Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 March 2023 – Wednesday, 12 April 2023
Monday, 2 October 2023 – Friday, 3 November 2023
Monday, 4 March 2024 – Thursday, 14 March 2024 (In-camera)
Friday, 15 March 2024
Tuesday, 16 April 2024 – Monday, 22 April 2024
Wednesday, 30 October 2024 – Friday, 1 November 2024

Virtual Hearing

Name of Registrant:	Louise Aslett
NMC PIN:	06A0867E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – (March 2006)
Relevant Location:	Durham
Type of case:	Misconduct
Panel members:	Suzy Ashworth (Chair, Lay member) Michael Duque (Registrant member) Tracey Chamberlain (Registrant member)
Legal Assessor:	Nigel Ingram (6 March 2023 – 12 April 2023, 2 October 2023 – 3 November 2023, 4 March 2024 – 15 March 2024) Michael Bell (16 April 2024 – 22 April 2024) Megan Ashworth (30 October 2024 – 1 November 2024)
Hearings Coordinator:	Renee Melton-Klein (6 March 2023 – 12 April 2023, 2 October 2023 – 3 November 2023) Taymika Brandy (4 March 2024 – 15 March 2024) Jumu Ahmed (16 April 2024 – 22 April 2024, 30 October 2024 – 1 November 2024)

Nursing and Midwifery Council:

Represented by David Cobb, Case Presenter (6 March 2023 – 12 April 2023, 2 October 2023 – 3 November 2023)
Represented by Anna Leatham, Case Presenter (31 March 2023)
Represented by Ben Edwards, Case Presenter (4 March 2024 – 15 March 2024)
Represented by Yusuf Sergovia, Case Presenter (16 April 2024 – 22 April 2024)
Represented by Mohsin Malik, Case Presenter (30 October 2024 – 1 November 2024)

Mrs Aslett:

Present and represented by Emily Mattin, Counsel instructed by the Royal College of Nursing (RCN)

No Case to answer:

Charges 1f), 13, 14, 15, 18c), 18d), 19a) and 19e)

Facts proved:

Charges 1c)
4b)
6a), 6b) and 6c)
7
10a), 10b) and 10d)
11
18b)
19b)
20 (in its entirety)
21 in relation to 20b) and 20c)
22b), 22c), 22d), 22f), and 22g)
23 in relation to 22b), 22c) and 22f)
24 (in its entirety)
25 (in its entirety)
26 (in its entirety)

Facts not proved:

Charges 1a), 1b), 1d) and 1e)
2 (in its entirety)
3 (in its entirety)
4a), 4c) and 4d)
5
6d
8
9 (in its entirety)
10c)
12 (in its entirety)
16 (in its entirety)
17 (in its entirety)
18a)

	19c) and 19d) 22a) and 22e)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge (as amended):

That you, a registered nurse:

1) Between October 2017 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague D in that you:

a) on more than one occasion spoke to Colleague D in a rude and sarcastic manner; **[NOT PROVED]**

b) blamed Colleague D for incidents without carrying out an investigation; **[NOT PROVED]**

c) referred to colleague D as an "Old Duffa"; **[PROVED]**

d) created an unsupportive work environment; **[NOT PROVED]**

e) disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by Occupational Health; **[NOT PROVED]**

f) put Colleague D on the rota to complete night shifts despite the recommendation made by Occupational Health; **[NO CASE TO ANSWER]**

2) On more than one occasion, following incidents of physical assaults by patients on Colleague D, you failed to deal with these incidents in a proper and appropriate manner by failing to:

a) check if, following such incidents of assault, Colleague D was fit to work; **[NOT PROVED]**

b) conduct debrief meetings with Colleague D; **[NOT PROVED]**

c) conduct a risk assessment and provide support to Colleague D; **[NOT PROVED]**

3) On 3 May 2018 you:

a) spoke to Colleague D in an aggressive manner; **[NOT PROVED]**

b) pushed a chair towards Colleague D and demanded that Colleague D carried it to the meeting room; **[NOT PROVED]**

4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that:

a) you created a hostile and/or unsupportive working environment for Colleague E; **[NOT PROVED]**

b) whilst en route to deal with an incident in relation to Colleague G, you said to Colleague E "I'm going to sort this little git" or words to that effect; **[PROVED]**

c) failed to provide Colleague E with all relevant training including, but not limited to violence and aggression training; **[NOT PROVED]**

d) disclosed concerns that Colleague E had raised with you in confidence with other Colleagues; **[NOT PROVED]**

5. On an unknown date you used an inappropriate restraint method on a patient; **[NOT PROVED]**

6. During your employment as Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague F in that you:

a) created a hostile and/or unsupportive work environment for Colleague F; **[PROVED]**

b) referred to a colleague as a "nuisance" and asked another colleague how you could "get rid of her" or words to that effect; **[PROVED]**

c) on more than one occasion said "oh it was you wasn't it [Colleague F]" and "just blame Jordan" or words to that effect; **[PROVED]**

d) on more than one occasion blamed Colleague F for incidents without conducting an investigation; **[NOT PROVED]**

7. On an unknown date during a BBQ for staff and patients you made inappropriate comments about patients and referred to them as "split arses" or words to that effect; **[PROVED]**

8. On more than one occasion, you displayed favouritism of some staff over others; **[NOT PROVED]**

9. On more than one occasion, in relation to Colleague G, you:

a) were rude and abrupt; **[NOT PROVED]**

b) failed to support Colleague G with their workload despite frequently being asked for help and support; **[NOT PROVED]**

10. On more than one occasion you engaged in inappropriate conduct towards staff in that you:

a) frequently swore in the presence of staff members; **[PROVED]**

b) made inappropriate innuendos; **[PROVED]**

c) often spoke badly of patients; **[NOT PROVED]**

d) created a hostile and/or intimidating environment for staff; **[PROVED]**

11. On an unknown date following an incident with a colleague, told a senior colleague to “go and sort that fucking cunt out” or words to that effect; **[PROVED]**

12. Between 1 May 2017 and 25 June 2018 failed to protect staff and patients by:

a) admitting patients into Appletree who were unsuitable for a rehabilitative environment as a result of their mental illness; **[NOT PROVED]**

b) failing to ensure that staffing levels were sufficient to meet the needs of the patients; **[NOT PROVED]**

c) failing to ensure the presence of responsible clinicians between 11 May 2018 and 23 May 2018; **[NOT PROVED]**

d) failing to support staff that had been subjected to violence by patients by not following appropriate procedures; **[NOT PROVED]**

e) failing to ensure that staff had completed Life Support Training before using rapid tranquilisation; **[NOT PROVED]**

13. On 8 May 2018 you misused the petty cash fund by submitting a claim for £108.00 for garden plants which were not purchased for the Home as you suggested; **[NO CASE TO ANSWER]**

14. Your actions at charge 13 above were dishonest in that you knew you were not entitled to take money from petty cash but did so anyway. **[NO CASE TO ANSWER]**

15. On an unknown date in 2018, you misused the petty cash fund by submitting a claim for a pair of trousers without following the correct procedure for petty cash payments; **[NO CASE TO ANSWER]**

16. Between 1 May 2018 and 25 June 2018 you breached Regulation 18(2) of the CQC (Registration) Regulations 2009 by failing to report 13 incidents to the CQC which included:

a) 10 incidents of assaults on patients; **[NOT PROVED]**

b) 2 incidents of patients absconding from the Home; **[NOT PROVED]**

17. Between April 2018 and June 2018 you failed to appropriately record and report incidents that had occurred involving patients in that you:

a) did not ensure that IR1 incident forms were completed with sufficient information; **[NOT PROVED]**

b) failed to record all significant incidents on the KP1 log system used by the Home; **[NOT PROVED]**

c) only reported those incidents when patients required hospital treatment or when police were called but did not inform the CQC as required to do so; **[NOT PROVED]**

18. On 7 September 2020, whilst the Nurse in Charge at Barrington Lodge:

a) did not respond immediately to the emergency alarm that had been activated; **[NOT PROVED]**

b) asked a senior carer to deal with Resident A whilst you continued with a telephone conversation; **[PROVED]**

c) failed to conduct 30 minute observations of Resident A; **[NO CASE TO ANSWER]**

d) failed to inform care assistant to conduct regular observations of Resident A during the course of your shift. **[NO CASE TO ANSWER]**

19. Following Resident A's fall you failed to follow the correct procedure in that you:
   a) did not make a record of the fall in Resident A's care records; **[NO CASE TO ANSWER]**
   b) did not complete a Datix report; **[PROVED]**
   c) did not complete a body map; **[NOT PROVED]**
   d) did not make an entry in Resident A's mobility care plan; **[NOT PROVED]**
   e) did not make an entry to confirm whether Resident A's next of kin had been informed about the fall. **[NO CASE TO ANSWER]**

20. Between September 2020 and November 2021, acted inappropriately towards colleagues, in that on one or more occasion you:
   a) undressed in the manager's office in front of colleagues and/or in view of the public despite there being a designated area for staff to get changed; **[PROVED]**
   b) spoke about sex and/or sexual positions; **[PROVED]**
   c) had inappropriate conversations about colleague's sexual activities; **[PROVED]**
   d) whilst getting undressed in front of a male colleague said "they're only tits" and "just getting my baps out" or words to that effect. **[PROVED]**

21. By your conduct at charge 21 above you sexually harassed colleagues in that:
   a) it was unwanted; **[PROVED]**
   b) it was sexual in nature; **[PROVED]**
   c) it had the purpose or effect of violating colleagues dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for colleagues; **[PROVED]**

22. On an unknown date/s in relation to Colleague A:
   a) attempted to pull down Colleague A's trousers whilst Colleague A was up a ladder; **[NOT PROVED]**

b) on one or more occasion, stuck your bottom out to make it difficult to pass by and said “would you not squeeze past my fat arse” or words to that effect; **[PROVED]**

c) on the occasion of charge 22b above, said “you’re meant to tell me that it’s not fat, it’s a perfect arse” or words to that effect; **[PROVED]**

d) said that you took home the large batteries for your sex toys and dildos; **[PROVED]**

e) threw orange juice at Colleague A whilst a new member of staff was being inducted; **[NOT PROVED]**

f) on one or more occasion, made inappropriate comments to female members of staff about Colleague A despite being told by Colleague A to stop; **[PROVED]**

g) said that Colleague B had been “fanny farting” which is why it smelt of fish; **[PROVED]**

23. By your conduct at charge 22 above you sexually harassed Colleague A in that:

a) it was unwanted; **[PROVED]**

b) it was sexual in nature; **[PROVED]**

c) it had the purpose or effect of violating Colleague A’s dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A; **[PROVED]**

24. Between September 2020 and November 2021, on one or more occasion, acted inappropriately and/or erratically by:

a) hiding and jumping out to frighten colleagues during a shift; **[PROVED]**

b) running up and down the corridor; **[PROVED]**

c) doing handstands in the lounge in the presence of residents; **[PROVED]**

d) spinning around the foyer on a chair with wheels during a handover; **[PROVED]**

e) frequently using the word “cunt” when referring to colleagues; **[PROVED]**

25. Between September 2020 and November 2021 you bullied and/or harassed Colleague B by:

a) referring to Colleague B as “big bird” and “fat lass”, or words to that effect: **[PROVED]**

b) on one occasion saying “come on nurse big bird, let’s get this done” or words to that effect; **[PROVED]**

c) on one or more occasion referring to other Colleagues as “fat” and “lazy” or words to that effect; **[PROVED]**

26. Between September 2020 and November 2021, you bullied and/or harassed Colleague C by:

a) referring to Colleague C as “fat” and “fat lass” or words to that effect; **[PROVED]**

b) on one or more occasion saying “you silly fat cunt” or words to that effect; **[PROVED]**

c) on one occasion kissing Colleague C on the forehead in the presence of residents and/or Colleagues. **[PROVED]**

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

Decision and reasons on application to amend the charge

The panel proposed to amend on its own volition, the following charges in order to provide clarity and more accurately reflect the evidence. The panel proposed to amend ‘*Appletree Care Home*’ to ‘*Appletree Hospital*’ in charges 1, 4, 6, and 13 and to correct a typographical error in charge 22c.

Mr Cobb, on behalf of the Nursing and Midwifery Council (NMC), and Ms Mattin, on your behalf, did not oppose the proposed amendments.

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

The panel was of the view that such amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments to ensure clarity and accuracy.

> "That you, a registered nurse:
>
> 1) Between October 2017 and May 2018 whilst employed as a Registered Manager at Appletree ~~Care Home~~ **Hospital**, you bullied and/or intimidated Colleague D in that you:
>
> > a) on more than one occasion spoke to Colleague D in a rude and sarcastic manner;
> > b) blamed Colleague D for incidents without carrying out an investigation;
> > c) referred to colleague D as an "Old Duffa";
> > d) created an unsupportive work environment;
> > e) disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by Occupational Health;
> > f) put Colleague D on the rota to complete night shifts despite the recommendation made by Occupational Health;
>
> 4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree ~~Care Home~~ **Hospital**, you bullied and/or intimidated Colleague E in that:

a) you created a hostile and/or unsupportive working environment for Colleague E;

b) whilst en route to deal with an incident in relation to Colleague G, you said to Colleague E "I'm going to sort this little git" or words to that effect;

c) failed to provide Colleague E with all relevant training including, but not limited to violence and aggression training;

d) disclosed concerns that Colleague E had raised with you in confidence with other Colleagues;

6. During your employment as Registered Manager at Appletree ~~Care Home~~ **Hospital,** you bullied and/or intimidated Colleague F in that you:

a) created a hostile and/or unsupportive work environment for Colleague F;

b) referred to a colleague as a "nuisance" and asked another colleague how you could "get rid of her" or words to that effect;

c) on more than one occasion said "oh it was you wasn't it [Colleague F]" and "just blame Jordan" or words to that effect;

d) on more than one occasion blamed Colleague F for incidents without conducting an investigation;

17. Between April 2018 and June 2018 you failed to appropriately record and report incidents that had occurred involving patients in that you:

a) did not ensure that IR1 incident forms were completed with sufficient information;

b) failed to record all significant incidents on the KP1 log system used by the ~~Home~~ **Hospital**;

c) only reported those incidents when patients required hospital treatment or when police were called but did not inform the CQC as required to do so;

22. On an unknown date/s in relation to Colleague A:

a) attempted to pull down Colleague A’s trousers whilst Colleague A was up a ladder;
b) on one or more occasion, stuck your bottom out to make it difficult to pass by and said “would you not squeeze past my fat arse” or words to that effect;
c) on the occasion of charge ~~2b~~ **22b** above, said “you’re meant to tell me that it’s not fat, it’s a perfect arse” or words to that effect;
d) said that you took home the large batteries for your sex toys and dildos;
e) threw orange juice at Colleague A whilst a new member of staff was being inducted;
f) on one or more occasion, made inappropriate comments to female members of staff about Colleague A despite being told by Colleague A to stop;
g) said that Colleague B had been “fanny farting” which is why it smelt of fish”

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

During the course of the hearing, Mr Cobb made an application that parts of this case be held in private on the basis that exploration of some aspects of witness evidence involves [PRIVATE]. The application was made pursuant to Rule 19.

Ms Mattin supported the application. She also made a further request that [PRIVATE] should also be heard in private.

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

Having heard that there will be reference to [PRIVATE], the panel determined to hold those parts of the hearing in private.

Decision and reasons on application to admit hearsay evidence (Appletree Hospital)

As a preliminary matter, the panel heard that there was a dispute between the parties about evidence from Dr 1 in respect of charges regarding Appletree Hospital. Dr 1 had declined to participate in these proceedings. The panel heard that it had been agreed by the parties that Dr 1's unsigned witness statement should not be admitted into evidence, but that the NMC still proposed to rely on an interview conducted with Dr 1 that formed part of the evidence of Witness 7. Ms Mattin objected to the admission of this interview into evidence on the grounds of fairness, in the circumstances of the agreed removal of Dr 1's direct written evidence.

Mr Cobb submitted that under Rule 31 the exit interview of Dr 1, as exhibited, should be admitted into evidence as hearsay. Dr 1 was not present at this hearing and, whilst the NMC had made substantial efforts to ensure their attendance, they had chosen to decline to attend these proceedings. He submitted that the exhibit was relevant to the charges. Further, he submitted that there are several exit interviews in the NMCs evidence given by witness who will not attend to which Ms Mattin has not objected, and as such, it was also fair to admit Dr 1's exit interview.

Ms Mattin objected to the admission of Dr 1's exit interview which was included in the NMC's exhibit bundle. She submitted that though there may be some relevance, it

was not fair to include as Dr 1 has refused to participate or act as a witness in this case.

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, 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 first concluded that the exit interview of Dr 1 was relevant to the charges. It then went on to considered whether it was fair to accept it into evidence.

The panel considered that there were other exit interviews included in the evidence of Witness 7 that would not be available for cross examination. The panel therefore determined that in the circumstances, it would be fair to admit the interview as it is neither crucial nor determinative. The panel will of course bear in mind the significant concerns raised by Ms Mattin about the evidence when it comes to attributing the appropriate weight to it.

Decision and reasons on application to admit hearsay evidence (Barrington Lodge)

The panel heard an application from the NMC on day 20 of the hearing, which was opposed by Ms Mattin, to admit hearsay evidence in the form of three witness statements, regarding the allegations in respect of Barrington Lodge, which go to support charges 18 and 19. This application was being made notwithstanding that the panel were yet to hear any live witnesses regarding these events. The panel were informed that Witnesses 11, 12, 13, and 14 did not intend to give live evidence despite all reasonable efforts having been made to secure their attendance.

The panel had the benefit of reading detailed written submissions from both Mr Cobb and Ms Mattin.

Mr Cobb submitted:

'I am making a Submission under Rule 31 of the NMC (Fitness to Practice) Rules 2004. Specifically, Rule 31 (1) provides that:-

> *"31 **(**1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place)."*

At this stage, I am moving that the evidence of the NMC Witnesses, [Witnesses 11, 12 and13] should be admitted under that Rule. Each of these Witnesses speak to the chapter of evidence relating to Barrington Lodge (Charges 18 &19). I should make clear that I acknowledge that I am approaching this Submission on a different basis as regards [Witness 14] and I will enlarge on those distinctions presently.

The Panel will be aware that the NMC has produced Witness Statements for each of these Witnesses (Witness Bundle. Pp 155 – 174). What is also relevant in this respect is that the Witness [16], who was the Investigator of this incident, includes as part of the evidence relating to her Investigation, statements which she obtained from [Witness 11] , [Witness 12], [Witness 13] and [Witness 14] (Exhibits [Witness 16] 4 - 8, NMC Bundle pp 598 – 612).

The Panel will have seen that [Witnesses 11, 12, 13, and 14] were employed as Care Assistants at Barrington Lodge. As a result, none of these Witnesses are Registered with the NMC, and cannot be subject to the requirement to co-operate with Investigations conducted by the NMC which applies to Registrants.

The Panel will be in little doubt that a number of organisational issues have arisen regarding bringing this group of witnesses to the Hearing. Without making excuses for shortcomings in what is a routine procedure in these cases, the combining of two Cases appears to have produced Witness Timetables which were conflicting and, with the benefit of hindsight, highly optimistic schedules of when Witnesses would be called. I have acknowledged previously that this was compounded by lines of communication which became confused as regards organisation as the case proceeded.

In any event, that timetable would have been disrupted by the first two days being Adjourned on the Registrant's motion and also the repeated communications difficulties which occurred while the Hearing was being run via Teams. (I should stress there is no criticism of the Motion which was made, as Miss Mattin was able to point to having received some Disclosure close to the original Starting Date).

It is accepted that, along the way, sight was lost to some extent of when these Witnesses would actually be required to attend, and any initial indications they had been given of their likely dates were overtaken fairly rapidly. It is understandable that these Witnesses may have assumed that the NMC no longer wished to call them, and that any arrangements they made with the Employer for time off had lapsed.

What I can say is that since last Tuesday, an Officer in the NMC has had responsibility for trying to contact these Witnesses, using the information held in their records of Phone Numbers and e-mail addresses. Also, on my direct instructions, Recorded Delivery Letters were sent out to [Witnesses 11, 12 and 13].

Copies of these letters are attached. The Recorded Delivery Slips are being searched for, and I hope will be forwarded soon, but I ask the Panel to accept on

my Professional responsibility that this was the mode used for notification. There is no other step which the NMC could have taken to contact these Witnesses in my Submission.

As was directed by the Hearing on Wednesday, I checked on Friday morning whether any of these Witnesses had responded and was advised in the negative. I accordingly advised the Panel Co – Ordinator that I would make the present submission to admit Hearsay today.

[Witnesses 11, 12, and 13]

My overall Submission is that the written evidence of these Witnesses has been disclosed timeously to the Registrant, and that the NMC – albeit in the circumstances described – has made every effort it reasonably could to bring these Witnesses.

As mentioned, these Witnesses have given written Statements to [Witness 16], who the NMC intend to lead in the course of this week. In my submission, the Statements given to [Witness 16] should be admitted on the same basis as the Exit Interview of [Dr 1] was admitted. They are relevant to proof of the Charges against the Registrant, and to the evidence [Witness 16] will give, and would render her evidence difficult to follow if it was not taken into account.

I would invite the Panel to admit the Hearsay evidence of these Witnesses.

[Witness 14]

I accept that the NMC has indicated previously that it did not intend to rely on the evidence of [Witness 14]. My submission essentially is that the written Statement which he provided to [Witness 16] (Exhibit [Witness 16] 7) is now in the same

position as the Statements of [Witnesses 11, 12, and 13], and has been disclosed previously to the Registrant.

In my submission, there is no unfairness at this stage in admission of all or any of these Statements comes with the obvious reservation that Miss Mattin will be entitled to address the Hearing on the weight to be given to Statements whose authors she is unable to cross – examine.

The Panel will require to consider whether the test of fairness mandates a different outcome for [Witness 14's] evidence, given the previous history. For completeness, if the Panel is against me with regard to the first group of Witnesses as [Witness 14's] Hearsay evidence, it follows that [Witness 14's] evidence would similarly excluded. Nevertheless, I invite the Panel to admit Exhibit [Witness 16] 7 also as Hearsay.

I anticipate that the Legal Adviser will direct the Panel that the primary test in considering a Rule 31 Submission is based on fairness. The process is of a Regulatory nature and the purpose of deciding on such is Submission is not one of punishing one or other party for how it has conducted matters.'

Ms Mattin submitted the following:

1. '*It is understood that the Nursing and Midwifery Council ("NMC") seek to persuade the Panel to rely upon the hearsay evidence of: [Witnesses 11, 12, 13, and 14]. No application has been made in respect of [Ms 5].*

2. *This application is opposed.*

<u>*Chronology*</u>

3. *The Panel will be well aware of the protracted nature of these proceedings which will not be repeated here save for those developments which relate to this application.*

4. *The NMC cite the two-day delay in starting these proceedings:*

> *"In any event, that timetable would have been disrupted by the first two days being Adjourned on the Registrant's motion and also the repeated communications difficulties which occurred while the Hearing was being run via Teams. (I should stress there is no criticism of the Motion which was made, as Miss Mattin was able to point to having received some Disclosure close to the original Starting Date)."*

5. *It is noted that the requested disclosure was not received "close to the original starting date" but in fact on the afternoon of Day 1 of the hearing. Whilst it will form no part of the panel's role to 'punish' the NMC for any perceived shortcomings in their investigation/presentation of the case, it is not accepted that any of the delays or wasted days can be attributed to the Registrant. The NMC's presentation of the case must have contextual relevance in the Panel's consideration of the fairness of this application.*

6. *On Tuesday 28 March 2023 the NMC were directed to "formalise" their case on Barrington, confirming which witnesses would be attending and any applications that may follow by 12:00 on Wednesday 29 March 2023 (day 17).*

7. *All parties understood that [Witness 10] and [Witness 16] were willing witnesses who had engaged with the NMC and would be giving evidence.*

8. *The NMC failed to sufficiently formalise their case. With an email update at 11:52 parties were informed that recorded letters had gone out "all the*

Barrington related witnesses" (email of 29 March 2023 from [Hearings Co-ordinator]). The NMC sought to call [Witness 10] at 9.00 on Thursday 30 March 2023.

9. *That course of action was opposed on behalf of the Registrant and made clear to the NMC upon receipt of the email update. Instructed counsel requested to address the panel before [Witness 10's] evidence and before the NMC embarked on the Barrington chapter.*

10. *Mr Cobb and counsel for the Registrant made submissions to the panel. Mr Cobb said that "recorded delivery letters went out last night". The NMC asked the Panel to hear the evidence of [Witness 10] and await further updates in respect of the remaining witnesses. Mr Cobb indicated, as he had done previously, that the NMC do not rely on the evidence of [Ms 5]. Contrary to the previous communication, the panel were informed that letters were in fact only sent to three of the witnesses [Witnesses 11, 12, and 13]*

11. *The Registrant's position was that the direction of the Chair had not been complied with and that the clear expectation was the NMC would set out their case before calling witnesses through the door. This had not been done. It was submitted that there was clear prejudice occasioned by the NMC's proposed course of action.*

12. *The Panel agreed with the Registrant's position and determined that the evidence of [Witness 10] could not be heard until the NMC set out their case. The direction and reasoning of the panel was as follows:*

    "The panel has made a decision on the submissions that have heard. Want to reiterate this is an incredibly unsatisfactory. We agree with Ms Mattin she should not be required to cross examine any witness until she knows

the case fully. She [Witness 10] will have to be released for today on the basis that is still not clear. We are in a position where the NMC have made arrangements recorded delivery been made.

In the position we reluctantly accept, until tomorrow lunchtime Friday 2pm to clarify its case."

(Counsel's note of Panel's oral determination at 10.32 Thursday 30 March 2023).

13. *The NMC were given until 14:00 to provide that information following the delivery of the recorded letters.*

14. *Shortly after 14:00 on Friday 31 March, [HC] forwarded communication from Mr Cobb. The following was sent to the parties:*

"I have made enquiries with the NMC and at this point, none of the Witnesses have responded to Phone or e-mail contact or to the Recorded Delivery letters. Given the time limit specified by the Panel, I am now confirming that the NMC will not seek to lead the evidence of the Witnesses [Witness 11], [Witness 12] and [Witness 13] directly.

Accordingly, I will be making a Hearsay Application in respect of the Witnesses [Witness 11], [Witness 12] and [Witness 13] and also [Witness 14] and [Ms 5]. That will be made in two parts, the reason for including [Witness 14] and [Ms 5] is that they are now in the same position for the others - that is they were not going be led for the NMC - but each are included in the Investigation of [Witness 16]. On the basis that [Dr 1]'s Exit Interview was admitted, referring [Witness 16] to their Statements can be a matter of Submission as to weight at a later stage, but that is different to the fairness of admitting them at this point. I appreciate that [Witness 14]

and [Ms 5] have been in a different position up to now, hence splitting the Submission into two parts."

