Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 23 October 2024 – Thursday, 31 October 2024
Monday, 11 November 2024

Virtual Hearing

Name of Registrant:	**Kaleigh Noakes**
NMC PIN:	18A0012W
Part(s) of the register:	Nurses Part of the Register- Sub Part 1 Mental Health Nurse, level 1 (29 March 2018)
Relevant Location:	Merthyr Tydfil
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant member) Karen Shubert (Registrant member) Richard Bayly (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Clara Federizo
Nursing and Midwifery Council:	Represented by Marcia Persaud, Case Presenter
Miss Noakes:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 6a, 6b, 6c, 7a, 7b, 7c, 7d, 7e, 7f, 8, 9, 10, 11b, 11c, 12a, 12b and 14
Facts not proved:	Charges 4, 5, 11a, 12c and 13
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on panel recusal

At the outset of the hearing, Mr Mitchell, the legal assessor, provided advice to the panel which centred on ensuring a fair hearing by highlighting three key areas where the panel possesses information that it normally should not. He advised:

1. Interim Order Awareness: The panel has been informed about an interim order related to Miss Noakes, information typically withheld until the impairment stage.

2. Witness Information: Miss Noakes' documents discuss Mr 1, a non-witness who has not provided a signed witness statement, meaning the panel should not consider his alleged statements.

3. Conditions of Practice: There is information from Witness 2 relating to conditions of practice which Miss Noakes may have been under which should have been redacted.

Mr Mitchell urged the panel to disregard these details, which have now been properly redacted, to avoid bias in its decision-making. He emphasised that if the panel cannot ignore these aspects, it should consider recusal to maintain fairness and the appearance of impartiality, noting that justice must not only be done but be seen to be done.

Dr Persaud, on behalf of the Nursing and Midwifery Council (NMC), also addressed concerns about fairness in the hearing due to the inadvertent exposure of information from Miss Noakes' bundle, which it should not have at this stage, but which has now been redacted.

Dr Persaud endorsed the legal advice that the panel should consider whether exposure to this material could infringe on Miss Noakes' Article 6 right to a fair hearing. If so, the panel should consider recusal to preserve impartiality.

Dr Persaud submitted that the NMC is not requesting that the panel recuses itself and that it is a matter for the panel on whether a fair hearing is achievable despite the exposure to redacted information. She emphasised that the panel should weigh the risk of prejudice independently.

The panel accepted the advice of the legal assessor.

The panel considered the three key areas separately first and then collectively. It noted that an interim order does not form the basis of the charges and was therefore irrelevant at this stage. It also noted that Mr 1 is not a witness in this case and therefore anything he may have said can properly be disregarded. The panel considered that whether or not Miss Noakes was on an interim conditions of practice order is not relevant to this stage of the proceedings.

The panel determined that, as a professional and experienced panel, it was able to put irrelevant information out of its mind. The panel was satisfied that it could conduct a fair hearing and keep to admissible evidence to reach a determination based on only the evidence that is before it.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Noakes was not in attendance and that the Notice of Hearing letter had been sent to Miss Noakes' registered email address by secure email on 24 September 2024.

Dr Persaud referred the panel to the email sent to Miss Noakes containing the Notice and the signed statement of the NMC Listings Officer who sent it. She submitted that the NMC had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Noakes' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Noakes

The panel next considered whether it should proceed in the absence of Miss Noakes. It had regard to Rule 21 and heard the submissions of Dr Persaud who invited the panel to continue in the absence of Miss Noakes. She submitted that Miss Noakes had voluntarily absented herself.

Dr Persaud referred the panel to the email from Miss Noakes to the NMC on 20 September 2024, which stated:

> *"I've asked not to be informed about anymore of this. Remove me off the register and remove my email. Carry on as you all need to and leave me be. Sent from my iPhone"*

Dr Persaud submitted that there had been no engagement at all by Miss Noakes with the NMC in relation to these proceedings since her last email on 20 September 2024 and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Noakes. In reaching this decision, the panel has considered the submissions of Dr Persaud, the correspondence from Miss Noakes and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Noakes;
- Miss Noakes has expressed she wishes to no longer be informed and has voluntarily absented herself;
- Miss Noakes has not re-engaged with the NMC and has not responded to any of the recent correspondence sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Noakes in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. Miss Noakes will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make

allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Noakes' decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

During the course of the hearing, the panel heard an application made by Dr Persaud to amend the wording of charges 4, 5, and 13.

The proposed amendments were to change the word *"uniform"* to *"identity badge"* in charge 4, correct a grammatical error in charge 5 and correct the date (month) from *"February"* to *"January"* 2022 in charge 13 and replace the words *"sign out"* with *"obtain senior carer signature to check/sign for"*. It was submitted by Dr Persaud that the proposed amendments would provide clarity and more accurately reflect the evidence.

The proposed amendments are as follows:

"That you, a registered nurse:

…

4) In June 2021, whilst wearing your NHS ~~uniform~~ ***identity badge****, you recorded a Tik Tok video with a caption that read 'total mood for work' and included you singing with the words 'I am fucking sick of it'*

5) *On or before August 2021 you created an Only Fans page titled "Boobs Everywhere" or alternatively you knew that the page had been created, which was ~~an~~ inappropriate and/or an inappropriate use of social media;*

…

13) *On 21 ~~February~~ **January 2022 and 23 January** 2022, you failed to ~~sign out~~ **obtain senior carer signature to check/sign for** medication for Resident B in the Drugs Liable to Misuse Book as required;"*

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

The panel considered each application separately and considered the merits of the case and fairness and whether injustice would be caused. The panel reminded itself that the principles of fairness and justice apply equally to both parties.

In regard to the proposed amendments in charge 5, the panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Noakes and no injustice would be caused to either party by the proposed amendment being allowed as this was merely the correction of a grammatical error in the charge. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

The panel was not satisfied that the proposed amendments in relation to charges 4 and 13 were fair nor appropriate, as it determined these were significant changes to the charge which Miss Noakes would not have been previously aware of. The panel determined that, in fairness, these proposed amendments should be sent to Miss Noakes for her observations. Accordingly, it requested that the NMC attempt to make contact with her and provide her with the details and request her response.

The panel heard additional submissions from Dr Persaud as to why it should accede to her applications to amend charges 4 and 13.

During the course of its deliberations and prior to the handing-down of facts, the panel was informed by Dr Persaud that Miss Noakes had not responded to the request for her observations on the proposed amendments, having been afforded a number of days in which to do so.

The panel did not allow such amendments to be made as it considered there would be prejudice and injustice caused to Miss Noakes if the proposed amendments were to be made at this late stage.

