Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Radisson Blu Hotel, No1 The Light, The Headrow, Leeds, LS1 8TL
30 September 2024, 1-2 October 2024 and 4 October 2024

Virtual Hearing

21-25 and 28-31 October 2024

Name of Registrant:	**Elizabeth Anne Gilmartin**
NMC PIN	83Y1869E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing (Level 1) – 25 March 1986 Registered Midwife Midwifery – 10 November 1988
Relevant Location:	Bradford
Type of case:	Misconduct
Panel members:	Des McMorrow (Chair – Registrant member) Sophie Kane (Registrant member) Alison Lyon (Lay member)
Legal Assessor:	Oliver Wise [30 September – 4 October 2024] Timothy Bradbury [From 21 October 2024 onwards]
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by James Edenborough, Case Presenter
Miss Gilmartin:	Not present and not represented
Facts proved:	Charges 1)a), 1)c), 1)d), 1)e), 1)f), 1)g)i), 1)g)ii), 1)j), 3)a), 3)b), 3)c), and 3)d)
Facts not proved:	Charges 1)b), 1)h) and 2)

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order – 18 months**

Decision and reasons on service of Notice of Hearing

At the outset of this hearing, the panel was informed that Miss Gilmartin was not in attendance and that the Notice of Hearing letter (the Notice) had been sent to her registered email address on 29 August 2024.

Mr Edenborough, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice provided details of the allegation, the time, dates, that it would be a hybrid hearing and, amongst other things, information about Miss Gilmartin's 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 Gilmartin had 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 Gilmartin

The panel next considered whether it should proceed in the absence of Miss Gilmartin. It had regard to Rule 21 and heard the submissions of Mr Edenborough who invited the panel to proceed in the absence of Miss Gilmartin. He referred the panel to the 'Proceeding in Absence' bundle which contained an email dated 13 May 2024 from the Royal College of Nursing to the NMC stating that they are *'coming off the record'* for Miss Gilmartin. The following was also stated in the email:

> *'Please find attached the case management form from the Registrant. Please note that she wants her case determined at a meeting and would not attend a*

hearing if one was to be held. Ms Gilmartin does not wish to engage any further in the NMC process.'

Mr Edenborough submitted that the NMC has received no response to any correspondence it has sent to Miss Gilmartin since it was informed that the RCN would no longer be acted on her behalf. He submitted that it appears that Miss Gilmartin does not wish to engage in these proceedings. Mr Edenborough submitted that given Miss Gilmartin's intention to disengage from the proceedings, it would be in the interests of justice to proceed in her absence. He submitted that witnesses have been warned to attend this hearing and to not proceed would be unfair to them.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as set out in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Miss Gilmartin.
- Miss Gilmartin has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing since the RCN came off the record for her.
- There is no reason to conclude that adjourning would secure Miss Gilmartin's attendance at some future date.
- A witness is due to attend today to give live evidence and others are due to attend.

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that are alleged to have happened in 2022 and further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of cases.

The panel was mindful that there is some disadvantage to Miss Gilmartin in proceeding in her absence. Although the panel noted that the evidence upon which the NMC relies was sent to Miss Gilmartin, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated as it 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. Furthermore, the limited disadvantage is the consequence of Miss Gilmartin's decision to absent herself from the hearing, waive her right 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 Gilmartin. The panel will draw no adverse inference from Miss Gilmartin's absence in its findings of fact.

Details of charge (as amended):

That you, a Registered Nurse:

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

   a) On one or more occasions gave Patient A greetings cards and/or an Amazon gift card and/or cash. **[Proved]**

   b) Gave Patient A a cake. **[Not proved]**

   c) Bought and sent a book to Patient A entitled 'The Secret To Teen Power' **[Proved]**

   d) Engaged in one or more inappropriate conversations during telephone calls with Patient A, as set out in Schedule 1 below. **[Proved]**

   e) On one or more occasions sent a text message to Patient A referring to yourself as 'Earth Mother' and/or 'Mother' **[Proved]**

   f) On one or more occasions sent a text message referring to Patient A as '[PRIVATE]' and/or '[PRIVATE]' **[Proved]**

   g) Failed to record significant information disclosed by Patient A in their records including:

      i) a failure by Notre Dame college to safeguard the patient **[Proved]**

      ii) a discussion about MASH (multi-agency safeguarding hub) **[Proved]**

   h) Told Patient A to dispose of their prescribed medication without clinical justification. **[Not proved]**

   i) On one or more occasions contacted Patient A by telephone and/or text message outside of working hours without clinical justification. **[Proved]**

2) On 23 February 2022 provided Patient A with a list of people you wanted to be harmed. **[Not proved]**

3) In relation to Patient A:

a) On an unknown date did not make a referral to Patient A’s social worker when they told you they were being [PRIVATE]. **[Proved]**
b) On 8 January 2022 did not make a referral to the crisis team and/or Patient A’s social worker when they read you a [PRIVATE]. **[Proved]**
c) On 9 January 2022 did not make a referral to the crisis team and/or Patient A’s social worker when they sent you a text message at 18:33 hours telling you they had [PRIVATE] earlier that day. **[Proved]**
d) Did not record any or all of the information disclosed as specified in charges 3 a) to c) in the patient’s records. **[Proved]**

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

Schedule 1

17 September 2021
6 December 2021
13 January 2022

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

Before hearing evidence from Patient A, the panel heard an application pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). The application was made by Mr Edenborough, on behalf of the Nursing and Midwifery Council (NMC) for the entire hearing to be held in private to protect the anonymity of Patient A.

Patient A supported this application.