15. *Further clarity was sought on behalf of the registrant as to which parts of the evidence for each witness will be sought to be adduced by hearsay. The Registrant is still not clear on the apparent distinction the NMC seeks to draw between these witnesses in their application.*

16. *The Panel will be aware of the changes of position with respect of [Ms 5]. It is not clear what attempts have been made to contact her. The further time was granted to allow the recorded delivery letters to take effect. [Ms 5] was not sent a recorded delivery letter. It now appears on receipt of the NMC's written submissions (as opposed to the update received on 31 march 2023) that [Ms 5] does not form a part of their application.*

The law

17. *Hearsay evidence is, by its very nature, not the best evidence, being second hand or reported. However, it is accepted that it is admissible in civil proceedings pursuant to the Civil Evidence Act (CEA) 1995. The admission of evidence in NMC proceedings is governed by the twin issues of relevance and fairness - the latter being decided in part through the consideration of criminal authorities.*

18. *The opposition to the NMC's application is made on the basis of fairness.*

19. *In the Appeal Court judgment in Horncastle Thomas LJ stated that it is "ordinarily essential that evidence of the truth of a matter be given in person by a witness who speaks from his own observation or knowledge."*

20. *While the NMC’s rules permit the admission of evidence that might not be admitted in criminal cases, they should not be regarded as an easy route to the admission of hearsay, such evidence must be carefully scrutinised.*

21. *The central requirement is 'fairness'. This was emphasised in Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216. in which Rimer LJ rejected the notion promoted by the NMC that the rule admitting evidence 'subject only to the requirements of relevance and fairness' establishes a general principle to admit hearsay evidence as a matter of course and then address the issue of fairness by determining the weight to attach to that evidence.*

22. *In Ogbonna, the Registrant “O” faced three serious charges all of which were found proved and she was struck off the register. On charge one, the NMC placed sole reliance upon the statement of O's line manager P, with whom she was not on good terms. P did not give evidence rather her statement was adduced as hearsay despite O's wish to cross-examine her. P had moved to the Caribbean. On appeal, Davies LJ found that the tribunal had misdirected itself in finding that P was not available since no inquiry had been made. The NMC (FTP) Rules 2004 required the tribunal to consider the overall fairness of the hearing before admitting hearsay and, given the misdirection the test had not been met.*

    In her judgment on the first appeal, Davies I stated that:

    “The evidence of the sole witness of fact was critical. That fact together with the evidence of bad feeling between the two women meant that every effort should have been made to secure [P’s] attendance. Fairness required that the appellant was entitled to test the evidence of [P] by way of cross-examination unless good and cogent reasons could be given for non-attendance.”

23. The Court of Appeal upheld Davies LJ's decision. Rimer LJ stated at paras 23-24 that:

"... decisions as to the admission or exclusion of a hearsay statement [are] to be governed by considerations, inter alia, of fairness ... [Here the NMC was seeking to adduce P's] statement as the sole evidence supporting the material parts of Charge 1 when it knew that that evidence was roundly disputed and could not be tested by cross-examination. It was [doing so in support of a case whose outcome could be and in the event was] the wrecking of [O's] career as a midwife, a career which had lasted over 20 years. I should have thought it was obvious that, in the circumstances, fairness to [O] demanded that in principle the statement ought only to be admitted if she had the opportunity of cross-examining [P] upon it. ... it should have been obvious to the NMC that it could and should have sought to make arrangements to enable such cross-examination to take place…"

24. While the case did not purport to lay down any more general principle other than the need for a proper consideration to be given to the criterion of fairness, the circumstance bear repeating since they are relevant to this case.

25. In the case of R (on the application of Bonhoeffer) v General Medical Council [2011] EWHC 1585 (Admin), the Court commented:

"There is… no absolute rule whether under Article 6 or in common law entitling a person facing disciplinary proceedings to cross-examine witnesses on whose evidence the allegations against him are based. Nor does such an entitlement arise automatically by reason of the fact that the evidence of the witness in question is the sole or decisive basis of the

evidence against him. Nor, so far as Rule 34 is concerned, does it follow automatically from a conclusion that hearsay evidence would be inadmissible under the gateways of section 114 and/or 116 of the 2003 Act that it would be unfair for the FTPP to admit it under the Rule." At [39]

"It is axiomatic that the ability to cross-examine in such circumstances is capable of being a very significant advantage. It enables the accuser to be probed on matters going to credit and his motives to be explored. It is no less axiomatic that in resolving direct conflicts of evidence as to whether misconduct occurred the impression made on the tribunal of fact by the protagonists on either side and by their demeanour when giving oral testimony is often capable of assuming great and sometimes critical importance." At [44]

"Nor in my judgment is the unfairness to the Claimant mitigated by the fact that the GMC's reliance on Witness A's hearsay evidence weakens the case against him or that the case against him may fail. The nature of the unfairness complained of is that the admission of evidence in the form of hearsay statements which could have been but will not be tested in cross-examination may lead to the charges against the Claimant being found by the FTPP to be correct, whereas if it were adduced in the form of oral testimony and tested in cross-examination it might be found to be incorrect or at least not accepted as probably correct. Such a result either is or is not unfair. If it is, it does not cease to be unfair merely because the admission of the hearsay evidence may lead to a different result." At [47]

26. *The case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 provides further guidance on the issue of fairness in the context of an absent witness. T was accused of using derogatory language about patients. The allegations were a number of years old. The CCC admitted and relied upon three witnesses of fact, two of whom refused to attend,*

citing alleged reasons of ill-health. The fact of their non-attendance was not communicated to T.

27. *Despite T disputing their evidence and it being sole and decisive in respect of certain matters, the CCC admitted the witness statements. The single live witness did not save the day for the NMC since that witness' evidence was bound up with the untried and untested absent witnesses.*

28. *In allowing the appeal, HHJ Thomas QC reaffirmed the principles in Ogbonna and Bonhoeffer. A review of the reasons shows that the CCC failed to take any proper steps to assess whether admitting the evidence was fair. It failed to consider: the sole and decisive nature of the evidence or T's written challenges; whether the reasons asserted for absence were in fact valid; what the NMC had done to facilitate attendance of witnesses or the provision of evidence by other means; the verticity, credibility or reliability of the witness statements; the seriousness of the allegations; and the impact of an adverse finding on T.*

<u>The NMC's application</u>

29. *The NMC's application relates to charges 18 and 19 as follows:*

    18. *On 7 September 2020, whilst the Nurse in Charge at Barrington Lodge:*
        a) *did not respond immediately to the emergency alarm that had been activated;*
        b) *asked a senior carer to deal with Resident A whilst you continued with a telephone conversation;*
        c) *failed to conduct 30 minute observations of Resident A;*
        d) *failed to inform care assistant to conduct regular observations of Resident A during the course of your shift.*

19. Following Resident A's fall you failed to follow the correct procedure in that you:

a) did not make a record of the fall in Resident A's care records;
b) did not complete a Datix report;
c) did not complete a body map;
d) did not make an entry in Resident A's mobility care plan;
e) did not make an entry to confirm whether Resident A's next of kin had been informed about the fall.

30. The NMC seek to adduce:

1) Witness statement of [Witness 10]
2) Investigatory interview of [Witness 10]
3) Witness statement of [Witness 12]
4) Investigatory interview of [Witness 12]
5) Witness statement of [Witness 13]
6) Investigatory interview of [Witness 13]
7) Witness statement of [Witness 14]
8) Investigatory interview of [Witness 14]

31. Mr Cobb refers to statements [Witness 16] obtained from the above witnesses. There are no statements but very brief records of an interview.

32. The following observations are in made in reply to the NMC's submissions:

The Panel will have seen that [Witnesses 10, 11,12, and 13] were employed as Care Assistants at Barrington Lodge. As a result, none of these Witnesses are Registered with the NMC, and cannot be subject to the requirement to co-operate with Investigations conducted by the NMC which applies to Registrants.

That is not correct. Whilst registered professionals are required to cooperate by virtue of the code, non-registrants can also be compelled to give evidence. Regulators are at liberty to apply to the High Court for a summons, issued under CPR pt 34. The Registrant is not aware of any principle in the rules or case law that lessens the efforts that should be made for non-registrant witnesses. It is concerning that the NMC appears to misunderstand their powers in respect of witnesses.

The Panel will be in little doubt that a number of organisational issues have arisen regarding bringing this group of witnesses to the Hearing. Without making excuses for shortcomings in what is a routine procedure in these cases, the combining of two Cases appears to have produced Witness Timetable which were conflicting and, with the benefit of hindsight highly optimistic schedules of when these would be called. I have acknowledged previously that this was compounded by lines of communication which became confused as regards organisation as the case proceeded.

This is a matter entirely for the NMC. These cases are several years old and it is for them to ensure witness issues are communicated to all parties. It appears the issue is non-cooperation, even if the witness timetabling had ran smoothly that would not change the position. It is not for the Registrant to bear the burden of the NMC's internal miscommunications.

Further, it had been understood that [Witness 12] was at one time lined up to give evidence.

33. *The Panel will note that the exhibit bundle purports to contain a statement from Resident A. It does not.*

Submissions

34. *The NMC note that the Registrant has had this evidence for some time. That does not address the unfairness occasioned by its admission. Although there is no absolute right to cross examine a witness there must be compelling reasons to deprive a registrant of this opportunity. The NMC state:*

… there is no unfairness at this stage in admission of all or any of these Statements comes with the obvious reservation that Miss Mattin will be entitled to address the Hearing on the weight to be given to Statements whose authors she is unable to cross – examine.

35. *This approach echoes that which was rejected by the Court of Appeal in Ogbonna v Nursing and Midwifery Council [2010] EWCA Civ 1216.*

36. *On a review of the above authorities, the panel's attention is drawn to the importance of the following considerations highlighted in the judgements:*

(1) *The decisive nature of the evidence - in this case the NMC seek to adduce hearsay in respect of 4/5 witnesses present on shift. Even on her own account [Witness 10] cannot speak to the Registrant's response to the member of staff who alerted her to an issue Resident A. Charges 18a and 18b would therefore rely solely on hearsay evidence the Registrant is unable to challenge. It is submitted that these witnesses would also give decisive evidence on the remainder of the charges, to which [Witness 10] can only give a partial picture.*

(2) *The level of factual conflict. There is a significant degree of factual dispute between the NMC witnesses and the Registrant, including:*

i. *Capacity in which [Witness 12] was on shift (the witnesses have different positions on this)*

ii. Information handed over about Resident A upon his return to the home

iii. Instructions given by the Registrant to staff following his return to the home

iv. Who alerted the Registrant to Resident A's condition

v. What the Registrant was told and what she replied

vi. The speed of the Registrant's response

vii. When the buzzer would have stopped sounding

viii. Presentation of Resident A in the bathroom, extent of visible injuries and clinical examination undertaken

ix. Whether the registrant would have been able to hear the emergency alarm from her office

x. Whether any staff members informed the Registrant they were concerned about a possible head injury

xi. Instructions given by the Registrant to three of the four witnesses the NMC seek to adduce by hearsay, this includes instructions for 30 minute observations and completion of relevant documentation (charge 19)

xii. The respective responsibilities of care staff and the Registrant who was the only registered nurse on shift as well as acting in managerial capacity

xiii. The care given to Resident A by the Registrant

xiv. The Registrant will give evidence that she had put a sensor mattress in place for the Resident

(3) Whether the reasons cited were valid. We have none. The NMC have never been clear as to when it became apparent these witnesses were not cooperating. The following submission from the NMC appears to be pure conjecture:

It is accepted that sight was lost to some extent of when these Witnesses would be required to attend, and any indications they had been given of

their likely dates were overtaken fairly rapidly. It is understandable that these Witnesses may have assumed that the NMC no longer wished to call them, and that any arrangements they made with the Employer for time off had lapsed.

(4) What the NMC have done to facilitate attendance. Evidence on this is scant and is focused on efforts made post day 17 of the hearing. Further, it appears no letters were sent to [Witness 14] or [Ms 5]. In the context of allegations that are three years old it is submitted that the NMC cannot reasonably assert they have done all that they could.

(5) Whether witness difficulties were communicated to the Registrant. It appears these witness difficulties have been clear to the NMC for a significant period of time. Nevertheless, their evidence was included in the final bundle sent in the week before the substantive hearing. When counsel inquired as to any changes to the batting order, the NMC only informed us of difficulties with [Dr 1] on Friday 3 March 2023.

(6) The veracity and credibility of the witness statements. There are a number of significant inconsistencies in the accounts which cannot be explored, for example who was it that went to get the registrant? Despite witnesses claiming it was [Witness 14] and giving evidence of an apparent conversation with the Registrant. He gives no such evidence.

The brevity of the interview records should be of further concern to the Panel. It had been the intention of the Registrant to explore those 'first' accounts in cross examination.

(7) The seriousness of the allegations and adverse finding on the registrant (following R (Bonhoeffer) v General Medical Council [2011] EWHC 1585 (Admin) serious damage to reputation or standing should now also be

considered. The allegations are plainly serious and risk attracting the most severe of sanctions.

(8) It is submitted that as in Thorneycroft, the evidence of [Witness 16] is inevitably bound up with the untried and untested absent witnesses.'

The panel accepted the legal assessor's written 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.

Therefore, the panel first considered whether the witnesses' statements were relevant to the charges. Both advocates accepted, as did the panel, that the witness statements were relevant as they provided eyewitness accounts relating to the events in dispute.

Secondly, in terms of the fairness of admitting the hearsay evidence, the panel determined that these were not crucial witnesses and as such would not provide sole and decisive evidence to these charges. It did however consider that their evidence provided an important context to the allegations being made against you.

The panel noted that it would be hearing from two live witnesses with eyewitness accounts on behalf of the NMC. Further, a statement from Witness 15 which spoke of the incident had been produced, and the panel was told that it was intended that she would give evidence for you. Additionally, you yourself would have the opportunity to give your own account in due course. The panel bore in mind that the statements sought to be admitted were prepared for the purpose of these regulatory proceedings and had been disclosed to you and your representative in a timely manner.

Whilst understanding the frustrations of Ms Mattin, prior to this application, in respect of the difficulties in case management that have beset this part of the NMC's case,

the panel was mindful of the considerable efforts expended by the NMC to secure the attendance of these witnesses, albeit at a late stage. The panel was further mindful of its responsibility to protect the public and the public interest. In these circumstances, the panel determined that it would be fair to accept into evidence the written statements of the three Barrington witnesses who were not attending and therefore to accept into evidence the witness statements of Witnesses 11, 12, and 14.

The panel would, of course, determine what weight to attribute to the hearsay evidence in due course at the conclusion of the NMC's evidence.

Decision and reasons on application to admit hearsay evidence (Lindisfarne Care Home Witness 20)

On day 24, the panel heard an application made by Mr Cobb under Rule 31 to allow the written statement of Witness 20 into evidence. Witness 20 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they did not wish to attend to give evidence. Mr Cobb told the panel that the evidence of Witness 20 went to charges 20 and 21. He told the panel that the witness statement had been extensively redacted and submitted that it revisited much of the evidence of Witness 19. He accepted that one exhibit to the statement was not relevant, and he did not seek to have this admitted.

Mr Cobb submitted that though he understood that there was a potential of possible animosity between you and Witness 20, this could be addressed as a matter of weight and can be dealt with fairly. He submitted that the evidence is not of a decisive nature.

Ms Mattin opposed the application to admit the statement and exhibit of Witness 20, on the basis of fairness. While she accepted that the evidence was relevant, she submitted that the fairness could not be properly addressed by weight given to it by

the panel. She told the panel that you had raised a grievance against this witness, who had a management position over you, and alleged that she had bullied you. She told the panel that you felt that you had been victimised and singled out by the witness. She submitted that Witness 20 had been clear that they did not want to participate in the proceedings.

Ms Mattin submitted that it would appear that Witness 20 had been told about a complaint made to the Care Quality Commission (CQC) and that the exhibit seems to direct itself to this complaint and seeks to blame you.

Ms Mattin drew the panel’s attention to Paragraphs 17-28 of her previous submissions on Hearsay which lays out her detailed legal argument in response to this application.

The panel accepted the advice of the legal assessor.

The panel was mindful that these proceedings were shortly to adjourn for a six-month period. The panel therefore, determined that as it remains unclear which witnesses will give evidence regarding the charges arising from Lindisfarne Care Home when the hearing resumes, the NMC's application to admit hearsay evidence at this time was premature. The panel therefore proposed to reconsider any application in this respect after the resumption of the hearing, if necessary, when more information would be available.

Decision and reasons on application to admit hearsay evidence (Lindisfarne Care Home Witness 20)

This hearing resumed on 2 October 2023. The panel heard that despite efforts to secure Witness 20’s attendance at this hearing during the interim break since April 2023 the NMC had been unsuccessful. Mr Cobb, therefore, resubmitted his hearsay application in respect to this witness. As described above, Mr Cobb submitted that

Witness 20's statement is extensively redacted, and that the extent of the evidence is restricted only to paragraphs six and seven. He submitted that these paragraphs address charges 20 and 21, however they are not sole and decisive in the matter, but rather corroborate evidence of Witness 19.

Ms Mattin renewed her objection that this evidence be accepted as hearsay. She submitted that there was considerable history between the parties, and that you had lodged a formal grievance about Witness 20. She submitted that it would be unfair for Witness 20's evidence to be considered unchallenged as the context of the grievance and the relevance of the anonymous CQC complaint, means that you make a number of allegations about Witness 20's behaviour.

The panel accepted the advice of the legal assessor.

The panel bore in mind its overarching duty, namely, to protect the public, patients and the wider interests of the profession.

The panel concluded that the evidence is relevant. In terms of fairness, that panel was satisfied that the evidence is not sole and decisive. The panel noted that Witness 19 addressed the same charge and that this witness had been heard under oath and had their evidence tested through cross examination.

The panel concluded that the application is in regard to good quality evidence as it was a witness statement collected by the NMC. The panel also considered the concerns raised by Ms Mattin but concluded that it can take this into account by giving appropriate weight to this evidence in all the circumstances. Furthermore, the panel noted that it would have the opportunity to hear directly from you in regard to your relationship with this witness and that this would allow you to speak directly to these concerns.

The panel therefore determined that it was fair to accept the Witness Statement of Witness 20 into evidence as hearsay and would determine its weight in due course.

Decision and reasons on application to admit hearsay evidence (Lindisfarne Care Home, Witness 17)

On day 29 of the hearing the panel were informed that the NMC's final witness, Witness 17, would not be attending the hearing to give evidence under oath. The panel heard that despite securing the witness's attendance several times during the course of this hearing, due to ongoing challenges of the running order, scheduling, and concluding earlier witnesses, she was not heard at those times and was subsequently unavailable to attend the hearing from 4 October 2023 until 19 October 2023 because she is out of the jurisdiction.

Accordingly, Mr Cobb made an application under Rule 31 that Witness 17's written statement be accepted into evidence as hearsay. He submitted that the evidence this witness provides is of a limited scope, as the original written statement covers considerable material which has been redacted. He submitted that this is also reflected in the extensive redactions in Exhibit .../04. He submitted that whilst reference is made at paragraph 27 of the Witness Statement to an Investigatory Report (Exhibit .../02), that document has not been exhibited by the NMC for these proceedings.

Mr Cobb submitted that the evidence of Witness 17 was relevant in that it describes how you were employed as the Deputy Manager of Lindisfarne Care Home and mentions concerns raised regarding your conduct and an accusation of bullying, which led to you being suspended. He submitted that these allegations are the subject of charges 20 to 26 and were investigated by Witness 17. He then submitted that the evidence was relevant. He said that it was not sole and decisive as the panel heard from four other live witnesses regarding these charges, and all were cross-examined.

Mr Cobb submitted that imposing a delay until Witness 17 could attend in person would be disproportionate and delay a final outcome to this case.

Ms Mattin objected to the application that the evidence of Witness 17 be accepted as hearsay. She submitted that it would not be fair. She submitted that though Witness 17 was the Operations Director at the Home and is said to have investigated you, no report has been provided, and it would not be fair to admit a partial picture of Witness 17's evidence.

In her written submissions to this application dated 5 October 2023, Ms Mattin submitted:

> *'The manner in which this case has been prosecuted, is deeply concerning. The panel and registrant are now in a position where, after over six weeks of evidence, across six months, the investigator for the third chapter is no longer willing to engage. We have only been aware of that fact after substantive witnesses have given their evidence and after a hearsay application was made in respect of the other manager…'*

Furthermore, Ms Mattin submitted that in regard to the investigation undertaken by Witness 17, there were a number of significant concerns about the manner in which complaints were investigated, evidence was taken, and what information was given to each witness.

The panel accepted the advice of the legal assessor.

The panel bore in mind its overarching duty, namely, to protect the public, patients, and the wider interests of the profession. In response to the written submission of Mr Cobb, the panel rejects any suggestion that the panel is accountable for the NMC's witness schedule not being adhered to.

The panel carefully considered the application and concluded that the evidence is relevant to charges 20 to 26. The panel then considered whether it was fair, in all the circumstances, to admit it. The panel was satisfied that the evidence is not sole and decisive in these matters, as Witness 17 addresses the same charges that live witnesses have been heard on and cross-examined under oath. The panel concluded that the application was in regard to good quality evidence as it was a witness statement collected by the NMC.

The panel also carefully considered the concerns raised by Ms Mattin but concluded that it can take these into account by giving appropriate weight to this evidence in all the circumstances. Furthermore, the registrant will have the opportunity to set out her position in her own evidence.

Accordingly, the panel determined that it was fair to accept the Witness Statement of Witness 17 into evidence as hearsay and would determine its weight in due course.

Application to stay proceedings on basis of abuse of process

Following the conclusion of the NMC's case, Ms Mattin made a written application, in regard to charges 20 to 26, to stay proceedings on the following grounds:

1. That it will be impossible to give you a fair trial.
2. That it would be unfair to proceed in the context of the case for Lindisfarne as a whole.

In respect of the first ground, Ms Mattin submitted that the evidence of Witness 17 and Witness 20 were crucial to the Lindisfarne Care Home evidence because as Witness 17 was the Operations Director, her evidence as to the management, culture and whistleblowing complaints is crucial. She submitted that Witness 20 was the Area Manager at the relevant time. She submitted that you raised issues of

victimisation and bullying from members of staff at the Home with both of these witnesses prior to the formal grievance being submitted.

Ms Mattin submitted that the investigation which is meant to have been conducted by Witness 17 was the basis of the written statements of the other Lindisfarne witnesses. She submitted that no report has been provided and there is reference to a number of materials which have never been disclosed. She submitted that a whistleblowing complaint is at the heart of this case. In her written submission she stated:

> *'The NMC disclosed the complaint to the Registrant in the course of these proceedings. Its significance is not only supporting the Registrant's case that Lindisfarne had a toxic culture, characterised by bullying and staff cliques, but that it was the trigger for an 'investigation' into the Registrant which was flawed and fundamentally comprised the evidence taken from this select group of staff. There is no evidence of an investigation into anyone but the Registrant following the anonymous complaint.'*

Ms Mattin submitted that the issues in regard to the charges that relate to Lindisfarne go further than merely criticising an investigation and giving a partial picture of the home. She submitted that the evidence of the witnesses who gave live evidence is contaminated by the way the investigation was conducted. She submitted that your case is that you were bullied and victimised at Lindisfarne, and this can no longer be explored with Witness 17.

Ms Mattin then addressed the second ground, namely that it would be unfair to proceed in the context of the case for Lindisfarne as a whole. She submitted that you have had to bear the burden of the NMC's shambolic preparation of evidence and witnesses. She stated that the burden is on the NMC to prove this case, but that it had been held together by ad hoc and successive hearsay applications, each of which was heard without any indication of how many more were to follow.

Ms Mattin submitted that it had been clear throughout these proceedings, that Witness 17 would be required at the conclusion of the Lindisfarne witnesses. She submitted that the NMC were aware on 14 September 2023 that Witness 17 was only warned for one day, however, this was not communicated to you. It was also evident from the beginning of these proceedings that warning a witness for a single day was not a sensible or practical way forward. She submitted that the NMC had over six weeks to present their case and if Witness 17 has disengaged even in part through frustration with the NMC, they must bear some responsibility for that.

Ms Mattin submitted that you should have known the case against you before it proceeded and that the manner in which the case has proceeded presented a clear injustice to you. She concluded that everything that has transpired, has created such a position of unfairness that proceedings should be stayed as an abuse of process.

Mr Cobb also made a written submission to the panel. He stated that he understood that the basis for the abuse of process application was that fundamentally, in the absence of an opportunity to cross-examine Witness 17 and Witness 20, whose evidence was admitted by the panel as hearsay, this part of the proceedings was rendered irrevocably unfair to you.

Mr Cobb submitted, however, that four witnesses had been heard and cross-examined in these matters and that the evidence supports the allegations set out in charges 20 to 26. He submitted that it is against this evidence, that it is your case that the inability to cross-examine Witness 17 and Witness 20 renders this chapter of proceedings so unfair that it would be an abuse of process to continue. However, he submitted that on many occasions the live witnesses had put to them your account of what is alleged in charges 20 to 26, or in some cases your denial of these events. Accordingly, he submitted that the panel can assess the evidence of the NMC witnesses overall fairly.

In regard to the whistleblowing complaint being "*at the heart of this case*", Mr Cobb submitted that the various internal statements previously mentioned were obtained during an investigation and were adjuncts to the Witness Statements obtained by the NMC independently. Furthermore, the NMC Witnesses were cross-examined on both sets of statements. He also submitted that the investigation which was undertaken by Witness 17 did not make any finding of sexual harassment by you, but only breaches of the home's Dignity at Work Policy. He submitted then that this outcome does not go to prove or disprove any of charges 20 to 26.

In regard to the proceedings, Mr Cobb submitted the following in his written submission:

> '*While it is fair to remark that the proceedings in this case have been unsatisfactory, with considerable problems arising in having Witnesses attend at the times and in the order intended, there is no issue of the evidence on which the NMC rely being withheld or produced in a surprise manner. Again as noted, Disclosure requests made on several occasions by the Registrant have been met, and on occasion applied to presenting the Registrant's case.*'

In conclusion, Mr Cobb submitted that the panel must bear in mind the public interest in the investigation of the charges. He submitted that this application does not achieve the kind of exceptional circumstances cited as necessary to stop the consideration of this chapter of evidence. Accordingly, he invited the panel to reject the abuse of process submission application.

The panel heard as did the parties and accepted the written advice of the legal assessor. The legal assessor directed the panel's particular attention to the NMC guidance on abuse of process. He advised the panel that an abuse of process is something it determines is so unfair and wrong that the court should not allow a

regulatory hearing to proceed. The legal assessor further advised, in line with NMC guidance, that this power may only be exercised in these possible circumstances:

- It will be impossible for the Registrant to have a fair hearing

- Continuing the case would, in all the circumstances, offend the Panel's sense of justice and propriety.

The panel considered the application of Ms Mattin. The panel first considered whether the issues raised in this case were the result of misadministration or was a deliberate course of conduct by the NMC to frustrate the ends of justice. The panel concluded that while the scheduling and hearing of witnesses in this case had been both frustrating to everyone and unsatisfactory in that hearsay applications were not made together or at an early stage, it was the result of administrative shortcomings within the NMC rather than bad faith by them. It was not the role of the panel to seek to punish the NMC for those failures by allowing this application.

The panel therefore went on to consider whether the administrative failures in this case would make it impossible to give you a fair hearing.

The panel concluded that Witness 20's evidence speaks only to charge 20a and as the panel has heard other evidence from live witnesses whose evidence which does speak to this charge. Those witnesses have been the subject of cross examination by your own counsel.

In regard to Witness 17 giving evidence, the panel determined that it is clear that she has not disengaged from these proceedings, it is just that she is unavailable. There was nothing before it to suggest that she did wish to disengage. The panel understands that she would be available to attend and give evidence from 18 October 2023, and was willing to do so.

You have made no application to adjourn the proceedings to enable the witness to attend.

The panel considered that its primary concern at the stage was in respect to the fair presentation of the case and its overarching duty to protect the public. The panel concluded that the two witnesses, whose evidence had already been admitted as hearsay, generally did not directly address charges 20 to 26. Furthermore, any potential unfairness would be addressed within the regulatory process namely, by the weight attached to that evidence, by you giving evidence herself under affirmation, if you wish, and by calling witnesses of your own.

The panel then considered that the four live witnesses who have attended these proceedings attested to the facts of the case and have been cross examined, spoke directly to the allegations subject to this application.

The panel determined that the NMC's accepted administrative failures do not reach the high bar required to establish an abuse of process nor did it justify the panel in taking the exceptional course of staying the charges the subject of the application.

The panel therefore further concluded, in line with the NMC guidance on abuse, that it would be contrary to the interests of justice and unfair not proceed with these charges. It would be a serious failure of the panel's duty, having heard all the evidence in this case, not to consider them.

Accordingly, the panel was satisfied that considering all the arguments ably advanced by both counsel before them that it was not "*impossible*" for you the receive a fair hearing in this case in relation to the charges complained of.

Further and finally the panel was not satisfied that its sense of justice and propriety would be "*offended by*" allowing this case to proceed in respect of these charges and

determined to refuse this application to stay proceedings as an of an abuse of process.