Details of charge (as amended)

That you, a registered nurse:

1) Failed to complete a Duty to Report Form in relation to a safeguarding matter concerning a vulnerable child;

2) Failed to inform the police and/or social services of your knowledge that a vulnerable child was [PRIVATE];

3) On 15 April 2021 you recorded and sent 2 voice messages to your work WhatsApp group that were inappropriate and/or unprofessional;

4) In June 2021, whilst wearing your NHS work uniform, you recorded a Tik Tok video with a caption that read *'total mood for work'* and included you saying words to the effect of *"I'm fucking sick of it"*;

5) On or before August 2021 you created an Only Fans page titled *"Boobs Everywhere"* or alternatively you knew that the page had been created, which was inappropriate and/or an inappropriate use of social media;

6) Between December 2020 and May 2021, on one or more occasion, you failed to complete and/or update, adequately or at all, clinical documentation relating to one or more patient including:

    a) Care plans;
    b) Treatment plans;
    c) Assessment plans;

7) Between February 2021 and May 2021, you failed to:

    a) give one or more patient their antipsychotic depot injection as prescribed;
    b) update one or more patient medication chart with correct clinical information;
    c) provide an adequate handover to colleagues in relation to one or more patient and/or sign medication charts;
    d) order medication for a patient resulting in the patient missing their depot injection;
    e) follow the Missed Depot Policy;
    f) check blood results during the Lithium clinic as required;

8) Between 17 June 2021 and 11 August 2021, while on a period of paid sick leave from your employer, you advertised and/or worked as a self-employed singer;

9) On 8 July 2021 having been informed by management that your conduct at charge 8 was unacceptable, you continued to work as a self-employed singer during your period of paid sick leave;

10) Your actions at charge 8 were dishonest in that you knew that you were not entitled to work in another paid role whilst in receipt of sick pay from your employer but chose to do so;

11) Between January 2022 and June 2022, on one or more occasion you;

a) came into work with your puppy which was in breach of the Home's no pets policy;
b) made and posted Tik Tok videos in various parts of the Home and in your uniform which were inappropriate;
c) made and posted a video with a vulnerable Resident in the middle of the night when the Resident should have been asleep;

12) On 7 June 2022 you failed to:

a) carry out adequately or at all, observations for Resident A following a fall, or alternatively, failed to record your observations;
b) document the incident in Resident A's care notes and/or the accident book;
c) complete a post incident report form;

13) On 21 February 2022 you failed to sign out medication for Resident B in the Drugs Liable to Misuse Book as required;

14) On 7 July 2022 you failed to sign out Buprenorphine on Resident C's drug chart;

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

Background

The charges arose whilst Miss Noakes was employed by Aneurin Bevan University Health Board (ABUHB) as a registered nurse and subsequently, employed by the Central Surgery

Nursing Home (the Home). She was referred to the NMC on 6 May 2022 by the Head of Nursing Education at ABUHB.

Miss Noakes faced several allegations related to her professional conduct at both ABUHB and the Home, leading to concerns about her reliability, behaviour and adherence to professional standards.

Miss Noakes disclosed that police visited her home due to a safeguarding issue involving [PRIVATE], who was suspected of an inappropriate relationship with a vulnerable [PRIVATE]. Miss Noakes stated that she had made a safeguarding referral regarding this vulnerable [PRIVATE], however, ABUHB found no record of any formal disclosure to social services.

Miss Noakes reported herself as sick but was allegedly observed socialising and performing as a paid singer during sick leave, despite being instructed by her employer not to do so. While on sick leave, following a review of her caseload, it was discovered that some patients under her care were allegedly found to have missed essential injections, lacked contact for extended periods and had incomplete records.

Miss Noakes allegedly left inappropriate voice messages in a team WhatsApp group, posted a video of herself lip-syncing an inappropriate song while appearing to be at work and shared photos on a webpage with inappropriate content. Miss Noakes resigned from ABHUB before a disciplinary hearing.

Similar concerns were raised at her subsequent employment at the Home, including alleged attendance issues, unprofessional conduct (such as bringing her puppy to work and making TikTok videos in uniform) and inadequate responses to a resident fall and medication errors. Miss Noakes resigned from the Home before any formal investigation could be completed.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Dr Persaud on behalf of the NMC and the 'registrant response' bundle submitted by Miss Noakes.

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

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

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

- Witness 1: Senior nurse at ABUHB;
- Witness 2: Registered manager at Central Surgery Nursing Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included reference to *Ivey v Genting Casinos* [2017] UKSC 67. It considered the witness and documentary evidence provided by both the NMC and Miss Noakes.

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

Charges 1 and 2

"That you, a registered nurse:

1) Failed to complete a Duty to Report Form in relation to a safeguarding matter concerning a vulnerable child;

2) Failed to inform the police and/or social services of your knowledge that a vulnerable child was [PRIVATE];"

These charges are found proved.

The panel considered each of the charges individually but have written them up together as they relate to the same regulatory concern.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report dated 18 November 2022, the safeguarding issue letter dated 22 April 2021, the Section 5 Practitioners concerns meeting notes on 27 May 2021 and the outcome meeting on 3 March 2022 regarding the duty to report.

The panel paid close attention to the documentary evidence, which established that Miss Noakes had a duty to report the safeguarding concern and complete the relevant form in this regard. It noted that the outcome of the meeting held on 3 March 2022 was 'substantiated'. The panel had reference to Witness 1's statement in which she referred to a vulnerable child and Miss Noakes not understanding that she had a duty to report this as a safeguarding issue.

The panel considered the following evidence:

"Concerns have been raised to us via her manager in relation to the possible exploitation/grooming of [PRIVATE]…who is open to…Children's Services… [A social worker] had disclosed that [Miss Noakes] was instrumental in sometimes picking [PRIVATE] up and bringing [PRIVATE] to the address of where [PRIVATE] with [PRIVATE]."

The panel considered the following evidence contained within the meeting on 3 March 2022:

"[Witness 1] stated that she believed that Kaleigh's failure to make a DTR, around what she had believed to be an abusive home life, was failing her responsibility as a registrant. She when asked had also informed [Witness 1] that she had done this, however social service found no evidence of a DTR. [A police officer] informed the group that Kaleigh had made a statement that the relationship began after the [PRIVATE] Birthday. Her failure to recognise a relationship between a [PRIVATE] and a vulnerable [PRIVATE] was also concerning to [Witness 1]."

The panel considered that the documentary evidence is corroborated by the oral and written evidence of Witness 1. The panel found Witness 1's oral evidence to be clear and consistent.

