9) On 16 February 2021, were verbally and/or physically aggressive towards healthcare professionals attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 3 and the evidence of Miss Hovery.

Witness 3 in her witness statement and oral evidence described an incident on 16 February 2021 where she visited Patient A with another HCA to administer insulin and change bandages. Witness 3 in her witness statement stated:

> *"Anita continued to target me during the visit. She accused me of making the wrong decisions regarding her mother's care and of being a "bloody idiot" and "cocky"… Anita continued to rant at me and insulted me with regards to my ability to take blood pressure. Anita continued to call me a "bloody idiot". Anita then left the room and shut the door behind her… When we left the Patient's house we shut the door behind us as we had been previously instructed to do so by Anita. She then yanked the door open and proceeded to stare at us as we walked down the drive."*

The panel noted that Witness 3 had recorded a DATIX on 16 February 2021, the day of the incident. Within the DATIX, Witness 3 recorded:

“The patient's daughter continued to target the HCA mentioned in this report. Accusing her of making the wrong decisions regarding [Patient A]’s care and being a 'bloody idiot' and 'cocky'..” [sic]

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour. She further stated:

“If you question as to why they have left relative with soaking wet dressing or constantly send uneducated people who do not know how to do the dressings,there treatment of me is disgusting as they do not like being questioned about the poor care my relative has received from them.” [sic]

The panel was persuaded by the evidence of Witness 3 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 3’s witness statement. The panel preferred the evidence of Witness 3 over the evidence of Miss Hovery.

The panel therefore found that on 16 February 2021, Miss Hovery was verbally aggressive towards healthcare professionals attempting to provide care to Patient A. However, it was of the view that there was insufficient evidence to support the allegation that Miss Hovery was physically aggressive to healthcare professionals.

The panel therefore find this charge proved to the extent of verbal aggression.

Charge 10

That you, a registered nurse:

10) On 13 June 2021, were physically aggressive towards a healthcare professional attempting to provide care to Patient A in that you intentionally pushed into them on one or more occasions.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 2 and the evidence of Miss Hovery.

Witness 2 in her witness statement described an incident on 13 June 2021 where she, alongside a trainee nurse, visited Patient A. Witness 2 in her witness statement stated:

> *"I entered the house and was stood in the kitchen doorway saying hello to the Patient, Anita was in the kitchen; she then came out and pushed past me shoulder to shoulder. I did not say anything to Anita."*

In oral evidence Witness 2 stated that, in regard to the above incident, she could not be entirely sure that Miss Hovery pushing past her shoulder to shoulder was intentional. Witness 2 stated that she gave Miss Hovery "the benefit of the doubt"

Witness 2 in her witness statement described a second incident during the same visit when she was preparing to give Patient A's insulin. She stated that Miss Hovery came back into the room and was standing by the patio doors on Patient A's right-hand side. Witness 2 stated:

> *"I was bending down in front of the Patient as I was about to give her insulin. At this point, Anita came whooshing past me and knocked into me. I had to get my balance to stop myself falling while I also had the insulin needle in my hand. I shouted at Anita that that was assault. I did not say anything else to Anita and left."*

Witness 2 in her oral evidence was very clear to the panel and stated that Miss Hovery on this occasion could have passed her without touching her and could have avoided contact. Witness 2 interpreted this contact as intentional.

The panel noted that Witness 2 had recorded a DATIX on 13 June 2020, the day of the incident. Within the DATIX, Witness 2 recorded the following:

> *"I regained my balance and told her this was assault she then went into a rant about nurses getting in her way." [sic]*

The panel noted that this DATIX entry was consistent with Witness 2's description of the second occasion when Miss Hovery went past her during the administration of insulin to Patient A.

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

> *"The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters,…they were not ever pushed past at all this is a lie this never happened at all."*

The panel was persuaded by the evidence of Witness 2 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 2's witness statement. The panel preferred the evidence of Witness 2 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 11a

That you, a registered nurse:

11) On 26 October 2021:

a) verbally abused healthcare professionals attempting to provide care to Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and the evidence of Miss Hovery.

Witness 1 in her witness statement described an incident that occurred on 26 October 2021 where she visited Patient A with a phlebotomist to administer insulin and change Patient A's leg dressing. Witness 1 in her witness statement stated:

> *"Anita shouted at us and said, "You are taking the piss" and "I'm not a fucking carer… Anita also said "I'm not a nurse, I work with animals" and "Fuck off. Get out of here" at [the phlebotomist] and I.*

The panel noted that Witness 1 had recorded a DATIX on 26 October 2021, the day of the incident. Within the DATIX, Witness 1 recorded the following:

> *"[Miss Hovery] was verbally abusive. Joint visit with another staff member...[Miss Hovery] shouted 'you are taking the fucking piss' 'I'm not a fucking carer'…" [sic]*

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

> *"The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters."*

The panel was persuaded by the evidence of Witness 1 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 1's witness statement. The panel preferred the evidence of Witness 2 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 11b

That you, a registered nurse:

11) On 26 October 2021:

b) verbally abused Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and the evidence of Miss Hovery.

Witness 1 in her witness statement described an incident that occurred on 26 October 2021 where she visited Patient A with a phlebotomist to administer insulin and change Patient A's leg dressing. She stated that when she was at Patient A's house, she could see "food and rubbish" on the floor. Witness 1 stated that Patient A had informed the phlebotomist that Miss Hovery had thrown contents of a bin over Patient A that morning and poured coffee over her lap. Witness 1 stated that as a result of her interactions with Patient A that day in relation to her care Witness 1 stated:

“Anita pointed at the Patient and said “She is talking fucking bollocks”.

The panel noted that Witness 1 had recorded a DATIX on 26 October 2021, the day of the incident. Within the DATIX, Witness 1 recorded the following:

“[Miss Hovery] shouted…'she is talking fuckin bollocks' pointing at patient.” [sic]

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

“The district nurses have lied they have made up lies about me to trust security who were also sending me threatening letters…there was never any food on the floor as it had been cleaned, nothing has ever been thrown they are lieing…” [sic]

The panel was persuaded by the evidence of Witness 1 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 1’s witness statement. The panel preferred the evidence of Witness 2 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 11c

That you, a registered nurse:

11) On 26 October 2021:
    c) threw a cloth and bag of cleaning equipment at Patient A.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 1 and the evidence of Miss Hovery.

Witness 1 in her witness statement described the incident that occurred on 26 October 2021 as described in charge 11b. Witness 1 in her witness statement stated:

> *"The Patient was sat in her chair and Anita threw a cloth and a bag of cleaning equipment at her. I do not recall what was in the bag. Anita then yelled at us to "Clean the fucking floor yourself".*

During panel questions Witness 3 was asked to respond to an email from Miss Hovery response, dated 7 June 2024, in which she stated Witness 3 was lying about rubbish being thrown at Patient A. Witness 3 denied this and stated Miss Hovery was by the sink in the kitchen and the phlebotomist asked if Miss Hovery could clear the mess that was around Patient A. She stated that Miss Hovery was shouting and swearing and she threw the cloth at Patient A.

The panel noted that Witness 2 had recorded a DATIX on 31 May 2020, the day of the incident. Within the DATIX, Witness 2 recorded the following:

> *"[Miss Hovery] threw a bag of cleaning stuff in Patients direction." [sic]*

The panel also noted that Witness 1 recorded that "Police called to house" in DATIX.

Miss Hovery, in an email sent to the panel dated 7 June 2024, stated that the district nurses and carers that would tend to Patient A were providing poor quality care. Miss Hovery also stated that they had lied about her behaviour:

> *"there was never any food on the floor as it had been cleaned, nothing has ever been thrown they are lieing about this as well but a dishcloth was put onto the side and they were told if you don't like my cleaning they could do it themselves."[sic]*

The panel was persuaded by the evidence of Witness 1 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned contemporaneous DATIX corroborated the details in Witness 1's witness statement and her oral evidence. The panel preferred the evidence of Witness 1 over the evidence of Miss Hovery.

The panel therefore find this charge proved.

Charge 12

That you, a registered nurse:

12) Between 11 May and 13 July 2021, routinely arrived late for work and/or training.

This charge is found proved.

The panel bore in mind that the charge contained the word "routinely" which it considered to have the dictionary meaning or regularly as Mr Kabasinskas submitted. It was of view that in order to find this charge proved, it would have to be satisfied that you were late for work and/or training on a regular basis. With this in mind, the panel took account of the evidence of Witness 6, Witness 9 and the evidence of Miss Hovery.

Witness 9 in her witness statement stated:

> *"Throughout the duration of Anita's supernumerary period, I had a number of concerns about her practice which are listed below:*
>
> *i. Anita was often late to work. Anita would often miss handover which would mean that it would be necessary for me to handover the patient to Anita separately and it would start the day late. We would be 30-60 minutes behind schedule and it would*

be necessary for me to then try to catch up that time later in the day following Anita's shift."

Witness 6 corroborated this in her witness statement stated:

"…the day shift on the Ward starts at 07:30 and staff are expected to be ready to listen to the safety briefing at the start of the shift. During her 13 week supernumerary period, Anita was late on the following occasions:

a. 11 May 2021, arrived at 08:25
b. 18 May 2021, arrived at 09:20
c. 19 May 2021, arrived at 08:40
d. 20 May 2021, arrived at 08:00
e. 8 June 2021, arrived at 11:00
f. 17 June 2021, arrived at 07:45
g. 29 June 2021, arrived at 10:40
h. 12 July 2021, arrived 08:45
i. 13 July 2021, arrived at 09:30"

The panel also took account of the E-roster provided by Witness 6. According to the E-roster, Miss Hovery had been late nine times between 11 May and 13 July 2021.

The panel noted that Miss Hovery had not directly addressed this charge in her email, dated 7 June 2024. However, she had stated, within the email, that she had missed some shifts due to [PRIVATE].

The panel was persuaded by the evidence of Witness 6 and Witness 9 which it deemed to be credible, reliable and consistent. It was also satisfied that the E-roster corroborated the details in Witness 6 and Witness 9's respective witness statements.

The panel also accepted that due to the number of times Miss Hovery was late, this amounted to routinely.

The panel therefore find this charge proved.

Charge 13

That you, a registered nurse:

13) Between 11 May and 13 July 2021, routinely failed to alert your employer, correctly or at all, that you would be late.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 6 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to alert her employer that she would be late.