Decision and reasons on application to amend the charge

The panel proposed on its own volition, to amend charge 12e in order to reflect the evidence more accurately. The panel proposed to add '*whilst employed as a Registered Manager at Appletree Hospital*' to the stem of the charge and to insert the word '*immediate*' ahead of '*Life Support Training*' in the limb of 12e.

Mr Cobb did not oppose the proposed amendments.

Ms Mattin submitted that whilst she did not oppose the proposed amendment to the stem of the charge, she did oppose the addition of the word '*immediate*' being added ahead of '*Life Support Training*' in the limb of 12e. She submitted that this amendment would cause unfairness as previous witnesses were not able to be cross-examined in regard to this wording.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such amendments were in the interest of justice and more fully reflected the evidence and the public protection issues identified. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. The panel was of the view that you may also address this in your oral evidence. The panel therefore concluded that it was appropriate to allow the amendments to ensure clarity and accuracy. Charge 12 will now read:

> "12. Between 1 May 2017 and 25 June 2018 **whilst employed as a Registered Manager at Appletree Hospital**, failed to protect staff and patients by:

a) admitting patients into Appletree who were unsuitable for a rehabilitative environment as a result of their mental illness;
b) failing to ensure that staffing levels were sufficient to meet the needs of the patients;
c) failing to ensure the presence of responsible clinicians between 11 May 2018 and 23 May 2018;
d) failing to support staff that had been subjected to violence by patients by not following appropriate procedures;
e) failing to ensure that staff had completed **immediate** Life Support Training before using rapid tranquilisation"

Decision and reasons on application of no case to answer

The panel considered an application from Ms Mattin that there is no case to answer in respect of charges 1e, 1f, 4c, 12e, 13, 14, 15, 18c, 18d, 19a, 19e. This application was made under Rule 24(7).

In relation to this application, Ms Mattin provided detailed written submissions to the panel in which she drew its attention to the following case law that may guide it in its consideration, namely: *R v Galbraith* [1981] 1 WR 1039 and *R v Shippey* [1988] Crim LR 767. Accordingly, she submitted that there should be no case to answer on charges in which the following are applicable:

R v Galbraith [1981] 1 WR 1039

'Limb 1 - If there is no evidence that the crime alleged has been committed by the defendant… the judge will ... stop the case.

Limb 2 - Where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is

inconsistent with other evidence…the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is [the judge's] duty, upon a submission being made, to stop the case.'

R v Shippey [1988] Crim LR 767

'"Where the state of the evidence, taken as a whole, is so unsatisfactory, contradictory, or so transparently unreliable, that no jury properly directed could convict upon it."'

Ms Mattin submitted detailed evidence in her written submissions for the panel's consideration and submitted that if the legal test as set out as above is applied there is no case to answer with respect to the charges listed above. She submitted that insufficient evidence has been presented to find the facts of the identified charges proved.

Mr Cobb also provided written submissions to be considered by the panel. He submitted that the standard for considering the no case to answer application is the balance of probabilities as established in the case of *Pope v General Dental Council* [2015] EWHA 278 (Admin).

Mr Cobb submitted that in regard to charges 1e, 4c, 12e, 13, 14, 15, 18c, the matters raised by Ms Mattin do not undermine the evidence submitted by the NMC and that the application for no case to answer should be rejected. However, the NMC did not oppose the submission of no case to answer in respect to charges 1f, 18d, 19a, 19e.

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

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

Charge 1e

> That you, a registered nurse between October 2017 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague D in that you disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by Occupational Health.

Ms Mattin's written submissions stated that:

> '*…there is no evidence that the registrant was aware of the occupational health report's recommendation for a stool or had the opportunity to implement the request in the one week between the [Occupational Health] report.*'

During cross examination, however, Colleague D said that she requested a stool, and that you verbally refused the request ahead of the occupational support letter being produced. The panel took into account that the stem of this charge is in regard to the general working conditions at Appletree and whether or not bullying or intimidation had occurred in this instance. There is no contemporaneous documentation before the panel, other than the occupational support letter, to demonstrate whether the request was made and denied. Therefore, the issue becomes a question of reliability between the witness and you. The panel determined that there is, when taken as a whole, contextual evidence that goes toward this charge. In regard to the reliability of the evidence of Colleague D, the panel will address this in due course. Accordingly, the panel is satisfied that all of this can be addressed at the fact finding stage and rejected the no case to answer application for charge 1e.

Charge 1f

> That you, a registered nurse between October 2017 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague D in that you put Colleague D on the rota to complete night shifts despite the recommendation made by Occupational Health.

The panel accepted the submissions of Ms Mattin and noted that the NMC did not oppose the application in relation to this charge. The panel then reviewed the evidence and accepts that it is not sufficient to consider this charge in line with Limb 2 of Galbraith. Accordingly, the panel accepted the no case to answer application in respect of charge 1f.

Charge 4c

> That you, a registered nurse between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that you failed to provide Colleague E with all relevant training including, but not limited to violence and aggression training.

The panel is satisfied that there is enough evidence to consider this charge at the fact finding stage. The panel took into account the job description for the role of Registered Manager at Appletree Hospital exhibited at .../1, and the oral evidence given by Colleague E, which is in the written transcript, at page 210. In this evidence, she states that staff had not received appropriate training to deal with violent residents at the Home.

Accordingly, the panel determined not to grant the application in relation to charge 4c. The panel will consider whether any failure to provide all relevant training amounts to bullying or intimidation, in the wider context, at the fact-finding stage.

Charge 12e

> That you, a registered nurse, between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital, failed to protect staff and patients by failing to ensure that staff had completed immediate Life Support Training before using rapid tranquilisation.

The panel noted that Witness 7 gave evidence that the practice of rapid tranquilisation occurred at Appletree Hospital and that it should be ensured that staff have immediate life support training when this occurs as evidenced in paragraphs 105 to 109 of her witness statement.

The panel noted from the evidence that it was the decision of Cygnet Health Care group not to train the staff at Appletree in immediate life support training. However, the panel was of the view that the public protection issue identified in this charge is not that you had withheld appropriate training but that you allowed rapid tranquilisation without the proper training to support this. In light of the evidence before it and its duty to protect the public, the panel was not satisfied that there was no case to answer in relation to charge 12e and denied the application.

Charges 13, 14, 15

> 13. On 8 May 2018 you misused the petty cash fund by submitting a claim for £108.00 for garden plants which were not purchased for the Home as you suggested;
>
> 14. Your actions at charge 13 above were dishonest in that you knew you were not entitled to take money from petty cash but did so anyway.

15. On an unknown date in 2018, you misused the petty cash fund by submitting a claim for a pair of trousers without following the correct procedure for petty cash payments;

The panel considered these three charges individually and determined that in every case the evidence was so weak, vague, and/or contradictory, in keeping with the standard set out in the second limb of Galbraith, that there was not a realistic prospect that it would find the facts of charges proved.

The panel accepted Ms Mattin's submissions in regard to these charges. Based on everything before it, the panel could not find these charges proved based on the evidence before it and accepted that there was no case to answer in relation to charges 13, 14, and 15.

Charge 18c

That you, a registered nurse on 7 September 2020, whilst the Nurse in Charge at Barrington Lodge failed to conduct 30 minute observations of Resident A.

The panel first considered that the evidence led by the NMC was Witness 10, who was the care assistant on duty at the time of incident, but due to time that had passed since the incident, she could not recall many of the details. However, the panel determined that the contemporary evidence, exhibited at [Witness 16]/18 undermines the charge, as it indicates that there were 30-minute observations in place for this patient at the time. The panel concluded, in keeping with the case of *Shippey*, that the state of the evidence, taken as a whole, was both unsatisfactory and contradictory and that it could not find the facts of the charge proved. Accordingly, the panel accepted that there was no case to answer in relation to charge 18c.

Charge 18d

> That you, a registered nurse on 7 September 2020, whilst the Nurse in Charge at Barrington Lodge failed to inform care assistant to conduct regular observations of Resident A during the course of your shift.

The panel accepted the submissions of Ms Mattin and noted that the NMC did not oppose the application in relation to this charge. The panel then reviewed the evidence, namely that Witness 10 recalled in cross examination that you had handed her an observation form to complete, and accepted that there is not sufficient evidence to consider this charge in line with Limb 1 of Galbraith. Accordingly, the panel accepted the no case to answer application in respect of charge 18d.

Charge 19a

> That you, a registered nurse, following Resident A's fall you failed to follow the correct procedure in that you did not make a record of the fall in Resident A's care records.

The panel accepted the submissions of Ms Mattin and noted that the NMC did not oppose the application in relation to this charge. The panel then reviewed the evidence, including the exhibit of Resident A's care notes at .../12 and the evidence of Witness 16. The panel concluded that the contemporaneous notes did contradict the charge in that the resident was being monitored following the correct procedure according to the care notes. Accordingly, the panel found there was no case for you to answer in relation to charge 19a.

Charge 19e

> That you, a registered nurse Following Resident A's fall you failed to follow the correct procedure in that you did not make an entry to confirm whether Resident A's next of kin had been informed about the fall.

The panel accepted the submissions of Ms Mattin and noted that the NMC did not oppose the application in relation to this charge. The panel then reviewed the evidence and noted that you had made an entry to confirm that Resident A's next of kin had been informed. Furthermore, the panel noted that Witness 16 conceded in cross examination that Resident A's daughter had been informed and that this was documented in the communication record. Accordingly, the panel found there was no case for you to answer in relation to charge 19e.

Background

You joined the register in 2006 as a Registered Mental Health Nurse ('RNMH'), the concerns in this case relate to two referrals outlined below.

At the time the initial concerns arose, you were employed as Hospital Manager and Registered Manager at Appletree Hospital ('Appletree'), a 26 bedded secure female mental health hospital that was part of Cambian Healthcare. You initially started working at the hospital in October 2012 as a Senior Staff Nurse. You became Head of Care at Appletree in November 2013 and Hospital Manager and Registered Manager in August 2014. Through a gradual merger process throughout 2018, Cygnet Group took over the operation of Appletree from Cambian (then known as CAS).

On 8 and 9 May 2018, the Care Quality Commission ('CQC') carried out an inspection of Appletree and the hospital received an overall rating of '*Good*'. Between April and June 2018, the CQC and Cygnet Group received three separate whistleblowing complaints regarding Appletree from former employees, including allegations made against you. As a consequence, you were suspended and an investigation was commenced.

Subsequently, the CQC carried out a further inspection of Appletree on 26 and 27 June 2018. The report raised the following concerns:

- Very high staff turnover;
- Several unsuitable patients had been admitted to Appletree;
- A high level of incident reporting for a rehabilitation unit;
- A high level of assaults, either on staff or peer to peer; and
- Incidents that were not appropriately reported to the CQC.

In addition, the investigation into the whistleblowing complaints identified a number of further concerns which included: the frequency of supervision and accuracy of supervision documentation, a lack of debrief following assaults, inadequacy of staff training, existence of a blame culture, and inappropriate behaviour and use of foul language towards staff and patients. You denied all allegations put to you during the local investigation.

A disciplinary hearing led to your dismissal for a failure to notify the CQC of reportable incidents as required under the Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009. Your appeal against this decision was rejected.

The regulatory concerns identified by the NMC in relation to your role of Registered Hospital Manager at Appletree are the subject of charges 1 to 17.

You commenced employment as Deputy Manager at Barrington Lodge (‘Barrington’) part of Four Seasons Health Care (‘FSHC’), on 10 June 2019. Allegations about your practice here came to light as the NMC investigated the earlier referral.

Concerns were raised regarding your management of a patient on 7 September 2020. It is alleged that you failed to attend an emergency situation in a timely manner to ensure that appropriate clinical observations were undertaken, and to maintain adequate records. Following a disciplinary hearing held on 5 October 2020, you were

dismissed from Barrington. The regulatory concerns identified by the NMC in relation to your practice at Barrington are the subject of charges 18 and 19.

The second referral regarding your practice was received by the NMC on 13 December 2021 from Witness 17, who was the Operations Director at Lindisfarne Care Home ('Lindisfarne'), part of the Gainford Care Home Group. At the material time, you were employed as a Deputy Home Manager. Lindisfarne commenced an investigation in respect of allegations made against you and you were suspended from duty towards the end of November 2021. Whilst you were suspended, the CQC received an anonymous letter of concern about Lindisfarne. The letter made a number of allegations about staff. When staff members were interviewed by Witness 18 on 7 and 8 December 2021, allegations were made about your sexual harassment of colleagues and inappropriate behaviour. It is your case that you were subject to bullying whilst working at Lindisfarne which you detailed in a statement/ diary on 18 November 2021. You resigned from Lindisfarne on 12 January 2021. The regulatory concerns identified by the NMC in relation to your practice at Lindisfarne are the subject of charges 20 to 26.

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 Cobb and by Ms Mattin.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Colleague D: Registered Nurse at Appletree, at the time of the allegations.
- Colleague E: Hospital Administrator at Appletree, at the time of the allegations.
- Colleague F: Registered Nurse at Appletree, at the time of the allegations.
- Colleague G: Support Worker at Appletree, at the time of the allegations.
- Witness 5: Registered Occupational Therapist at Appletree, at the at the time of the allegations.
- Witness 6: Lead Registered Occupational Therapist at Appletree, at the time of the allegations.
- Witness 7: Regional Quality Assurance Manager for Cygnet Health Care, at the time of the allegations.
- Witness 8: Regional Operations Director for Cygnet Health Care, at the time of the allegations.
- Witness 9: CQC Inspection Manager, at the time of the allegations.
- Witness 10: Care Assistant, at Barrington Lodge at the time of the allegations.
- Witness 14: Health Care Assistant, at Barrington Lodge at the time of

allegations.

- Witness 16: Regional Support Manager, at Four Seasons Health Care, at time of the allegations.
- Witness 17: Operations Director at Lindisfarne, at the of the allegations.
- Witness 19: Senior Care Assistant at Lindisfarne, at the of the allegations.
- Witness 20: Care Home Manager at Lindisfarne, at the of the allegations.
- Colleague A: Handyperson at Lindisfarne, at the of the allegations.
- Colleague B: Deputy Manager at Lindisfarne, at the of the allegations.
- Colleague C: Senior Care Assistant at Lindisfarne, at the of the allegations.

The panel also heard oral evidence from the following witness, on your behalf:

- Witness 15: A friend and Domestic Cleaner at Lindisfarne, at the time of the allegations.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Ms Mattin.

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

Charge 1a)

1) Between October 2017 and May 2018, whilst employed as the Registered Manager at Appletree Care Home, you bullied and/or intimidated Colleague D in that you:
   a) on more than one occasion spoke to Colleague D in a rude and sarcastic manner;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D and your evidence, together with the background of Colleague D's whistleblowing complaint to the CQC.

The panel was satisfied that in order to prove this charge, the NMC must show that you spoke to Colleague D in a rude and sarcastic manner on more than one occasion, and that this amounted to bullying and/or intimidating Colleague D.

The panel observed that the NMC provided no contemporary documentary evidence to support this specific charge. There was no direct support for this charge from any other NMC witness.

The panel noted that the only specific allegations made by Colleague D that you had spoken to her rudely were:

- Using the nickname “Old Duffa” on unspecified occasions;
- in respect of the arrival of an admission on her last working day on 3 May 2018; and
- in respect of her allegation that you demanded that she carry a chair to a meeting room on the same day.

All of these incidents are the subject of separate charges in these proceedings and therefore to find this sub-charge proved in relation to any of these incidents would risk duplication.

The panel found that there was insufficient evidence to find that you had spoken to Colleague D on more than one occasion in a rude and/or sarcastic manner. The charge could therefore not be found proved in relation to bullying or intimidating conduct towards Colleague D.

Charge 1b)

1) Between October 2017 and May 2018, whilst employed as the Registered Manager at Appletree Care Home, you bullied and/or intimidated Colleague D in that you:
    b) blamed Colleague D for incidents without carrying out an investigation;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D and your evidence, together with the background of Colleague D’s whistleblowing complaint to the CQC.

The panel was satisfied that in order to prove this charge, the NMC must show that you blamed Colleague D for incidents without carrying out an investigation, and that this amounted to bullying and/or intimidating Colleague D.

The panel found that there was no evidence upon which it could find that Colleague D was blamed in any way for the incident relating to the take away: Colleague D was not on shift at the time and she accepted that her knowledge of this incident was second-hand.

The single incident on which Colleague D gave evidence in support of this charge related to her inability to get hold of an out of hours doctor during a shift on an unknown date. She said that afterwards you had told her that you had sent an email regarding a change in the doctors' rota, and had blamed her for not reading the email, whereas she was sure that she had not received the email. In your evidence, you recalled that you were on call that day, and observed that Colleague D had not contacted you when she was unable to access the doctor. You denied that there was any attribution of "*blame*" when you had informed Colleague D that an email had been sent about the change. You explained that the Medical Director was responsible for changes to the doctors' rota, rather than you. The panel accepted your evidence on this matter.

The panel found that there was insufficient evidence to prove that you had blamed Colleague D for incidents without carrying out an investigation. That being the case, the charge could therefore not be found proved in relation to bullying or intimidating conduct towards Colleague D.

Charge 1c)

1) Between October 2017 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague D in that you:

c. referred to colleague D as an "Old Duffa"

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague D and your evidence, together with the background of Colleague D's whistleblowing complaint to the CQC.

The panel was satisfied that in order to prove this charge, the NMC must show that you referred to colleague D as an *'Old Duffa*', and that this amounted to bullying and/or intimidating Colleague D.

The panel noted that Colleague D gave evidence that you had referred to her on more than one occasion as an '*Old Duffa'*. Although the panel took into account that under pressure of giving oral evidence, under cross-examination now, five years after events, Colleague D's memory appeared to become less clear. The panel took particular account of the clear and unambiguous statement made by Colleague D in her witness statement taken three years closer to the time of events, that you had referred to her in this way.

The panel also took into account that it had heard evidence from various sources during the proceedings about the culture of "*banter*" at Appletree, and your use of inappropriate language. In the light of this contextual evidence, the panel was not persuaded by your denial that you had not referred to Colleague D in this way. In the circumstances, the panel found that it was more likely than not that you had referred to Colleague D as an *'Old Duffa'*.

The panel went on to consider whether this should be considered conduct by which you had bullied or intimidated Colleague D. The panel considered the NMC guidance titled '*How we determine seriousness'* (Reference: FTP3, last updated 27 February 2024), specifically, the section titled 'Discrimination, bullying, harassment and

victimisation', in this respect. It determined that *'Old Duffa'* was a derogatory term used for an older person who was incompetent, stupid, or slow to learn, and that as this was unwanted, offensive and insulting, this did constitute bullying. The panel noted Colleague D's evidence that it happened *'weekly'* and found this to illustrate a likely pattern of behaviour.

The panel therefore finds this sub-charge proved.

Charge 1d)

1) Between October 2017 and May 2018, whilst employed as the Registered Manager at Appletree Care Home, you bullied and/or intimidated Colleague D in that you:
   d) created an unsupportive work environment;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D and your evidence, together with the background of Colleague D's whistleblowing complaint to the CQC.

The panel was satisfied that in order to prove this charge, the NMC must show that you created an unsupportive work environment, and that this amounted to bullying and/or intimidating Colleague D.

The panel observed that Colleague D gave evidence that she found the environment to be unsupportive, with *'passive aggressive management',* but that she was unable to give specific examples of when she herself had experienced this, other than in relation to not having been able to get hold of the out of hours doctor and subsequently being '*blamed* ' for not reading the email. The panel observed that much of the evidence offered by the NMC to support this charge was non-specific in

nature, and related to an investigation conducted sometime after Colleague D's departure from the hospital, with which Colleague D was not involved.

The panel acknowledged that you did not accept that you had created an unsupportive work environment for Colleague D, or more generally. You gave evidence that it was Ms 1 who had day-to-day responsibility for the management of the nurses (of whom Colleague D was one), and that you spent considerable amounts of time away on hospital business and in meetings. The panel found your evidence on this matter to be credible, and largely supported by the findings of the CQC inspection in May 2018, by which time it noted that you had been Hospital Manager for four years. The panel heard that although the internal investigation had uncovered that staff at Appletree did have concerns about management, both the investigator (Witness 7) and a senior manager who gave evidence to the panel (Witness 8) felt that it was plausible, with hindsight, that you had been made a scapegoat for the cultural issues identified in the investigation.

The panel noted that Colleague D's probationary review documentation indicated that she had not found it easy to work at Appletree, and that she had been supported by colleagues and management during her employment. The panel noted that evidence indicated that Ms 1 had determined that Colleague D's performance during her time at Appletree was below the expected standard, which Colleague D did not accept, and noted Colleague D's tendency to direct her criticisms to *"the Head of Care and the Manager*" rather than to either person specifically. The panel had concerns that the chain of command, and where different responsibilities sat, may not have been clear to Colleague D and observed that her expectations of the Hospital Manager's input into her role may have been unrealistic.

The panel accepted your evidence that you were not Colleague D's line manager, and did not have much to do with her due to your other responsibilities.

The panel found that there is insufficient evidence to find that you created an unsupportive work environment. The charge could therefore not be found proved in relation to bullying or intimidating conduct towards Colleague D.

Charge 1e)

1) Between October 2017 and May 2018, whilst employed as the Registered Manager at Appletree Care Home, you bullied and/or intimidated Colleague D in that you:

    e) disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by occupational health;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D and your evidence, together with the background of Colleague D's whistleblowing complaint to the CQC.

The panel was satisfied that in order to prove this charge, the NMC must show that you disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by occupational health, and that this amounted to bullying and/or intimidating Colleague D.

The panel noted that Colleague D was clear in her oral evidence that Ms 1 had asked her to make her request for a stool through Occupational Health, and that the letter Colleague D obtained from Occupational Health related to an assessment on 24 April 2023, around a week before her last shift at Appletree Hospital. The letter was addressed to Colleague E. There was no evidence on the date when this was received by Appletree Hospital, or by you specifically.

You gave unchallenged evidence that the letter would have been for the attention of Ms 1, as Colleague D's line manager, rather than for you, and that you had no knowledge of the letter. Further, the panel observed that Colleague D's evidence was that there was no mention of the letter before she left, rather than that her direct request was denied after the letter was received. Additionally, Colleague D accepted in evidence that she could potentially have obtained a stool herself from elsewhere in the building.

The panel found that there was insufficient evidence to find that you had disregarded Colleague D's request for a stool in the clinical room despite the recommendation made by occupational health. The charge could therefore not be found proved in relation to bullying or intimidating conduct towards Colleague D.

Charge 2

2) On more than one occasion, following incidents of physical assaults by patients on Colleague D, you failed to deal with these incidents in a proper and appropriate manner by failing to:
    a) check if, following such incidents of assault, Colleague D was fit to work;
    b) conduct debrief meetings with Colleague D;
    c) conduct a risk assessment and provide support to Colleague D;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D, Witness 9 and your evidence.

The panel first noted that it had heard evidence about the policies and procedures in place at Appletree at that time regarding physical assaults on staff from Witness 9 and from you. This included that an incident form was required to be completed

following any assault on a member of staff by a patient; the Police to be informed if the incident was deemed an assault; and that no formal debrief was required, however some form of debrief was expected in the circumstances. The panel was of the view that the evidence it had heard was consistent and credible.

The panel noted that it had not been supplied with copies of any policies or procedures relating to incidents of assaults by patients on staff that were applicable to the organisation at the time.

Regarding incidents of physical assaults by patients on Colleague D, the panel noted that Colleague D's witness statement referred to two alleged incidents, as follows:

> *'In some time in the last week of April 2018 I was giving a patient her medication in the clinical room and, as I was handing her the medication pot, she suddenly punched me in the face. I am not able to recall the name of this patient …I completed and incident form and placed it on the meeting room table at handover, as is the procedure. However, neither the Registrant nor [Ms 1] said anything to me about the incident, there was no-debrief and they never asked if I was doing okay…*
> *On another occasion which I believe was around January 2018, I took a patient to a GP visit with the assistance of a support worker… when we arrived at the GP's office, the patient slapped me out blue when we were getting out of the vehicle…*
> *I completed and incident form for this incident as well, and placed it on the meeting room table at handover…'*

The panel noted that when Colleague D was asked about whether she had completed incident forms in respect of the alleged assaults, she stated *'probably'* and that she also accepted that she did not always complete incident forms. The panel noted that no incident forms had been provided by the NMC to support the charge,

and that there were no contemporaneous records to support Colleague D's statement that the alleged assaults had occurred.

In your evidence to the panel, you explained that you were not aware of Colleague D suffering assaults from patients, and that you believed that if Colleague D had documented these incidents, you would have been made aware of them. With reference to the second assault outlined by Colleague D, you told the panel that as the Registered Manager of Appletree you had a good working relationship with the GP practice, and if they were aware of this assault, you believed the practice would have informed you. The panel accepted your evidence in respect of this charge as it found that it was cogent and credible.

The panel found that there was insufficient evidence to support a finding that you had been made aware of any assaults by patients on Colleague D. The panel was satisfied that knowledge of the assaults would be a prerequisite for your ability to deal with such incidents appropriately.

You explained that in your role as the Registered Manager at Appletree you had overall responsibility for the hospital. However, you and Colleague D both confirmed that Ms 1 was Colleague D's direct line manager. The panel observed that the duty to carry out the tasks set out in sub-charges 2a) to 2c) was likely to rest with Ms 1, rather than with you, in accordance with the procedures spoken about.

The panel was satisfied that there was no evidence that you knew about any assaults by patients upon Colleague D. Further, it found that if those assaults did take place, the primary duty to support Colleague D would be likely to rest with Ms 1 as Colleague D's manager, rather than with you as Hospital Manager.

Accordingly, the panel finds this charge not proved.

Charge 3

3) On 3 May 2018 you:

a) spoke to Colleague D in an aggressive manner;

b) pushed a chair towards Colleague D and demanded that Colleague D carried it to the meeting room;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague D, your evidence and the documentary evidence before it.

In relation to charge 3a), the panel noted Colleague D's statement as follows:

> *'[…] around 12:30pm […] just as soon as I sat down, the Registrant entered the cafeteria and shouted at me in an aggressive tone "your admission is here". I replied that I was just getting something to eat and following this the Registrant just walked out of the dining room[…]*
> *In the middle of the morning, the Registrant was re-arranging some of the furniture, ready for the [CQC] inspection and as I passed her in the middle of this busy day, she pushed a chair in my way and demanded I carried it out to the meeting room in the reception area.'*

The panel noted that in her oral evidence, Colleague D accepted that she may have felt *'oversensitive'* during this shift, in the context of what was a very busy and challenging day. Taking into consideration the evidence it had heard from Colleague D regarding the context of the working environment and how she was feeling at the material time, the panel was of the view that it was plausible for Colleague D to have misinterpreted your tone when you delivered the news that her admission had arrived.

The panel noted that in evidence, you accepted that you had informed Colleague D that her admission had arrived, as you said that she needed to be made aware of this. You deny that you spoke to Colleague D in an aggressive manner.

The panel also had regard to the notes of Ms 1's local investigation meeting conducted by Witness 7 on 6 July 2018. It noted that Witness 7 had asked Ms 1 about this alleged incident and recorded that Ms 1 had said:

> *'I remember that, [Colleague D] was having dinner. [Ms Aslett] said [Colleague D] to let you know and she slammed down knife and folk [sic] and said "So what am I supposed to do, eat faster?" [Ms Aslett] was not aggressive.'*

Whilst the panel accepted that this is hearsay evidence, it determined that weight could be attached to it as a contemporaneous account of this specific incident, which supported your evidence that you did not speak to Colleague D aggressively.

The panel considered that your evidence in respect of this sub-charge had been plausible and consistent. Therefore, the panel accepted your evidence and concluded that, you had not spoken to Colleague D in an aggressive manner on 3 May 2018.

In relation to sub-charge 3b), the panel noted that it had not been provided with any documentary evidence to support the assertion in the charge. It took into account that you deny pushing a chair towards Colleague D or demanding that she carry the chair to the meeting room, however you accept that it is possible that you may have asked her to do so. The panel bore in mind that the burden of proof rests upon the NMC and in the absence of further evidence, the panel was not satisfied that you had pushed a chair towards Colleague D and demanded that she carry it to the meeting room on 3 May 2018.