The panel bore in mind that Miss Noakes stated that she reported the safeguarding matter. However, the panel had no documentary evidence before it to validate this claim.

The panel determined that, on the balance of probabilities, it was more likely than not that Miss Noakes failed to complete a Duty to Report Form in relation to a safeguarding matter concerning a vulnerable child and failed to inform the police and/or social services of her knowledge that a vulnerable child was [PRIVATE].

Accordingly, the panel finds charges 1 and 2 proved.

Charge 3

"That you, a registered nurse:

3) On 15 April 2021 you recorded and sent 2 voice messages to your work WhatsApp group that were inappropriate and/or unprofessional;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report dated 18 November 2022, the voice recordings and a transcript of these.

The panel considered that the documentary evidence is corroborated by the oral and written evidence of Witness 1. The panel found Witness 1's oral evidence to be clear and consistent.

The panel heard the actual voice recordings and assessed the tone and manner of what was said in these. This included the use of profanity on a professional group communication platform. It determined that on 15 April 2021 Miss Noakes recorded and sent 2 voice messages to her work WhatsApp group that were inappropriate and unprofessional.

Accordingly, the panel finds charge 3 proved.

Charge 4

"That you, a registered nurse:

4) In June 2021, whilst wearing your NHS work uniform, you recorded a TikTok video with a caption that read *'total mood for work'* and included you saying words to the effect of *'I'm fucking sick of it'*;"

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary evidence before it and the oral and written evidence of Witness 1.

The panel had sight of the TikTok video. Whilst the panel found that the caption and the words used in reference to work are present in the video as set out in the charge, the panel found this charge not proved as Miss Noakes is not seen to be wearing an NHS uniform in the video.

Further, the panel heard evidence from Witness 1 that Community Psychiatric Nurses do not wear uniform.

Accordingly, the panel finds charge 4 not proved.

Charge 5

"That you, a registered nurse:

5) On or before August 2021 you created an Only Fans page titled "Boobs Everywhere" or alternatively you knew that the page had been created, which was an inappropriate and/or an inappropriate use of social media;"

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary evidence before it and the oral and written evidence of Witness 1.

The panel had sight of the screenshots of Miss Noakes' alleged 'Linkfly' links to social media and 'Onlyfans' profile before it. The panel noted that Miss Noakes' name is included but no photo of her face. It also noted that Miss Noakes denied that this was her profile and stated that her account had been hacked.

The panel heard oral evidence from Witness 1 stating that she was not certain that the page she saw was Miss Noakes' profile.

The panel determined that the evidence in support of this charge failed to show that Miss Noakes either created or knew the page had been created. Therefore, it concluded that the NMC had not discharged the burden of proof.

Accordingly, the panel finds charge 5 not proved.

Charge 6 (in its entirety)

"That you, a registered nurse:

6) Between December 2020 and May 2021, on one or more occasion, you failed to complete and/or update, adequately or at all, clinical documentation relating to one or more patient including:

    a) Care plans;
    b) Treatment plans;
    c) Assessment plans;"

This charge is found proved in its entirety.

The panel considered each of the charges individually but have written them up together as they relate to similar regulatory concerns involving planning documentation that occurred at the same workplace.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report and notes from the meeting held on 22 April 2021 with Miss Noakes.

Additionally, the panel bore in mind Witness 1's statement in which she relayed the following:

> *"Another concern was that Kaleigh had not completed clinical documentation including care plans, treatment plans and assessments. This related to her practice between December 2020 and May 2021. These concerns were picked up when Kaleigh was off sick and other staff had to pick up her cases."*

The panel considered that the documentary evidence clearly shows that the care plans, treatment plans and assessment plans of patients under Miss Noakes' care were incomplete, and this is corroborated by the evidence of Witness 1. The panel found Witness 1's oral evidence to be clear and consistent.

The panel also noted that when these issues were initially raised with Miss Noakes, she admitted that she failed to realise that she had not undertaken the completion of these patient plans.

Accordingly, the panel finds charges 6a, 6b and 6c proved.

Charge 7 (in its entirety)

"That you, a registered nurse:

7) Between February 2021 and May 2021, you failed to:

a) give one or more patient their antipsychotic depot injection as prescribed;
b) update one or more patient medication chart with correct clinical information;
c) provide an adequate handover to colleagues in relation to one or more patient and/or sign medication charts;
d) order medication for a patient resulting in the patient missing their depot injection;
e) follow the Missed Depot Policy;
f) check blood results during the Lithium clinic as required;"

This charge is found proved in its entirety.

The panel considered each of the charges individually but have written them up together as they relate to similar regulatory concerns that occurred at the same workplace.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report, the Home's 'Anti-psychotic Depot Injections Guidance for Missed Doses' and 'Medication Management Policy'.

The panel considered that the policies outline what to do when depot injections are missed. The documentary evidence in the Investigation Report and appendices demonstrate that Miss Noakes' notes were incomplete, and this is corroborated by the evidence of Witness 1. She stated:

> *"Seven patients were identified as having issues with their antipsychotic depot injection. There were Depot charts unsigned, along with poor record keeping so it was not clear if patients had their depot's or not. It was clear some patients had been receiving their depot's up to two weeks late…*

…Kaleigh was not able to explain why she missed Depot injections or signing charts. She said that she hadn't even known about missing them".

With regards to sub charges 7c, 7d and 7e, the panel considered the following evidence from Witness 1:

"Kaleigh had failed to record or handover what was needed to be covered, several patients made contact regarding depot injections that Kaleigh had not highlighted were due. One patient arrived for an injection that Kaleigh had forgotten to order and therefore couldn't be given. The missed depot policy does not appear to have been followed and no escalation."

With regards to 7f, the panel considered the following evidence from Witness 1:

"One of Kayleigh's roles was to take bloods and check results of these in Lithium clinic. Another CPN when covering lithium clinic raised that she could not find evidence in the notes from one clinic that any results had been checked from the previous clinic. These were checked and no abnormalities identified. Lithium levels are monitored as lithium toxicity can be life threatening and required immediate action."

The panel found Witness 1's oral evidence to be clear and consistent.

The panel noted that Miss Noakes did not deny missing the depot injections, she stated she did not realise she had not completed these tasks as required.

The panel determined that, on the balance of probabilities, it was more likely than not that Miss Noakes failed to follow prescriptions, update and sign medication charts, provide adequate handovers, order medication, follow the Missed Depot Policy and check blood results of one or more patients between February 2021 and May 2021.

Accordingly, the panel finds charges 7a, 7b, 7c, 7d, 7e and 7f proved.