Witness 6 in her witness statement stated:

> *"If Anita was going to be late for a shift, if should have called the floor coordinator's mobile telephone number to let them know. The process for communicating lateness and non-attendance was communicated to Anita. On many of these occasions there was a failure to follow the correct process to update the floor coordinator of the lateness or non-attendance."*

The panel also noted that in an email sent to Miss Hovery, dated 25 June entitled "Meeting Summary – Review of formal performance review period", concerns had already been raised about Miss Hovery's attendance and lateness prior to the meeting. During this

meeting, the panel noted that the importance of punctuality and attendance was discussed with Miss Hovery.

In light of the above, the panel was satisfied that Miss Hovery had duty to alert her employer that she would be late. In light of this, the panel then went on to consider whether Miss Hovery had routinely failed to alert her employer, correctly or at all, that she would be late. It also bore in mind that due to the word “routinely” being in the charge, the panel had to be satisfied that she failed in this regard on a regular basis.

The panel bore in mind that it is for the NMC to prove the charge. The panel had already accepted the evidence of Witness 6, in charge 12, which demonstrated that Miss Hovery was late on nine occasions. However, it noted that there was no documentary evidence or direct witness that could demonstrate whether Miss Hovery had failed to alert her employer that she would be late.

The panel took account of an email sent by Miss Hovery to the Clinical Educator, dated 12 July 2021. The email suggested that on one occasion Miss Hovery had called to inform her employer she would be late however, she used the wrong method, namely using the switchboard as opposed to the calling the Floor Coordinator directly.

The panel noted that in Witness 6’s evidence she indicated that on many occasions, Miss Hovery had not followed the correct procedure. As there were only two occasions, namely 11 May 2021 and 13 July 2021, in evidence to the panel this was insufficient to persuade the panel that this was a routine failure. It was therefore of the view that the NMC had failed to meet the threshold of ‘routinely’ as described in the charge.

The panel therefore find this charge not proved.

Charge 14

That you, a registered nurse:

14) On 01 June 2021 and 21 June 2021, failed to attend resuscitation training.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Witness 6 and the evidence of Miss Hovery.

Witness 6 in her witness statement stated:

> *"In addition to arriving late, Anita failed to attend the following training days:*
> *a. 1 June 2021, Resuscitation level 3*
> *b. 21 June 2021, Resuscitation level 2"*

The panel took account of an email, dated 21 June 2021, sent in regard to Miss Hovery's alleged failure to attend the Resuscitation Level 3 (Immediate Life Support) training which appeared to have occurred on 1 June 2021. However, it noted that the email stated that '*it looks like*' Miss Hovery did not attend.

Witness 6, in her oral evidence confirmed the information she had received in relation to Miss Hovery's alleged non-attendance on the 1 June 2021 training. However, Witness 6 conceded that she could not find an email or any documentary evidence to support the allegation that Miss Hovery's had not attended the training that was due to occur on 21 June 2021.

The panel took account of an email Witness 6 had sent to Miss Hovery, dated 25 June entitled "Meeting Summary – Review of formal performance review period". Under the sub-heading, entitled "Attendance and lateness" it stated:

"We discussed that you had failed to turn up on two occasions for ILS training that had been booked for the 1st of June 21st of June. You did not follow the correct procedures for notifying that you would not be attending."

The panel also noted that it had no information before it pertaining to a response from Miss Hovery in relation to the allegations of her non-attendance of the training on either 1 June or 21 June 2021.

In light of the above, the panel was satisfied that the NMC had not met the evidential burden to satisfy it that on 01 June 2021 and 21 June 2021, Miss Hovery had failed to attend resuscitation training.

The panel therefore find this charge not proved.

Charge 15

That you, a registered nurse:

15) Between 06 and 28 May 2021 failed to follow a reasonable management instruction that you contact the NMC about fitness to practise proceedings of which you were subject.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 5 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to follow a reasonable management instruction that she contact the NMC about fitness to practise proceedings of which she was subject.

The panel took account of a letter sent by the NMC to the registered email address of Miss Hovery, dated 6 August 2020. This letter informed Miss Hovery that concerns had been raised about her Fitness to Practice raised by Kent Community Health NHS Foundation Trust. It had no evidence before it that Miss Hovery had received or read this letter.

The panel took account of an email sent by Lead Nurse for Critical Care at Imperial College Healthcare NHS Trust dated 6 May 2021 in regard to a meeting she had just had with Miss Hovery. It stated:

> *"I mentioned that the NMC are trying to get hold of her regarding a case and advised her that she should try and get hold of them."*

The panel also took account of a further email, dated 13 May 2021, sent by the Senior Sister at Imperial College Healthcare NHS Trust to Miss Hovery. It considered Miss Hovery's failure to contact the NMC to be:

> *"…considered a breach under the Trust Conduct Policy and we will dealing with the matter under such Policy."*

The panel was therefore satisfied that Miss Hovery had a duty to follow a reasonable management instruction that she contact the NMC about fitness to practise proceedings of which she was subject. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty.

The panel took account of the aforementioned email sent to Miss Hovery on 6 May 2021. It bore in mind that Miss Hovery, at this point, ought to have known that she was subject to an investigation pertaining to her fitness to practice. However within the email dated 6 May 2021 where the Lead Nurse for Critical Care mentioned that the NMC were trying to contact Miss Hovery, the Lead Nurse stated that Miss Hovery was "quite shocked" to hear this and was not aware that they had been trying to contact her".

Witness 6 in her witness statement corroborated this and referenced the email dated 6 May 2021. She continued in her witness statement:

> *"On 13 May 2021, Anita attended an informal performance review meeting with [the Senior Sister]. During the meeting, Anita said that she had still not made contact with the NMC.*

The panel took account of the aforementioned email, dated 13 May 2021, sent by the Senior Sister at Imperial College Healthcare NHS Trust to Miss Hovery which stated:

> *"Most importantly, despite the fact that you were reminded and emphasized the importance to contact the NMC in our last meeting on the 6th May regarding pending enquiries they are conducting, you stated you still had not manage to speak to them and had not send an e-mail as advised by us. The gravity of this was emphasized by…the unit Senior Nurse and you need to know that this needs to happen as soon as possible and that failure to do so will be considered a breach under the Trust Conduct Policy and we will dealing with the matter under such Policy."*

Witness 6 in her witness statement continued:

> *On 21 May 2021, I had another meeting with Anita. At the time of the meeting, Anita had still not made contact with the NMC but reported that she said that she had left messages. During the meeting, I called the NMC with Anita present in the office and we were unable to get through.*

The panel took account of an email sent by Witness 6 to Miss Hovery, dated 24 May 2021 which stated:

> *"In our last meeting we discussed the requirement for you to make contact with the NMC regarding an ongoing investigating which they have been trying to contact you*

regarding. We tried to contact them on Friday unsuccessfully but you have since made contact with them and have now shared contact details and have opened up communication channels to support their investigation."

However, the panel noted that Witness 6 in her witness statement stated:

"On 28 May 2021, I asked Anita if she made contact with the NMC but she said that she had not. At this point we called the NMC together and she was able to speak to the screening case officer."

The panel was persuaded by the evidence of Witness 6 which it deemed to be credible, reliable and consistent. It was also satisfied that the aforementioned emails dated 6, 13 and 24 May 2021 corroborated the details in Witness 6's witness statement.

The panel was satisfied that Miss Hovery had ample opportunity from 6 May 2024 to follow a reasonable management instruction and contact the NMC about fitness to practise proceedings of which she was subject to.

The panel therefore find this charge proved.

Charge 16

That you, a registered nurse:

16) Between 12 April 2021 and 29 June 2021, failed to follow a reasonable management instruction that you obtain a) a Cerner card b) access to the HealthRoster system.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 8 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to follow a reasonable management instruction that she obtain a) a Cerner card b) access to the HealthRoster system.

Witness 8 in his witness statement stated:

> *"I conducted Anita's local induction on her first day and, along with the other members of the clinical education team, would have had regular contact with her during her supernumerary induction period."*

The panel noted that Witness 8 had undertaken Miss Hovery's induction. It then took account of the "Critical Care New Starter Record". Under the heading entitled "Orientation day" there is a sub-heading entitled "ICT" which references *"Cerner"*. Additionally under the sub-heading "Maps" it details the following:

> *"Contact details, NHS start date, E-roster, Rota, A/L, Study leave…"*

This detailed the duties Miss Hovery had to undertake in order to operate within the Trust. It was therefore satisfied that Miss Hovery had a duty to follow a reasonable management instruction that she obtain a) a Cerner card b) access to the HealthRoster system. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty.

The panel took account of an email from Witness 6 to Miss Hovery, dated 25 June, entitled '*Meeting summary – Review of formal performance review period*'. Under the sub-heading '*Cerner Card Eroster Access*' it stated:

> *"You still do not have a functioning Cerner card and are unable to access e-roster. We discussed all new starters normally have this enabled within their first couple of*

weeks supernumerary. We would expect you to be able to communicate with the Cerner team and E-roster following the initial inductions instruction to activate these systems and enable access."

The panel then noted that Witness 6 in her witness statement stated:

"I met with Anita on 29 June 2021 to discuss her Cerner and e-roster access…

Anita was unable to obtain a Cerner card which is a card that is used by staff on the Ward to access the electronic patient record keeping system. It was identified that she did not have a Cerner card as she was unable to complete the discharge competency of her ICCA workbook.

During her orientation day the process for obtaining a Cerner card was discussed with Anita and it was followed up with her via e-mail in addition to the initial email she received from [Witness 8] when she started. It is also one of the objectives set out on the New Starter Record."

The panel took account of the file note of the meeting with Miss Hovery dated 29 June 2021. The file note established that Miss Hovery still did not have access to a Cerner card or the E-roster.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that Witness 6, who was her manager, did not support her and prevented her from doing her job.

The panel was persuaded by the evidence of Witness 6 and Witness 8 which it deemed to be credible, reliable and consistent. It was also satisfied that both witness statements were supported by documentary evidence. The panel preferred the evidence of Witness 6 and Witness 8 and was not persuaded by Miss Hovery's assertion that Witness 6 had not supported her.

The panel therefore find this charge proved.