Accordingly, the panel finds this charge not proved in its entirety.

Charge 4a)

4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that:

    a) you created a hostile and/or unsupportive working environment for Colleague E;

This sub-charge is found NOT proved.

In considering this sub-charge, the panel took into account Colleague E's oral and written evidence, your evidence, and the documentary evidence available to it.

The panel heard that Colleague E, although an experienced administrator, had not worked within any clinical environment before she came to Appletree. The panel determined that the locked psychiatric environment of Appletree, which was clearly challenging at times even for experienced nurses, would have been a very unusual and unfamiliar context for Colleague E. The panel noted that Colleague E's witness statement, and complaint to the CQC, relied heavily on her opinion about the way things were being done at Appletree rather than factual examples of shortfalls she identified herself, and that she associated with a number of other staff at the hospital who were known to have had "*fallings-out*" with Ms 1 and you (particularly Colleague D, Colleague F, and Colleague G). The panel observed that it had been demonstrated that some of Colleague E's beliefs about what had happened at Appletree (for example, that Colleague F had been dismissed, and that you had referred him to the NMC) were incorrect. The panel noted Colleague E's evidence that she did not have a lot of contact with you at all during her employment at Appletree.

The panel accepted your evidence of the support offered and given to Colleague E to perform her role, and the lengthy induction process carried out for her. The panel did not find Colleague E's assertion that she had received "*no training whatsoever*" to be credible, and found that her expectations that the Hospital Manager might offer to cover Reception for her so that she could have a break, or directly assist her with administrative work, may have been unrealistic. The panel accepted your evidence that Appletree's support workers assisted with covering Reception, which Colleague E supported with her own evidence. The panel noted that you were not Colleague E's line manager.

The panel took into account the wider cultural issues at Appletree as identified in the subsequent investigation by Witness 7. However, whilst acknowledging that Colleague E had found Appletree to be a challenging work environment, it was satisfied that there was insufficient evidence to demonstrate that you had created a hostile and unsupportive working environment for Colleague E. Therefore the charge could not be found proved in relation to your bullying or intimidating Colleague E.

Charge 4b)

4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that:

> b) whilst en route to deal with an incident in relation to Colleague G, you said to Colleague E "I'm going to sort this little git" or words to that effect;

This sub-charge is found proved.

When considering this sub-charge, the panel took into account the evidence of Colleague E, your evidence, and the documentary evidence available.

The panel heard from Colleague E that you had made the comment in her presence as you were on your way to suspend Colleague G pending an investigation into her

conduct, and that this was the first incident of this sort with which she had been involved. The panel noted that you denied that you had made this comment in reference to Colleague G. However, it took into account the documentary evidence from the investigatory process that identified concerns about your inappropriate use of language, and found that it was more likely than not that you had made the comment heard by Colleague E.

The panel went on to consider whether this comment could be considered to have bullied and/or intimidated Colleague E. The panel felt that although the comment had not been aimed at Colleague E and could not be considered to be bullying her, it would have been considered by a reasonable objective person to be intimidating for Colleague E, and noted that Colleague E described that your demeanour at the time was "*serious/angry*". The panel was satisfied that the comment was intimidating to Colleague E. Accordingly the panel finds this sub-charge proved.

Charge 4c)

4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that:

c) failed to provide Colleague E with all relevant training including, but not limited to violence and aggression training;

This charge is found NOT proved.

When considering this sub-charge, the panel considered the oral and written evidence of Colleague E, and your evidence.

The panel noted Colleague E's discomfort about being encouraged to sit with the patients to have her lunch, and her belief that she needed some MAPA training (for managing violent behaviour) to be able to cope with any incidents that might occur. The panel accepted your evidence that it was not within your gift to organise training,

which was controlled higher up the organisational structure, and that it would not be usual to organise MAPA training for an administrator, but that Colleague E would have a personal alarm in case of any danger. The panel also noted that you were not Colleague E's line manager, who would ordinarily be the person to whom training requests would be directed, and that Ms 1 was responsible for organising training within Appletree. The panel noted Colleague E stated that she had raised the issue with Ms 1 and another staff member, but did not state that she had raised the matter with you.

The panel had no evidence before it that Colleague E was required to have any specific training as part of her role, or that it was your specific responsibility to provide that.

The panel therefore finds that there is insufficient evidence upon which to find that you failed to provide appropriate training for Colleague E. Therefore the charge could not be found proved in relation to your bullying or intimidating Colleague E.

Charge 4d)

4) Between January 2018 and May 2018 whilst employed as a Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague E in that:

> d) disclosed concerns that Colleague E had raised with you in confidence with other Colleagues;

This charge is found NOT proved.

In considering this sub-charge, the panel took account of the oral and written evidence of Colleague E, and your evidence.

The panel determined that Colleague E had made an assumption that you had breached her confidence with another colleague, when that colleague had observed

that Colleague E was “*stressed*” immediately after the colleague had been speaking with you outside. This was the foundation of the charge. You denied that you had breached Colleague E’s confidence, and observed that if you had noticed that Colleague E was stressed, the other colleague may have noticed that too.

The panel found that there was insufficient evidence in the circumstances upon which to find it likely that you had disclosed Colleague E’s personal confidential matters, and therefore the charge could not be found proved in relation to you bullying or intimidating Colleague E.

Charge 5

> 5) On an unknown date you used an inappropriate restraint method on a patient;

This charge is found NOT proved.

In reaching this decision, the panel took into account, the evidence of Colleague G, Witness 8 and your evidence.

The panel noted that Colleague G’s witness statement:

> *‘On a date that I do not recall, I witnessed the Registrant exercising in appropriate restraint on a patient …*
> *I witnessed the Registrant place [the patient] in a headlock and drop [the patient] down to the floor as a means of restraining [them]. This action is not an appropriate or safe method of restraint to use on a patient, and is not in line with the restraint training (MAPA Training) which is given to staff.*

Following this, the Registrant managed to close the door to [the patients] room and I am not aware of what happened following the exercise of this restraint. However, I am not aware that [the patient] suffered any injuries.'

The panel had regard to Colleague G's evidence, noting that she had spoken about her experience as a Support Worker at Appletree, the allegations made against her relating to inappropriate methods of de-escalation, and the subsequent disciplinary proceedings, which she felt that you had conducted unfairly. The panel did not consider Colleague G's evidence to be wholly neutral.

The panel considered whether there was any corroborating evidence to support Colleague G's account. The panel observed that it was not provided with any supporting contemporaneous documentation or records, despite Colleague G having spoken about others witnessing the incident. The panel considered that Colleague G's evidence that you had allegedly restrained the patient in a headlock and closed the door simultaneously, without any other person assisting, was not sufficiently credible.

The panel then considered your evidence in which you denied this allegation. You stated that you were well-trained in techniques of physical restraint, that two members of staff were always required to restrain a patient and that you would not attempt to do that alone. You stated that the "*headlock*" described by Colleague G was a highly inappropriate method of restraint and not one that you would use. The panel noted the evidence of Witness 8, who attested to your clinical skills and judgment and stated that you were '*careful and considered risk'*.

In all the circumstances, the panel was not satisfied that there was sufficient evidence before it to support that you had allegedly used an inappropriate method of restraint on a patient.

Accordingly, the panel finds this charge not proved.

Charge 6a)

6) During your employment as Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague F in that you:
   a) created a hostile and/or unsupportive work environment for Colleague F;

This sub-charge is found proved.

When considering this sub-charge, the panel considered the oral and written evidence of Colleague F, your evidence, the evidence of Colleague D and Colleague E, and the documentary evidence available.

The panel found Colleague F to be a credible and compelling witness, and found that the evidence he gave about his time at Appletree was balanced and considered. The panel accepted your evidence, supported by Colleague F in many respects, that Colleague F found elements of practice as a nurse at Appletree challenging, and had a history of disciplinary interventions. The panel was satisfied that you had given Colleague F a number of chances to improve his practice and to gain new skills. The panel found that the work environment for Colleague F was not an unsupportive one in an objective sense, although it acknowledged that it seemed so to him.

The panel acknowledged the evidence of Colleague D and Colleague E that they felt that Colleague F had not properly been supported, but noted that these colleagues may not have been aware of Colleague F’s employment record or the measures put in place to support him.

The panel noted Colleague F’s strong feeling that towards the end of his time at Appletree he was working in an environment in which he was constantly belittled both by you and Ms 1, and under considerable scrutiny, which he felt was unfair. He said, [PRIVATE] and that he felt “*consistently targeted*”. The panel acknowledged

that the evidence of Colleague D and Colleague E supported the suggestion that the working environment for Colleague F appeared hostile.

The panel accepted that Colleague F considered that you bore substantial responsibility for the working environment which he found damaging, whilst noting that you were not his line manager, and that many of the concerns in his evidence also related to the actions of Ms 1. The panel was satisfied that by your actions, you had created a hostile work environment for Colleague F.

The panel found that the conduct of which Colleague F complained fell within the definition of bullying in the NMC's guidance, in that it was undermining and humiliating behaviour that had caused [PRIVATE] to Colleague F, and that there is likely to have been a pattern of this behaviour over a period of time. The panel therefore found this sub-charge proved.

Charge 6b)

6) During your employment as Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague F in that you:
    b) referred to a colleague as a "nuisance" and asked another colleague how you could "get rid of her" or words to that effect;

This sub-charge is found proved.

When considering this sub-charge, the panel took into account the evidence of Colleague F and your evidence, and the documentary evidence produced for the purposes of the internal investigation. The panel acknowledged that there was no direct documentary evidence in support of this charge.

The panel noted that Colleague F stated that he remembered overhearing this interaction between you and Ms 1 as "*clear as day*", and "*very well*". The panel

acknowledged that you denied having had said the words alleged, and gave evidence that you were well-disposed towards the member of staff concerned who [PRIVATE]. However, on balance, and considering the wider evidence, the panel found that it preferred the evidence of Colleague F in respect of this sub-charge. The panel was satisfied that it was likely that you had made the comment alleged.

The panel noted that Colleague F gave this incident in support of what he felt was your bullying behaviour. It observed that while the comment was not aimed at Colleague F, it would have been likely to be intimidating for Colleague F to have witnessed you talking in this manner about a fellow staff member. The panel therefore finds this sub-charge proved.

Charge 6c)

6) During your employment as Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague F in that you:
    c) on more than one occasion said "oh it was you wasn't it [Colleague F]" and "[Colleague F]" or words to that effect;

This sub-charge is found proved.

When considering this charge, the panel took account of the oral and written evidence from Colleague F, and your evidence. The panel also considered the documents produced for the internal investigation.

The panel accepted Colleague F's clear evidence that you made the comments alleged. The panel found that his evidence was compelling on this point, and that it was plausible that what started as a joke or "*banter*" from you (as Colleague F referred to it), would have trickled down to become part of the culture of the working environment that Colleague F was exposed to, and which [PRIVATE]. The panel noted your evidence that you "*wouldn't blame him*", but found on the basis of all the

evidence that it was likely that you had used these words, or words to this effect, as alleged.

The panel was satisfied that the conduct referred to in the sub-charge amounted to bullying within the NMC's guidance, being undermining or insulting conduct that caused Colleague F [PRIVATE]. The panel therefore found this sub-charge proved.

Charge 6d)

6) During your employment as Registered Manager at Appletree Hospital, you bullied and/or intimidated Colleague F in that you:

    d) on more than one occasion blamed Colleague F for incidents without conducting an investigation;

This charge is found NOT proved.

When considering this charge, the panel took into account the evidence of Colleague F and your evidence.

The panel noted that you were not Colleague F's line manager, and that Ms 1 was. The panel observed that it would be likely that Ms 1 would have control over the question of whether to investigate clinical incidents for the nurses, including Colleague F. On this basis, the panel found the responsibility for commencing investigations did not sit with you and therefore found this sub-charge not proved.

Charge 7

7) On an unknown date during a BBQ for staff and patients you made inappropriate comments about patients and referred to them as "split arses" or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague G, your evidence and the documentary evidence before it.

The panel noted Colleague G's witness statement:

> *'on one occasion we hosted a barbeque at Appletree for the patients. The Registrant arrived and greeted some of the patients by saying "hello split arses". I thought that this was very inappropriate of the Registrant...'*

The panel acknowledged that Colleague G had been the only witness that provided evidence in respect of this specific allegation. However, it took into account the evidence before it about the culture of "*banter*" at Appletree in the documentary evidence from the investigatory process that supported concerns about your use of inappropriate language. The panel took into account that this was likely to have been a more social occasion, and as such perhaps produced an atmosphere of inappropriate informality.

In the light of this contextual evidence, the panel was not persuaded by your denial that you had not referred to patients in this way. Although the panel acknowledged that there was no evidence that Colleague G had raised this at the time, it concluded that as a result of the culture at Appletree, it was likely to have been difficult for Colleague G, a Support Worker, to raise this matter against you, the Hospital Manager.

In all the circumstances, the panel found that it was more likely than not that you had made inappropriate comments about patients and referred to them as "*split arses*" or words to that effect.

Charge 8

8) On more than one occasion, you displayed favouritism of some staff over others;

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence from the NMC's witnesses in respect of Appletree, and your evidence.

The panel acknowledged that there was a body of evidence before it that some staff found aspects of the working environment at Appletree difficult, and that there appeared to be multiple close-knit groups amongst the staff. The panel acknowledged that the general opinion of Colleague D, Colleague E, Colleague F and Colleague G, and shown in some of the interviews conducted for the investigation, was that you did display favouritism towards certain members of staff. The panel was mindful however, that this was opinion evidence, and that no objective evidence had been provided to support this assertion.

The panel noted that the witnesses did not make reference to any specific examples of where favouritism could clearly be shown, and found that it was likely that the opinions they shared were formed without full knowledge of all the circumstances. In the absence of cogent evidence, the panel could not be satisfied that you had displayed favouritism of some staff over others.

Accordingly, the panel finds this charge is not proved.

Charge 9a)

9) On more than one occasion, in relation to Colleague G, you:

a) were rude and abrupt;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague G, Colleague E, your evidence, and the documentary evidence before it.
The panel observed that Colleague G believed that you had become "*rude and abrupt*" to her after she had declined on one occasion to make you a cup of tea. However, the substance of this concern appeared to be the manner in which you had conducted an investigatory interview of Colleague G after she had been witnessed to be "*goading*" a patient. The panel noted that you were not involved in the disciplinary hearing relating to Colleague G, but that she had been dismissed, and an appeal against her dismissal was rejected. The panel observed that the notes of the meeting showed that Colleague G had been very upset at potentially losing her job due to her behaviour. The panel was satisfied that in these circumstances she could not be considered a reliable arbiter of whether the manner in which you conducted the interview could be considered "*rude and abrupt*".

The panel noted the evidence of Colleague E that did not indicate that you had been "*rude or abrupt*" to Colleague G when you suspended her from duties pending the investigation into her behaviour. Therefore, the panel could not be satisfied that you had been rude and abrupt to Colleague G.

Accordingly, the panel finds this charge not proved.

Charge 9b)

9) On more than one occasion, in relation to Colleague G, you:
   b) failed to support Colleague G with their workload despite frequently being asked for help and support;

This charge is found NOT proved.

In reaching this decision took into account the evidence of Colleague G, your evidence and the documentary evidence before it.

The panel noted Colleague G's witness statement:

> *' I felt that the Registrant was not a caring a supportive manager. The reasons I felt like this was due to experiencing her failing to support me on several occasions...'*

Colleague G was a Support Worker at the hospital. The panel noted its earlier findings regarding the line management for clinical staff at Appletree, in that, whilst you accepted overall responsibility for staff as the Hospital Manager, supporting staff would have line managers below you to whom they could go with concerns. The panel accepted that you were not Colleague G's line manager. In light of this, the panel did not find that it was your primary duty or responsibility to support Colleague G with their workload, and indeed that it would be unrealistic to expect that a Hospital Manager would directly support a Support Worker with their workload.

Accordingly, the panel finds this charge not proved.

Charge 10a)

> 10) On more than one occasion you engaged in inappropriate conduct towards staff in that you:
>
> > a) frequently swore in the presence of staff members;

This charge is found proved.

In considering this sub-charge, the panel took into account the oral and written evidence of Colleague E, Colleague F, Colleague G, Witness 5, Witness 7 and

Witness 8, and the documentary evidence produced. The panel also took into account your evidence.

The panel heard compelling oral evidence from Witness 5 regarding your inappropriate language, and in particular an incident that took place in a morning meeting where you had required everyone to say the word "*cunt*". The panel noted that Ms 1 also appeared to refer to this incident in Witness 7's investigatory meeting with her.

The panel observed that Witness 7 had identified that the investigation demonstrated that there were concerns among staff about your swearing. The panel noted that several staff members interviewed by Witness 7 and her predecessors in the investigatory process had raised concerns about your swearing and inappropriate use of language with colleagues, and that Witness 8 had stated in his investigatory interview that he "*had a chat with [Ms Aslett] around 7 months ago about swearing and toning it down".*

The panel noted that it had found to be credible the evidence given by Colleague D, Colleague E, and Colleague G about your use of inappropriate language and swearing. The panel noted the considerable amount of documentary evidence supporting the internal investigation (exhibited and referenced by Witness 7) that made reference to your inappropriate language and swearing in the workplace. The panel acknowledged that there was evidence that this behaviour made some of your colleagues uncomfortable.

In the light of the compelling evidence placed before the panel from a number of witnesses about your tendency to swear in the workplace in Appletree, the panel found that your denials lacked credibility.

The panel found it likely that you frequently swore in front of staff members at Appletree, and was satisfied that this represented inappropriate conduct.

Accordingly, this sub-charge is found proved.

Charge 10b)

10) On more than one occasion you engaged in inappropriate conduct towards staff in that you:

b) made inappropriate innuendos;

This sub-charge is found proved.

In considering this sub-charge, the panel took into account the oral and written evidence of Colleague E, Colleague F, Colleague G, Witness 5, Witness 7 and Witness 8, and the documentary evidence produced. The panel also took into account your evidence.

The panel noted the credible and compelling evidence of Witness 5 that you regularly used innuendos, which was supported by Witness 5's contemporaneous interview for the purposes of the internal investigation. The panel noted the evidence of Witness 7 that her investigation had identified this as a concern in your management of Appletree, and that Witness 7 had exhibited an interview with Witness 5, who had been uncomfortable to be the target of innuendos from you; the panel observed that Witness 8 had also referred in his investigatory statement to his knowledge of the incident referred to.

In the light of the considerable evidence placed before the panel about your tendency to make innuendos in the workplace in Appletree, the panel found that your denials lacked credibility.

The panel found it likely that you made innuendos in your workplace on more than one occasion, and was satisfied that this represented inappropriate conduct.

Accordingly, this sub-charge is found proved.

Charge 10c)

> 10) On more than one occasion you engaged in inappropriate conduct towards staff in that you:
>
> c) often spoke badly of patients;

This sub-charge is found NOT proved.

When considering this sub-charge, the panel took into account all of the evidence before it from the witnesses in respect of Appletree, and your evidence. The panel noted that the NMC conceded that it had not provided any direct evidence to support this specific sub-charge.

The panel was satisfied that there was insufficient evidence to support a finding that you often spoke badly of patients. The panel noted the evidence of Witness 5 and Witness 8 in particular that you were patient-focused. The panel accordingly finds this sub-charge not proved.

Charge 10d)

> 10) On more than one occasion you engaged in inappropriate conduct towards staff in that you:
>
> d) created a hostile and/or intimidating environment for staff;

This charge is found proved.

When considering this sub-charge, the panel took into account all of the evidence before it from the witnesses in respect of Appletree, and your evidence.

The panel noted its findings in respect of the specific working environments of Colleague D, Colleague E, and Colleague F as set out above. The panel noted that Witness 7 had identified concerns about the working culture at Appletree when you were Hospital Manager, and that a large number of staff had commented in their investigatory interviews that they found your somewhat unpredictable behaviour and foul language to be intimidating.

The panel noted that both Witness 7 and Witness 8 had said that in hindsight they considered that it was plausible that you had become a scapegoat for the issues at Appletree, that it was acknowledged had only become clear with the benefit of hindsight. However, the panel found that as Hospital Manager, it was your responsibility to set an appropriate professional tone and that you would have been responsible, in large part, for the culture at the organisation. The panel was satisfied that the weight of the evidence supported a finding that you created a hostile and intimidating environment for staff, and that this represented inappropriate conduct.

Accordingly, this sub-charge is found proved.

Charge 11

> 11) On an unknown date following an incident with a colleague, told a senior colleague to “go and sort that fucking cunt out” or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5, your evidence and the documentary evidence before it.

The panel noted Witness 5 witness statement:

> ‘*The Registrant could be very rude and inappropriate when speaking to and about staff members at Appletree. The Registrant liked to engage in banter with staff members, but only on her terms. I can think of a specific example of this which is as follows: the Registrant appeared to have a good relationship with a nurse named [Ms 2], and from what saw they appeared to banter often. However, on one occasion I was in the MDT office with [Ms 2], and the Registrant, and overheard [Ms 2], making a comment to the Registrant. I am not able to recall what [Ms 2], said to the Registrant, but the Registrant got angry about whatever it was that [Ms 2], said. Shortly following this, the Registrant entered [Ms 1]'s office (who was the head of care at the time) and told [Ms 1] something to the effect of "go and sort that fucking cunt out". I was present in [Ms 1]'s office when the Registrant said this. I knew that the Registrant was referring to [Ms 2], due to having witnessed her conversation with [Ms 2], in the MDT office moments prior to her outburst in [Ms 1]'s office. I thought this was very inappropriate conduct on the part of the Registrant.’*

The panel also had regard to Witness 5’s oral evidence which was consistent with his witness statement. In response to being asked whether Witness 5 could have been mistaken about what he had heard, as you do not accept stating this; Witness 5 responded “*No. That’s true to my knowledge, 100 percent”*. The panel was not persuaded by your evidence that you had not stated this. The panel also noted the evidence of other witnesses in this case in respect of your inappropriate use of language about and towards staff. In all the circumstances, the panel accepted Witness 5’s evidence as it found it credible and consistent. The panel was of the view that this compelling evidence illustrated a likely pattern of behaviour.

The panel found that it was more likely than not that you had told a senior colleague to “*go and sort that fucking cunt out*”. Accordingly, the panel therefore finds this charge proved.

Charge 12a)

12) Between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital failed to protect staff and patients by:

a) admitting patients into Appletree who were unsuitable

This sub-charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of Witness 7, Witness 8 and Witness 9, the evidence of the other NMC witnesses, your evidence, and the documentary evidence before it.

The panel acknowledged that the evidence relating to the process of admissions at Appletree was provided by you and by Witness 8. It was satisfied that that admissions to Appletree were determined by a multi-disciplinary team ('MDT'), and that the Responsible Clinician would have legal responsibility for each admission. The panel also noted your evidence that you did, on occasion, refuse admission to patients you considered unsuitable, and the evidence of Witness 8 who stated that he supported your right to decline patients whom you considered unsuitable because if things went wrong, the responsibility would fall on you.

The panel further acknowledged the evidence of Witness 8 that the patients at Appletree tended to be a challenging group by nature of their illnesses, and further that the clinical presentation of patients can change during their admission.

The panel acknowledged your evidence in respect of admissions of patients and particularly noted your reference with others to "*Friday fish market*" telephone calls. You told the panel that you felt under pressure by organisational management to admit more patients for financial reasons, and that both Witness 7 and Witness 8 had acknowledged the pressure that you were under to admit patients.

The panel noted that it heard conflicting evidence about the level of incidents at Appletree. It observed that although Witness 7 identified in her investigation that staff and patients did not always feel safe, and Witness 9 identified a high level of incidents in the CQC report, Witness 8 gave evidence that the level of incidents at Appletree was generally in line with those of other similar hospitals at the time.

The panel found that the evidence provided by the NMC for this charge was largely anecdotal, and that the NMC had not provided cogent evidence of any specific patients who, it alleged, you had inappropriately admitted to Appletree based on any objective criteria, or any cogent link between their admission and the alleged failure to protect any staff or patients.

Accordingly, the panel finds this sub-charge is found not proved.

Charge 12b)

> 12) Between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital failed to protect staff and patients by:
>
> > b) failing to ensure that staffing levels were sufficient to meet the needs of the patients;

This sub-charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of all of the NMC witnesses, your evidence, and the documentary evidence before it.

The panel acknowledged the evidence of Witness 9 that she had found Appletree's staffing levels to be requiring of improvement whilst you were Hospital Manager, and your evidence that you did not believe this to be correct but had not had the opportunity to challenge it in the factual accuracy process. It noted the evidence of Witness 8 that it was rare at that time for Appletree to fall below safe staffing levels.

The panel noted that it had received evidence that staff did not always feel safe at Appletree and that some witnesses felt that staffing levels were insufficient. However it was satisfied that the staffing levels required and recommended by the organisation were not within your control as Hospital Manager.

The panel found that it had insufficient evidence on which to find this sub-charge proved.

Charge 12c)

> 12) Between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital failed to protect staff and patients by:
>
> > c) failing to ensure the presence of responsible clinicians between 11 May 2018 and 23 May 2018;

This charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of Colleague D and Witness 9, the documentary evidence, and your evidence.

The panel noted that it had received evidence that the Medical Director was responsible for the doctors' rota, and that you were on annual leave for the majority of the period identified and were not made aware of any concerns. The panel noted that the Medical Director was involved in the departure of the Responsible Clinician on 11 May 2018 and would therefore have been aware of the need to ensure appropriate cover.

The panel found that it had insufficient evidence to support the charge that it was your responsibility to ensure the presence of responsible clinicians at the relevant time.

Charge 12d)

> 12) Between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital failed to protect staff and patients by:
>
> > d) failing to support staff that had been subjected to violence by patients by not following appropriate procedures;

This sub-charge is found NOT proved.

When considering this sub-charge, the panel took into account all of the evidence provided by the NMC's witnesses and the documentary evidence, and your evidence.

The panel noted that the CQC's inspection in May 2018 identified that '*Staff felt well supported following an incident and had access to formal and informal de-brief which was documented and supported by Psychology staff*'. The panel acknowledged that although Witness 7 had provided evidence that the staff did not always agree with this assessment, the NMC had provided no policy or procedure that it alleged that you had not followed.

The panel accepted your evidence of the process of debriefing and support that was usual at Appletree following an incident of this nature, which was primarily carried out by the clinical team underneath you who dealt with the management of staff on a day-to-day basis, and that this was in the process of being formalised towards the end of your tenure as Hospital Manager.

The panel found that it had insufficient evidence to find this charge proved.

Charge 12e)

12) Between 1 May 2017 and 25 June 2018 whilst employed as a Registered Manager at Appletree Hospital failed to protect staff and patients by:

e) failing to ensure that staff had completed immediate Life Support Training before using rapid tranquilisation;

This sub-charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of Witness 7, Witness 8, Witness 9, the documentary evidence and your evidence.

The panel noted that although all staff had basic life support training, Witness 7 recommended that immediate life support training be considered for introduction at Appletree because of the use of rapid tranquilisation. The panel noted that Witness 9 identified this as outside your control, and a "*provider issue*". It acknowledged that this evidence was supported by Witness 8's recollection that the debate about whether immediate life support training would be provided to staff at Appletree was going on at organisational level, and that training budgets were poor. Witness 8 noted that the training of staff met the CQC's requirements at the time.

The panel noted that the use of rapid tranquilisation on a patient would be prescribed by the doctor, and that all staff were trained in basic life support.

The panel was satisfied that the provision of staff training in immediate life support was not within your ability to provide, and on this basis finds this charge not proved.

Charge 16

16) Between 1 May 2018 and 25 June 2018 you breached Regulation 18(2) of the CQC (Registration) Regulations 2009 by failing to report 13 incidents to the CQC which included:

a) 10 incidents of assaults on patients;

b) 2 incidents of patients absconding from the Home;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witnesses 8 and 9, your evidence and the documentary evidence before it.