Charge 8

"That you, a registered nurse:

8) Between 17 June 2021 and 11 August 2021, while on a period of paid sick leave from your employer, you advertised and/or worked as a self-employed singer;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report, the Absence Report, the Facebook posts and Miss Noakes' response.

The panel considered that the documentary evidence is corroborated by the oral and written evidence of Witness 1. The panel found Witness 1's oral evidence to be clear and consistent.

The panel had regard to Miss Noakes' absence report and Facebook posts. It found that the dates on Miss Noakes sickness record coincide with the dates Miss Noakes advertised the events on Facebook and/or worked as a self-employer singer.

The panel also noted that, in her letter dated 13 July 2021, Miss Noakes admitted to working as a self-employed singer as she requested permission from Witness 1 to *"undertake self-employed work as a singer at weekend whilst absent from work"*.

Accordingly, the panel finds charge 8 proved.

Charge 9

"That you, a registered nurse:

9) On 8 July 2021 having been informed by management that your conduct at charge 8 was unacceptable, you continued to work as a self-employed singer during your period of paid sick leave;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the Investigation Report, the Absence Report, the Facebook posts, the letters dated 9 July 2021, 13 July 2021 and 27 July 2021, the Managing Attendance at Work Policy, the proof of sick pay received and the correspondence/report to Counter Fraud.

The panel noted that in the letter dated 9 July 2021, Witness 1 outlines that she contacted Miss Noakes by phone on 7 July 2021 *"to advise that in line with the All Wales Managing Attendance at Work Policy (Section 2 – Undertaking other work whilst absent) once reported as absent due to sickness, an employee should not undertake work including, self-employment, without the prior written consent of the manager".* The letter specified that violating this policy could constitute a breach of contract and lead to disciplinary action.

The panel assessed the evidence of sick pay received by Miss Noakes against Facebook posts promoting her live singing performances. It found that the dates on her sickness record aligned with those of her self-employed singing engagements, as advertised on Facebook. These posts, promoting 'live' performances with 'booked seating', featured events on 9, 12, 15, and 19 July 2021, dates following Witness 1's communications. The posts also extended as late as 19 December 2021, several months afterward.

The panel considered that the documentary evidence is corroborated by the oral and written evidence of Witness 1. The panel found Witness 1's oral evidence to be clear and consistent.

The panel determined that, on the balance of probabilities, it was more likely than not that on 8 July 2021, having been informed by management that undertaking and/or advertising work as a self-employed singer whilst on paid sick leave was unacceptable, Miss Noakes continued to do so.

Accordingly, the panel finds charge 9 proved.

Charge 10

"That you, a registered nurse:

10) Your actions at charge 8 were dishonest in that you knew that you were not entitled to work in another paid role whilst in receipt of sick pay from your employer but chose to do so;"

This charge is found proved.

In reaching this decision, the panel took into account the evidence considered in charges 8 and 9 above.

The panel first considered Miss Noakes' state of mind at the time and determined that she was aware that she should not be working as a self-employed singer whilst on paid sick leave.

The panel considered that Miss Noakes was aware of the sickness policy, as Witness 1 had specifically instructed her not to engage in any other work while on paid sick leave.

The panel referred itself to the evidence it considered in Charge 9, and it found that Miss Noakes had continued to work despite this directive from Witness 1.

The panel considered the perspective of an ordinary decent person, how they would view Miss Noakes' actions in these circumstances and whether they would consider these to be dishonest. The panel concluded that a member of the public would indeed find Miss Noakes' actions to be dishonest, particularly after being explicitly informed that her conduct was unacceptable.

Accordingly, the panel finds charge 10 proved.

Charge 11a)

"That you, a registered nurse:

11) Between January 2022 and June 2022, on one or more occasion you:

a) came into work with your puppy which was in breach of the Home's no pets policy;"

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2, the message and photo from Miss Noakes sent to the team's WhatsApp group and the Home's 'Welcome Book' which includes the no pet policy.

The panel noted that Miss Noakes admitted having brought her puppy to work and that the evidence of Witness 2 corroborates this.

However, the panel had sight of the Home's policy document on this matter. The policy stated:

"Due to the nature of the care we provide at Central Surgery, we have a no- pet's policy. We are aware that pets proven themselves to be valuable companions to people, and we want to continue this relationship, therefore, you dog is welcome to visit, but please be mindful that they may respond differently to various situations that he/she may encounter on the home…"

The panel determined that the Home's no pet policy was inconsistent as it appeared to welcome dogs. It also noted that the policy document was written in June 2022.

Furthermore, the panel heard oral evidence from Witness 2 to the effect that she wouldn't have minded the dog being brought in if it were in a cage or if it was well behaved and vaccinated.

The panel was not satisfied that the NMC had discharged the burden of proof as the evidence was tenuous and did not show that there was a clear breach of policy.

Accordingly, the panel finds charge 11a not proved.

Charges 11b and 11c

"That you, a registered nurse:

11) Between January 2022 and June 2022, on one or more occasion you;

a) …
b) made and posted Tik Tok videos in various parts of the Home and in your uniform which were inappropriate;
c) made and posted a video with a vulnerable Resident in the middle of the night when the Resident should have been asleep;"

These charges are found proved.

The panel considered each of the charges individually but have written them up together as they relate to the same regulatory concern.

In reaching this decision, the panel took into account the evidence of Witness 2. It noted Witness 2's evidence with regards to 11b and 11c:

> *"Kaleigh had also been using TikTok whilst being in work in full uniform. She filmed herself in the kitchen at the home making a trifle. Another video showed her singing in the Treatment Room. She also posted videos from outside the building in the middle of the night and in the lounge of the home.*
>
> *I believe she would film herself on her phone. Kaleigh put another concerning video on the Whatsapp group. This video showed her outside on the patio with a resident at 1am. I know that this resident had capacity but that wasn't the point. [PRIVATE] should have been in bed at 1am. [PRIVATE]."*

The panel considered that the documentary evidence is corroborated by the evidence of Witness 2. The panel found Witness 2's evidence to be clear and consistent.

The panel noted that it did not have the TikTok videos before it. However, it also noted that Miss Noakes did not deny having made and posted TikTok videos in various parts of the Home, in uniform and with a Resident when they should have been asleep.

The panel determined that such actions were inappropriate.

Accordingly, the panel finds charges 11b and 11c proved.

Charge 12a and 12b

"That you, a registered nurse:

12) On 7 June 2022 you failed to:

a) carry out adequately or at all, observations for Resident A following a fall, or alternatively, failed to record your observations;
b) document the incident in Resident A's care notes and/or the accident book;"

These charges are found proved.