Charge 17

That you, a registered nurse:

17) On 5 July 2021, failed to follow a reasonable management instruction that you remove your nail varnish.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 9 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to follow a reasonable management instruction that you remove your nail varnish.

The panel took account of the Imperial College Healthcare Trust's Hand Hygiene Policy provided to the panel by Witness 6. Under the heading "Preparation for hand hygiene including bare below the elbows and hand care" it stated:

> "Nails are to remain short and natural, which precludes the wearing of varnish…"

The panel noted that the Hand Hygiene policy was dated 2024. However, Witness 6 in her oral evidence stated that the policy that would have applied when Miss Hovery was employed was similar and included the same principles.

The panel was therefore satisfied that Miss Hovery had a duty to follow a reasonable management instruction that you remove her nail varnish. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty.

Witness 6 in her witness statement stated:

> *"On 5 July 2021 [a] Band 7 Clinical Practice Educator, sent an email to [Senior Sister] to provide feedback on Anita and stated that Anita was wearing nail varnish during her shift."*

The panel took account of the email from the Band 7 Clinical Practice Educator, Witness 6 stated was sent on 5 July 2021, which stated:

> *"I am writing to feedback that Anita was wearing nail varnish to her shift today. At 07:35 when I prompted her to get changed in to scrubs I asked her why she had nail varnish on. She said she was going to remove it with alcohol wipes before going to the bedspace.*
>
> *This inevitably delayed the start of her shift when she is meant to start at 07:30. I went to the bedspace at 09:00 to find that she had only removed x2 nails of nail varnish. I asked her to please step out of the bedspace to remove it all as it is against infection control policy and uniform policy to have nail varnish on.*
>
> *When I returned at 10:15 she still had it on and [Witness 9] had just sent her away from the clinical area to remove it reiterating my instruction. This situation has caused an unnecessary interruption to the patient care and Anita's supernumerary time. I have asked [Witness 9] to feed back to me later as to when the nail varnish was finally removed."*

The panel was mindful that this amounted to hearsay because the Band 7 Clinical Practice Educator had not attended to give evidence at this hearing nor provided a formal witness statement. As a result, there was no way to test the veracity of the contents within the email. However, it noted that the contents of the email are supported by the witness statement of Witness 9 who stated:

"I can remember on one occasion, I had to ask Anita to take her nail varnish off because this is against Trust policy."

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 6 and Witness 9 which it deemed to be credible, reliable and consistent. It was also satisfied that both witness statements were supported by documentary evidence. The panel preferred the evidence of Witness 6 and Witness 9 and was not persuaded by Miss Hovery's response.

The panel therefore find this charge proved.

Charge 18

That you, a registered nurse:

18) On 09 July 2021, failed to follow a reasonable management instruction in that you worked on bed space 3 when you had been allocated bed space 5.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 10 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to follow a reasonable management instruction in that she worked on bed space 3, when she had been allocated bed space 5.

Witness 10 in her witness statement stated:

> *"There is a board in the staff room which clearly states where each staff member is allocated and to which patient for that shift. This is a form of pre-allocation and where staff are allocated will depend on both the needs of the patients and fellow colleagues."*

The panel was therefore satisfied that Miss Hovery had a duty to work on her allocated bedspace. In light of this, the panel then went on to consider whether Miss Hovery had failed in her duty to follow reasonable management instruction in that she worked on bed space 3, when she had been allocated bed space 5.

Witness 10 in her witness statement confirmed that she and Miss Hovery had been allocated to work in Bed Space 5. She stated:

> *"When I went to Bed Space 5, Anita was not there. I went looking for Anita and found her standing in Bed Space 3. I asked Anita whether she was supposed to be in Bed Space 5 as I had been allocated to work with her. Anita said that she was not. I asked Anita to go and check the allocation board again. Anita came back and confirmed that she was allocated with me and I told her that was fine and that we needed to get to work. We returned to Bed Space 5."*

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 10 which it deemed to be credible, reliable and consistent. The panel preferred the evidence of Witness 10 and was not persuaded by Miss Hovery's response.

The panel therefore find this charge proved.

Charge 19

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

19) Failed to pass the IV Theory Course – Drugs Calculations Assessment.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 7, Witness 8 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to pass the IV Theory Course – Drugs Calculations Assessment.

Witness 6 in her witness statement stated:

> *"The administration of medication, particularly IV medication, is a fundamental aspect of nursing on the Critical Care Ward. As many of the patients on the Ward are seriously unwell or on ventilators, a lot of their medication is administered intravenously. As such, nurses on the Ward are required to pass the IV Therapy Course – Drugs Calculations Assessment ("the Assessment") in order to progress and achieve their other objectives and to meet the expected standard on the Ward."*

The panel was therefore satisfied that Miss Hovery had a duty to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a

band 5 nurse by passing the IV Theory Course – Drugs Calculations Assessment. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty.

Witness 7 in her witness statement stated:

> *"In order to be classed as competent to practise independently, it is necessary for the supernumerary member of staff to pass the Drug IV Calculations Test. In order to pass the test, the 20 questions must all be answered correctly and therefore 100% is required.*
>
> *Anita failed the Drug IV Calculations Test on seven occasions. This is extremely out of the ordinary to have not passed the test after numerous attempts despite their own self directed learning and coaching from the education team which was extensive in comparison to what would usually be offered. It is not unusual for a member of staff to fail once. Twice is rarer but seven times is extremely unusual and concerning."*

This is corroborated by Witness 6 in her witness statement. She stated:

> *"During her 13 week supernumerary period, Miss Hovery undertook and failed the test on the following seven occasions:*
>
> *a. 28 April 2021, achieving a score of 66%*
> *b. 10 May 2021, achieving a score of 66%*
> *c. 11 May 2021, achieving a score of 79%*
> *d. 12 May 2021, achieving a score of 79%*
> *e. 20 May 2021, achieving a score of 75%*
> *f. 17 June 2021, achieving a score of 50%*
> *g. 30 June 2021, achieving a score of 54%"*

Witness 8 confirmed in his oral evidence that he sat with Miss Hovery during some of the examinations.

The panel took account of an email, dated 22 June 2021 provided by Witness 6. She stated she had received it from the Head of Learning systems. It corroborated the information contained in Witness 6's witness statement in relation to the IV Theory Course – Drugs Calculations Assessments Miss Hovery had undertaken and failed during her 13 week supernumerary period.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 6, Witness 7 and Witness 8 which it deemed to be credible, reliable and consistent with each other. It also noted that the witness statements were supported by documentary evidence. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had failed her IV Theory Course – Drugs Calculations Assessments. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by failing the IV Theory Course – Drugs Calculations Assessments.

The panel therefore find this charge proved.

Charge 20

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

20) Routinely failed to give and/or take handover in a logical and systematic way.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 8, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to give and/or take handover in a logical and systematic way.

Witness 12 in her witness statement stated:

> *"At 14:00, I gave Anita the opportunity to hand over to me to practice familiarising herself with ICIP. The handover was not in a logical approach and required further practice to ensure a safe and effective handover when she is out of her supernumerary period."*

The panel was therefore satisfied that Miss Hovery had a duty, on this particular unit, to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely giving and/or taking handover in a logical and systematic way. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred on a regular basis for it to be considered a "routine" failure.

Witness 12, who worked a day shift with Miss Hovery on 10 June 2021, in her witness statement stated:

> *"We also set aside time for Anita to practice an end of shift handover. This was very jumbled, Anita was getting distracted and mixed up."*

Witness 8, who observed Miss Hovery on 24 June 2021 between 07:30 and 10:00, in his witness statement stated:

> *"The handover started at 07:45 and concluded at 08:15. During this time Anita took two sides of A4 notes. Anita's note taking appeared jumbled and did not seem to be systematic or organized. Anita's handwriting style was very difficult to interpret.*
>
> *When making notes at the handover, I would consider it would be good practice to organise the information systematically, for example by using the ABCDE approach…*
>
> *…Anita did not appear to be fully focused on the handover and was looking at the patient monitor and writing down numbers which were not relevant to the matter being discussed."*

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 8 and Witness 12 which it deemed to be credible, reliable and consistent with each other. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failed to giving and/or taking handover in a logical and systematic way. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failed to giving and/or taking handover in a logical and systematic way.

The panel therefore find this charge proved.

Charge 21

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

21) Routinely failed to carry out the tasks listed at Schedule 1 within a reasonable timeframe.

Schedule 1

1) Observations
2) Patient assessments
3) Medication administration
4) Nursing care
5) Record keeping
6) Safety checks

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 8, Witness 9, Witness 10, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to carry out the tasks listed at Schedule 1 within a reasonable timeframe.

Witness 6 in her witness statement stated:

"Anita's Performance objectives and performance feedback forms indicate that she

was unable to complete hourly observations, patient assessments, nursing care such as dressing changes in reasonable time frames, expected of a new starter to Critical Care."

The panel was of the view that the above made it clear that there was a duty on Miss Hovery to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse to carry out the tasks listed at Schedule 1 within a reasonable timeframe. The panel also noted that this was in accordance with the NMC's Code of Conduct in relation to record keeping etc. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred on a regular basis for it to be considered a "routine" failure.

The panel noted that Witness 12, who observed Miss Hovery nursing practice in relation to all six areas of schedule 1 on 4 May 2021. Witness 12 stated:

> *"By 11:00, we had achieved the 09:00 and 10:00 observations (with prompting), an ABG (led by me), safety checks and only the A&B parts of the assessment. At Anita's level of previous experience, I expected that the following would have been achieved (without prompting):*
>
> > *a. Documenting the patients observations every hour*
> > *b. bedside safety checks and cleaning*
> > *c. patient A-E assessment*
> > *d. patient repositioning (we roll the patient to change their position every 4 hours, the first is due at 9am)"*
> > *e. ABG (Arterial blood gas- a blood test)*
> > *f. Usually will have finished morning break by 1100*
> > *g. Looking at the drug chart every hour and administering any prescribed medications"*

Witness 12 continued to explain in her witness statement that Miss Hovery failed to carry out all the tasks listed schedule 1.