The panel had regard to Regulation 18(2) of the CQC (Registration) Regulations 2009 and accepted that this did impose a legal duty on you to notify the CQC of incidents. Notwithstanding this, the panel found that there was insufficient evidence before it in respect of the 13 incidents there were allegedly not reported, including ten incidents of assaults on patients and two incidents of patients absconding from the Home.

Witness 8 provided both oral and written evidence in respect of this charge and the panel noted that when challenged during cross-examination, Witness 8 did accept that you were an '*easy scapegoat'* for the issues arising from the CQC inspection. The panel also considered that the factual accuracy of this alleged failure detailed in the CQC report was challenged by Witness 8. In oral evidence, Witness 8 explained that, after your departure, he had written a response to the CQC on behalf of the organisation challenging the number of incidents that had allegedly not been reported because the organisation had identified '*repeated documentation, IR1's that were linked to the same incident'.* The panel also noted that one incident identified had taken place after your suspension. In all the circumstances, the panel was of the view that the evidence in respect of the number of incidents that were allegedly not reported was unclear and there was also insufficient evidence overall to support the charge.

The panel could not be satisfied that between 1 May 2018 and 25 June 2018 you breached Regulation 18(2) of the CQC (Registration) Regulations 2009 by failing to

report 13 incidents to the CQC including the incidents stated in the charge. Accordingly, the panel finds this charge not proved in its entirety.

Charge 17a)

> 17) Between April 2018 and June 2018 you failed to appropriately record and report incidents that had occurred involving patients in that you:
>
> > a) did not ensure that IR1 incident forms were completed with sufficient information;

This sub-charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of Colleague D, Witness 7, your evidence, and the documentary evidence provided.

The panel was satisfied that the responsibility for the initial completion of the IR1 incident report form lay with the member of staff involved, or witnessing the incident in question. It observed that the NMC had failed to identify or provide any policy or procedure detailing the process for completion of the incident report, or to identify where the IR1 forms it had produced were deficient.

The panel determined that it had insufficient evidence upon which to find this sub-charge proved.

Charge 17b)

> 17) Between April 2018 and June 2018 you failed to appropriately record and report incidents that had occurred involving patients in that you:
>
> > b) failed to record all significant incidents on the KP1 log system used by the Hospital;

This sub-charge is found NOT proved.

When considering this sub-charge the panel took into account the evidence of Witness 7, Witness 8, Colleague E, your evidence, and the documentary evidence provided.

The panel noted that the KPI log was a document produced for internal organisational management purposes. The panel was satisfied that this was independent of reporting requirements to the CQC, and was an administrative task that was likely to have been delegated below Hospital Manager level, and indeed was completed by Colleague E. The panel observed that the NMC had not provided documentary evidence of any policy or procedure that it alleged you had not complied with in terms of completion of the KPI log.

The panel found that there was insufficient evidence upon which to find this sub-charge proved.

Charge 17c)

> 17) Between April 2018 and June 2018 you failed to appropriately record and report incidents that had occurred involving patients in that you:
>
> > c) only reported those incidents when patients required hospital treatment or when police were called but did not inform the CQC as required to do so;

This sub-charge is found NOT proved.

In considering this sub-charge, the panel took account of the evidence of Witness 7, Witness 8, the documentary evidence and your evidence.

The panel noted that you disagreed with Witness 7's interpretation of the Regulation that deals with the requirement to notify the CQC of incidents. The panel found your evidence that the requirement to notify the CQC of incidents did not apply to each

and every patient-on-patient assault, but that a threshold would need to be met to trigger notification, was more plausible in the circumstances. The panel noted that the NMC had not supplied any policy to support Witness 7's view that every patient-on-patient assault would require notification to the CQC, or identified any specific instance in which it alleged that the requirement had not been met.

Accordingly the panel determined that it had insufficient evidence upon which to find this charge proved.

Charge 18a)

> 18. On 7 September 2020, whilst the Nurse in Charge at Barrington Lodge:
>
>   a) did not respond immediately to the emergency alarm that had been activated;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of the NMC witnesses, particularly Witness 10 and Witness 13, your evidence, and the evidence of Witness 15.

The panel first considered the contextual evidence it had heard in respect of this incident. It noted that you had been the nurse in charge of the unit, and as a result of the Home Manager's unexpected absence, you were also covering her managerial responsibilities at the Home. When Resident A was discovered on the floor, you were on the phone to the Care Commissioning Group ('CCG'), taking a scheduled call on behalf the Home Manager. Further, the panel noted that Resident A had been discharged from hospital after sustaining injuries from a previous fall and returned to the Home on 7 September 2020. All the witnesses the panel heard from had confirmed that Resident A had frequent falls.

During oral evidence, you explained that you had not heard the emergency alarm at the material time, due to the noise in your surrounding environment and because you were on the telephone. You stated that Witness 15 had come down to the office to make you aware that the emergency alarm had been activated in respect of Resident A.

The panel noted the evidence of Witness 15:

> *'I was working in one of the resident's bedrooms when I heard the emergency buzzer so I followed the buzzer and went to see if I could help. The resident was sat on the floor in between the wall and the toilet he showed no signs of any distress.*
>
> *[Witness 10] was stood next to the resident and asked me to go and get Louise who was the nurse on shift. I ran up to the nurse's office and the door was shut when I entered the room Louise was on the telephone.*
>
> *I said to Louise the alarm was going which she had not heard as within the office there was no alert system. I alerted Louise to the resident sat on the floor [...]'*

The panel also took into account that Witness 10 had confirmed in her oral evidence that she had stopped the emergency alarm prior to you arriving, whilst staff had gone to get you.

The panel noted that it had heard conflicting evidence in respect of how long the emergency alarm had been sounding for and where in the building it could be heard. The panel accepted your evidence that you were not aware of the alarm. The panel found that there was insufficient evidence to support that you were aware that the emergency alarm had been activated and yet you did not attend.

Accordingly, the panel determined that it had insufficient evidence upon which to find this charge proved.

Charge 18b)

> 18. On 7 September 2020, whilst the Nurse in Charge at Barrington Lodge:
>
> b) asked a senior carer to deal with Resident A whilst you continued with a telephone conversation;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of the NMC witnesses, particularly Witness 13, your evidence, and the evidence of Witness 15.

The panel noted Witness 15's evidence:

> *'[Mrs Aslett] told me to go and get the senior carer from downstairs as she could not get off the phone…'*

Further, the panel noted your retrospective record in Patient A's Assessed Needs Care Plan dated 12 September 2020 as follows:

> *'initial assessment undertaken by [Witness 13] due the nurse being on zoom/ call with CCG'*

The panel also noted that in your oral evidence you had confirmed that you had asked Witness 15 to ask Witness 13 to attend to Resident A as you were on the telephone.

Accordingly, the panel finds this charge proved.

Charge 19b)

> 19. Following Resident A's fall you failed to follow the correct procedure in that you:
>
> b) did not complete a Datix report;

This charge is found proved.

The panel took into account the evidence of Witness 16, your evidence and the documentary evidence before it.

The panel noted that you conceded that you had not completed a Datix in respect of this incident.

Accordingly, the panel found this charge proved.

Charge 19c)

> 19. Following Resident A's fall you failed to follow the correct procedure in that you:
>
> c) did not complete a body map;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 16, your evidence, and the documentary evidence before it.

The panel had regard to your oral evidence, in which you confirmed that you had completed a body map following Resident A's fall. The panel also noted that in the local investigation report exhibited by Witness 16, it lists: '*Appendix 13 Body maps x 4 [Resident A]*'. However, the panel was only provided with one body map, not

pertaining to this incident. Witness 16 conceded during cross examination that she did not know what had happened to the other body maps, and that they had been not been included in the documentation she had provided to the NMC. The panel noted that Witness 16 also conceded that there were shortfalls in her investigation.

The panel had regard to Resident A's daily notes and the record made by you on 7 September 2020, which states: '…*body map completed'* . A further retrospective entry was made by you in Resident A's daily Assessed Needs Care Plan on 12 September 2020 (for 7 September 2020) that states: *'…body map completed…'* .

In light of the contemporaneous documentation supporting your recollection of this incident, the panel found that it was likely that you had completed a body map following Resident A's fall.

Accordingly, the panel finds this charge not proved.

Charge 19d)

> 19. Following Resident A's fall you failed to follow the correct procedure in that you:
>
> > d) did not make an entry in Resident A's mobility care plan;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 16, your evidence and the documentary evidence before it.

The panel was not provided with the Home's policy regarding the requirement to make an entry in Resident A's mobility care plan. The panel noted that Witness 16 had conceded in oral evidence that there was no such policy in place. The panel also noted its findings in respect of charge 19c), in that you had made entries in Resident

A’s daily notes and Assessed Needs Care Plan confirming the documentation and actions taken following Resident A’s fall.

Accordingly, the panel determined that it had insufficient evidence upon which to find this charge proved.

In respect of these following charges regarding Lindisfarne, the panel took into account its earlier findings regarding your behaviour and your use of inappropriate language in the workplace at Appletree. The panel noted that Witness 17, who conducted the local investigation, was aware of your previous referral to the NMC by Appletree, but could identify no evidence that this prejudiced her investigation in any way. The panel therefore deemed this irrelevant.

Charge 20a)

> 20. Between September 2020 and November 2021, acted inappropriately towards colleagues, in that on one or more occasion you:
>
> > a) undressed in the manager’s office in front of colleagues and/or in view of the public despite there being a designated area for staff to get changed;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B and Witnesses 17, 19 and 20, and your evidence.

The panel noted Witness 19’s witness statement:

> *‘I have witnessed […] inappropriate behaviour by Louise. The first pertains to her getting changed in the manager’s office. I would estimate that this happened between three and five times while I was present. There would be*

other staff members present. There would be other staff members present in addition to me, usually a night nurse or nurses. […]

Following this, there were several other occasions when I would be in the manager's office […] Louise would take her top off and get changed […] '

The panel noted your evidence, that you did accept using the manager's office to get changed and that Ms 3, the Home Manager, was aware of you using the office in this way and had allowed this. Further, you stated that you would ensure that you were obscured by a large filing cabinet and that you always wore a vest top underneath.

The panel noted the evidence of the other witnesses it had heard from in respect of this incident, namely, Colleague B and Witnesses 17,19 and 20, including that the manager's office was used for meetings and for documentation, and that you were seen in your bra whilst getting changed there.

The panel acknowledged that events occurred in the context of COVID-19, and that the designated staff changing areas were not ideal, but noted that they were used by the other staff members. The panel found your evidence that you invariably wore a vest top to be inconsistent with the other evidence it had heard, and with your own evidence that you were uncomfortable changing in the Century room, which you said was also used by a male member of staff. Further, notwithstanding that the panel accepted that Ms 3 may have told you that you could use her office to get changed, the panel found that, in the circumstances, you should have known that it was inappropriate to use the office for this purpose, particularly when other people were present.

Accordingly, the panel finds this charge proved.

Charge 20b)

20. Between September 2020 and November 2021, acted inappropriately towards colleagues, in that on one or more occasion you:

b) spoke about sex and/or sexual positions;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B and Witnesses 17 and 19, and your evidence.

The panel noted Colleague B's witness statement:

'Louise was very sexually orientated in conversations. Her topic of conversation with other members of staff could be quite full-on with lots of details around sex and sexual positions.'

The panel noted that this is supported by the evidence of Witness 19, which states:

'The second incident of sexual harassment was when Louise was discussing positions with colleagues. I cannot recall the exact date of this incident, …Louise was in the middle floor lounge and was talking to at least three carers …'

The panel noted that you deny this allegation. However, the panel were not persuaded by your evidence that you would not have made the comments alleged. It accepted the two consistent accounts of Colleague B and Witness 19, and found that it was more likely than not that you had spoken about sex and/or sexual positions and that this was inappropriate in the workplace.

Accordingly, the panel finds this charge proved.

Charge 20c)

20. Between September 2020 and November 2021, acted inappropriately towards colleagues, in that on one or more occasion you:

c) had inappropriate conversations about colleague's sexual activities;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 19 and your evidence.

The panel noted Witness 19's witness statement:

'… I was doing the medication round at the time so I was not paying much attention to their conversation, however Louise asked something about my wife and I trying 'golden showers' and put me on the spot. I think I responded "no" and continued with the medication round. Again, I felt a little awkward and like Louise was acting inconsiderately and unprofessionally…'

The panel noted you deny this allegation. However, the panel were not persuaded by your evidence that you would not have made the comments alleged. It accepted the evidence of Witness 19, which it found credible and consistent with his more contemporaneous account given during the local investigation. In all the circumstances, the panel found that it was more likely than not that you had conducted inappropriate conversations about colleague's sexual activities.

Accordingly, the panel finds this charge proved.

Charge 20d)

20. Between September 2020 and November 2021, acted inappropriately towards colleagues, in that on one or more occasion you:

d) whilst getting undressed in front of a male colleague said “they’re only tits” and “just getting my baps out” or words to that effect;

This charge is found proved.

The panel noted Witness 19’s witness statement:

> *‘… I walked into the manager’s office and found Louise in a half-dressed state. I immediately apologised and went to leave the room and Louise made light of it, making comments such as “they’re only tits”, and “just getting my baps out”…’*

The panel noted you deny this allegation. The panel acknowledged Witness 19’s more contemporaneous statement supported the evidence he gave to the panel. It was satisfied that Witness 19’s evidence was credible in this regard. In all the circumstances, the panel found that it was more likely than not that you had made comments to the effect of those alleged, namely, “*they’re only tits*” and “just getting my baps out”.

Accordingly, the panel finds this charge proved.

Charge 21

21. By your conduct at charge 21 above you sexually harassed colleagues in that:

a) it was unwanted;

b) it was sexual in nature;

c) it had the purpose or effect of violating colleagues dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for colleagues

This charge is found proved in relation to charges 20b) and 20c).

In reaching its decision, the panel took into account its findings in respect of charge 20 and the evidence of Colleague B and Witness 19.

The panel considered the NMC guidance (last updated 27 February 2024) in respect of harassment including sexual harassment:

> *'Harassment is defined by the Equality Act 2010 as someone engaging in unwanted conduct that's related to a protected characteristic or is of a sexual nature. The behaviour has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. It's necessary to take the perception of the person who's the subject of the conduct and any other circumstances into account. As well as harassment linked to a protected characteristic as defined by the Equality Act, harassment can also be unwanted conduct that is unrelated to a protected characteristic which someone finds offensive or which makes someone feel intimidated or humiliated'.*

The panel also bore in mind the advice of the legal assessor in regards to the decision in the case of *Professional Standards Authority for Health and Social Care v (1)Health and Care Professions Council (2) Leonard Ren-Ye Yong* [2021] EWHC 52 (Admin). It also had regard to the definition of sexual harassment within Section 26 of the Equality Act 2010.

In respect of charges 20a) and 20d), the panel took into account that it had found that your behaviour was inappropriate. Taking into consideration the evidence it had heard from Witness 19, it also concluded that it was unwanted and created a uncomfortable atmosphere for your colleagues. Notwithstanding this, there was insufficient evidence before it to conclude that this behaviour was sexual in nature,

and the panel was not persuaded that, in these specific circumstances, these elements of your behaviour represented sexual harassment.

In respect of charges 20b) and 20c), the panel considered that there was evidence that your behaviour was both unwanted and sexual in nature. It also noted that Witness 19 had given evidence that these comments made him feel uncomfortable and "*awkward*" and that he felt reluctant to raise these issues with you, as his superior, thereby creating a difficult working environment. The panel also noted that both Colleague B and Witness 19 in oral evidence expressed their discomfort in being present whilst you had spoken about these inappropriate matters. The panel also noted Witness 19's witness statement:

> *'…You could have a normal conversation with her but quite often she would make the conversation sexual in nature. I am not really comfortable with sexual discussions and I tended to go very quiet on these occasions.'*

The panel concluded that your conduct had the effect of violating your colleagues dignity. In all the circumstances, the panel concluded that your inappropriate behaviour found proved at charges 20b) and 20c), did amount to sexual harassment.

Accordingly, the panel finds this charge proved in relation to charges 20b) and 20c).

Charge 22a)

> 22. On an unknown date/s in relation to Colleague A:
>
> > a) attempted to pull down Colleague A's trousers whilst Colleague A was up a ladder;

This charge is found NOT proved.

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

The panel noted Colleague B's witness statement in which she confirmed that she had witnessed the alleged incident.

The panel also noted that Colleague A had stated that this alleged incident occurred in his local statement for the investigation. However, in his evidence to the panel, Colleague A stated '*When I came down the ladder I could see that she was making a gesture as if to pull down my trousers, but she did not actually touch them',* which it noted to contradict his more contemporaneous evidence.

The panel noted that you deny attempting to pull down Colleague A's trousers and in your oral evidence you explained that you had hold of the ladder Colleague A was on, and that Colleague A had thrown something at you and shouted '*rat*', and that you had grabbed his legs in fear. You said you had taken this joke in good humour. The panel noted that although Colleague A denied throwing something at you from the loft, Colleague B had also witnessed him doing so.

In all the circumstances, the panel found that it had insufficient evidence on which to find this charge proved.

Charges 22b) and 22c)

> 22. On an unknown date/s in relation to Colleague A:
>
> > b) on one or more occasion, stuck your bottom out to make it difficult to pass by and said "would you not squeeze past my fat arse" or words to that effect;
> >
> > c) on the occasion of charge 22b above, said "you're meant to tell me that it's not fat, it's a perfect arse" or words to that effect;

These sub-charges are found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B, Witnesses 17 and 19, your evidence, and the documentary evidence before it.

The panel noted Colleague A's witness statement:

> *'… The room is quite narrow and when I would try and move past Louise she would bend over the desk and stick her bottom out and say, "would you not squeeze past my fat arse" and then, "you're meant to tell me that it's not fat, it's a perfect arse".*
>
> *When this happened, I would either move back and wait for her to stand up, or leave and come back later to get the keys. It made me feel uncomfortable and there was no need for it…'*

The panel noted you deny this allegation. The panel took into account the evidence of Colleague B and Witnesses 17 and 19, pertaining to your use of inappropriate language at Lindisfarne, which it had found credible. It considered the evidence it had heard from Witness 19 about your interaction with Colleague A.

The panel also accepted the evidence of Colleague A in this respect as being consistent with the other witnesses' evidence of inappropriate behaviour in the workplace. In all the circumstances, the panel found that it was more likely than not that on more than on one or more occasion, stuck your bottom out to make it difficult to pass by and said "*would you not squeeze past my fat arse*" or words to that effect and, on the same occasion, you stated "*you're meant to tell me that it's not fat, it's a perfect arse*" or words to that effect.

Accordingly, the panel finds this charge proved.

Charge 22d)

22. On an unknown date/s in relation to Colleague A:

    d) said that you took home the large batteries for your sex toys and dildos;

This sub-charge is found proved.

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

The panel noted Colleague A's witness statement that states:

> *'…The third incident occurred when I was looking for batteries. At the Home, there are door-guards which automatically close the doors in the event of a fire alarm. These require battery changes every few months and the batteries are kept in the administrator's office. I was looking for the batteries and I asked Louise where they were and she said that she took them home for her dildos and sex toys. I was aware that she would respond like this when anyone asked her about the batteries…'*

The panel noted you deny this allegation. You accept that an interaction took place about the batteries, but allege that Colleague A said the words that he attributes to you. The panel noted that Colleague A accepted that he had subsequently sent you a meme via WhatsApp that referenced this interaction.

The panel bore in mind its earlier findings in respect of your use of inappropriate language, in that there was a likely emerging pattern of behaviour. It also took into account the evidence of Colleague B and Witnesses 17 and 19 pertaining to your inappropriate behaviour at Lindisfarne, which it had found credible. In all the

circumstances, the panel found that it was more likely than not that you said to Colleague A that you took home the large batteries for your sex toys and dildos.

Accordingly, the panel finds this charge proved.

Charge 22e)

> 22. On an unknown date/s in relation to Colleague A:
>
> e) threw orange juice at Colleague A whilst a new member of staff was being inducted;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account Colleague A's evidence and your evidence.

The panel noted Colleague A's witness statement:

> *'… [Mr 1] and I were out in the garden trimming the hedges. Louise had pushed open one of the windows in the Home so that she could smoke her vape out of it. As I turned away from the window, she put her hand out of it and threw a glass of orange juice on me...'*

The panel noted that you deny this allegation. It also noted that in the notes recorded of your local investigation meeting on 13 December 2021, in relation to an allegation made by Colleague A, that you had thrown a cup of water over him, you stated *' He says I threw a cup of water over him out the window, there is no way on gods earth you can get a cup of water, a cup of anything, a cup pout of those windows because of the window guard*. *yeah, I did squirt him with water'*. However, the panel noted that water had been referenced at the local investigation, not orange juice.

The panel also noted your oral evidence in which you explained that the windows were restricted in a way that would not you to throw a cup of orange juice out of one. The panel was not provided with any further evidence in support of Colleague A's recollection of this incident. In all the circumstances, the panel was not persuaded that there was sufficient evidence to determine that the alleged incident had taken place.

Accordingly, the panel finds this charge not proved.

Charge 22f)

> 22. On an unknown date/s in relation to Colleague A:
>
> f) on one or more occasion, made inappropriate comments to female members of staff about Colleague A despite being told by Colleague A to stop;

This sub-charge is found proved.

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

The panel noted Colleague A's witness statement:

> *'… comments that Louise would make when I was bending over to do something, for example fixing a water leak in the kitchens under the sink. Louise would tell other staff to "stop drooling or they would have a snail trail in their pants". Again, I felt she only did this for attention around other members of staff. I found these comments embarrassing and condescending. After she made these comments a few times, I told her to stop and that no one was interested in what she was saying. She would say that it was just 'banter' and*

that she was only joking. When I asked her to stop, she would stop in that moment but then do it again the next day.'

The panel noted you deny this allegation. The panel bore in mind the evidence it heard from Witness 19 about your interaction with Colleague A, which it found plausible in the circumstances. It also took into account the evidence of Colleague B and Witnesses 17 and 19, pertaining to your use of inappropriate language at Lindisfarne, which it had found credible. It accepted the evidence of Colleague A on this matter as plausible. In all the circumstances, the panel found that it was more likely than not that on one or more occasion, you made inappropriate comments to female members of staff about Colleague A despite being told by Colleague A to stop.

Accordingly, the panel finds this charge proved.

Charge 22) g)

22. On an unknown date/s in relation to Colleague A:
    g) said that Colleague B had been "fanny farting" which is why it smelt of fish;

This charge is found proved.

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

The panel noted Colleague A's witness statement:

'…Louise and I were in the lift at the Home. On a Friday the Home always makes fish and chips for the residents. The kitchen is next to the handyperson cupboard in the basement and the lift, so any odours from the kitchen get into

the lift. Louise had been smoking outside and came into the lift at the same time as me. It was just the two of us in the lift. Louise then commented that [Colleague B] must have been fanny farting which is why it smelled of fish … she was referring to [Colleague B] . I was disgusted at her comment and did not know why she would say that about a colleague. It was unnecessary. I did not say anything in response.'

The panel noted you deny this allegation.

The panel bore in mind its earlier findings in respect of your use of inappropriate language, and noted that the nature of the relationship between you and Colleague A was at times playful (for example, the loft incident with the "*rat*", the evidence before the panel regarding squirting each other with water, and the discussion about batteries that was followed by a WhatsApp message). It also took into account the evidence of Colleague B and Witnesses 17 and 19, pertaining to your use of inappropriate language at Lindisfarne, which it had found credible. Therefore, the panel was not persuaded by your evidence that you would not have behaved in the way alleged.

The panel accepted the evidence of Colleague A as credible in respect of this incident. In all the circumstances, the panel found that it was more likely than not that you said that Colleague B had been "fanny farting" which is why it smelt of fish.

Accordingly, the panel finds this charge proved.

Charge 23

23. By your conduct at charge 22 above you sexually harassed Colleague A in that:

a) it was unwanted;

b) it was sexual in nature;

c) it had the purpose or effect of violating Colleague A's dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A;

This charge is found proved in relation to charges 22b), 22c) and 22f).

In reaching its decision, the panel took into account its findings in respect of charge 22 and the evidence of Colleague A.

The panel considered the NMC guidance (last updated 27 February 2024) in respect of harassment including sexual harassment, the advice of the legal assessor, and the provisions of section 26 of the Equality Act as set out above.

The panel then account of the evidence it had heard in respect of your working relationship with Colleague A. The panel considered that there had been examples of mutual playful behaviour, as set out above. The panel noted your evidence and the documentary evidence that there was a culture of "*banter*" at the Home. It was satisfied found that on some occasions, where only you and Colleague A were present, your behaviour with Colleague A was likely to have been a consensual exchange that could not be considered in the circumstances to be unwanted. For these reasons the panel was not satisfied that your actions at charge 22d) and 22g) amounted to sexual harassment.

However, the panel was satisfied that the behaviour of which Colleague A complained that took place in front of colleagues was clearly unwanted in the circumstances, as demonstrated by Colleague A's actions at the time.

The panel noted that in respect of charges 22b) and 22c), Colleague A had stated:

> *'When this happened, I would either move back and wait for her to stand up, or leave and come back later to get the keys. It made me feel uncomfortable*

and there was no need for it. The other nurses at the handover would be present'.

In relation to charge 22f), the panel noted that Colleague A had stated:

> '*I found these comments embarrassing and condescending. After she made these comments a few times, I told her to stop… she would stop in that moment but then do it again the next day'.*

The panel was satisfied that the comments referred to in charges 22b), 22c) and 22f) were sexual in nature, and were unwanted. The panel accepted the evidence of Colleague A to the effect that these elements of your conduct had the purpose of violating Colleague A's dignity. The panel concluded that your behaviour at charges 22b), 22c) and 22f), did amount to sexual harassment.

Accordingly, the panel finds this charge proved in relation to charges 22b), 22c) and 22f).

Charge 24

> 24. Between September 2020 and November 2021, on one or more occasion, acted inappropriately and/or erratically by:
>
> a) hiding and jumping out to frighten colleagues during a shift;
> b) running up and down the corridor;
> c) doing handstands in the lounge in the presence of residents;
> d) spinning around the foyer on a chair with wheels during a handover;
> e) frequently using the word "cunt" when referring to colleagues;

This charge is found proved in its entirety.

In considering the individual sub-charges, the panel took into account the evidence of Colleagues B and C, Witnesses 17 and 19, your evidence, and the documentary evidence before it.

In respect of charge 22a), the panel noted Colleague B's witness statement:

> *'…Louise would hide and jump out at staff in the Home to frighten them. I cannot say exactly when she did this as she would do it a lot, normally in the corridors that the bedrooms lead off. She would hide by the bedroom, and then shuffle forward on her hands and knees to scare staff. She would do this quite regularly, perhaps a few times a month.*
>
> *This mostly happened to other staff rather than to me. I would know about it because it would be discussed, for example Louise would said I've just frightened XYZ, or other staff would tell me…'*

The panel also noted Colleague C's witness statement:

> *'…[Mrs Aslett] would run up and down the Home corridors, do handstands in the lounge while residents were...*
> *She would do this in front of both residents and colleagues…It was bizarre, silly and quite embarrassing to watch.*
>
> *On one occasion we were doing a handover in the morning, during which Louise was supposed to be accepting a handover from the night nurse, and she spent that time spinning around the foyer on a chair with wheels. [Ms 3] came to the door while Louise was doing this and shrugged her shoulders as if to say what are you doing?' As far as I am aware, this was the only reprimand Louise received. I thought this behaviour was unacceptable and it should have been dealt with as she was supposed to be listening to the handover at the time. I cannot recall the date of this incident…*

…Louise would constantly use the word "cunt", so much so that I felt that it was her favourite word. She would use it daily when talking about colleagues and when aiming abuse at them.'

The panel had regard to the CQC whistleblowing letter dated stamped 6 December 2021. The panel acknowledged that the allegations in this letter against Colleague B bore some similarities to those specified in this charge against you. However, the panel had no evidence of who the author of this letter was or their role at Lindisfarne. It therefore attached little weight to it.

The panel also took into account the evidence of Colleague A and Witnesses 17 and 19, pertaining to your use of inappropriate language at Lindisfarne, and also the evidence it had heard regarding the culture of banter and silliness at the Home (for example, the loft incident with the "*rat*", the evidence before the panel regarding squirting each other with water, and the discussion about batteries that was followed by a WhatsApp message).