The panel considered each of the charges individually but have written them up together as they relate to the same regulatory concern.

In reaching this decision, the panel took into account the evidence of Witness 2, the Falls and Prevention Policy Protocol and Post Incident form dated 7 June 2021.

The panel had regard to the notes written and signed by Witness 2, on 10 June 2022, under the section 'further action to be taken':

> *"[Miss Noakes] did not keep close observations during the night. Unsure whether hit head. No vital signs obtained during the night. Accident form not completed after incident. Not completed until night of 9.6.22 as sick previous night (5.6.22). Only post incident completed. Protocol not followed completely."*

The panel considered that the documentary evidence is corroborated by the evidence of Witness 2. The panel found Witness 2's oral evidence to be clear and consistent.

The panel noted that Miss Noakes indicated that she was not aware of these requirements and that she had to undertake them and complete the necessary paperwork. Therefore,

on the balance of probabilities, it is more likely than not that she failed to undertake/record observations and document the incident on Resident A's care notes.

Accordingly, the panel finds charge 12a and 12b proved.

Charge 12c

"That you, a registered nurse:

12) On 7 June 2022 you failed to:

c) complete a post incident report form;"

This charge is found NOT proved.

In considering this sub charge, the panel had regard to a Post Incident Report form referred to in Witness 2's statement. The panel noted that the form had been signed by Miss Noakes and dated 7 June 2022. The panel considered that Witness 2 had informed it that this form had not been completed until 9 June 2022 due to Miss Noakes' sickness leave. However, the panel considered in the absence of any further evidence to contest this discrepancy, the NMC had not discharge the burden of proof.

Accordingly, the panel finds charge 12c not proved.

Charge 13

"That you, a registered nurse:

13) On 21 February 2022 you failed to sign out medication for Resident B in the Drugs Liable to Misuse Book as required;"

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary evidence before it and the oral and written evidence of Witness 2.

The panel had sight of the Drugs liable to Misuse book for Resident B. It considered that the evidence of Witness 2 and documentary evidence does not suggest that Miss Noakes failed to sign out medication for Resident B on 21 February 2022.

The panel noted that the NMC wished to make a substantial amendment to this charge at a very late stage. The NMC sought to alter the charge to reflect Witness 2's testimony to the panel in respect of Miss Noakes not obtaining a counter signature for Resident B's medication on 21 and 23 January 2022. The panel determined that such a late and substantial amendment would be unfair to Miss Noakes.

The panel was not satisfied that the NMC had discharged the burden of proof as the evidence did not show what is alleged in the charge.

Accordingly, the panel finds charge 13 not proved.

Charge 14

"That you, a registered nurse:

14) On 7 July 2022 you failed to sign out Buprenorphine on Resident C's drug chart;"

This charge is found proved.

In reaching this decision, the panel took into account the Drugs liable to Misuse book for Resident C and the oral and written evidence of Witness 2.

The panel had sight of the Drugs liable to Misuse book for Resident C and accepted that on the date in question Miss Noakes failed to sign out Buprenorphine on Resident C's drug chart.

The panel considered that the documentary evidence is corroborated by the evidence of Witness 2. The panel found Witness 2's oral evidence to be clear and consistent.

Accordingly, the panel finds charge 14 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Noakes' 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 practise kindly, safely and professionally.

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

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

Submissions on misconduct

Dr Persaud referred the panel 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.'*

Dr Persaud invited the panel to take the view that the facts found proved amount to misconduct.

Dr Persaud identified the specific, relevant standards where Miss Noakes' actions amounted to misconduct. She submitted that Miss Noakes' actions show a pattern of behaviour inconsistent with the standard expected of a registered nurse, with instances of unprofessionalism, inadequate safeguarding of vulnerable individuals and dishonesty. She submitted the following in relation to misconduct in the charges found proved:

- Safeguarding Failures: Charges 1 and 2 relate to Miss Noakes' failure to protect a vulnerable child, in breach of Code 17, which mandates raising concerns when someone is at risk.

- Record-Keeping Deficiencies: Charges 6, 7, and 14 point to poor record-keeping practices, with risks to patient safety due to unclear or missing documentation, in breach of Code 10.

- Unprofessional Social Media Use: Dr Persaud highlighted charges related to unprofessional posts, including a video on TikTok and shared recordings on WhatsApp involving a vulnerable patient, breaching Code 5 on privacy and Code 20 regarding the use of digital platforms.

- Medication Mismanagement and Patient Safety: Charges 12a and 12b indicate negligence in administering medication and monitoring a patient after a fall, raising

concerns about patient harm and breaching relevant parts of the Code on medicine management.

- Dishonesty and Misuse of Sick Pay: Charges 8, 9, and 10 outline dishonest actions, as Miss Noakes allegedly claimed sick pay while working elsewhere, further violating Code 20's requirement for honesty and integrity.

Dr Persaud submitted that these instances collectively represent a concerning pattern from December 2020 to July 2022 as these showed a prolonged disregard for professional standards and patient safety. She submitted that Miss Noakes' actions were a serious departure from the standards expected of a registered nurse, highlighting the risk to patient safety and unprofessionalism, and therefore, Miss Noakes' actions amounted to misconduct.

Dr Persaud directed the panel to sections of the code which she said had been breached.

Submissions on impairment

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

Dr Persaud submitted that Miss Noakes' actions indicate an ongoing risk to patient safety and public trust in the profession. Dr Persaud stated that Miss Noakes' fitness to practice is impaired on all four grounds of the *Grant* test for assessing professional impairment, as follows:

a) Risk to Patients: Dr Persaud submitted that Miss Noakes' behaviour, including failures in administering critical medications and observing patients after incidents, presented clear risks to patient safety. Dr Persaud referred the panel to instances of missed depot injections and missed observations following a vulnerable resident's fall as examples of risks stemming from her disorganised approach to responsibilities.

b) Damage to the Profession's Reputation: Dr Persaud submitted that Miss Noakes' actions, such as posting videos in uniform on TikTok and sharing inappropriate messages on a team WhatsApp group, were publicly visible and harmed the profession's image. She submitted that these actions brought the nursing profession into disrepute.

c) Breaches of Professional Tenets: Dr Persaud submitted that Miss Noakes' conduct was found to violate core tenets of nursing, including acting in the best interest of others and maintaining professionalism, as outlined in Codes 4.2, 20.1, 20.6, and 21.3 of the NMC Code.

d) Dishonesty: Dr Persaud highlighted Miss Noakes' dishonesty in claiming sick pay from one employer while working elsewhere for financial gain. She submitted that this conduct further evidenced a disregard for honesty and professional integrity.