Witness 12 in her witness statement also observed Miss Hovery on 10 May 2021. She expressed concern about Miss Hovery's failure, in relation to schedule 1, to carry out patient's observations, patient assessments and safety checks. She stated:

> *"At 09:00, we had completed the patient's observations, safety checks and parts A+ B of the patient's assessment, which took 20 minutes. At this point we were beginning to get delayed. Ideally by this time the A-E assessment should be completed, particularly given as we were in a side room with a stable patient. There were no environmental distractions to contribute to this delay."*

Witness 12 in her witness statement also observed Miss Hovery's failure, in relation to schedule 1, to carry out, adequate record keeping, medication administration and nursing care. She stated:

> *"By 10:00, the A&E assessment had finished. However, we had not yet rolled or looked at the drug chart. The drug chart should be checked every hour to ensure medications are administered on time. Ideally, the patient should have been repositioned between 09:30 to 09:30. This is to keep within the flow/ routine of the unit and prevent delays to the day."*

The panel further noted that Witness 12 was concerned about Miss Hovery's timeliness in relation to areas in schedule 1 on 29 May 2021, 9 and 10 June 2021.

The panel also noted that Witness 8, who carried out an assessment of Miss Hovery on 24 June 2021. He expressed concerns about Miss Hovery's timeliness and thoroughness in relation to safety checks and observations. Witness 8 in his witness statement stated:

> *"Anita's safety check commenced at 08:16 and concluded at 08:47…*
>
> *… Anita took 32 minutes to carry out her safety checks but there was a hypotensive*

episode of approx. 10 minutes, during which time the checks were suspended.

I was concerned that Anita was not conducting safety checks in a timely or thorough manner. Conducting the safety checks is a basic induction competency and Anita will have received considerable coaching from the other nurses while she was working on a supernumerary basis."

In regard to observations, Witness 8 in his witness statement stated:

"The Observations (Obs) for 0800 were documented at 09:07, followed closely by the 0900 obs…

… Observations should be recorded as close to the hour as possible."

Witness 10 was allocated to supervise Miss Hovery during one of her supernumerary shifts on 9 July 2021. She was concerned about Miss Hovery's timeliness in relation to nursing care, safety checks and patient assessments. Witness 10 in her witness statement stated:

"It took Anita more than 15 minutes to complete the first set of observations… I informed Anita that she needed to be quick in doing the first set of observations, bed safety checks and A to E assessment, ideally within the first 30 minutes… I expected Anita to be able to complete the patient observations, bed safety checks and A to E assessment by 08:30 to 08:40 and to have fully documented these by no later than 09:00. Anita took too long to complete these tasks. Anita should have been able to complete the above tasks within a smaller timeframe."

The panel also noted that Witness 10, who observed Miss Hovery on 9 July 2021, also expressed concern about Miss Hovery's timeliness in relation to nursing care and observations. She stated:

“It took Anita more than 40 minutes to complete a CVC dressing and a small elbow wound dressing. I expected this to take a competent practitioner a maximum of 15 to 20 minutes. Anita did follow the ANTT procedure well, however, it took her far too long. I was shocked that it had taken Anita 40 minutes. It cannot take this long to complete simple wound dressings as this will impact other nursing care.”

The panel considered the witness statement of Witness 9 in which she summarised her overview of concerns of Miss Hovery’s nursing skills. This was pertaining to her time keeping throughout the shift and her inability to complete tasks. Witness 9 commented on Miss Hovery’s record keeping and stated:

“Anita's documentation was awful. Anita would often record observations completely incorrectly. It would also take Anita and incomprehensible amount of time to complete her documentation. Anita would often finish her shift at 15:30. I would come in for my night shift at around 19:00 and Anita would still be at work stating that she was finishing her documentation. I believe on one occasion Anita was still completing documentation at 23:00.”

Witness 9 provided further detailed observations of Miss Hovery’s practice on 5 July 2021 and was concerned about timeliness in relation to observations, patient assessments and record keeping.

The panel also considered the documentary evidence in relation to Miss Hovery’s assessment. It took account of the feedback forms from those who supervised Miss Hovery. This included various emails sent by Witness 12 to Witness 9 between 7 May 2021 and 2 July 2021.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 6, Witness 8, Witness 9, Witness 10, Witness 12 which it deemed to be credible, reliable and consistent with each other. It also noted that there was documentary evidence to support the witness statements. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failed to carry out the tasks listed at Schedule 1 within a reasonable timeframe on multiple occasions. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failed to carry out the tasks listed at Schedule 1 within a reasonable timeframe on multiple occasions.

Charge 22

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

22) Routinely failed to accurately complete A-E assessments.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 7, Witness 9, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to accurately complete A-E assessments.

Witness 6 in her witness statement stated:

“Anita has been unable to achieve her objective of completing accurate A to E assessment. This is a full patient assessment using the A-E prompt which includes airway, breathing, circulation, disability, and exposure.”

The panel was therefore satisfied that Miss Hovery had a duty to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse accurately completing A-E assessments. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred on a regular basis for it to be considered a “routine” failure.

Witness 12, who worked a shift with Miss Hovery on 4 May 2021 between 07:30 and 15:30, in her witness statement stated:

“The safety checks were not fully completed, Anita got very flustered and distracted by things not deemed as a safety check, such as looking at the nasogastric tube length, and assessing the arterial line VIP score.”

Witness 12, who then worked a day shift with Miss Hovery on 10 May 2021 between 07:30 and 15:30, in her witness statement stated:

“We went into detail regarding assessment of a sedated level 3 patient. Anita had a poor understanding of the basic A-E assessment. I do not feel that she had used this structured approach in her previous clinical setting, due to her confusion as to what falls under each category.”

Witness 12, then worked a day shift with Miss Hovery on 29 May 2021 between 07:30 and 15:30. In her witness statement she stated:

“Despite teaching Anita several times how to complete an A-E assessment her assessment was D,E,C,AB.”

The panel noted further concerns from Witness 12 on 10 June 2021 and from Witness 9 on 5 July 2021.

The panel also considered the documentary evidence in relation to Miss Hovery's assessment. It took account of the feedback forms from those who supervised Miss Hovery. This included various emails sent by Witness 12 to Witness 9 between 7 May 2021 and 2 July 2021.

The panel also noted that Witness 7 had provided Miss Hovery feedback from her A-E assessment she had undertaken on 30 June 2021. In an email sent to Miss Hovery on 30 June 2021 Witness 7 stated that Miss Hovery documented inaccurate A-E Patient observations into the clinical information system.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 6, Witness 7, Witness 9 and Witness 12 which it deemed to be credible, reliable and consistent with each other. It also noted that there was documentary evidence to support the witness statements. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failed to accurately complete A-E assessments on five occasions, namely on 4, 10 and 29 May 2021, 10 June 2021 and 5 July 2021. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failing to accurately complete A-E assessments.

The panel therefore find this charge proved.

Charge 23

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

23) Routinely failed to accurately take and/or record observations.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 9, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to accurately take and/or record observations. It determined that taking and/or recording observations was one of the fundamental tenets of the nursing profession that you would have known and is reflected in the NMC Code of Conduct.

The panel was therefore satisfied that Miss Hovery had a duty to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by accurately taking and/or recording observations. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred a regular basis for it to be considered a “routine” failure.

Witness 12, who worked a day shift with Miss Hovery on 10 May 2021, outlined Miss Hovery’s failure to accurately take and record observations. In her witness statement Witness 12 stated:

“In the afternoon, I went through the chart to check Anita's documentation. Some aspects of care had been charted as completed when we had not completed them. An example was charting to state that the ETT had been repositioned every hour, and documenting that the patient’s chest had been auscultated several times throughout the shift, when we had only completed this in the morning...”

Witness 12 worked a day shift with Miss Hovery, on 29 May 2021, and outlined her concerns about Miss Hovery’s accurate assessment in assessing the patient’s chest and her records pertaining to this. In her witness statement Witness 12 stated:

“When assessing the patient's chest, she auscultated over the gown, informed me of the patient's heart sounds and also kept deflating the cuff each time she measured cuff pressures. I have been through all of these assessment skills several times on our previous shifts together.”

Witness 12 also worked a day shift with Miss Hovery on 10 June 2021. In her witness statement she stated:

“Anita documented part of the patient's assessment under 04:00 this morning. The shift we were working was between the hours of 07:30 and 15:30. Therefore documenting your notes under 04:00 is incorrect as we were not on shift at this time...”

Witness 12, who observed Miss Hovery on 24 June 2021 between 07:30 and 10:00, in his witness statement stated:

“The handover started at 07:45 and concluded at 08:15. During this time Anita took two sides of A4 notes. Anita’s note taking appeared jumbled and did not seem to be systematic or organized. Anita's handwriting style was very difficult to interpret.

When making notes at the handover, I would consider it would be good practice to

organise the information systematically, for example by using the ABCDE approach…

…Anita did not appear to be fully focused on the handover and was looking at the patient monitor and writing down numbers which were not relevant to the matter being discussed."

Witness 9, who was allocated to supervise Miss Hovery during one of her supernumerary shifts on 5 July 2021, in her witness statement stated:

"From the documentation which was completed, a large majority was incorrect…"

The panel also considered the documentary evidence in relation to Miss Hovery's assessment. It took account of the feedback forms from those who supervised Miss Hovery. This included various emails sent by Witness 12 to Witness 9 between 7 May 2021 and 2 July 2021.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 9 and Witness 12 which it deemed to be credible, reliable and consistent with each other. It also noted that there was documentary evidence to support the witness statements. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failing to accurately take and/or record observations on four occasions, namely on 10 and 29 May 2021, 10 June 2021 and 5 July 2021. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of

knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failing to accurately take and/or record observations.

The panel therefore find this charge proved.

Charge 24

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

24) Routinely failed to respond appropriately to changes in patient conditions and/or requests made at ward round/by the medical team.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 6, Witness 8, Witness 9, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to respond appropriately to changes in patient conditions and/or requests made at ward round/by the medical team.

Witness 6 in her witness statement stated:

> *"Anita required prompting to deliver care and respond to changes in patient condition or requests from the ward round/medical team. This was reported by [Witness 9] and [Witness 12].*
>
> *Throughout Anita's supervisory period she was allocated stable level 3 patients. Peers at the same point in their Critical care career pathway would now be*

expected to care for stable level 2 and 3 patients independently. These may be newly qualified nurses or nurses with less than a year's pre critical care experience."