The panel noted that you deny these allegations and that during your oral evidence, you denied ever using the word '*cunt*' as it made you feel extremely uncomfortable. However, the panel had regard to notes of your local investigation meeting in which you alleged that Colleague A had called you a '*cunt*' and you stated that you '*didn't take anything by it',* which the panel found was inconsistent with your evidence. In all the circumstances, the panel was not persuaded by your evidence that you would not have behaved in the way alleged.

The panel accepted the evidence of Colleagues B and C as credible in respect of this incident. It also found that their evidence was consistent with the other witnesses' evidence of inappropriate behaviour in the workplace.

The panel concluded that it was more likely than not, that you had behaved in the way stated in charges 24a) – 24e).

Accordingly, the panel finds this charge proved in its entirety.

Charge 25

> 25. Between September 2020 and November 2021 you bullied and/or harassed Colleague B by:
>
> > a) referring to Colleague B as “big bird” and “fat lass”, or words to that effect:
> > b) on one occasion saying “come on nurse big bird, let’s get this done” or words to that effect;
> > c) on one or more occasion referring to other Colleagues as “fat” and “lazy” or words to that effect;

This charge is found proved in its entirety.

In considering the individual sub-charges, the panel took into account the evidence of Colleagues A, B and C, your evidence, and the documentary evidence before it.

The panel had regard to the NMC’s guidance on harassment (cited earlier) and bullying (ref: FTP-3 last updated 27 February 2024) which states:

> ***‘Bullying*** *can be described as unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls. Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the*

public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.'

The panel noted Colleague B's witness statement:

> *'Louise would also comment on mine and my colleague's weight. She would call me 'big bird' or 'fat lass' or 'Olive from 'On The Buses". For example, if there was a controlled drug to administer she would say 'come on nurse big bird, let's get this done.*
>
> *She made these comments every time we worked together, it was constant. I do not mind a joke or a laugh, so I would think she's just having a bit of fun, but it was a regular occurrence. [PRIVATE] but not everyone is like that. Louise would make a beeline for someone who was overweight and make a comment.'*

In respect of charge c), the panel noted Colleague A's witness statement :

> *'Louise would call [Ms 4], the administrator, "fat" and "lazy". If Louise saw anyone overweight she would always say, "look at that fat person". Louise constantly made comments of this nature. As far as I am aware, she would not make these comments directly to the person, but she would make them to other people.'*

The panel noted that Colleague C also states in her witness statement that you would call her *'fat'* and that you would also *'exaggerate having to squeeze past me and pretend there was no room to get past'.*

The panel also considered that it heard evidence of a previously close and good-natured relationship between you and Colleague B. However, Colleague B also stated that your inappropriate commenting was constant, every shift, '*quite hurtful'*

and that you were *‘quite a strong character to challenge’*. The panel accepted the evidence of Colleagues A, B and C as credible in respect of this charge. It also found that their evidence was consistent with the other witnesses’ evidence of inappropriate behaviour in the workplace. The panel noted that although Colleague B had tolerated your behaviours and did not appear to cause emotional harm to Colleague B, your behaviour at charges 25a) – 25b) was unwanted and certainly capable of causing emotional harm and an intimidating working environment.

The panel also considered that although your behaviour in respect of charge 25c) was not directed exclusively at Colleague B, it noted that the NMC Guidance states: *‘the presence of bullying … in the workplace can have an extremely negative effect on the work environment, performance and attendance’.* Taking into account the Guidance, the panel was satisfied that your behaviour towards Colleague B at charges 25a) – 25c) was a pattern of disrespectful behaviour which did amount to bullying. The panel had insufficient evidence before it that your behaviour amounted to harassment.

Accordingly, the panel found this charge proved in its entirety in respect of your bullying of Colleague B.

Charge 26

> 26. Between September 2020 and November 2021, you bullied and/or harassed Colleague C by:
>
> > a) referring to Colleague C as “fat” and “fat lass” or words to that effect;
> > b) on one or more occasion saying “you silly fat cunt” or words to that effect;
> > c) on one occasion kissing Colleague C on the forehead in the presence of residents and/or Colleagues.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the evidence of Colleagues B and C, your evidence, and the documentary evidence before it.

The panel noted Colleague C's witness statement:

> *'Louise would belittle me and mention my weight at every opportunity. For example, if I was having a sandwich for my lunch she would call me you fat this or you fat that, "fat" or "fat lass". She would also exaggerate having to squeeze past me and pretend there was no room to get past. When doing this, she would say, "you silly fat cunt". This happened every time we were on shift together. She would always do this when other colleagues were around, it was as if she liked to have an audience. I found it embarrassing and it got to the point that I did not want to come into work…*
>
> *…A couple of months after Louise started at the Home, I reported the comments she made about my weight to [Colleague B] as she was who I reported to at the time. I believe that Louise was speaking to someone else in a similar way, so [Colleague B] spoke to [Ms 3] on our behalves…. When [Colleague B] realised that [Ms 3] had not taken any action, she spoke to Louise herself. I do not know if their conversation was an official meeting or an informal conversation…*
>
> *Shortly after [Colleague B] spoke to Louise about the comments, I was working in the lounge room with the residents and other members of staff. Louise walked into the room and came up to me and kissed me on my forehead. I asked her what that was for, but she did not reply. She smirked and walked off.'*

It also noted Colleague B's witness statement:

> *'I witnessed Louise making a comment to [Colleague C], a senior care assistant, about her weight on a couple of occasions. [Colleague C], is my sister. [Colleague C], spoke to [Ms 3] about these comments, saying that Louise was making them all the time. I do not think anything was done in response to her complaint, so [Colleague C] came to me instead and I could see how upset she was.'*

The panel accepted the evidence of Colleagues B and C as plausible, it also found that their evidence was consistent with the other witnesses' evidence of your inappropriate use of language in the workplace. In respect of Colleague C, it also found that her evidence was consistent with her contemporaneous local investigation evidence. The panel acknowledged that that these witnesses were relatives, notwithstanding this, the panel did not identify any evidence of bias or collusion.

The panel noted that Colleague C felt '*belittled*' and '*on-edge*' as a result of your behaviours towards her in the presence of others. The panel also noted that your behaviour made Colleague C feel that she did not want to come into work as a result of the embarrassment. In regards to charge 26c), the panel was of the view that your conduct was intimidating. Taking into account the NMC Guidance on bullying, the panel was satisfied that your behaviour towards Colleague C at charges 26a) – 26c) was a pattern of disrespectful behaviour which did amount to bullying. The panel had insufficient evidence before it that your behaviour amounted to harassment.

Accordingly, the panel found this charge proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness

to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Evidence

At misconduct and impairment stage, you gave evidence again on oath to the panel.

You were initially asked questions by Ms Mattin. You drew the panel's attention to the further reflection you had written since the facts decision and that you wished this to stand in part as your further evidence. You said that you accept the panel's determination fully, and understand the importance of the proceedings, but still maintain your case as to what happened during that time period. You confirmed that you qualified in 2006 as a Mental Health nurse and had no NMC referrals before these proceedings, no issues with any employers, no formal warnings, and you had worked in healthcare since leaving school. You confirmed that you had never been accused of any similar behaviours in respect of bullying or sexual harassment. You confirmed that you have been suspended since the interim order hearing in January 2021 (later you agreed that this in fact took place in January 2022).

In respect of the impact of your suspension and the proceedings, you referred the panel to your statement, but asked the panel to note that regardless of the allegations that had been made you were still attending and were still committed to the proceedings. [PRIVATE], as all you have known is nursing and caring, and despite everything that remains your drive and passion, and you know nothing else. [PRIVATE]. You said that you felt you had let yourself down [PRIVATE]. [PRIVATE].

[PRIVATE].

You were asked what you had learned from the regulatory process. You said that you had reflected a lot on this and [PRIVATE], but that you hoped the length of time had allowed the panel to recognise that you were committed and resilient, and have a willingness to learn. You said that you understand why nurses need to be held to account, and said that it was also important that nurses are empowered and have the opportunity to approach their regulator with issues relating to employers that affect them. You said that you had learned a lot about yourself in terms of your resilience, how people are perceived and how we perceive other people, and how people can perceive things negatively even in the absence of malice.

You were asked to summarise your roles since the end of the period covering the charges. You said that you had had a number of positions within healthcare and that you have worked at Butterwick Hospice ("Butterwick") since February 2021 (later agreed to be February 2022) in a role that encompasses policy, risk, procedures, quality assurance, and extending the services within the hospice.

You were asked why you had stayed within healthcare. You said that this was where you belong: that it is your heart, passion, and dedication. You said that the management structures within Butterwick are very flat and that underneath the Chief Executive, you sit with the Director of Care's Clinical Service Team, and work with the clinical teams although you don't work clinically.

You said that in March 2021, on the day you started, you had a CQC inspection, which was challenging as the organisation was deemed to require improvement. You said that in your role as Quality and Governance Lead, you aimed to ensure those ratings were changed and that you had implemented processes to do that, and that you had taken over managing the children's inpatient unit together with the Director of Care, and had worked with staff nurses, health care assistants and a wide team of other senior managers and Trustees, as well as external providers, the CQC and the Integrated Care Board, to achieve this.

You were asked to think back to the challenges of environment and organisational pressures at Appletree and explain how you approach organisational challenges in your current role. You said that you had learned a lot from Appletree about process, monitoring systems, and making them better for an organisation, and at Butterwick you had learned the importance of engaging more with the CQC and allowing them to be more involved within the service with regular meetings. You said that the teams within Butterwick had been fragile, with cultural challenges without any governing process, so you had used your learning on the importance of staff education, and spending time and giving support and guidance on systems.

You were asked how you approach managing people now. You said that following the issues at Appletree in 2019 you had self-funded a leadership and management course, and had also done top-ups of your learning since through NHS England. You said that you had also done some learning about recognising yourself as a person, considering how you are reflected, and how junior staff perceive you. You said that you now take a much more formal approach at work, and set boundaries.

You were asked to provide an example of this from your current role. You said that you had looked at what boundaries meant as a manager and for nursing. You said that as a nurse in mental health, the boundaries with patients were second nature but you wanted to understand more about what self-boundaries meant, and had looked at implementing professional boundaries within legal and ethical frameworks. You

said that you understood that this protects patients and employees but also that well-defined boundaries avoided misinterpretation, and ensured roles and expectations were clear, so it is important to set boundaries to uphold standards.

You said that you were now very formal at work, very mindful of your behaviours and actions, and how you may come across to other people. You said you did not engage in '*banter*' and had learned a lot about '*banter*' in these proceedings. You said that the boundaries of your professional working life was very different. You said that your role in itself was challenging for a lot of people within the organisation, and it was a big part of your role to deal with compliance and quality, which can often expose what teams and individuals are not doing, and that you need to address that in a way that is professional. You said that you understood that if you did not have clear boundaries and expectations from the outset, you could not expect a team to reflect that. You said that you think a lot more before you speak, and are very mindful of what other people say and how they behave in terms of what you would tolerate and accept. You said that if you were speaking to a team member on a one-to-one basis, they became more informal in approach, you will maintain your boundary and you do not engage on that level.

You said that you had been able to take forward these changes in practice and that you felt that they had brought more mutual respect, more value, and felt that it had allowed you to thrive. You said that you understood that not having boundaries can cause [PRIVATE] conflict at work, and can in turn cause quite a toxic environment. You acknowledged that lack of boundaries were a feature of your time at Appletree and said that you recognised that you were not provided with those from the outset. You noted that at Appletree you went from Senior Staff Nurse to Head of Care to Registered Manager and were not interviewed for the last two positions, didn't receive any formal induction into roles, and had no appraisal other than as Senior Staff Nurse. You said that you were not provided with the level of expected boundaries within those roles, and that had been very different in your current role.

You said that it had been the same at Lindisfarne, that there had been no induction, no supervision, no appraisal, and you were told almost just to get on with it. You said that Butterwick is very different, and that you were provided with a full induction, support, a monthly one to one meeting, a job description with key responsibilities, and that expectations were set from the outset.

You said that you absolutely accepted that you have responsibility for maintaining boundaries as a Registered Nurse, and that looking back, because nobody had ever made any comment about your conduct, behaviour, or professional boundaries being an area of concern, you had not previously felt the requirement to address that. You acknowledged that this had been identified by the allegations made in this process.

Ms Mattin asked you, in relation to sexual harassment, about your reflections since these proceedings and what you considered to be the risks and harms in the workplace. [PRIVATE]. You said that you had completed training in respect of sexual harassment in 2021 and what that meant to different people, and how what you do can be perceived as sexual harassment even if you don't think it is.

You said that you did understand and recognise that sexual harassment is a problem that affects men as well as women from your training in 2021, and that you had done a further piece of training as well about comments that can be made, and that you understood that sexual comments are not harmless banter, that they can be degrading, humiliating, and offensive. You said that much depended on peoples' perception and how they viewed these things, and that nurses and managers need to think carefully about their behaviour, how that is perceived, and to take into account the victim's perception, how they feel and if they feel that it was sexual harassment.

You were asked to describe the risks and harms of nurses behaving in that way in a clinical environment. You responded that it was against the Code, and would affect public confidence in nurses, and the protection of patients and staff. You acknowledged that it can have a detrimental effect on the individual, the profession,

people in the community and the public confidence. You said that before these proceedings you had never been accused of any level of sexual harassment. You said that you had learned, had looked again at your training resources, that you understand more about it now and how it makes people feel. You said it had also given you insight into events that had affected you previously, and had improved your understanding of these.

You were asked how it felt as a nurse to know that someone has felt that way about your behaviour. You said, "*I'm mortified and so, so sorry that someone has felt that way. I would never intentionally set out to hurt anybody. I'm sorry that they felt that way*".

You were asked whether you recognised as being harmful the use of sexual language, sexual terms and sexual "*banter*", and the specific dangers of that behaviour. You said that you did. You said, "*I still do need to maintain my case regarding that allegation*", but that you recognised the effect that those behaviours have on colleagues, patients, and the profession. You acknowledged that comfort in the workplace is important as that's when patients get the best care.

You were asked whether you now seek to foster environment where people don't feel humiliated and degraded. You said that you do, and referred to your training on leadership and management, and around sexual harassment, and as a "*Freedom to Speak Up Guardian*". You said that this was required at Butterwick and that you felt it important as part of your learning to embed a just culture, to help people feel supported and listened to, and offer them support and guidance if for some reason they couldn't go to their manager. You said that you had approached Butterwick's Senior Leadership Team with the idea for the Freedom to Speak Up Guardian training, as you thought that it would benefit the organisation to foster that culture as it would have a positive effect for staff, patients, and the care provided, and they agreed. You said that this now was being rolled out within Butterwick.

You were asked what you now do about any situation where you don't get along personally with a colleague, in comparison with how you would have dealt with it three to five years ago. You said that your role entailed the ability to be challenging to be some people, and gave an example of working with the operations team to ensure they were meeting standards, which became a challenge personally with that team because the audit process had shown an area that was not compliant. You said that you had spent time with them and had spoken to them, and understood that it had almost felt to the team that it was a personal attack even though it wasn't, and their initial response had been to take it personally. You said that you had accepted that they had taken it personally, and that the difference was that you accepted someone's perception and how that makes them feel, and had worked on putting a supportive plan together with those involved to get the right outcome. You said that you had got more oversight. You said that your role was different now as you have to be the one doing the checks and balances, whereas previously you were just informed about them or had an expectation that these things would be dealt with by someone else, so you had an awareness of it but were not necessarily managing it before.

You were asked whether, when confronted with the situation where you did not have a good personal relationship, you approached the situation differently. You said that you would think about gaining that rapport, and having difficult conversations with people in a safe and respectful environment, and working out how you could work together to ensure any issues didn't impact on the rest of team and the patients that you all cared for. You said that you had done this in your current role and gave an example where a colleague had declared that they would not follow a particular process, and you had felt quite taken aback at way they had spoken and had "*snarled back slightly*" and said that you needed to make sure the process was adhered to. You said that following the exchange you had taken yourself away and went for a walk, and had thought about how you could make the situation better to change how you had both responded and how they had approached it. You said that you then spoke privately to the staff member and explained that you didn't appreciate

the way they had spoken to you, and asked whether there was anything that you did beforehand or within an email that caused them to be upset. You said that it wasn't about you personally, but stated that you took responsibility that you may have done something to provoke that reaction. You said that your starting point in any relationship was now to examine yourself, and to ask whether it was something you did to cause you upset, so that you and the colleague could work on any conflict or address the underlying cause of a rift.

Ms Mattin noted that the panel had heard from people previously managed by you, and that it was clear from its findings that it accepted that some of those were not treated well by you, and gave evidence of the impact of your behaviour. She asked what you had learned, having heard that evidence and read the panel's findings about your management style in this challenging process. You said that it had never been your intention to bully or hurt anybody, and that you were really not that kind of person. You said that [PRIVATE], that you were sorry they had felt that way, and it certainly was not your intention to make anyone feel that you had bullied them.

You were asked whether your management style had changed. You said that it had changed due to the leadership and management course that you did, and that you were not using the excuse of having had no training before, but that it had given you insight into leadership and management, what that means, how it affects teams and can make or break a team. You said that it had changed your approach, that you understand more about managing people in difficult circumstances, and had undertaken some training in conflict management to recognise conflicts within the team and how you could affect that by having boundaries. You said that you accept your responsibility as Registered Manager to set the tone for staff working at a facility, but noted that you had spent six years with the organisation before the allegations at Appletree, and had never been informed of concerns about your performance or behaviour.

You said that in your current role you had developed positive relationships with your colleagues and that these were evidenced in your bundle of documentation, in the one-to-one supervisions you had had, and throughout the proceedings.

Ms Matting reminded you that there was evidence from the NMC's witnesses that during the relevant time your behaviour could be unpredictable, which you had accepted to an extent, and asked if you could understand how difficult is for a member of staff who perceives a manager to be unpredictable. You said that you absolutely did, and that it was your responsibility to be an active role model in order to lead the team. You said that you understand how being unpredictable can change people's perceptions and have a negative impact on the environment. You observed that being that role model sits clearly within the Code, and that you have a professional obligation to do that and understand importance of treating people fairly and with integrity. You said that you wished to promote a positive culture, positive self-worth and patient care, and environment, within the boundaries set for yourself.

You were asked whether you had reflected on importance of ensuring that personal challenges did not spill into workplace, and what you would do differently when challenges arose. You said that before the process, you had a "can do attitude" and would continue regardless, but that you do things differently now, recognise that you need to put yourself first whereas historically you would put yourself last. You said that [PRIVATE], but that you have been able to speak to your manager about them and have learned that if you do that it doesn't have a negative impact on your work, if you put yourself first. You said that you had looked closer at emergency mental health first aid at work, as you recognised that a lot of staff had mental health problems or came across events out of their control, and felt the need to ensure that staff members were supported and events do not spill out at work. You said that you were using the Mental Health at Work awareness training personally yourself and had also made a plan that could be used in the organisation at work for staff having life events, and that this Wellness Action Plan was being rolled out by HR within the organisation. You said that you recognised that people may still want to come to

work during life events, but that events can be a hindrance and have a negative aspect, so learning from your negative experiences had positively contributed to you, to all staff and to Butterwick.

In respect of events at Barrington, Ms Mattin asked if you understood the risks of not having completed the Datix in respect of the relevant incident. You said that you did. You said that you don't know why you had not completed the Datix, that it was just human error, and that you had said that you would do it but the manager already had by that point. You said that now, incident reporting is a big part of your role, that you manage all of the risks within the organisation, and incident reporting as well. You recalled that Barrington was a difficult environment, that it had a core culture of resistance to change and was quite a hostile environment at times, but acknowledged that regardless, you should have completed the Datix.

In respect of the charges found proved at Lindisfarne, Ms Mattin asked you if there was anything about your conduct or relationships that you regret or would do differently. You said again that you maintained your case on what happened at Lindisfarne, but that you were sorry that staff felt that way, because it would never be your intention to make staff feel like that. You said that the training and the understanding that you had gained since then, and through these proceedings, had been second to none. You said that you were not sure that if you had behaved differently the outcome would have been different because you had become "*a target*" as soon as you had started to raise concerns about bad practice and as soon as you had raised the need for a CQC notification about a pressure sore that should have been done by a colleague. You said that, as a result, you had then become the victim of bullying by your Area Manager. You said that you would do it again for the sakes of patient care, accountability and reporting and that you had got personal gain from that as well, in work relationships and [PRIVATE]. You said that Lindisfarne was a challenging environment, but you believed those encounters had allowed you to grow as person, a nurse, a manager, a colleague, and [PRIVATE].

Ms Mattin asked if you were still a patient-centred nurse. You said that you absolutely were, and that at Butterwick you have interactions with patients, and you desperately want to be back to being someone who can work clinically. You said that you had maintained your training and kept working in a health environment, where you were well-supported by the Director, clinical team and Trustees. You said that still go and spend time at patients' bedsides, especially if they have no family and that to see the patients, to spend time with them, to be there in their final stages, was very humbling. You said that you recognised that there is a need for hospice services for mental health patients who don't often have the opportunity to have that dignified, compassionate death. You said that you would like to be a part of changing that, and to provide the staff with the required skills and support to do this within a hospice environment. You said that Butterwick only opened its adult inpatient unit in August last year and that the majority of nurses were adult or general nurses with no specific understanding around people with mental health problems and the complexities of their care. You said that there is still a big stigma around mental health and that it was phenomenal to be part of a hospice service for those patients, which you are not sure anyone else offers.

You said that if you are permitted to regain your PIN, you would hope to stay where you are within Butterwick. You said that your role had evolved so much over the last two years and was ever-evolving, and you love your job, but you miss being the nurse, and being able to care for people in that way, so it would be your intention to do that. You confirmed that your most recent reflection had been completed since the determination on the facts and that it included confirmation that you were having counselling, testimonials, letters, recent appraisal documents from your manager, and a number of policies that you had devised during time in Butterwick. You confirmed that your supervisor was the Director of Care, who is a registered nurse and had supervised you since you started at Butterwick. You confirmed that the bundle also contained your job description, a letter from the Chief Executive of Butterwick, evidence that you were accepted onto and completed a quality and improvement course, other certificates, and cards from patients' families, etc. You

explained that you had also included the CQC report from Butterwick to show that you are a good manager and a good nurse, and have the skills and ability to support the team to implement change. You said that the children's unit had been given a rating of '*Requires Improvement*', then you took over in March, and it was rated as '*Good*' when it was reinspected in August. You said that your relationship with your current colleagues was "*brilliant*" and that it was open, honest, and professional.

You were asked whether you discussed these proceedings with your current colleagues. You said yes, and that you have been fully open and transparent since you started at Butterwick when you had a meeting with Chief Executive and HR at the time. You said that you had shared everything through these proceedings, and that the Trustees were updated after each part of the proceedings. You said that you have had discussions with all of the personnel upwards from you and your team, so that the staff you work with were aware. You said, "*I have not hid*" and that you believed in being open, honest, and transparent.

You were asked what you could add to the profession if you were allowed to return to nursing. You reiterated that you do love your role but said that you are a nurse and have a wealth of experience. You said that you have that ongoing desire to be a nurse, and that it's a privilege to be a nurse and to care for people with a wide range of issues. You said that you know it's a cliché but that you would say "*nurse*" if cut in half like a stick of Blackpool Rock and that desire has never faded. You said that you hoped that the panel had recognised that despite the challenges, complexities [PRIVATE] you had encountered, you had still turned up every day, had been resilient and had maintained professionalism. You said that you also recognise that there's learning to be had, and you felt you had done that as a person and as a nurse. You said, "*I'm so, so sorry to those people that they felt that way*". You said that it was not your intention, and was not who you were as a person. You said that you offered thanks to those people and to the process and to the NMC for allowing you the opportunity to learn, and grow up, and develop. You reiterated that your current workplace would support you to return to nursing.

You were asked whether there was anything you could identify that you could further work on. You said that you always need to work on yourself and your skills, regardless of the situation, and that we all need to learn and reflect continuously. You said that you could not put into words the amount of learning this experience had given you at this stage.

You were then cross-examined by Mr Segovia on behalf of the NMC. You clarified that you were the Registered Manager of Appletree, as your third position there, and then you were Deputy Manager at Barrington. You said that at Lindisfarne although you were employed as Deputy Manager, your role there and at Barrington was primarily as a nurse, but you didn't often work in that capacity. You said that at Lindisfarne you had been suspended for a time in November 2021, and then resigned in January 2022 after various allegations were investigated and not upheld; then additional allegations were made against you after receipt of a whistleblowing complaint in December 2021 that you were not involved in. You agreed that your Interim Order Hearing took place in January 2022.

Mr Segovia noted that you accepted the written decision, and you confirmed that you had had a chance to reflect on the facts found proved. He referred to a summary of the charges found proved, and asked if your reflection had taken account not just of the findings the panel made, but also of its reasoning, as the panel had been quite specific about each issue found proved. You said that you had reflected on things throughout the whole process and said that it wasn't a matter that you did not take seriously.

Mr Segovia took you through the panel's determination on the facts and its specific findings about your conduct in respect of each of the charges found proved. He observed that the panel had found proved against you many allegations of bullying behaviour, that you were intimidating, that you were undermining and insulting, created a hostile atmosphere, and that you had sexually harassed colleagues, in a

period extending from 2017 to the end of 2021. He asked what you thought about your conduct now. You referred to your earlier evidence and said that you had explained how you felt, how the findings made me feel, and said that you had undertaken a lot of training and guidance around those areas specifically.

[PRIVATE]. You said that whilst you had accepted the panel's determination and understood the importance of it, you still maintained your case as to what occurred. You said that you had spent years reflecting on these allegations, back to 2018, and this was a long time for you to question yourself, and examine what kind of person you were. You said that you did not profess to be perfect, but you had accepted the determination and had not walked away. You said that you had grounded yourself, learned, taken further education, training, and guidance to ensure that those two "*aspects*" did not cross your path again.

You were asked whether you had previously looked back and tried to understand how your behaviour could be perceived. You replied that prior to 2018 nobody had ever raised issues about you being a bully or intimidating, so it was only following the organisation's internal investigation at the time, which did not uphold the allegations, and your referral to the NMC, that you had revisited everything and started the reflective process again.

You were asked whether when the allegations were made about Lindisfarne, after the allegations at Appletree, you had not recognised concerns with your behaviour. You replied that there were never any allegations of this sort at the Prestige Group where you worked for six months after leaving Appletree, and none at Barrington; so it was not a continual report or pattern. You said that at Lindisfarne they were aware of the allegations made previously against you, and that you "*became a target*" there because you reported an incident. You said that only a couple of months prior to referring you to the NMC Lindisfarne had provided you with good reference for the NMC.

[PRIVATE]. You said that you had never said that you didn’t recognise bullying, and recognised what the panel had found, and were not flippant. You said that rather than choosing to walk away from the proceedings you chose to accept the determination and to look further at it and at what it meant. You said that you had learned about people’s perception, and that what one person perceived as bullying, another would not.

You said that you had not taken any aspect of these allegations lightly, [PRIVATE], and that you had tried to take learning from the panel’s determination in order to better yourself and prevent issues later on. You said that recently you had prepared a bullying presentation at work, and had researched further. You said that it was great to listen to staff’s different perceptions about what bullying means to them, and that some colleagues thought that (for example) if a manager was constantly asking them to do something outside their role they would perceive this as the manager having faith in them wanting to learn, whereas another person would consider it bullying as it represented more work. You said that you had learned a lot about the recognition of perception.

Mr Segovia asked you to explain how, if [PRIVATE] whilst at Lindisfarne and understood about bullying, you did not understand what you were doing to others. You replied that you would still maintain your case; however, you accepted the determination. Mr Segovia accepted that you were entitled to maintain your denials.

You were asked what you thought your colleagues in the nursing profession would think when they saw what this person had done to other colleagues. You referred to your bundle of letters and testimonies. You said that the panel would hear from your colleagues. You said that you had always been open and honest with them and that some of them were shocked.