Further, Dr Persaud submitted that Miss Noakes' showed limited evidence of insight, remorse or effort to strengthen her practice as her reflective accounts and testimonials did not substantively address the regulatory concerns. Given the prolonged period over which these incidents occurred, Dr Persaud submitted that there is a high risk of repetition of such conduct in future. Therefore, she invited the panel to conclude that a finding of impairment is necessary to ensure public safety and maintain confidence in the nursing profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *CHRE v (1) NMC (2) and Grant* [2011] EWHC 927 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin)*, GMC v Chaudhary* [2017] EWHC 2561 (Admin) and *PSA v GMC & Uppal* [2015] EWHC 1947 (Admin).

When considering both misconduct and impairment the panel took into account Miss Noakes' written representations as to the circumstances of some of the charges and her reflections.

The panel ensured that where relevant these points were put to the witnesses at the facts stage where, by and large, they were not accepted.

In respect of the charges Miss Noakes (in summary) informed the panel:

1. In June 2022 she was placed on a lot of shifts due to poor organisation. Some staff were on holiday leaving the home short staffed. She did 21 shifts in June and struggled with this.
2. The medication error occurred when she first started and had undergone only a two-hour induction. For example, she was not informed where the Drug Liable of Misuse Book was kept.
3. Her supervisions came to halt when she was *"forced to go on day shifts".*
4. She asked for safeguarding training but was told to download the NHS app.
5. Regarding charge 12, she did complete documentation but was unaware of the separate accident book until the following night.
6. As regards social media, she said that the company actively encouraged workers to promote the company.

Decision and reasons on misconduct

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

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

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

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

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care'

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

While each charge was considered individually in relation to misconduct, the panel grouped charges together where they related to the same area of regulatory concern.

Charges 1 and 2

The panel considered the context around these charges in that Miss Noakes had knowledge of the [PRIVATE] between the vulnerable child and [PRIVATE]. The panel was particularly concerned that Miss Noakes had failed to recognise the potential abuse by [PRIVATE]. In the circumstances, the panel determined that this was a serious failure to report a safeguarding concern.

The panel had regard to NMC guidance on 'Misconduct' (FTP-2a), and in particular the section 'Risk of harm', which set out:

"In some circumstances, the way a professional conducts themselves outside professional practice could indicate deep-seated attitudinal issues which could pose a risk to colleagues and people in the professional's care.

Professionals must be able to work with and care for the public, including those who are vulnerable. They exercise skills, have access to personal and sensitive information and materials, and undertake responsibilities that give them access to people who are vulnerable to abuse. Professionals need to be able to provide care for a diverse range of people and to work as part of diverse teams. Discriminatory attitudes can have a direct impact on the quality of care provided."

The panel found that Miss Noakes' actions, in failing to safeguard a vulnerable child, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 3

The panel was deeply concerned that Miss Noakes' voice messages to her colleagues on the workplace WhatsApp group contained highly inappropriate and unprofessional language, including profanity. It noted that the WhatsApp group was created specifically for professional communication.

The panel considered the inappropriate voice messages to be particularly serious due to the professional context of the group. The panel found that Miss Noakes' misuse of social media in a work-related setting fell significantly short of the conduct and standards expected of a nurse, and therefore, amounted to misconduct.

Charge 6

The panel reviewed evidence from Witness 1, who indicated that failing to complete clinical documentation posed *"a wide variety of risks and impact to patients and their safety".*

The panel found that the incomplete patient care plans, treatment plans and assessment plans was a pattern of behaviour over six months, constituting a prolonged period of repeated actions that compromised patient safety across several planning documents and involved multiple patients.

The panel also noted that Miss Noakes' lack of awareness regarding these failings further increased the seriousness of the issue.

The panel determined that Miss Noakes' failure to maintain the required clinical documentation over an extended period, and for multiple patients, fell significantly short of the conduct and standards expected of a nurse and constituted misconduct.

Charge 7

The panel considered Miss Noakes' actions in charge 7 related to a concerning pattern of repeated clinical errors, spanning several months and involving numerous patients.

The panel noted that Witness 1 provided evidence on the severe impact on patient safety, as patients missed essential medication. The failure to administer prescribed antipsychotic depot injections was particularly serious as these have substantial implications on the immediate well-being of vulnerable patients.

Furthermore, the panel considered these failings even more serious given that Miss Noakes appeared unaware of her multiple clinical oversights.

The panel found that Miss Noakes' repeated range of clinical failings over an extended period, affecting multiple patients, fell significantly short of the conduct and standards expected of a nurse and constituted misconduct.

Charges 8, 9 and 10

The panel had regard to the NMC guidance on 'Making decisions on dishonesty charges…' (DMA-8), which discusses the seriousness of misconduct in respect of dishonesty: *"never allow…personal interests to outweigh the duty to be honest, open and truthful".*

The panel had regard to Miss Noakes' explanation that her self-employment as a singer was a way of coping with her personal struggles. The panel noted that Miss Noakes could have undertaken such activities in a voluntary capacity, but this was not the case.

The panel considered that despite explicit instructions from her primary employer to cease her additional employment whilst off sick, Miss Noakes continued working as a self-employed singer. This suggested that Miss Noakes allowed her personal interests to outweigh her duty to be honest, open and truthful.

Whilst the panel noted that this was not the most serious instance of dishonesty in the spectrum, it was however, a serious falling short of the standards expected of her as a nurse, given the importance of honesty and integrity in the nursing profession.

The panel determined that Miss Noakes' actions, in receiving sick pay from the Home while simultaneously earning a second active income as a singer, particularly after being instructed not to, fell significantly short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 11b and 11c

Witness 2 told the panel that making TikTok videos in the workplace setting and in uniform was against social media policy of the Home. Further, Witness 2 told the panel that there was an adverse impact upon the vulnerable resident who should have been encouraged to be asleep rather than participating in a TikTok video.

The panel considered that making and posting the TikTok video of the vulnerable resident carried a risk of breaching confidentiality of the residents of the Home. It also considered that there was a risk to the resident's safety from a moving and handling perspective as Miss Noakes had taken him outside in middle of night.

The panel concluded that Miss Noakes' actions, in making and posting inappropriate social media videos in the workplace, while in uniform, during work hours and involving a vulnerable resident, were unprofessional. These actions violated the Home's social media policy and fell significantly short of the conduct and standards expected of a nurse, which therefore, amounted to misconduct.