The panel was of the view that it made it clear that there was a duty on Miss Hovery to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by respond appropriately to changes in patient conditions and/or requests made at ward round/by the medical team. In addition, it was also satisfied that Miss Hovery ought to have known about this duty as it is covered 13.1 of the NMC Code of Practice which stated a nurse must accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred on a regular basis for it to be considered a "routine" failure.

Witness 12, who observed Miss Hovery on 4 May 2021, in her witness statement stated:

"In the morning, the patient started to have a seizure, the Doctor was present and asked us to give IV Lorazepam urgently. I said to Anita that at present, we are stopping what we are currently doing to prioritise administering this drug, and requested that she quickly go to the pharmacy fridge to get it for me. She arrived back several minutes later with a large handful of stock which were on my stocking up list (syringes etc). I explained to Anita that although it is useful to use the opportunity when leaving the side room to collect all required stock for the day, however this drug was urgent, and in a different situation those minutes could have been detrimental to the patient's condition."

Witness 8, who observed Miss Hovery on 24 June 2021, stated:

"During the hypotensive episode, Anita noted that the alarm sounded and looked

at the monitor, saying that the patient was 'in Ventricular Fibrillation' ("VF"). She cancelled the alarm and turned away from the monitor.

In my experience, VF constitutes a cardiac arrest as it means that a primary part of heart is not beating. I would expect a competent practitioner to pull the emergency buzzer and, when appropriate, put out a crash call if they suspected that a patient were in VF. The crash team are an external team in the Hospital who provide care and support during cardiac arrests."

The panel also noted that Witness 8 had outlined further concerns, regarding his observation of Miss Hovery on 24 June 2021, about her response to the change in Glasgow Coma Scale. Witness 8 stated that the discrepancy should have prompted suspicion and an urgent medical review ought to have been requested – it was not.

Witness 8, in his witness statement, also stated in reference to a consultant ward round:

"…Anita only acknowledged that the Consultant was present at the very end of this time (by stopping what she was doing and appearing to be paying attention to the team in the bedspace). Before then she had been investigating the ventilator settings with her back turned to the group of clinicians who had entered the bedspace and were audibly discussing the patient."

The panel also considered the evidence of Witness 9. She had a number of concerns about Miss Hovery during her supernumerary period. In her witness statement she stated:

"Anita could not prioritise tasks. Anita would often get fixated on one task even if there was something else which she should have been concerned by. For example, on one occasion, Anita was fixated with suctioning the patient, although the patient was about to go into a cardiac arrest. Anita could not see the bigger picture."

The panel also considered the documentary evidence in relation to Miss Hovery's assessment. It took account of the feedback forms from those who supervised Miss Hovery. This included various emails sent by Witness 12 to Witness 9 between 7 May 2021 and 2 July 2021.

The panel had no information before it from Miss Hovery in relation to this particular charge. In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 8, Witness 9 and Witness 12 which it deemed to be credible, reliable and consistent with each other. It also noted that there was documentary evidence to support the witness statements. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failing to accurately take and/or record observations on three occasions, namely on 4 May 2021 and twice on 24 June 2021. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failing to respond appropriately to changes in patient conditions and/or requests made at ward round/by the medical team.

The panel therefore find this charge proved.

Charge 25

That you, between 12 April 2021 and 20 September 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that you:

25) Routinely failed to observe proper hand hygiene and/or aseptic non-touch technique and/or infection control.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Witness 7, Witness 8, Witness 12 and the evidence of Miss Hovery.

In order to find this charge proved, the panel had to be satisfied that Miss Hovery had a duty to observe proper hand hygiene and/or aseptic non-touch technique and/or infection control.

Witness 7 in her witness statement stated:

> *"ANTT is a mandatory competency for all members of staff who have any clinical application to their job."*

The panel also took account of the Imperial College Healthcare Trust's Hand Hygiene Policy provided to the panel by Witness 6. The panel noted that the Hand Hygiene policy was dated 2024. However, Witness 6 in her oral evidence stated that the policy that would have applied when Miss Hovery was employed was similar and included the same principles.

The panel was of the view that the above made it clear that there was a duty on Miss Hovery to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by observing proper hand hygiene and/or aseptic non-touch technique and/or infection control. In light of this, the panel then went on to consider whether Miss Hovery had failed in this duty. The panel also had to be satisfied that this occurred on a regular basis for it to be considered a "routine" failure.

Witness 12, who observed Miss Hovery on 10 June 2021, in her witness statement stated:

"Anita had poor hand hygiene and ANTT (aseptic non-touch technique). Anita required frequent reminding to change her gloves and wash her hands. For example, Anita was touching the floor then touching the CVC line, providing hygiene care then not changing gloves, not changing gloves or hand gelling after suctioning and touching the phone with gloves on. During the shift I have to remind Anita on five occasions to wash her hands.."

The panel also noted that on the same shift, Witness 12 had concerns when Miss Hovery had put her personal items on the bed before they were due to go for a CT scan. Witness 12 asked her to remove her bag and jumper and reminded Miss Hovery to remain bare below the elbows. Witness 12 stated:

"From an infection control point, we do not place any belongings on the bed and our jumpers and bags should not be in the bed space area."

Witness 12, who also observed Miss Hovery on 2 July 2021, in her witness statement stated:

"Anita required prompting with hand hygiene, touching the CVC with dirty gloves, not changing gloves after personal hygiene, throwing sharps (broken vial and scissors) in the clinical waste bin…

… Anita was not maintaining ANTT, or the 'clean hand dirty hand' technique, as well as touching the surrounding bed area as she had not properly exposed the patient because she did not want to draw the curtains. I then had to stop prepping for CT to assist as I was concerned regarding infection control."

Witness 8, who observed Miss Hovery on 24 June 2021, in his witness statement stated:

"Anita did not observe adequate hand hygiene, PPE choice or ANTT (Aseptic Non

Touch Technique) on multiple occasions…

… Anita did not [de]contaminate her hands once during the 45 minutes and she had multiple occasions to do so. All nurses should follow the 'five moments of hand hygiene', which nurses are taught as a standard nursing procedure."

The panel also considered the documentary evidence in relation to Miss Hovery's assessment. It took account of the feedback forms from those who supervised Miss Hovery. This included various emails sent by Witness 12 to Witness 9 between 7 May 2021 and 2 July 2021.

In an email sent to the panel dated 7 June 2024, Miss Hovery stated that she always washed her hands. She also stated that she was a competent nurse with 24 years nursing experience. She stated that she does not lack competence and she was not supported.

The panel was persuaded by the evidence of Witness 7, Witness 8 and Witness 12 which it deemed to be credible, reliable and consistent with each other. It also noted that there was documentary evidence to support the witness statements. The panel preferred the evidence of the NMC witnesses and was not persuaded by Miss Hovery's response.

The panel was satisfied that Miss Hovery had routinely failed to observe proper hand hygiene and/or aseptic non-touch technique and/or infection control on four occasions, namely twice on 10 June 2021, on 24 June 2021 and 2 July 2021. It turned to the stem of the charge and was satisfied that between 12 April 2021 and 20 September 2021 Miss Hovery had failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse by routinely failing to observe proper hand hygiene and/or aseptic non-touch technique and/or infection control.

The panel therefore found this charge proved.

Decision and reasons on application to admit emails from Miss Hovery to the NMC into evidence

Before Mr Kabasinskas addressed the panel on misconduct, he made an application, under Rule 31 to allow emails sent by Miss Hovery, dated 9 and 10 January 2024 be admitted into evidence. He submitted that these emails would be relevant to the panel's consideration of Miss Hovery's current impairment.

With regards to relevance, Mr Kabasinskas reminded the panel of charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11. He submitted that these charges are related to Miss Hovery's abuse to healthcare professionals and abuse to Patient A.

Mr Kabasinskas submitted that he would be inviting the panel to find Miss Hovery's fitness to practice impaired. He submitted that the aforementioned emails relate to attitudinal concerns the NMC have about Miss Hovery. He submitted that he would be inviting the panel to consider if the attitudinal concerns can be remediated or if they are likely to be repeated.

Mr Kabasinskas submitted that the emails are relevant to the charges as it demonstrates Miss Hovery's attitude which can be seen to be abusive and racist. He submitted that within the emails, Miss Hovery refuses to interact with the NMC Case Officer because she was from Africa. In the email dated 10 January 2024 she stated:

> *'Ps am not being rasist some of my closest friends are Kenyan indian European Malaysian American canadian Chinese Japan Philippines plus others many of these have stayed with me but due to this recent experience from african home carers , will not be in contact via email with african due to concerns ny personal emails in regard to my case could be used on there phones affecting our privacy, so if case officer is african I will have absolutely no contact with them. This african man held phone up behind me facing my relative, for this reason I will not be*

contacting an African person even if they work for the nmc as they cant be trusted with our personal information and will not have my personal information sent to there phones. After this experience in our home. I know not everyone is the same but unfortunately due to this experience and also the very poor care my relative has also recieved from this nationality in hospital at present, will not be discussing any of my case with african people. I also had another african carer try on coming into our home try to force me to sit in a room for absolutely no reason when I was doing something in the kitchen for my relative when they arrived...' [sic]

With regards to fairness, Mr Kabasinskas drew the panel's attention to the case *Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin)* which stated that the panel are entitled to consider other material that can assist in deciding whether a registrants fitness to practice is impaired or not.

Mr Kabasinskas submitted that in the case of *Nicholas-Pillai,* the attitude of the practitioner gave rise to the allegations against him. He submitted that the attitude of Miss Hovery gave rise to the charges 2, 3, 5, 6, 7, 8, 9, 10 and 11. He further submitted that Miss Hovery had made strong racial views towards the NMC Case Officer which crossed a line, and demonstrated attitudinal issues, and it would be fair to admit the emails into evidence.

Mr Kabasinskas submitted that Miss Hovery had not attended the hearing, nor was she represented. He submitted that she may state that she was not provided notice that an application would be made for the emails to be admitted into evidence.

Mr Kabasinskas submitted that Miss Hovery sent the abusive emails to the NMC. He informed the panel that the NMC had to change the Case Officer, not to accede to Miss Hovery's request, but to protect the Case Officer. In the same email dated 10 January 2024, she stated:

'…Thanks if case officer is african they will not be hearing from me and I immediately request a change. I do not want my personal information sent to there phones at all…' [sic]

Mr Kabasinskas also submitted that the emails Miss Hovery sent to the panel during these proceedings reflects her attitude.