Mr Segovia said that he was inviting you to try to put yourself in the position of a colleague. You said that it was important to look at that, but the communications

showed that things were very different on paper to the way they were in person. [PRIVATE]. You said that you could see and understand how it looks. You said that it was the most horrendous time of your life, but that you had grown since then. You said that you didn't know how else Mr Segovia wished you to express that you had not taken the allegations lightly, and had actually done something about the allegations that were made. You said that you would not be speaking to him as the Safeguarding Lead for the Teesside ICB if you were identified as a bully and a harasser. You said that the ICB had approached you. You said that you were also deputy Safeguarding Lead for Butterwick. You said that you would not be leading the project looking at patient incidents and events at Butterwick, would not have undergone Freedom to Speak Up training, had positive feedback, and thank you cards, if you were naturally that kind of person.

Mr Segovia asked you to step back and think about a registered nurse looking at this decision, and consider whether they would find that the behaviour that the panel found proved was totally appalling, encompassing bullying and sexual harassment. You said that the colleagues that you had "*shown that to*" had disagreed, and were shocked. You said that the allegations had been shared with the Director of Care who is a nurse, the clinical trustees, and a consultant. You said that they had had a level of acceptance of the decision, and were not agreeing or disagreeing. You said that they had seen what was on paper but they have not seen that in practice.

Mr Segovia asked you again to step back, and to take yourself out of the picture, but on reflection whether you agreed that most reasonable colleagues thinking about the decision would consider it a pattern of behaviour appalling to other colleagues. You said that you didn't agree that colleagues you didn't work with would agree with that. You said that, regardless of other colleagues and nursing professionals looking at this, you would expect professionals to look at what that person has person learned, or done to rectify that as it had happened a long time ago, and it would be more relevant to assess what had changed, what the person was doing now. You said that you would expect compassion and understanding of where that nurse is now. You

said that you were not sure what more you needed to say, as you had answered that question for the last half an hour.

Mr Segovia asked you to consider what view members of the public might have if they looked at this behaviour from a registered professional. You replied that the public might have a view but referred the panel to the testimonies you had supplied from patients' family members and those outside the healthcare environment. You said that you knew and understood that nurses should be held accountable by the NMC to the Code, but it was also important that nurses needed to ensure lessons were learned. You said that you understood and accepted what Mr Segovia was saying, and that you knew he was pulling out from the determination what the panel had found proved, but you considered it important also that there were some allegations that the panel didn't find proved in respect of bullying and sexual harassment.

Mr Segovia invited you to clarify some matters. You explained that Butterwick House is Butterwick Hospice's children's inpatient unit, and that you started working at Butterwick in February 2022. You agreed that the CQC report you had provided to the panel was not about any one person, and was about the service, and noted that your position was named approvingly within the report. You reiterated that you had said that you were a good nurse and a good manager, and accepted that you cannot currently work as a nurse, but that the CQC report referred to your supportive, approachable management.

You then answered questions from the panel. You said that as manager of the Home Care service at Butterwick you are responsible for three staff; when you managed the Children's unit you were responsible for four nurses and nine health care assistants. You said that you had been responsible for staff appraisals for the seven months you managed the children's unit, and at the moment for the Home Care service you do the appraisal for the co-ordinator and she does appraisals for the two HCAs.

You were asked to go into more detail about the management course you had undertaken. You said that you started this when you were at Appletree then continued it at Prestige. You said it was a Level 4 Leadership and Management course for care homes lasting around nine months, and that you were assigned work and the college would come in and assess you at Prestige. You said that you had done top-ups since via NHS England.

The panel noted that not all of the testimonials were recent, and none since the panel had handed down its determination, and asked if you had shown any colleague the determination and let them read it. You said that you had, and that the Director of Care at Butterwick shared documents with the Chief Executive, and the Chair and Board of Trustees. You said that Witness 21 could clarify this, and that all of your character witnesses had seen the determination. Finally, you clarified that you had worked on your reflection document over a period of time since the decision on facts was handed down.

The panel also heard oral evidence from the following witnesses, on your behalf:

- Witness 21: Director of care for the clinical services at Butterwick Hospice, registered manager and your line manager;

Witness 21 gave evidence under oath. She described Butterwick Hospice as a Hospice with adult's and children's inpatient units, a family and support service, and a home care service, and associated charitable projects. She said that the Hospice was a charity and that she was the Director of Care for the clinical services.

In relation to you, Witness 21 told the panel that she met you in March 2019 when you were working with Prestige Care at Parkfield Care Centre. She said that you were the temporary manager whilst this was being commissioned, while a replacement permanent manager was found. She told the panel that she was the

recruited replacement manager, and that you had worked with her for three to four months, supporting her induction. Thereafter, she said, you left to work at another home and were not in close contact with her. She told the panel that Butterwick Hospice had approached her to take on the position of a Clinical Governance Lead and that she had then moved to the Director of Care post, and as her previous position was vacant, she had called you and asked if you were interested in this role. She said that she had stepped back from your recruitment process, and that the Chief Executive and the HR Manager had interviewed you so that it would be a fair process. She said that your position changed from being a Clinical Governance Lead to '*Quality Governance Lead*' so that this was not a clinical role.

Witness 21 told the panel that she became aware of these NMC concerns during your recruitment process as Quality Governance Lead. She said that the Chief Executive and the HR Manager were aware of them and saw no reason as to why you should not take the job. She said that you started at Butterwick on 1 February 2022.

Witness 21 also told the panel that she had daily contact with you and observed your work frequently, and that formal supervisions take place every six to eight weeks with an annual appraisal. She told the panel that she was aware of the NMC proceedings, and said that you had been honest and transparent throughout. She said that she shared with the Chief Executive and the HR Manager all of the documentation and information you had provided to her as your line manager. She told the panel that you have their support. She said that when she became your line manager, you went through the allegations with her in detail, and that you had kept her up to date throughout the proceedings.

In relation to your position as Quality Governance Lead, Witness 21 told the panel that you mentor people, challenge them, and coach them using your years of experience. She said that staff do like to go to you because they find you to be approachable, accessible, and like to talk to you.

As your manager, Witness 21 told the panel that she found you to be challenging in a positive way, as you challenge each other. She said that you are always respectful and willing to work hard, and that she trusts your judgement. She said that your role is not clinical, but that you are part of the clinical services.

Witness 21 told the panel that she has no concerns about your behaviour. She said that the difficult part of your job is to challenge people, which can be uncomfortable, and that you are never confrontational but say things as they are. She said that your priorities are the patients and the organisation as a whole. [PRIVATE]. She said that you are loyal to the organisation and that you put patients and staff first.

Witness 21 described to the panel what charges she was aware of, and said that she had never heard you swear.

Further to panel's questions of Witness 21 and clarificatory questions from Mr Segovia, it was clear that Witness 21 had not had sight of the panel's full determination as to the facts found proved, but only notification of some of the charges found proved. Ms Mattin told the panel that you were content that Witness 21, and all the other witness you are bringing forward to give a character reference, should read the panel's determination on the facts before giving their evidence at this stage. This was arranged.

[On 16 April 2024, Witness 21 could not finish her evidence as she had not read the panel's full decision on the facts found proved. The panel directed Witness 21 to remain on oath and to return on 18 April 2024 to finish her evidence after having read the panel's determination on the facts.]

After Witness 21 had given her evidence, you returned to give further evidence to the panel on oath.

Ms Mattin noted that you had been asked questions about what the witnesses had been sent, and that it was clear that Witness 21 had not in fact been sent the full reasons of the panel for finding the facts proved. She noted that you had chosen to be recalled on the matter, and asked what you would like to tell the panel.

[PRIVATE]. You said that you took that as the proven aspects from the document sent to you on 15 March 2024. You said that you were not a lawyer, and your understanding is limited, and you were very sorry that you gave the indication that you had emailed Witness 21 the full document.

[PRIVATE]. You said that you spoke to Witness 21 properly in the afternoon and had the full determination open on your laptop, and informed her about the proven aspects and the aspects not proven and said that you would send it over for her to look at. You said that your intention was to send it and your belief was that you had done so; [PRIVATE]. You said that you truly believed that you had sent that specific document to Witness 21, but that you clearly had not, and that you were sorry that you had given the impression that you had.

You reiterated that you were slightly confused the previous day and there had been a misunderstanding of meanings and terminology, and the events that occurred had clearly meant that you had not sent the document to Witness 21. You reiterated that you were confident that you had discussed with Witness 21 the nature of the allegations and the ones that were proven, and said that you talked about it all the time, and not just with Witness 21. You said that the process had gone on for such a long time, and that the only time you had been unable to discuss the matter was when you were giving your evidence and remained under oath for many days. You said that you accepted that you had not given her all of the documents information from the case as it was a hefty amount, but said that you thought you were doing the right thing by keeping your line manager in the loop as to the events that have occurred.

You were asked whether you planned to send the determination to the other three character witnesses. You said that you did not plan to send them the determination but they were aware what the proven charges were. You said that you didn't want to bombard them with lengthy documents with legal terminology, due to their limited understanding of those terms.

Ms Mattin reminded you that you were asked whether the witnesses had the details of the panel's findings, and she asked you why you had replied that they did. You said that you thought you were being asked whether you had made the witnesses aware of the proven charges against you, i.e. what the panel identified as proved and not proved. You referred to a document exhibited to the panel containing the proven charges (for ease at this stage), and said that you had done this verbally with all three of the remaining character witnesses. You said that you thought that this summary was a good aid and to send the witnesses to support their evidence, so you had amended it to try to make it make sense, and had removed the charges not highlighted. You accepted that the document missed out the charges found proved in respect of Barrington and in respect of the definition of sexual harassment, but said that it wasn't your intention to mislead, and that it was intended to be more as a note or an aid to the witnesses. You said that when you had received the panel's document, it took you a long time to navigate through it.

You were asked what constituted your understanding of what the Trustees had been told. You said that you reported to Witness 21, and that you had also had discussions with the Chief Executive and the HR department. You said that you updated Witness 21 and that she updated the Chief Executive, HR and the clinical Trustees out of courtesy and respect. You emphasised that the Trustees are volunteers, and had nothing to do with the terms of your employment or operational aspects. You said that you understood that they had been fully appraised of the outcome of the facts stage as Witness 21 had let you know following a board meeting. You accepted that you had given the impression that your manager and the Trustees had seen the full document, and said that you were sorry you gave that

impression. You said that you had misinterpreted the question and your understanding was different, but you had thought that you had sent Witness 21 the full document. You confirmed that all of your character witnesses had now been sent the relevant part of the panel's determination to read before giving evidence, and that you had sent this the previous evening. You said that it was not your intention to mislead the panel, and that you profusely apologised. You said that you had learned from that to try to take a few seconds to understand and to clarify and you should have clarified what was meant by that question before answering. You said that it was a very big learning curve for you, and [PRIVATE].

Mr Segovia then asked you questions. He said that he felt that he had been clear when he had asked you whether you had sent the actual determination with the reasoning of the panel and asked whether it had been clear what his question was. You said that it had not been, and that sometimes questions were quite long and asked in different ways. You said that you believed at the time that you had answered what he had asked. You said that you had believed that you had sent the document that you had received to Witness 21, and that was your error. You said that you thought the determination part meant the proven aspects from that document, because to you they were the important aspects. You said you had made a mistake, an error, you had misinterpreted what was meant and not fully understood, and you were sorry.

Mr Segovia asked if you would agree with him that the best way for anyone to have a clear understanding is to read what it is that the panel has said about the charges it has found against you. You replied that this was part of your lesson learned, and this was why you had sent the document to all of the witnesses due to appear for you.

Mr Segovia asked what your intention was in respect of letting the Trustees have sight of the document. You said that it was your understanding that the trustees were kept informed by your line manager.

In response to a subsequent question from Ms Mattin, you said wouldn't personally have any objections to sending the full document to the Trustees, and would do so if they asked for it, but that the difficulty you have is that there are channels to go through for the Trustees, and they are volunteers. You said that you did not have an immediate plan to do so, but you would be happy to.

On 18 April 2024, after having read the panels determination, Witness 21 told the panel that she did not wish to modify the evidence she gave on 16 April 2024, and that the person she read about in the panel's determination is not the person she knows.

- Witness 22: Children's administrator for Butterwick Hospice;

Witness 22 gave evidence under affirmation. She told the panel that she had known you for over six years, which predated her employment at Butterwick, where she had been working for over a year, and that you are a friend. She said that she was aware of the charges found proved by the panel and that she had read the panel's determination. She told the panel that, after reading the panel's determination, she continues to stand by her character reference for you. She said that in a personal capacity, you are loyal, considerate, supportive and loving. She said that both you and she keep your personal and professional lives separate, and that she finds you supportive and approachable at work. She said that staff regularly come to see and speak to you as you are approachable and caring. She also told the panel that she has no concerns about your behaviour towards staff or colleagues.

Witness 22 told the panel that she has not seen any of the characteristics of the charges throughout her years of knowing you, and that she feels that you are open and transparent. She said that you are highly regarded by the staff at Butterwick. She told the panel that you have reached out to her for support when you have needed it.

- Witness 23: Clinical manager for Adult Inpatient Unit at Butterwick Hospice, Registered Nurse and Registered Manager;

Witness 23 gave evidence under oath. She told the panel that, after being appraised of the panel's determination, she continues to stand by her character reference letter, dated May 2022. She told the panel that she was aware of the NMC proceedings as she had spoken to you about them, and that everything in the panel's determination accords with the information you had previously given her.

Witness 23 told the panel that she met you at Butterwick as you were one of her interviewers, and that you had been nothing but kind, supportive and professional towards her. She told the panel that you had supported her to develop professionally, and step up her people management skills. She said that you were her informal mentor figure and that she valued your professional tips. She told the panel that she has observed you to have good professional relationships with staff and that you get on well with them, despite having to have difficult conversations because of your position in the organisation. She said that you speak to her patients with care and compassion and that you are a good example of being kind and team-focused. She told the panel that she does not know you to be anything but professional, and that she has no concerns about your behaviour.

- Witness 24: Registered Mental Health Nurse.

Witness 24 gave evidence under affirmation. He told the panel that initially he met you professionally at Barrington Lodge, where he would often work temporarily. He said that there were a lot of issues with the culture at Barrington, but that you were supportive in changing that culture. He said that at Barrington, he had observed you regularly for two or three shifts per week, and for some weeks more frequently. He told the panel that you were kind, caring and accessible. He told the panel that he also worked with you at Lindisfarne and had observed you there as well, without concerns. He said that you continued to be professional, supportive and been

pragmatic in changing the culture there too. He told the panel that he also observed you in Butterwick to be working well with staff, and that you have a good team around you.

Witness 24 told the panel that the morale in mental health nursing is low. He said that you always try to uplift people and lift that morale. He said that he had observed you working well with patients and that you could build a good rapport with everyone. He told the panel that he had read the panel's determination and stands by his evidence. He said that you are an amazing and fantastic nurse, and what he read in the panel's determination was not the person he knows. He said that personally and professionally, the panel's determination does not accord with his experience with you. He said that Butterwick is flourishing because of the work that you do. He said that he was aware of the charges before he read the determination, as he had had personal discussions with you about it, as you had reached out to him when you needed support.

Mr Segovia's submissions on misconduct and impairment

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

Mr Segovia submitted that, in Appletree, you were the registered manager, which meant that you were in a position of authority when the incidents took place. Similarly, at Barrington and at Lindisfarne, you were the Deputy Home Manager and in a position of authority in particular to unregistered staff. He reminded the panel that it had found that bullying, intimidation, and sexual harassment took place. He submitted that there was a pattern of behaviour towards your colleagues in two different places of work.

Mr Segovia took the panel through its reasoning for the charges found proved. He submitted that this was a case in which the behaviour fell right at the bottom of the spectrum in terms of what was expected of you as a registered professional as there was a catalogue and a pattern of dreadful behaviour towards colleagues. He observed that as you were in a position of authority, there was additional trust placed in you as other nurses would look at you as an example as to the standard and behaviour expected of a registered professional. He further submitted that engaging in this type of behaviour can destroy the working environment as it can indirectly impact the care of the patients.

Mr Segovia referred the panel to the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where your actions amounted to misconduct. He submitted that paragraphs 20, 20.1, 20.3 and 25 of the Code are engaged, and referred the panel to the introduction to the Code, which specified that colleagues have the right to expect that nurse colleagues will adhere to appropriate standards of behaviour with them, as they do with patients.

Mr Segovia submitted that, even without referring to the Code, it is clear that there was a serious falling short of the standards expected of a registered nurse, but that the Code also makes it clear that these values apply to the behaviour you displayed with your colleagues. Therefore, he invited the panel to take the view that the facts found proved amount to serious misconduct.

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

In paragraph 74 of Mrs Justice Cox judgment in the case of *CHRE v NMC and Grant*, 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; …*
>
> *d) ….'*

In relation to limb a), Mr Segovia said that the Code makes it clear that behaviour towards colleagues is also an important aspect of practice, and that potential harm to colleagues can be read into this limb of the test. He submitted that a pattern of behaviour which involves bullying, intimidation and sexual harassment undoubtedly risks putting colleagues at risk of harm, and that the panel did find that your behaviours had caused harm.

Further, in relation to limbs b) and c), Mr Segovia submitted your behaviour and conduct has in the past brought the nursing profession into disrepute and has in the past breached fundamental tenets of the nursing profession. He submitted that you displayed serious attitudinal issues in your behaviour throughout a considerable period of time between 2018 and 2021. He said that your conduct had got worse as you had started sexually harassing colleagues. He submitted that it would be proper for the panel to make a finding of current impairment based on your past conduct, to mark that your conduct was profoundly serious, to uphold proper standards and to maintain confidence in the nursing profession.

Mr Segovia stated that this was not a case of clinical concerns, so your insight is the critical factor to the assessment of future risk. He submitted that the panel must be satisfied that you have learnt, reflected, and have a real understanding in depth of your behaviour towards colleagues. He noted that even though the panel has found the facts proved, you continue to choose to deny them.

Mr Segovia observed that you undertook a leadership and management course in 2019 but then a short time later, you were sexually harassing and bullying colleagues. Therefore, he questioned whether you had learnt and understood the seriousness of your conduct. He suggested that the concerns were behavioural and attitudinal. He suggested that the character referees did not have understanding of your work in a registered capacity.

Mr Segovia submitted that, even if the panel was not of the view that there was a future risk present, in order to mark the seriousness of the facts which were found proved, it should find current impairment. He further submitted that it was for the panel to decide as to what the future risk is, by taking account of your learning and insight.

Ms Mattin's submissions on misconduct and impairment

Ms Mattin provided written submissions to the panel:

> *'INTRODUCTION*
>
> *1. It is the overarching submission on behalf of the Registrant that she is not currently impaired on the proven charges.*
>
> *SUBMISSIONS*
> *2. The definition of misconduct is a high threshold constituting serious professional misconduct.*
>
> *The charges that relate to Barrington do not satisfy that threshold. The Registrant admitted in evidence that she failed to complete a datix that day, she offered to do so the following day but one had already been done. It is submitted that the overall findings of the panel in relation to the care of Resident A are important context to the proven charges.*
>
> *3. In considering the application of the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J), it is submitted that the proven charges do not evidence any past or future risk of patient harm. Nor is dishonesty a feature of this case.*

4. Overall, it is submitted that the conduct is remediable, has been remedied and is highly unlikely to be repeated. It is argued that the Registrant does not continue to present a risk to members of the public in her role and that in all the circumstances of this case assessing the matter now in 2024, public confidence does not demand a finding of impairment.

5.[…]*. The Registrant has provided reflective statements, testimonial letters, certificates evidencing training, policies that she has authored, evidence of her supervision/appraisals at Butterwick and other material which, it is submitted, is a testament to her commitment to the profession.*

6. The Registrant deserves credit for her engagement with the NMC process. This is particularly in light of the protracted nature of these proceedings. She has given evidence at both stages in the proceedings and sought to assist the panel [PRIVATE]. [PRIVATE]

7. Whilst it will form no part of the panel's role to 'punish' the NMC for any delays or shortcomings in their investigation/presentation of the case, it must have contextual relevance in the Panel's consideration of the Registrant's engagement in this hearing which has taken place over the course of over a year for events which are now between 3-7 years old.

8. It is clear from the registrants evidence that her registration and role as a nurse is central to her identity, [PRIVATE] and purpose. The panel or are aware that the registrant has been suspended from practice for over two years, [PRIVATE]. Notwithstanding those challenges, she has demonstrated a marked resilience and continuing commitment to a return to nursing. She told the panel, "I stayed in healthcare because that's where I belong, where my heart is, where passion is".

9. The challenge the Registrant has faced in the second stage of these proceedings is how a nurse can have a fair chance before a Tribunal to maintain her case, without being unfairly penalised for the panel finding against her. The panel will no doubt be advised of how appellate courts have navigated this tension.

10. The panel are cautioned from equating a maintenance of innocence with lack of insight – see Karwal v General Medical Council [2011] EWHC 826. It is submitted that the Registrant should not be criticised for denying the allegations, she was entitled to do so as a fundamental tenant of the right to a fair trial. Whilst the matter of insight and repetition will be an evaluative judgment of the Tribunal, sensitive to the facts of this case. It is clear, that there has been a marked move away from automatically holding that a Registrant's denial against her as an aggravating feature when considering insight at subsequent stages.

11. Support for a nuanced approach to the assessment of insight was reiterated in Sayer v General Osteopathic Council [2021] EWHC 370 (Admin)
[…]

12. Maintenance of innocence is of potential relevance in some cases but its relevance should be properly considered in context [see Dr Raisah Sawati v The GMC [2022] EWHC 283 (Admin)]. This is not a dishonesty case as in Sawati and the panel are invited to distinguish that case from this. […]

13. Whilst the panel in their determination on a number of occasions remark that they are not persuaded by the Registrant's evidence or it was outweighed by other contemporaneous evidence or other witnesses evidence being preferred, there is not present in the determination the kind of detailed or consistent criticism of her defence/s as one might find in cases of 'rejected

defences' involving dishonesty. e.g. see for example the reasoning of charge 6b, 6c, 7.

14. It is also important to consider how the panel determined the Registrant's evidence in the round, it is of note that a number of parts of the Registrant's evidence were accepted and that much is clear from the reasoning of charges found not proved. This is not a registrant who has been found to be dishonest or wholly lacking in credibility.

15. Whilst the registrant maintaining her factual case makes demonstrating insight more challenging, admitting the charges is not a necessary condition to establishing that she understands the gravity of the charges found proven and is unlikely to repeat it (see Sayer above). In this case it is submitted that she has demonstrated a thorough understanding of the gravity of the charges found proven in her extensive written and oral evidence. The Registrant has taken the allegations seriously and given evidence on the risks and harms those behaviours entail.

16. The registrant has accepted the determination of the panel and showed a sincere appreciation of the importance of their task and the importance of nurses being held accountable by their regulator. She also gave evidence of the importance of colleagues being empowered to raise issues and has done a significant amount of work on bullying and whistle blowing (i.e. speak up guardian, policies at Butterwick).

17. It is also evident from her early reflections that the Registrant has identified significant [PRIVATE] that were operative during her time at Appletree and Gainford. The Registrant has given clear evidence on the support she has sought out since (counselling from the RCN for example and reaching out to colleagues). [PRIVATE].

18. The Registrant has been committed to her own improvement and professional development (management training, sexual harassment training, speak up guardian training). [PRIVATE]. The Registrant gave detailed evidence about her conscious decision to act more formally at work. She told the panel she is mindful of her actions and how she comes across to other people "if we talk about banter as an example, I don't engage in that kind of behaviour, learnt a lot about banter through these proceedings with colleagues don't engage in any aspect of (inaudible) I feel that boundaries of professional working life is different". It is submitted that this is supported by the live evidence of the Registrant's current colleagues.

19. Further, the years she has worked without referral, issue or complaint are important considerations to the risk of repetition. The evidence the panel have had about the Registrant goes further than an absence of issues. It is clear that she is highly regarded in her current role, as a colleague and in the context of her seniority. The panel are aware the Registrant was invited to manage the children's unit for 6-7 months whilst a permanent employee was found. It is submitted that the evidence of the Registrant's success in her current role is of heightened significance in light of the nature of this employment. The Registrant has an important position in an emotive, high pressure clinical environment, where she is required to work with colleagues across multiple disciplines and hold staff to account for procedures, patient safety and quality assurance. The Registrant has navigated these challenges to the benefit of Butterwick Hospice.

20. It is clear that she has been under the close supervision of her manager and the role has involved the heightened scrutiny of CQC investigations in the context of a service which at the time she joined, was performing poorly. The panel are invited to consider the supervision records provided by the Registrant, which demonstrate significant progress in her current role and

support provided in relation to these. She has excellent feedback for relationships with staff.

21. The panel have had the benefit of live evidence from both clinical and non-clinical staff who currently work with the Registrant. This has complemented a wealth of testimonial evidence, some of which has come from colleagues the clinical settings that form a part of these proceedings. The live evidence at stage two, included her current line manager of over two years and [Witness 24]*, who worked with the registrant in two of the clinical settings that form a part of these proceedings and in her current non-clinical role.*

22. [Witness 21], an experienced nurse and manager of Butterwick, has daily contact with the Registrant. Whilst [Witness 21] had not received the written determination from the Registrant, it is nevertheless clear from her evidence that the Registrant has been "very honest and open in proceedings…. I have felt that Louise has been open with me she has shared documentation with me, kept me up to date in terms of what has been happening what has been said" (counsel's note of her evidence). She recalled the specifics of allegations and confirmed that they would discuss the proceedings at the "end of each day" when the registrant was going through the hearings.

23. The Registrant has been described as a "diligent" team member, with an "open door policy".

24. She and other witnesses testified to the transformative effect the Registrant has had at the hospice. The panel have the benefit of independent evidence in this regard […]

25. [Witness 21] was clear that she has no concerns about the registrant, who she described as having been "remarkable" in her own conduct through the

NMC process. It is submitted that [Witness 21's] evidence is highly probative and relevant to the registrant's current fitness to practise.

26. [Witness 22] also gave live evidence to the panel. She works at Butterwick in a junior and non-clinical capacity. She has known the registrant both personally and professionally. It was clear from her evidence that notwithstanding a personal relationship, the registrant has maintained proper professional boundaries at Butterwick. [Witness 22] remarked that they keep their "work and home life separate".

27. [Witness 22] gave evidence that she is "kept in high regard" on the unit and is highly respected. She described her as trustworthy and supportive.

28. The panel also heard from nurse [Witness 23] who is the current clinical manager for the adults inpatient unit at Butterwick Hospice, a role she has had for 8 months. [Witness 23] was working in Butterwick for 14 months prior to opening the adult inpatient unit. [Witness 23] told the panel that she had discussed these proceedings with the registrant about a year ago and that they had had frank discussions. She also noted that the registrant had kept her informed and updated as to the progress of the hearing. Having read the panels determination, she confirmed that nothing contained therein "came as a surprise or was different to what Louise said to me in the past". […]

29. [Witness 23] told the panel of times that she has approached the registrant to discuss difficult issues with staff members, advice on team building and in particular guidance in supporting her to deal with a member of staff on long-term absence. She was concerned about approaching this issue in a supportive way and turn to the registrant for help. [Witness 23] describe the Registrant and is having positive relationship with staff across the disciplines […]

30. [Witness 23] gave specific evidence about the registrant's manner, and approach to interviewing staff, including in the context of incident investigation. She remarked, that she had "always been impressed by the kindness and gentleness, often asking direct questions still able to put them at ease."

31. [Witness 23] told the panel that she had no concerns about the language or behaviour of the registrant, and had never known the registrant to be anything but professional. […]

32. [Witness 24] … has had the benefit of observing the registrant throughout a number of years in both clinical and nonclinical roles. He describes her as an approachable and supportive colleague. In line with the evidence of other witnesses, he also speaks to her drive for promoting professional standards and patient care. [Witness 24] has experienced the registrant as a manager and describes observing "Ms Aslett extend her kindness to the permanent care team she leads by offering her support and operating an open door policy."