Charge 12a and 12b

The panel considered that Resident A was a vulnerable resident that suffered a fall. No clinical assessment was documented or communicated to other staff, and as such, patient safety was breached.

The panel was informed by Witness 2 that observations were vital following a resident fall to assess for injuries and monitor any potential deterioration. The panel noted that failing to establish a clinical baseline hinders the ability to detect further complications.

The panel determined that this case exemplified extremely poor record-keeping and represented a significant breach of patient safety.

The panel concluded that Miss Noakes' failure to document the fall incident and perform a clinical assessment of Resident A posed a serious risk to patient safety. Her actions fell significantly short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 14

The panel considered that, although Miss Noakes' failure to sign out Buprenorphine on Resident C's drug chart was a clinical failing involving a controlled drug, each proven charge must be assessed individually rather than collectively. Given that this was an isolated incident, the panel determined that, while this failure was inadequate and far from ideal, it was not sufficiently serious on its own to amount to misconduct.

The panel identified seven key areas of concern and the charges relevant to each:

- Safeguarding failings (charges 1 and 2)
- Medication errors (charge 7a)
- Record keeping errors (charges 6 and 12a)
- Dishonesty (charges 8, 9 and 10)
- Clinical assessment error (charge 12a)
- Social media misuse (charges 3, 11b and 11c)
- Breach of patient safety (charges 6, 7, 11c, 12a and 12b)

Overall, with the exception of charge 14, the panel found that Miss Noakes' actions in all of the charges set out above did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In addition to the submissions from the NMC, the panel also had regard to the following from Miss Noakes in relation to impairment:

- Miss Noakes has completed a number of (undated) NMC Reflective Accounts Forms – In summary, these state that she will deal with situations differently and not rush into decisions but look at the situation as a whole and handle matters in a more professional manner.

The panel also had testimonials including:

(a) A care assistant (undated) who speaks of Miss Noakes as being *"an enthusiastic, upbeat, kind and professional nurse …… I found her role as a RMN to be exemplary".*
(b) An email dated 11 August 2022 from a patient's mother. *"I find her to be caring, kind, and thoughtful. She is always willing to help others often by putting her own needs to the side. ….. I would not hesitate to leave my son, vulnerable 21 yrs, my mum (84) or anyone else in Kayleigh's care….".*

The panel was unfortunately unaware of what Miss Noakes has been doing professionally since the concerns in this case arose. The panel reminded itself of the email referred to in this determination under the heading proceeding in absence:

> *"I've asked not to be informed about anymore of this. Remove me off the register and remove my email. Carry on as you all need to and leave me be. Sent from my iPhone"*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

The panel finds that limb (a) is engaged as to the past and the future. The panel finds that Resident A and other patients were put at risk as a result of Miss Noakes' misconduct in charges 6, 7, 11c, 12a and 12b, and in the absence of remorse, reflection or strengthened practice, the panel finds that Miss Noakes was liable in the future to act so as to put a patient or patients at unwarranted risk of harm.

The panel finds that limbs (b) and (c) are also engaged as Miss Noakes' misconduct in all of the charges found proved, with the exception of 14, had breached a total of 20 parts of the Code and breached the fundamental tenets of the nursing profession, and therefore, brought its reputation into disrepute.

The panel finds that limb (d) is engaged as to the past and the future, particularly in relation to the misconduct found in charges 8, 9 and 10 which involve dishonesty. The panel noted that she provided no evidence of insight that her misconduct was wrong and no evidence that she will not repeat this misconduct. The panel is satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered the information contained within Miss Noakes' response bundle. Based on the information before it, the panel finds Miss Noakes' insight to be very limited as she has not demonstrated an understanding of how her actions put the patients at a risk of harm, why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel noted that Miss Noakes had not shown remorse in the documents she supplied to the panel and only sought to blame others. At this time, there is no information before the panel to suggest any developed insight since the incidents.

The panel then referred to the guidance in *Cohen* and considered whether the misconduct in this case is capable of being addressed.

The panel considered that the following areas of misconduct could be remediable with further reflection and further retraining: medication errors, record keeping error, medical or clinical assessment error and the resulting breaches of patient safety.

However, the panel considered following areas of misconduct to be indicative of a deep-seated attitudinal issue:

1) Miss Noakes' failure to safeguard vulnerable young person and to understand the risk posed to them
2) Miss Noakes' sustained dishonesty with her employer
3) Miss Noakes' repeated inappropriate and unprofessional social media usage

The panel considered that whilst Miss Noakes' dishonesty was not at the higher end of the spectrum of severity. However, it was a sustained dishonesty and continued even after being instructed by her employer that she should stop, it was still indicative of a deep-seated attitudinal issue. The panel considered the NMC's guidance that such attitudinal issues are significantly harder to remedy than those that can be addressed through simple retraining.

The panel carefully considered the evidence before it in determining whether or not Miss Noakes has remedied the concerns. The panel took into account Miss Noakes' response bundle, which included her reflection forms and positive testimonials. However, the panel noted that Miss Noakes had also sought to shift blame on others. The panel had no information before it of remorse, reflection on conduct or evidence to suggest that Miss Noakes has taken steps to strengthen her practice.

In light of this, the panel is of the view that there is a high risk of repetition based on the lack of insight and the absence of any evidence to show Miss Noakes has strengthened

her practice. Based on the limited evidence before it from Miss Noakes, the panel could not be confident that the misconduct would be unlikely to occur again, particularly in relation to the safeguarding and patient safety concerns, and that Miss Noakes could currently practice kindly, safely or professionally. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required because a well-informed member of the public would be concerned if a nurse, who had been dishonest, had acted inappropriately and unprofessionally on multiple occasions and had failings for a prolonged period in a range of fundamental nursing skills, were not found impaired. It determined that public confidence in the nursing profession would be undermined, and standards would not be maintained if impairment were not found. Therefore, the panel also finds Miss Noakes' fitness to practise impaired on the grounds of public interest.

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

The hearing was adjourned on 31 October 2024. It resumed on 11 November 2024.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Noakes was not in attendance and that the Notice of Hearing letter had been sent to Miss Noakes' registered email address by secure email on 4 November 2024.

Dr Persaud submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, date, the transcripts of the previous hearing and that this hearing was to resume virtually, including instructions on how to join and, amongst other things, information about Miss Noakes' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Noakes

The panel next considered whether it should proceed in the absence of Miss Noakes. It had regard to Rules 21 and 32(3). It heard the submissions of Dr Persaud who invited the panel to continue in the absence of Miss Noakes.