Mr Kabasinskas invited the panel to admit the emails Miss Hovery sent to the NMC on 9 and 10 January 2024 into evidence.

The panel heard and accepted the advice of the legal assessor. He reminded the panel that Miss Hovery had not been provided with notice that this application was going to be made. He asked the panel to consider whether it would be fair to consider the application without providing Miss Hovery the opportunity to make representations in response.

The panel took account of the submissions made by Mr Kabasinskas and the legal advice.

The panel decided to provide Miss Hovery with an opportunity to see the emails Mr Kabasinskas would like the panel to admit into evidence and make any representations regarding relevance and fairness.

The panel bore in mind that it had been informed by the Hearings Coordinator that Miss Hovery had been sending him emails during the panel's deliberations on this application, so it would appear that she is currently available. In light of this, it directed the Hearings Coordinator to send Miss Hovery the emails and invite representations regarding Mr Kabasinskas' application. The panel would have asked for Miss Hovery to respond by 15:00 today. If the panel do not receive a response, it will proceed with its consideration of the application to admit the emails Miss Hovery sent to the NMC on 9 and 10 January 2024.

Miss Hovery responded to the email sent by the panel, through the Hearings Coordinator, however she did not address the application made by Mr Kabasinskas.

In the interest of fairness, the legal assessor put forward submissions he believed a legal representative may make on Miss Hovery's behalf. He stated that said legal representative may object to the application as unfair, irrelevant and prejudicial.

The legal assessor drew the panel's attention to *Nicholas-Pillai* and cited the following:

> *'In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him...'*

The legal assessor stated that the panel would have to consider if the email gave rise to the specific allegations against Miss Hovery.

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

With regards to relevance, the panel noted that many of the charges in this case, and of which the panel found proved, relate to rude, offensive or verbally aggressive behaviour. As a result, it was of the view that the panel would have to consider attitudinal concerns in regard to those charges in relation to Miss Hovery's conduct as a registered nurse.

The panel took account of the emails from Miss Hovery dated 9 and 10 January 2024. It bore in mind that she had voluntarily sent them to the NMC, her regulator, knowing that she had an upcoming Fitness to Practice hearing in relation to her conduct as a registered nurse.

The panel further considered that the emails from Miss Hovery dated 9 and 10 January 2024 provided the panel with some insight in relation to her attitude towards these charges, which gives rise to attitudinal concerns and further potential misconduct which are pertinent to these charges.

With regards to fairness, the panel was of the view that admitting these emails into evidence maybe prejudicial to Miss Hovery. However, the panel bore in mind that its overarching objectives of the NMC is 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.

The panel was of the view that any documentation that demonstrate attitudinal issues, related to the charges, which may have an impact on public protection and confidence in the nursing profession should be admitted into evidence. The panel was satisfied that this applies to Miss Hovery's emails.

The panel therefore determined that the emails were relevant and that no unfairness or prejudice would be caused by admitting it into evidence.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved in respect of charges 1a, 1b, 2, 3, 4a, 4b, 5a, 6, 7, 8, 9, 10, 11a, 11b, 11c, 12, 15, 16, 17 and 18 amount to misconduct and whether the charges found proved in respect of charges 19, 20,21, 22, 23, 24 and 25 amount to a lack of competence and, if so, whether Miss Hovery's fitness to practise is currently impaired by reason of misconduct and/or lack of competence. 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.

Submissions on misconduct

Mr Kabasinskas referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He also referred the panel to the case of *Nandi v GMC [2004] EWHC 2317 (Admin)* and *Schodlok v General Medical Council [2015] EWCA Civ 769*. He reminded the panel that the misconduct had to be serious and a pattern of non-serious misconduct could cumulatively amount to serious misconduct.

Mr Kabasinskas invited the panel to take the view that the facts found proved amount to misconduct as Miss Hovery's actions fell below the standards expected of a registered nurse. He directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, Miss Hovery's actions amounted to misconduct.

Mr Kabasinskas reminded the panel that charges 1, 4 and 12 related to single instances of Miss Hovery's lateness. He submitted that charges 1 and 4 in isolation may not amount to serious misconduct. However, charges 1, 4 and 12, combined may amount to cumulative serious misconduct.

Mr Kabasinskas reminded the panel that charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 are in relation to Miss Hovery's abuse towards healthcare professionals. He submitted that this amounted to misconduct and, in addition cumulatively, amounted to a pattern of serious misconduct over a period of time.

With regards to charge 15, Mr Kabasinskas submitted that the NMC code imposed a duty on Miss Hovery to engage with the NMC. He submitted that that Miss Hovery received instructions from management to contact the NMC which she failed to do for 22 days, despite being prompted multiple times, this amounted to serious misconduct.

With regards to charge 16, Mr Kabasinskas submitted that a failure to carry out management instructions within a reasonable timeframe amounted to serious misconduct.

With regards to charge 17, Mr Kabasinskas submitted that it was accepted by the NMC that a failure to remove nail varnish on one occasion may not amount to serious misconduct. He also submitted that, in regard to charge 18, that working on the incorrect bedspace on one occasion may not on its own amount to serious misconduct.

Mr Kabasinskas submitted that if the panel are not with him regarding charges 15 and 16, then he reminded the panel that the stem of these charges relate to a failure to follow management instruction. He submitted that cumulatively, they amounted to serious misconduct.

Submissions on lack of competence

Mr Kabasinskas submitted that the NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Mr Kabasinskas invited the panel to take the view that the facts found proved amount to a lack of competence. He directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, Miss Hovery's actions amounted to a lack of competence.

Mr Kabasinskas submitted that charge 19 related to fundamental aspects of nursing on a critical care ward. He further submitted that charges 20, 21, 22, 23, 24 and 25 related to fundamental aspects of nursing in an intensive care unit. He submitted that that the failings were wide ranging despite extensive assistance being provided.

Mr Kabasinskas submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that Miss Hovery was made aware of the issues around her competence?
- Is there evidence that she were given the opportunity to improve?
- Is there evidence of further assessment?

Mr Kabasinskas submitted that these questions could be answered in the affirmative and as a result, Miss Hovery's actions amounted to a lack of competence.

Submissions on impairment

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

Mr Kabasinskas submitted that limbs a, b and c of the *Grant* test were engaged. He submitted that Miss Hovery demonstrated failure across fundamental areas of nursing practice.

With regards to lack of competence, namely charges 19 to 25, Mr Kabasinskas submitted that the NMC accepts that it had not seen evidence to suggest that Miss Hovery's actions caused harm to patients. However, he submitted that there was a risk of harm due to poor nursing techniques.

With regards to charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 Mr Kabasinskas reminded the panel that these charges took place in Patient A's home. He submitted that while Miss Hovery was not working in a nursing capacity at the time, healthcare staff have a right to attend a patients home without being subjected to bullying behaviour.

Mr Kabasinskas submitted that there was evidence that two members of staff were required to visit Patient A's home as a direct result of Miss Hovery's behaviour. He submitted that this meant that staff would be taken away from providing care to other patients.

Mr Kabasinskas referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*.

With regards to charges 19 to 25, Mr Kabasinskas reminded the panel that they related to Miss Hovery's clinical practice and were capable of remediation.

Mr Kabasinskas submitted that charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 are related to abusive behaviour and referred the panel to the NMC's Guidance on seriousness and more specifically bullying and harassment.

Mr Kabasinskas submitted that in relation to charges 1, 4 and 12 there were contextual factors that could have contributed to Miss Hovery's lateness, namely [PRIVATE]. He submitted that the issue occurred in 2019, 2020 and on multiple occasions in 2021. He submitted that this could suggest an attitudinal problem and reminded the panel that this had not been remedied over three years with three different employers.

Mr Kabasinskas submitted that charges 12 to 16 relate to Miss Hovery's failure to follow reasonable management instructions. He submitted that this could also suggest an attitudinal issues.

Mr Kabasinskas submitted that Miss Hovery had not provided evidence of insight, remorse or remediation to address any of the charges. He also stated that she had not provided the panel with a reflective statement.

Mr Kabasinskas submitted that Miss Hovery, in her emails to the panel during the fact stage, denied she was abusive to healthcare staff. He further submitted that Miss Hovery in emails dated 9 and 10 January 2024 sent to the NMC demonstrated racial and discriminatory views which showed that her attitudinal and deep rooted problems had not been addressed. He submitted that Miss Hovery had not explained to the panel how she would act differently in similar circumstances. He submitted that Miss Hovery continued to deny the charges after she had been sent the panel's decision on the facts.

Mr Kabasinskas submitted that the risk of repetition remains high. He invited the panel to find Miss Hovery's fitness to practice impaired on both public protection and public interest grounds.

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

Decision and reasons on misconduct

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to serious misconduct and/or lack of competence. Secondly, only if the facts found proved amount to serious misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Miss Hovery's fitness to practise is currently impaired as a result of that serious misconduct and/or lack of competence.

When determining whether charges 1a, 1b, 2, 3, 4a, 4b, 5a, 6, 7, 8, 9, 10, 11a, 11b, 11c, 12, 15, 16, 17 and 18 amount to serious misconduct, the panel had regard to the terms of the Code.

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

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.1 treat people with kindness, respect and compassion*
>
> ***20 Uphold the reputation of your profession at all times***
>
> *To achieve this, you must:*
>
> *20.1 keep to and uphold the standards and values set out in the Code*

20.2 …treating people fairly and without discrimination, bullying or harassment

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of serious misconduct. The panel bore in mind that charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 occurred while Patient A, a relative of Miss Hovery, was receiving care in her home. Miss Hovery was not practicing as a registered nurse while in Patient A's home therefore the concerns arose outside of her professional practice. While the charges occurred outside of Miss Hovery's professional practice, the panel had to consider the impact her actions had on her professional practice as a nurse.

The panel took account of the NMC Guidance entitled 'How we determine seriousness' (reference FTP-3). Under the sub-heading 'Discrimination, bullying, harassment and victimisation' it stated:

'The Code says that nurses, midwives and nursing associates must treat people fairly without discrimination, bullying or harassment. It also states that individuals should be aware of how their behaviour can affect and influence the behaviour of others, be sure not to express personal beliefs inappropriately and use all forms of communication responsibly...