33. [Witness 24] […] described observing the registrant two to three shifts a week for a period of two years. He worked with a register in at Barrington Lodge and Gainford. [Witness 24] gave detailed evidence about the issues in relation to the culture at both workplaces. It was his experience that the registrant was trying to work and improve the culture. […]

34. He described professional and clinical support that the registrant had provided him. [Witness 24] *told the panel that the registrant was "an accessible, supportive professional".*

35. He observed that, despite being a mental health nurse, the registrant's knowledge in relation to general nursing outshone that of some general nurses.

36. [Witness 24] has observed the registrant in her non-clinical capacity at Butterwick. He told the panel that since she had been recruited, she has been "pragmatic and organised, lifted the service, improve protocols and services". He described her as flourishing and gave evidence consistent with others, that working in Butterwick that she got on well with the team around her, and that he had no concerns about her behaviours. [Witness 24] had read the panels for determination and was emphatic that it reflected his discussions with the registrant.

37. It is submitted that [Witness 8's] evidence of the Registrant's clinical skills and relationships with patients is relevant […]

38. […]

39. The Registrant spent over twenty years on the Register before her referral. In that time, working in challenging mental health settings, she had no regulatory or disciplinary issues with employers. She has had no such issues in the three years since these charges.

40. The Registrant has demonstrated a thorough and consistent commitment to professional development. Notwithstanding her suspension, she has kept her employment in an allied role for over two years and sought to maintain her clinical skills and knowledge as far as possible. The Registrant is in the difficult position of any suspended professional – to show she is fit to practise, whilst complying with an order that prevents her from practising.

41. It is submitted that the conduct the panel have found is capable of remedy and has been remedied by reflective work, training and work in an allied role. The panel have had extensive evidence from well informed clinical and non-

clinical colleagues who have worked with the registrant and speak of a dedicated, professional and caring colleague.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Calheam v GMC* [2007] EWHC 2606, *Shodlock v GMC* [2015] EWHC Civ 769, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant*, *Cohen v GMC* [2008] EWHC 581 (Admin), *Sawati v GMC* [2022] EWHC 283 Admin, and *PSA v NMC* [2017] CSIH 29.

Decision and reasons on misconduct

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

The panel was satisfied that charge 18b) did not represent misconduct as your action was reasonable in the circumstances. The panel was satisfied that Charge 19b) did not represent misconduct as this was simply an error, and did not meet the required standard of seriousness.

With those exceptions, the panel was satisfied that your actions as represented by the charges found proved did fall significantly short of the standards expected of a registered nurse, and amounted to a breach of the Code. This is because you have been found by the panel to have bullied and intimidated colleagues, used inappropriate language, created a hostile work environment for colleagues, displayed inappropriate behaviour, and engaged in sexual harassment. The Code's introduction states that it '*provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care…[it] should be seen as a way of reinforcing professionalism*'.

The panel was satisfied that there had been a breach of the following specific sections of the Code:

'20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.4 *…*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
20.6 *…*
20.7 *…*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was satisfied that your actions in the charges found proved represented a serious falling-short of the standards expected of a registered nurse and did amount to misconduct.

Decision and reasons on impairment

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

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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

The panel was satisfied that limb a) of the test in *Grant* is satisfied as to past conduct. The panel finds that your colleagues' mental health and emotional wellbeing were put at risk as a result of your misconduct. It was satisfied by the evidence presented by the NMC at the facts stage that, by your actions, you did cause some of your colleagues emotional harm. The panel was further satisfied that the hostile and unsupportive work environment that you created for certain colleagues, and your inappropriate behaviour in the clinical environment, may have put patients indirectly at risk.

The panel was satisfied that limb b) of the test in *Grant* is satisfied as to past conduct. The panel was satisfied that your misconduct had brought the nursing profession into disrepute, and that members of the public would be shocked that a registered nurse had behaved in such a way as the panel has found you to have behaved, in the clinical workplace.

The panel was satisfied that limb c) of the test in *Grant* is satisfied as to past conduct. The panel was satisfied that your misconduct had breached the fundamental tenets of the nursing profession, and that fellow members of the profession would be extremely disappointed that a registered nurse had behaved in such a way as the panel has found you to have behaved. Nurses have the right to expect to be supported by their nurse managers in their challenging working environments, and superiors' respect and support is necessary to enable colleagues to give the best care to patients.

The panel then considered whether the *Grant* test could be satisfied in respect of the risk of future misconduct. In doing so, it considered the guidance in the case of *Cohen.*

The panel found that the misconduct in this case is difficult, but not impossible, to remediate. The panel had particular concern that there was a pattern of behaviour in two separate workplaces, the first at Appletree in 2017-2018 and the second at Lindisfarne in 2020-2021, and noted that the inappropriate behaviour escalated to encompass sexual harassment at the second workplace. The evidence accepted by the panel demonstrated that a number of members of staff at both workplaces had been directly negatively impacted by your misconduct. The panel felt that the repetition of the behaviour in a second workplace, and its escalation to a level where it represented sexual harassment, indicated potential serious attitudinal concerns.

The panel carefully considered the evidence before it in determining whether or not you have sufficiently strengthened your practice. The panel first considered your oral evidence to the panel at this stage of proceedings, which was supported by a detailed written reflection and other documentation, and reminded itself also of the oral evidence you have previously given and the documentation previously submitted. The panel noted that whilst you state that you accept the panel's determination and acknowledge the importance of the regulatory process, you still do not accept the "*factual matrix*" of the charges that the panel has found proved, and that you maintain your denials of these charges.

The panel noted your repeated expressions of regret that your colleagues "*felt this way*", and your repeated assurances to the panel that its findings do not reflect the person that you are, and how difficult you have found it to accept some of the panel's findings. The panel further noted that whilst you accept the impact that this level of misconduct can have on individuals and on the clinical workplace, and therefore on patient care, you do not accept that your actions caused this impact at Appletree and Lindisfarne.

The panel [PRIVATE], and accepts that no concerns about inappropriate conduct were brought to your attention at an early stage of your management career as a nurse. The panel finds that this failure to demonstrate effective leadership and management to you, or to ensure that you were properly prepared for your nursing management roles at Appletree, may have contributed to your shortfalls. However, the panel found your oral evidence and reflective piece to be largely self-absorbed, and to lack empathy for those who had shared their negative experiences of working with you.

Although you told the panel that you have a better understanding of professional boundaries and no longer engage in '*banter*' at work, the panel was not satisfied that you fully understood that your failure in these respects in the past led to the specific behaviour that had affected your colleagues or the clinical environment, and therefore why it was necessary for your behaviour to change so that your misconduct did not occur again.

The panel noted that you frequently referred to the Leadership and Management course you completed in 2019 as having assisted you to understand management roles, but that your failings at Lindisfarne occurred after you had completed that course in 2020 and 2021.

The panel found your reflective piece to be academic in nature, rather than specific about the misconduct found proved. Although it is clear that you understand good practice, and that you have introduced significant elements of your learning into your current working environment in a positive and constructive way, the panel was not persuaded that your demonstration of insight had got to the heart of the failings that occurred to lead you to the circumstances in which you now find yourself, or that you have fully taken responsibility for the events that have occurred. The panel was not satisfied that you had developed insight into the effect on the reputation of the profession of a nurse in a senior management position being found to have bullied

and sexually harassed colleagues, and the negative impact on the public's trust in nurses.

The panel was reassured by the evidence of your current colleagues, Witnesses 21, 22 and 23, that you are a professional, caring, highly-respected team member at Butterwick who had not displayed any of the behaviours that the panel found you to have displayed at Appletree and Lindisfarne. It noted the evidence of your longstanding occasional co-worker, Witnesses 24, that you are a good clinical nurse and had not demonstrated these behaviours to him. It noted that you had discussed the matters charged by the NMC with your colleagues, and that senior management and the Butterwick trustees are aware of proceedings. The panel heard that your colleagues said that you had been open and honest about events.

The panel noted that your character witnesses had been supplied with the panel's determination on the facts of the case very recently to their appearances before the panel, and that they had all given evidence in your support without having had time to digest the panel's detailed findings on the basis of the evidence it had heard at the earlier stage of proceedings (particularly in the case of your direct manager, Witness 21). The panel noted that at the time of giving evidence, all of your character witnesses said that the independent panel's determination did not alter their previous view of you, which it found surprising due to the seriousness of the charges found proved.

The panel noted that it is clear that Butterwick has progressed and improved whilst you have been in your current role, and that you have instigated and contributed to initiatives to improve workplace wellbeing in that environment, which is challenging by nature. The panel noted that it is clear that you benefit from strong and supportive management yourself in this current role, which was missing at Appletree and Lindisfarne. Whilst accepting the evidence provided the panel notes that you are not currently in a clinical role at Butterwick and that due to your suspension you do not currently represent the nursing profession, as you did at Appletree and Lindisfarne.

The panel noted the testimonials and learning certificates you supplied.

The panel gave careful consideration to how it could be sure it was treating you fairly at this stage of proceedings in the light of its rejection of your denial of the facts of the charges found proved. The panel considered the case of *Sawati* particularly the guidance set out in paragraphs 103 to 110. The panel was satisfied that you did not only reject your former colleagues' perception of what had happened (i.e. did not say that they had simply misinterpreted what you said, or your meaning when you said it), but that in fact you denied that the incidents specifically described by the NMC's witnesses and which the panel had found proved had occurred at all. You have described how you believe that you were and remain the victim of conspiracies against you, both at Appletree and at Lindisfarne, and effectively make a counter-allegation that all of the witnesses who have given evidence against you are dishonest because the events they have described to the panel did not take place. The panel remains unpersuaded that this is likely.

The panel also considered that, taking all of your evidence into account, the level of insight you have demonstrated is currently insufficient for the panel to be satisfied that it is highly unlikely for your misconduct to reoccur. However, the panel was of the view that your insight has the potential to develop in the future. The panel was also concerned as to whether the strategies of professionalism that you have developed in your current role would stand up to the pressure of a clinical role, particularly a clinical management role, if the strong management support from which you currently benefit were absent.

Weighing all of the factors, and directing its mind to the inherent tension of principles where the panel has rejected your defence to the charges found proved, the panel considered the essence of its analysis. The panel is not satisfied that you have been honest with yourself or with the panel in your approach to your own shortcomings.

The panel therefore finds that it is not highly unlikely that your misconduct will reoccur.

On this analysis, the panel found that there was a potential future risk of misconduct under the test in *Grant* in respect of limbs a), b) and c).

The panel has therefore decided that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel bore in mind 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 determined that a finding of impairment on public interest grounds is required because the public and profession would expect that the gravity of the charges found proved would be marked by a finding of current impairment of fitness to practise. The panel is satisfied that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore finds your fitness to practise also impaired on the grounds of public interest.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. This included further documentation provided on your behalf at this sanction stage, which included:

- A further reflection, written since the panel's findings of misconduct and impairment were handed down on 22 April 2024;
- Curriculum Vitae;
- Certificates and evidence of training;
- Job description of your current role as a clinical trainer (since 23 September 2024;
- Last supervision from Butterwick Hospice on 3 May 2024; and
- Supervisions (in current role) from 29 September 2024 to 16 October 2024

The panel has 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 Malik informed the panel that in the original Notice of Hearing, dated 30 January 2023, the NMC had advised you that it would seek the imposition of a sanction in the range from a suspension order for a period of 12 months to a striking-off order if your fitness to practise was found to be impaired. He submitted that the NMC's position now, was that a striking-off order would be the appropriate and proportionate order.

Mr Malik submitted that the aggravating features include: a pattern of misconduct over a lengthy period of time, namely from 2017 to 2018 and 2020 to 2021; the attitudinal issues, the nature of the case which includes sexual harassment and the limited insight demonstrated by you.

Mr Malik submitted that there are no mitigating features in this case.

In relation to no order or caution order, Mr Malik submitted that the nature of this case is too serious to take no action or to consider a caution order, because it involves serious harassment and bullying. He submitted that this case is not at the lower end of the seriousness spectrum and regulatory action is required to maintain confidence in the profession. He submitted that neither of these options were appropriate or proportionate.

In relation to a conditions of practice order, Mr Malik referred to the NMC's Guidance '*Conditions of practice order*' (Reference: SAN-3c) and said that this order is more suitable for cases where there are clinical concerns which can be identified to allow a registrant to practice with support. He submitted that this would not be the proportionate order for your case, particularly as the panel determined that you have an attitudinal issue and there was a risk of repetition. He said that, albeit you accept the panel's findings, you continue to deny the facts found proved by the panel. He therefore questioned how the concerns can be remediated if you continue to deny the charges that were found proved.

Mr Malik submitted that there is no real evidence before the panel today which demonstrates any steps you have taken to strengthen your practice or of any developing insight. Therefore, there is a significant risk of repetition and consequently a risk of harm to the public and patients. He further submitted that a conditions of practice order would not be appropriate as there are no areas in your clinical practice that is in need of assessment or training; rather, the fundamental issues lie in relation to your conduct and attitude, bullying behaviour and sexual harassment.

In relation to a suspension order, Mr Malik referred to the NMC's guidance: '*Suspension order*' (Reference: SAN-3d). He submitted that there were two instances of misconduct and a pattern of behaviour in two separate workplaces, and that the sexual harassment behaviour escalated further at Lindisfarne. Further, he said that

the panel had found your evidence and reflective piece self-absorbed, lacking empathy and that that you did not fully understand your misconduct. He further told the panel that you had undertaken a leadership and management role course in 2019. However, the misconduct took place in 2020 and 2021. Mr Malik submitted that the misconduct is serious, includes attitudinal concerns and your insight was limited. Therefore, a suspension order would not be appropriate as the misconduct in this case is incompatible with you remaining on the register.

Mr Malik moved on to the NMC's guidance on 'Striking-off order' (Reference: SAN-3e). He submitted that the nature (sexual harassment and bullying) and seriousness of your misconduct calls your professionalism into question. He submitted that these concerns are difficult to address as they were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. He submitted that the trust and confidence in the profession can only be maintained by the imposition of a striking-off order.

Mr Malik referred the panel to your updated and undated reflective statement and said that you now accept the panel's determination on the facts found proved and how your conduct had brought the nursing profession into disrepute and how your behaviour was not expected of a registered nurse. However, he submitted that there continues to be clear evidence of harmful and deep-seated and attitudinal problems, and the misconduct raise fundamental concerns about your professionalism. Further, public confidence in the profession can only be maintained by removing you from the register.

Ms Mattin provided written submissions to the panel, which she expanded upon in her oral submissions:

1. *'It is the overarching submission on behalf of the Registrant that the Panel should consider a sanction of a conditions of practice order. Such a sanction will adequately protect the public, promote public confidence and maintain*

oversight.

2. *It is submitted that a striking off order is a disproportionate sanction that has no regard to the particular circumstances of this case and the panel's findings, the Registrant's mitigation, the lack of repetition in the years since, evidence from colleagues and evidence of a significant commitment to the profession and personal development.*

3. *The Registrant has maintained employment in healthcare, she has demonstrated a continuing commitment to patient care, nursing and personal development. The Registrant has provided reflective statements, testimonial letters, certificates evidencing training, policies that she has authored, evidence of her supervision/appraisals and other material which, it is submitted, is a testament to her commitment to the profession.*

4. *It is clear from the Registrants evidence, continuing commitment to this process and reflection that her registration and role as a nurse is central to her identity, [PRIVATE] and purpose. [PRIVATE]. Notwithstanding the robust and proper criticisms/challenges these proceedings have entailed, she has demonstrated a marked resilience and continuing commitment to a return to nursing and recognition of the position of privilege that nurses occupy in our society. She told the panel, "I stayed in healthcare because that's where I belong, where my heart is, where passion is"*

<u>Insight</u>

5. *It is of note that the panel have previously found the Registrant to have introduced significant elements of her learning into her current working environment in a positive and constructive way (page 167 of determination). The panel expressed concern about the academic and self-absorbed nature of the Registrant's reflection at stage 2. The panel were of the view that her insight has the potential to develop.*

6. *It is a challenge for any registrant to reflect on conduct where there remains a factual dispute – to step back on conduct that they have been litigating for a number of years and analyse the findings as if it concerned another. The Registrant's most current reflection demonstrates a development in her insight, and it is submitted addresses the concerns identified by the panel at stage 2 about the Registrant's limited ability to reflect on her own conduct over the personal cost of these proceedings. The panel also have the Registrant's most recent certificates and supervisions. The benefit of a conditions of practice order is that it could allow for further work to be done in this area, in a controlled and managed way.*

7. *As discussed at Stage 2, support for a nuanced approach to the assessment of insight was reiterated in Sayer v General Osteopathic Council [2021] EWHC 370 (Admin).*

8. *It is also important to consider how the panel determined the Registrant's evidence in the round, it is of note that a number of parts of the Registrant's evidence were accepted and that much is clear from the reasoning of charges found not proved. This is not a Registrant who has been found to be dishonest or wholly lacking in credibility. The Registrant has taken the allegations seriously and given evidence and reflections on the risks and harms those behaviours entail.*

9. *It is submitted that a consistent and tangible measure of insight can be found not just in the paper submitted by a nurse, authored for such proceedings but in the actions of the registrant in the years since her suspension. The Registrant has worked in allied professions since her suspension and had no further issues, disciplinaries or referrals.*

10. *The registrant has accepted the determination of the panel and showed a sincere appreciation of the importance of their task and the importance of*

nurses being held accountable by their regulator. She clearly accepts the importance of colleagues being empowered to raise issues and has done a significant amount of work on bullying and whistle blowing (i.e. speak up guardian, policies at Butterwick).

[…]

15. *It is submitted the Registrant's time spent suspended from the register also has some relevance when determining the position as it stands today, and the proportionality of a term of suspension as a substantive order on public confidence/interest grounds. We are not advocating for a time served approach, but the fact that a nurse was previously under an interim order, and for how long, are relevant background factors in deciding on what a proportionate length of sanction might be and what work has been achieved already through the mechanism of a suspension.*

16. *Where there is particular concern about a sanction going to public confidence in the profession, or to the declaring and upholding standards of conduct, it is submitted that there should be much greater consideration to proportionality, even more so where there has been such a protracted chronology as there is in this case.*

17. *It is argued that the Registrant does not continue to present a risk to members of the public in her role and that in all the circumstances of this case assessing the matter now in October 2024, does not demand a suspension from practice.*

[…]

19. The Registrant has already paid a substantial price for her conduct. [PRIVATE]. It is the only profession the Registrant has ever known, she has spent her life building that knowledge and experience.

20. [PRIVATE]

Work undertaken whilst under suspension

21. The Registrant has been committed to her own improvement and professional development (management training, sexual harassment training, speak up guardian training). [PRIVATE] she had [PRIVATE] a management course and done further top up management style and leadership training through NHS England. The Registrant gave detailed evidence about her conscious decision to act more formally at work. She told the panel she is mindful of her actions and how she comes across to other people. It is submitted that this is supported by the live evidence of the Registrant's colleagues at Butterwick.

22. [PRIVATE].

23. Further, the years she has worked without referral, issue or complaint are important considerations to the practicality of any conditions of practice order. The evidence the panel have had about the Registrant goes further than an absence of issues. The Panel heard evidence she was highly regarded at Butterwick, as a colleague and in the context of her seniority. The panel are aware the Registrant was invited to manage the children's unit for 6-7 months whilst a permanent employee was found. It is submitted that the evidence of the Registrant's work in her previous and current roles is of heightened significance in light of the nature of this employment. The Registrant has occupied important positions in an emotive, high pressure clinical environments, where she is required to work with colleagues across multiple disciplines and hold staff to account for procedures, patient safety and quality

assurance. The Registrant has navigated these challenges to the benefit of Butterwick Hospice and more recently as a clinical trainer.

24. *It is clear that she has been under the close supervision of management and her role at Butterwick involved the heightened scrutiny of CQC investigations in the context of a service which at the time she joined, was performing poorly. The panel are invited to consider the supervision records provided by the Registrant, which demonstrate significant progress in her current role. She has been deemed to have excellent feedback for relationships with staff in her previous role at Butterwick (see page 116 of exhibit 40).*

25. *In written submissions made on behalf of the Registrant at stage 2,* […]*. The panel also heard evidence as part of the NMC's case from witnesses that spoke to the Registrant's clinical skills and dedication to patients: "She was a good clinician. She had good clinical knowledge. She generally had good relationships with the patients. She was careful. She considered risk."* […]*. The panel may recall evidence from other witnesses that the Registrant was a patient centred nurse.* […]

26. *The Registrant spent over twenty years on the Register before her referral. In that time, working in challenging mental health settings, she had no regulatory or disciplinary issues with employers. There is no evidence of further incident in the years since these charges. The Registrant is in the difficult position of any suspended professional – to demonstrate an appropriate sanction would allow her to continue to practise, whilst complying with an order that prevents her from practising.*

27. *To impose a striking off order would be inappropriate, disproportionate and draconian. There is no evidence of ongoing concerns.*

Conclusion

28. *It is submitted that a conditions of practice order is the proportionate outcome in this matter in 2024. The Registrant has made significant progress in allied roles and it is submitted that a suspension order would prolong the punitive impact on the Registrant to the detriment of her ability to strengthen her practice. The Registrant would now benefit from close supervision and support - carefully managed by appropriate conditions.*

29. *The panel could consider conditions to require supervision, targeted training and progress reports. The Registrant's order would be subject to the review and oversight of a future panel.'*

The panel accepted the advice of the legal assessor. Her advice included reference to the cases of: *Council for the Regulation of Healthcare Professionals v GMC & Southall* [2005] EWAC 579 (Admin), *Atkinson v GMC* [2009] EWHC 3636 (Admin), *Giele v GMC* [2005] EWHC 2143 (Admin), *O v GMC* [2015] EWHC 2949 (Admin) and *Adil v GMC* [2023] EWCA Civ 1260.

Decision and reasons on sanction

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

The panel took into account what it considered to be the aggravating features as follows:

- The misconduct included sexual misconduct. The panel had regard to the SG which identifies sexual misconduct as a serious category of misconduct.

Whilst the panel was of the view that sexual harassment will always be serious, it bore in mind that the sexual harassment was in respect of words, not deeds and so was at the lower end of seriousness for sexual harassment. Nevertheless, the words were highly inappropriate in the workplace, and had become part of the work culture.

- The misconduct included bullying behaviour towards staff and colleagues.
- The misconduct was a pattern of behaviour over a period of two years in two workplaces;
- You had been in senior positions; and
- Your actions had created a hostile environment which had potentially put patients indirectly at risk of suffering harm.

The panel had regard to its findings at the impairment stage, to the effect that it had concerns about your attitudinal issues and your apparent lack of insight. In particular, the panel noted that it had not been satisfied at that time that you had been honest with yourself or the panel in your approach to your own shortcomings. Therefore, the panel specifically considered whether this was still the position and whether, therefore they should be regarded as aggravating factors.

The panel noted that at the impairment stage, it had been of the view that your insight had the potential to develop in the future. It bore in mind that a further six months had elapsed since it announced its decision on impairment. The panel had regard to your latest reflective piece. It considered that you have used that time to further reflect on your misconduct and its impact on your colleagues, the profession and public confidence. The panel considered that you have now taken ownership of your behaviour and understood the depth of its impact. The panel was of the view that in the last six months, you have developed significant insight into your failings and misconduct. Because of your significant progress in the last six months, the panel therefore determined that the current position is that there are no aggravating factors in relation to attitudinal issues and lack of insight.

The panel disagreed with Mr Malik that there were no mitigating factors in this case. It considered that there were a number of mitigating features.

The panel was of the view that your insight has developed significantly over the protracted course of these proceedings which have lasted some 18 months. It took into account your updated reflective piece and considered that you have taken the opportunity since the decision on misconduct and impairment was handed down in April 2024, to properly reflect on the panel's decision and reasons. Over the course of that six months, the panel considered that you now take accountability for your actions and understand the impact such behaviour has on colleagues and public confidence in the profession.

Further, the panel was of the view that you have used the time over which the regulatory process has taken, to strengthen your practice in a health care setting, albeit not in the role of a nurse. The panel considered that there is clear evidence of you following good practice, both in your time at Butterwick Hospice Care where you were the Quality and Governance Lead between February 2022 and 17 September 2024 as well as in your new role as a managerial trainer since 23 September 2023. You have been subject to an interim suspension order on your registration since 10 January 2022 and during this period, you have been working in non-registered managerial positions without any concerns. You provided the panel with testimonials which attest to your ability to manage people successfully and facilitate disputes. There is no evidence before the panel today as to any new concerns.

[PRIVATE].

The panel took into account the commitment you have shown to good practice whilst working in a clinical work environment. The panel also took into account your full engagement and your attendance in this whole process. It noted that the length of this substantive hearing was longer than expected which may have caused you difficulties to present your case in the best light.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case in which the misconduct was not at the lower end of the spectrum. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified and would not sufficiently mark the seriousness of your misconduct or meet the wider public interest aspect of the case, namely maintaining public confidence and upholding standards. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

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

The panel considered that the majority of these factors were present in your case. In respect of your current position and your recent progress, the panel was satisfied that there is no current evidence of harmful deep-seated personality or attitudinal problems.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. It noted that although misconduct was not related to your clinical practice it was related to your practice as a manager. It was of the view that your updated reflections demonstrated a development of your insight and the testimonials attest to your improved management style. The panel noted that at the impairment stage it had not been satisfied that your misconduct was highly unlikely to be repeated. Although the panel considered that the risk of repetition had continued to reduce since that time, it was mindful that you have not been tested in a nursing role for a considerable period of time.

In light of your continued development of insight, the panel was confident that you would be willing to comply with conditions of practice. It was of the view that a conditions of practice order would allow you an opportunity to return back to nursing practice to demonstrate your continued developing insight in a clinical setting.

The panel had regard to the fact that the misconduct dates back to 2021 and there have been no concerns raised in your non-registered management positions. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

The panel also considered whether a conditions of practice order was sufficient to address the public interest concerns, given the seriousness of the misconduct itself. The panel bore in mind that you have already been subject to an interim suspension order for approaching three years. Whilst the interim suspension was imposed to address public protection and public interest concerns, the panel also bore in mind that the practical effect has been that you have already been suspended from the register for a considerable period of time. The panel was satisfied that in such circumstances, public confidence would not be undermined if, knowing that you have already been suspended for nearly three years, you were permitted to return to practice under a conditions of practice order.

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

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

In making this decision, the panel carefully considered the submissions of Mr Malik in relation to the sanction that the NMC was seeking in this case. The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the particular circumstances of your case given the passage of time and your developing insight. The panel noted that an interim suspension order was imposed in 2022 and since then, you have continued to work in a clinical setting. The panel was of the view that a conditions of practice order would give you an opportunity to demonstrate your developing management style in a registered practice setting. The panel was also of the view that a conditions of practice order is also an opportunity to demonstrate the NMC's values: fairness, kindness, ambition and collaboration.

The panel noted that you want to return back to practice as a registered nurse. It appreciated that you are working as a training manager and that a conditions of practice order will give you an opportunity to practice in a registered role whilst being supervised by the condition. It noted that you are currently working in a non-registered role with a long-standing friend who has given evidence on your behalf in these proceedings.

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

For the purpose of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. In every clinical setting in which you work, you must keep a reflective practice profile. This profile requires you to write a reflection at least every 6 weeks in respect of your practice, covering in particular:
    a) when you have been challenged;
    b) when difficult conversations have needed to be had;
    c) working as part of a team;
    d) details of your leadership and interpersonal relationships in a professional context and
    e) being a role model.

   You must ensure your line manager for each clinical setting signs off your reflective practice profile after each meeting.

   You must send your case officer a copy of the entire reflective profile seven days before the next review hearing.

2. In every clinical setting in which you work, you must meet with your line manager at least every six weeks to discuss your practice and reflective profile, to ensure that you are making progress towards aims set in your reflective discussions.

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

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

5. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis

when you are working in a self-employed capacity.

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

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

The period of this order is for 18 months to give you an opportunity to return back to nursing practice and for you to comply with the conditions.

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

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik who invited the panel to impose an interim conditions of practice order for a period of 18 months to cover the appeal period.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any appeal period.

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

That concludes this determination.