Dr Persaud referred the panel to the previous correspondence sent by the NMC to Miss Noakes. She submitted that there had been no engagement at all by Miss Noakes with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. She submitted that Miss Noakes had voluntarily absented herself.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Noakes. In reaching this decision, the panel has considered the submissions of Dr Persaud and the advice of the legal assessor. It had particular regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Noakes;
- Miss Noakes has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The panel has reached the sanction stage and there is a strong public interest in expeditiously dealing with the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Noakes.

The panel drew no adverse inference from Miss Noakes' absence in its decision making.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Noakes off the register. The effect of this order is that the NMC register will show that Miss Noakes has been struck-off the register.

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

Submissions on sanction

In light of the panel's findings on misconduct and impairment, Dr Persaud outlined that public protection was a primary concern. She submitted the following aggravating and mitigating factors for the panel to consider:

- Aggravating Factors: Miss Noakes demonstrated a lack of insight, remorse and understanding of the risks posed to patients due to her actions, which included dishonesty and poor record-keeping. Her actions reportedly brought the profession into disrepute, and the panel identified these as serious breaches of fundamental professional standards.

- Mitigating Factors: Some positive feedback was submitted, including testimonies regarding Miss Noakes' enthusiasm and care. However, this was counterbalanced by her repeated neglect of clinical responsibilities and failure to address her professional deficiencies.

Dr Persaud submitted that taking no action or imposing a caution order would be insufficient to protect the public due to the severity and variety of the concerns found proved. In regard to a conditions of practice order, she submitted that while some issues could potentially be remediated through training, serious concerns like dishonesty and attitudinal problems were deemed incompatible with this approach.

Dr Persaud submitted that a 12-month suspension with review is the appropriate sanction to mitigate the risks identified and would allow time for Miss Noakes to reflect and demonstrate improvement, without permanently removing her from the register. Dr Persaud highlighted that Miss Noakes has recently qualified as a nurse (three years) and perhaps handed in her notice in a moment of anger or immaturity. She noted that Miss Noakes has positive testimonials which attest to her clinical practice. Therefore, a suspension might be more appropriate at this time, as a temporary removal may provide an opportunity for growth and reflection. She submitted that this would meet the public

interest while giving Miss Noakes a chance to rectify her shortcomings. However, Dr Persaud also noted that Miss Noakes has since dis-engaged with the fitness-to-practice process.

Dr Persaud submitted that the panel must weigh the need for public protection against Miss Noakes' rights, balancing proportionality in deciding the appropriate action. She submitted that this is ultimately a matter for the panel.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of remorse, insight and any evidence of strengthened practice into failings
- Repeated misconduct over a period of time
- Conduct which put patients and a child at risk of suffering harm

The panel determined that there were no mitigating features in this case.

The panel considered that Miss Noakes reflections did not take accountability for her actions or demonstrate any insight, but rather she sought to blame others. Further, the panel noted that two out of the three testimonials were neither signed nor dated. The panel considered testimonials to be limited and therefore could not place much reliance on them.

The panel had regard to the SG. The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Furthermore, the panel determined that to take no action would not serve to protect the public.

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 Miss Noakes' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Noakes' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order. Similarly to taking no action, the panel determined that a caution order would not serve to protect the public.

The panel next considered whether placing conditions of practice on Miss Noakes' registration would be a sufficient and appropriate response. The panel recognised that whilst there are conditions which could be formulated to address the concerns that can be rectified through retraining, however, the deep-seated attitudinal concerns, which it deemed to be more serious, were very difficult to remediate. In light of this, there panel determined that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Miss Noakes' registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel determined that none of the factors above were engaged in this case. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Miss Noakes' actions are entirely incompatible with her remaining on the register.

The panel also had regard to the guidance on 'Considering sanctions for serious cases' (SAN-2), in particular the section 'cases which involve dishonesty'. The panel determined that dishonesty is more serious if it involves personal financial gain for breach of trust and pre-meditated deception in that Miss Noakes' dishonest conduct continued despite being told to stop by her employer.

The panel considered that Miss Noakes' failure to demonstrate remorse, accountability in her reflections, any insight or steps taken to remediate her practice to be all the more serious in the context of the charges found proved against her.

In addition, the panel were very concerned by Miss Noakes' conduct in relation to her failure to safeguard a vulnerable child and her failure to inform the police and/or social services that a vulnerable child was [PRIVATE].

Having regard to all the above, the panel determined that a suspension order would therefore not be a sufficient, appropriate or proportionate sanction. The panel determined that whilst a suspension order would protect the public for a short period of time, it would not adequately address the public protection issues identified, nor would it serve to meet the public interest.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG (SAN-3e):

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

The panel determined that the regulatory concerns about Miss Noakes did raise fundamental questions about her professionalism, in particular her attitudinal issues. It considered there were three components of deep-seated attitudinal concerns identified at the misconduct stage:

1) Miss Noakes' failure to safeguard a vulnerable young person and to understand the risk posed to them.
2) Miss Noakes' sustained dishonesty with her employer.
3) Miss Noakes' repeated inappropriate and unprofessional social media usage, including doing so during work hours and the involvement of a patient.

The panel noted that Miss Noakes had not demonstrated accountability or acknowledgement of the seriousness of these concerns or showed awareness that such conduct was unacceptable.

The panel considered that the public would be deeply concerned if a nurse facing serious misconduct, involving multiple instances of dishonesty, and demonstrating no insight into the impacts of such conduct were allowed to remain on the register.

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

In making this decision, the panel carefully considered the submissions of Dr Persaud in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a suspension order would not sufficiently protect the public or meet the public interest in this case due to the lack of remorse and insight by Miss Noakes. Further, the panel noted that Miss Noakes stated that she no longer wishes to engage with the process, and therefore, there was no realistic prospect of her remediating the serious concerns should a suspension order be imposed. As such, the panel determined that a striking-off order was the only sanction suitable in this case.

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

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

This will be confirmed to Miss Noakes in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Noakes' own interests until the striking-off 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 Dr Persaud. She submitted that there is a 28-day appeal period which provides Miss Noakes with the opportunity to consider the decisions of the panel. She submitted that an interim suspension order for a period of 18 months will give the NMC sufficient time to deal with any potential appeal if one were to be made.

Decision and reasons on interim order

The panel was satisfied that an interim suspension 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, the risk of repetition and the reasons set out in its decision for the substantive striking-off order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order to protect the public, address the public interest and reflect the seriousness of the charges found proved. To do otherwise would be incompatible with its earlier findings. The period of this order is for 18 months to allow for the possibility of an appeal to be made and concluded.

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

That concludes this determination.