…Discriminatory behaviours of any kind can negatively impact public protection and the trust and confidence the public places in nurses, midwives, and nursing associates. We therefore take concerns of this nature seriously regardless of whether they occur in or out of the workplace. These concerns may suggest a

deep-seated problem with the nurse, midwife or nursing associate's attitude, even when there's only one reported complaint'

Within the aforementioned NMC Guidance, bullying is defined as *'…unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting... It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face…'*

Additionally, with regards to harassment, the same NMC Guidance stated, *'The behaviour has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment.'*

When considering charges 2, 3, 5a, 7, 8, 9, 10 and 11 individually, the panel was of the view that Miss Hovery had demonstrated patterns of bullying and harassment inside of Patient A's home. It bore in mind that it heard evidence from the healthcare professionals who visited Patient A in her home and attested to this. Witness 3 in particular stated that Miss Hovery was getting in her face in an aggressive way which left her "*red faced*" and crying. Witness 3 stated she needed a time out due to the verbal aggression which delayed her ability to see other patients.

The panel also bore in mind that, as a result of this, healthcare professionals were afraid to visit Patient A's home. It heard evidence from all the healthcare professionals who stated that they had an increased level of anxiety and distress at the thought of visiting Patient A's home while Miss Hovery was present. The panel also heard evidence that verbal warning and a warning letter was issued by healthcare professionals to Miss Hovery with regards to her behaviour which may result in the withdrawal of care to Patient A. Subsequent future visits by healthcare professionals to Patient A's home had to be conducted in pairs to ensure staff safety due to Miss Hovery's behaviour.

In light of the above, the panel considered Miss Hovery's actions in charges 2, 3, 5a, 7, 8, 9, 10 and 11 individually fell significantly short of the conduct and standards expected of a

registered nurse and were serious departures from the Code, amounting to serious professional misconduct.

With regards to charge 6, the panel considered leaving a note calling the healthcare professionals "*dumb nurses*" to be inappropriate and unprofessional. However, in isolation, it was of the view that it would not be considered deplorable by fellow practitioners and did not amount to serious misconduct.

Nevertheless, when considered cumulatively with charges 2, 3, 5a, 7, 8, 9, 10 and 11 the panel considered this to be a part of a pattern of bullying behaviour which amounted to serious misconduct.

With regards to charge 15, the panel noted that a registrant had a duty to engage with their regulator and this is outlined in the Code. Additionally, as a registered nurse following management instructions is generally considered a condition of employment, the panel inferred, therefore, that this obliges Miss Hovery to follow any reasonable management request. In the panel's view, management was effectively asking Miss Hovery to adhere to the Code and contact her regulator. It bore in mind that Miss Hovery had ample opportunity from 6 and 28 May 2021 to contact the NMC. However, despite numerous prompts from management Miss Hovery failed to do so, until Miss Hovery's manager personally ensured the call had been made. The panel therefore determined that Miss Hovery's actions in charge 15 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

With regards to charge 16, the panel heard evidence from Witness 6 pertaining to the importance of obtaining a Cerner card. She stated that it allowed nurses access to the electronic patient record keeping system. It heard evidence that a registered nurse working at this particular hospital had to undertake certain tasks, namely recording patient notes, electronically. The panel was of the view that Miss Hovery failure to follow reasonable management instruction to obtain her Cerner card, despite being prompted.

This meant she was unable to write patient notes and access records which had the potential to impact patient safety.

The panel therefore determined that Miss Hovery's actions in relation to charge 16 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

With regards to charge 17, the panel bore in mind that Witness 6 stated that the request for Miss Hovery to remove her nail varnish was in accordance with section 6 of the Hand Hygiene Policy and section 3 of the Uniform policy. The panel also bore in mind that an intensive care unit has very strict infection control procedures. It considered that patients within an intensive care unit would be vulnerable to infection and nail varnish carries an increased risk of infection.

The panel noted that Witness 6 stated that Miss Hovery's Aseptic Non Touch Technique (ANTT), while working within the intensive care unit, was poor which had the potential to place the vulnerable patients at further risk of harm.

Miss Hovery' failure to follow reasonable management instructions in removing her nail varnish, in the context of working in an intensive care unit, failing to adhere to the Hand Hygiene Policy and the Uniform policy and, subsequently, carrying out ANTT poorly, had the potential to have a significant impact on patient care.

The panel therefore determined that Miss Hovery's actions in relation to charge 17 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

With regards to charge 18, the panel noted it had found that Miss Hovery failed to follow reasonable management instructions by working on the wrong bedspace when she had been allocated her bed on the staff notice board. However, it bore in mind that Witness 10 had stated that she did not consider it to be a significant issue. Witness 10 stated that

when she informed Miss Hovery of her error, Miss Hovery began working on the correct bedspace. The panel did not consider the conduct in this charge, namely incorrectly responding to the board allocation in isolation, amounted to serious misconduct.

However, the panel bore in mind that Miss Hovery had been told multiple times during induction how the ward worked and how bedspaces were allocated. Despite being told multiple times, Miss Hovery continued to make these errors. Therefore, when considered cumulatively with charges 15, 16 and 17 the panel considered that charge 18 amounted to serious misconduct.

Decision and reasons on lack of competence

When determining whether charges 19, 20,21, 22, 23, 24 and 25 amount, individually or collectively to a lack of competence, the panel had regard to the terms of the Code. In particular, the panel considered following standards are engaged in this case:

> ***'6 Always practise in line with the best available evidence***
>
> *To achieve this, you must:*
>
> *6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work co-operatively***
>
> *To achieve this, you must:*
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> *8.2 maintain effective communication with colleagues*
>
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*
>
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> ***9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.4 take account of your own personal safety as well as the safety of people in your care

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection'

The panel bore in mind, when reaching its decision, that Miss Hovery should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

When considering charges 19, 20, 21, 22, 23, 24 and 25 individually, the panel determined that Miss Hovery's performance demonstrated a lack of competence.

The panel took account of the contextual factors in relation to Miss Hovery's lack of competence. It considered the fact that she was working on an intensive care unit where the skills described in the aforementioned charges are particularly important and are the fundamental aspects of safe and effective nursing practice for a band 5 nurse.

The panel bore in mind that Miss Hovery was made aware, over a significant period of time, in relation to all of the concerns described in the charges. She was initially placed on a three week supernumerary period following her induction and was unable to demonstrate the competencies. Miss Hovery was then asked to attend a Formal Performance Management Review meeting on 24 May 2021 in accordance with the Trust's Poor Performance Policy where she was made aware of the concerns described in the charges.

Following another three-week supernumerary period Miss Hovery was asked to attend another formal performance review meeting on 25 June 2021. She was placed on a development program, provided with mentors to observe her shifts and given significant support. Despite this and following a 13-week supernumerary period, Miss Hovery was still unable to meet the standard required of a Band 5 Staff Nurse on the Ward.

In light of this, the panel was satisfied that Miss Hovery failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as band 5 nurse.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Miss Hovery's practice was below the standard that one would expect of the average registered nurse acting in Miss Hovery's role.

In all the circumstances, the panel determined that Miss Hovery's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and lack of competence, Miss Hovery's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) ...'*

For reasons already set out above, the panel considered that limbs a, b and c were engaged by Miss Hovery's misconduct and lack of competence in this case.

Starting with misconduct, with regard to charges 1, 4 and 12 the panel was of the view that being late to a shift could have a major impact on the ward and patient care and place patients at an unwarranted risk of harm. It bore in mind that it had heard evidence to suggest that agency nurses are used to ensure wards have sufficient staffing levels so that the level of care expected is provided and to ensure the safety of patients.

Additionally, with regard to charges 15 to 18, the panel was of the view that a failure to follow reasonable management instructions could also place patients at an unwarranted risk of harm. It bore in mind that Miss Hovery was working in an intensive care unit and her failure to adhere to the Hand Hygiene Policy and the Uniform policy by removing her nail varnish placed the vulnerable patients within the ward at an unwarranted risk of harm. Additionally, her failure to obtain a Cerner card meant that she was unable to undertake certain nursing tasks such as making patient notes. The panel noted that this could have had an impact on patient safety and may have placed patients at an unwarranted risk of harm.

With regard to charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11, the panel was of the view that Miss Hovery's rude and aggressive behaviour towards healthcare staff placed Patient A at risk. The healthcare professionals stated in their evidence that they felt anxious attending Patient A's home while Miss Hovery was present which could have had an impact on the care of Patient A. Additionally, this could also have resulted in in the withdrawal of care to Patient A.

The panel considered that Miss Hovery, as a registered nurse, had a duty to treat the healthcare professionals kindly and professionally. In addition, if Miss Hovery had concerns regarding Patient A's care, these should have been escalated via the complaints procedures within the Trust.

In relation to all the above charges, the panel found that Miss Hovery's failings breached fundamental tenets of nursing practice and that her misconduct was liable to bring the nursing profession into disrepute.

Moving onto lack of competence, with regard to charges 19 to 25, the panel was of the view Miss Hovery had placed vulnerable patients in an intensive care unit at an unwarranted risk of harm. This was because she was unable to achieve the standard required of a band 5 nurse despite extensive support and mentoring.

The panel found that Miss Hovery's lack of competence had breached the fundamental tenets of the nursing profession. It also bore in mind that the public would lose faith in the medical profession if they were to witness Miss Hovery's practice as a nurse and may be apprehensive to come to a hospital for treatment. It was of the view that her lack of competence therefore brought the reputation of the medical profession into disrepute.

The panel recognised that it must make an assessment of Miss Hovery's fitness to practise as of today. It referred to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* and considered whether the concerns identified in her nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and lack of competence and considered whether Miss Hovery had provided evidence of insight and remorse.

Regarding insight the panel noted that Miss Hovery, in email correspondence, had denied all of the charges in relation to misconduct and lack of competence. It recognised her right to contest the charges. However, it noted that after receiving the panel's determination regarding facts Miss Hovery, through email correspondence to the panel, continued to deny the charges.

With particular regard to charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 Miss Hovery in her email continued to call the witnesses liars, she had not accepted responsibility for her actions nor had she demonstrated any remorse or insight. Additionally, the panel noted that it did not have detailed recognition from Miss Hovery as to the impact the patterns of bullying and harassment that occurred inside of Patient A's home had on the healthcare professionals, Patient A and the nursing profession. Further, the panel do not have any information which would demonstrate how she would approach similar circumstances in the future.

There was also no recognition regarding the impact her being late to shifts or her failure to follow reasonable management instructions had on patients, colleagues and the nursing profession.

With regards to Miss Hovery's lack of competence, the panel bore in mind that addressing the concerns would require her to recognise them, reflect on them, and develop insight into what she did and how she would avoid making the same mistakes again. The panel noted that there was no recognition from Miss Hovery that her lack of competence was a problem nor the impact it could have had on patients, colleagues and the nursing profession.

In light of the above, the panel determined that it had no evidence Miss Hovery had any insight in relation to her serious misconduct or lack of competence.

The panel was satisfied that the serious misconduct and lack of competence in this case is capable of being addressed. The panel carefully considered the evidence before it in determining whether or not Miss Hovery had taken steps to strengthen her practice in relation to the serious misconduct and lack of competence identified.

With regards to the charges related to rude and abusive behaviour it bore in mind that it had found patterns of bullying and harassment. It took account of the NMC's guidance

entitled ‘How we determine seriousness’ (reference FTP-3). Under the sub-heading ‘Discrimination, bullying, harassment and victimisation’ it stated:

> *‘Conduct of these types can be more difficult to address as they suggest an attitudinal problem.’*

The panel was of the view that Miss Hovery’s behaviour with regards to the pattern of bullying and harassment were attitudinal and therefore more difficult to remediate.

With regards to lack of competence, the panel bore in mind that support was put in place and attempts had been made to address the areas of concern over an extended period of time. Despite this, the failings continued. It also bore in mind that Witness 5, in her witness statement stated:

> *‘Anita's practice concerned me greatly. Anita did not have the basic knowledge nor was she able to retain information. There was also no demonstration from Anita that she had tried to better herself or reflect on the teaching which she had been given. I would never have felt confident to leave Anita with even a more junior member of staff. I was certainly not confident in Anita working independently. Even with a patient or Unit with a lower acuity, I do not think that she could practice competently as she lacks the basic knowledge required to execute the standards expected of a registered nurse.’*

The panel bore in mind that the serious misconduct and lack of competence in this case was capable of being addressed. However, in the absence of evidence of insight or strengthened practice there was no evidence that the concerns had been remedied to date. The panel noted that it had no evidence before it of any action taken by Miss Hovery to acknowledge, address or remedy the concerns identified in relation to the matters in this hearing, or the attitudinal issues which appear to underpin them.

The panel is of the view that in the absence of insight, remorse and evidence that Miss Hovery had strengthened her practice, in the areas of concern identified by the panel, Miss Hovery was liable to repeat her actions in the future. Were those actions to be repeated, there would be a risk of further abuse and aggressive behaviour to healthcare professionals, unwarranted harm to patients in her care, as well as of further damage to the reputation of the profession and further breaches of fundamental tenets of the profession. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel was satisfied that, having regard to the nature of the misconduct and lack of competence in this case, *'the need to uphold proper professional standards and public confidence in the profession would be undermined'* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if Miss Hovery's fitness to practise was not found to be impaired and therefore public confidence in the nursing profession would be undermined if Miss Hovery were allowed to practice unrestricted.

For all the above reasons the panel concluded that Miss Hovery's fitness to practise is currently impaired by reason of misconduct and lack of competence 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 Miss Hovery off the register. The effect of this order is that the NMC register will show that Miss Hovery has been struck-off the register.

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

Submissions on sanction

Mr Kabasinskas took the panel through the aggravating and mitigating factors he considered to be engaged in this case.

Mr Kabasinskas submitted that this case is too serious to take no action or impose a caution order.

Mr Kabasinskas submitted that conditions of practice order may address concerns regarding Miss Hovery's lack of competence. He submitted however that a conditions of practice order must be measurable and there had to be evidence that Miss Hovery would engage and comply with it. He submitted that there had been no acknowledgement or recognition from Miss Hovery that there are issues with her competence that can be addressed with such an order.

Mr Kabasinskas also submitted that a conditions of practice order would not address Miss Hovery's abusive behaviour.

Mr Kabasinskas submitted that Miss Hovery's behaviour in charges 2, 3, 5a, 6, 7, 8, 9, 10 and 11 were unacceptable and incompatible with her remaining on the NMC Register. He submitted that the abusive behaviour occurred over a period of time, was systematic,

verbal and physical. He also submitted that there was a risk of Patient A having her care withdrawn as a result of Miss Hovery's behaviour.

Mr Kabasinskas submitted that the NMC is inviting the panel to impose a striking off order. He informed the panel that in the Notice of Hearing, dated 17 April 2024, the NMC had advised Miss Hovery that it would seek the imposition of a striking off order if it found her fitness to practise currently impaired.

Mr Kabasinskas submitted that Miss Hovery still holds strong views about the healthcare professionals to this day. He further submitted that she had no insight, remorse or recognition how her behaviour affected others and the nursing profession. He submitted that this behaviour is incompatible with remaining on the NMC register.

Mr Kabasinskas submitted that the imposition of a suspension order would not be appropriate in this case. He submitted that the abusive behaviour was not a single instance and did not occur on a single shift. He submitted that Miss Hovery had deep seated attitudinal problems as evidenced by the emails she had sent to the NMC and the panel prior to and during this hearing.

Mr Kabasinskas submitted that there had been a repeat of the abusive behaviour. He cited the emails Miss Hovery sent to the NMC on 9 and 10 January 2024, and the numerous emails she had sent to the panel during the hearing. He submitted that Miss Hovery still shows discriminatory views and is still abusive to the healthcare professionals. He submitted that Miss Hovery had no insight and reminded the panel that it had found that there was a risk of Miss Hovery repeating the concerns.

Mr Kabasinskas reminded the panel that a striking off order would not be an option to the panel if this was just a lack of competence case. He submitted that as this was also a misconduct case, a striking off order is open to the panel.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of abusive and aggressive behaviour over a prolonged period of time;
- Significant lack of insight into failings and no recognition, remorse or remediation of Miss Hovery's behaviour and how it affected healthcare professionals;
- Miss Hovery's conduct put patients at risk of harm particularly Patient A;
- Evidence of bullying, harassment and discriminatory behaviour in emails to the NMC.

The panel also took into account the following mitigating features:

- [PRIVATE].

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

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 Miss Hovery's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is

at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Miss Hovery's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Hovery's registration would be a sufficient and appropriate response.

The panel took into account the SG, and the indicative factors which may indicate that a conditions of practice order is suitable namely if there is no evidence of general incompetence. The panel bore in mind that Miss Hovery had already been provided with extensive support and mentoring over a 13-week supernumerary period. Despite this, she failed on numerous occasions to reach the standard expected of a band 5 nurse. It appeared to the panel there is evidence of general incompetence with regards to Miss Hovery's nursing practice.

There was no evidence to give the panel any confidence that Miss Hovery would, at this stage, be able or willing to engage or comply with conditions imposed on her practice. Her communications with her regulator in respect of this case, namely her lack of insight into her failings, suggested that she would not. Additionally, she had stated that she had no intention of returning to the profession. In addition, the panel considered that conditions of practice would only be workable if Miss Hovery had shown remorse and insight, and there was an absence of evidence of those elements.

Additionally, the panel reminded itself of Miss Hovery's deep seated attitudinal issues which are reflected in her emails to the NMC and the panel. Miss Hovery appears to blame others and does not take personal and professional responsibility for her actions. The panel concluded that this could not be addressed with a conditions of practice order.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Hovery's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel took account of the NMC Guidance entitled 'How we determine seriousness' (reference FTP-3). Under the sub-heading 'Discrimination, bullying, harassment and victimisation' it stated:

> *'The NMC takes concerns about bullying, harassment, discrimination and victimisation very seriously…it can have a serious effect on workplace culture, and therefore the safety of people receiving care, if it is not dealt with…*
>
> *… To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition…*
>
> *When a professional on the register engages in these types of behaviours, the possible consequences are far-reaching. Members of the public may experience less favourable treatment, or they may feel reluctant to access health and care services in the first place.*

…In such cases where displaying discriminatory views and behaviours is proved, some level of sanction will likely be necessary unless there's been insight at the most fundamental level and the earliest stage. However, if a nurse, midwife or nursing associate denies the problem or fails to engage with the fitness to practise process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence…

… Even when they occur outside professional practice, such concerns can raise fundamental questions about the ability of a nurse, midwife or nursing associate to uphold the standards and values set out in the Code.'

The panel noted that Miss Hovery appeared to demonstrate discriminatory views which she had not been charged with nor findings against her and she continues to deny. However, the panel applied the principles of the guidance. It considered that Miss Hovery's emails dated 9 and 10 January 2024 to her regulator, the NMC, provided it with further contextual information regarding how Miss Hovery may conduct herself as a registered nurse with Black and ethnic minority healthcare workers and patients.

The panel also took account of the emails Miss Hovery sent the panel in relation to this hearing, dated 26 June 2024, which stated:

'I have been treated very badly and not fare being blamed by you all for things that never happened by people who were not present and do not even know what happened, and you have been lied to by [Witness 4] and the district nurses, they should loose there registration for what they have done to me and our relative…'

The panel was of the view that Miss Hovery demonstrated no insight whatsoever into the matters found proved. Miss Hovery continued to deny her involvement in the concerns raised, blamed the nurses, healthcare professionals and continued to call into question their credibility even after the fact finding stage, referring to them as liars.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Hovery's actions, her attitudinal issues, lack of insight and her discriminatory and racist views is fundamentally incompatible with Miss Hovery remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Miss Hovery's behaviour, in relation to her misconduct and subsequent attitudinal issues raised fundamental questions about her professionalism. It was clear to the panel she had demonstrated absolutely no insight into the concerns raised. It determined that, in light of Miss Hovery's behaviour and attitudinal issues, the public would expect Miss Hovery's name be removed from the NMC Register.

Miss Hovery's behaviour were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Hovery's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Hovery's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Miss Hovery 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 Miss Hovery's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. Given the panel's findings in relation to sanction he submitted that only an interim suspension order for a period of 18 months will be appropriate. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.