Mr Baron, on behalf of Colleague A, did not oppose this application.

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

The panel decided to hold the entire hearing in private to protect the anonymity of Patient A.

Rule 19 (revisited) application

After Patient A had finished giving evidence, they indicated that they would like to have the opportunity to observe the hearing.

Having determined that the entire hearing should be heard in private, the panel was directed to Rule 19(4) of the Rules in which the following is stated:

> 4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

The panel heard the advice of the legal assessor.

The panel considered that Patient A, although they are the referrer and central witness in this case, Patient A is a member of the public as defined by the Rules and would therefore be unable to observe the hearing.

When the hearing resumed on 21 October 2024, Mr Edenborough provided the panel with a Skeleton argument on behalf of the NMC and made an application to revisit its decision on allowing Patient A to observe the hearing. His application was made on the following grounds:

a. *The Panel were incorrectly and/or incompletely advised on the law when they made their original decision.*

b. *There is new material relevant to the balancing exercise which was not before the Panel at the time they made their original decision.*

Mr Edenborough submitted that a variation of the Rule 19 application to allow Patient A to observe is in the interests of justice and the interests of fairness to Patient A. He submitted that as it was decided to hear the entire hearing in private to protect Patient A's privacy, it would create an absurdity if they were not permitted to observe the hearing.

Mr Edenborough informed the panel that Patient A is currently working with the NMC to produce a victim impact statement to be provided to the panel at a later stage. Mr Edenborough submitted that Patient A is available to address the panel directly on his request to observe the remainder of the hearing if required.

Mr Baron opposed this application. He submitted that Rule 19(4) is clear in defining the category of person who is permitted to attend a private hearing, and that Patient A does not fall within this category. Mr Baron also submitted that any impact statement should be written without the influence of Patient A hearing any further evidence.

The panel accepted the advice of the legal assessor who reminded the panel of the provisions set out in Rule 19 of the Rules:

‘19.(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.

(2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant’s physical or mental health must be conducted in private.

(2A)All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—

> *(a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and*
> *(b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.*

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied

> *(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and*
> *(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.*

(4) In this rule, “in private” means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.’

He confirmed the previous legal advice in that the construction of Rule 19(4) is unambiguous and clearly defines the parties permitted to be present during a hearing that is conducted wholly in private.

The panel considered that there was no new information to undermine its previous decision and the rule 19(4) is clear and unambiguous. However, the panel decided to speak with Patient A and invited them to join the hearing.

Patient A told the panel that when they indicated that they supported the application for the entire hearing to be in private, it was not explained to them that this would mean that they could not observe the hearing and that the decision would not be published online. Patient A stated that their understanding of the application was that this meant that their name would not be included in any public records. Patient A stated that they would like to be able to observe the hearing and read the panel's decision. Patient A confirmed that they are content for the hearing to be public with their identity anonymised.

Mr Edenborough informed Patient A that if the hearing was made public, then someone who knew the details of this case may be able to identify them.

Patient A said that they will leave it to the panel to determine, and it is their wish to be able to observe and be able to read the decision in full.

Having heard further information from Patient A, the panel decided to revoke its previous decision to hear the entire hearing in private and decided to hold the remainder of the hearing in public. The panel considered that it was appropriate to hear Patient A's evidence in private to protect their anonymity. The panel decided that it was in the interests of fairness to Patient A for them to be able to observe the hearing and to read the determination. The panel noted that Patient A's anonymity will be protected by ensuring that their name is not included in the public domain.

The panel was mindful that Patient A has not yet provided a victim impact statement. The panel therefore made a direction that Patient A must provide the NMC with their victim impact statement before they observe the hearing. The panel also made a

direction that if Patient A were to observe the hearing, they must do so by telephone rather than via MS Teams.

Decision and reasons on application to amend charge 1)b)

After the NMC had called all of its witnesses, Mr Edenborough made an application pursuant to Rule 28 of the Rules, to amend the wording of charge 1)b) which currently reads as follows:

> *'1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:*
>
> *b) Gave Patient A a cake with a teddy on it.'*

Mr Edenborough submitted that during the evidence of Patient A, they said that they did not recall the cake having a teddy on it. He therefore invited the panel to make the following amendment to properly reflect the evidence:

> *'1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:*
>
> *b) Gave Patient A a cake. ~~with a teddy on it~~.'*

Mr Baron, on behalf of Colleague A, did not oppose this application.

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

The panel considered that the proposed amendment did not alter the substance of the charge and it better reflects the evidence. The panel noted that this application was not opposed and considered that this amendment could be made without any injustice to any party. The panel therefore granted this application and charge 1)b) now reads as follows:

'1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

b) Gave Patient A a cake.'

Decision and reasons on application to admit hearsay evidence of Mr 2

Mr Edenborough made an application to admit the witness statement and exhibits of Mr 2 into evidence as hearsay. He submitted that the NMC were expecting to call Mr 2 as a witness however, despite its best efforts, the NMC has been unable to locate this witness. Mr Edenborough referred the panel to a number of documents which included information that Mr 2 was no longer employed by the Trust and that after enquiries from the NMC, it was confirmed that *"his departure did not concern allegations of dishonesty and there was nothing… that would affect his credibility as a witness in general."* Mr Edenborough submitted that the NMC instructed a company to trace Mr 2, but this was unsuccessful.

Mr Edenborough submitted that Mr 2 had an investigatory role and produced a report containing a number of appendices which included interview notes and transcripts of calls. He submitted that the material produced by Mr 2 is clearly relevant to the charges and should be admitted as hearsay.

Mr Baron submitted that he had no strong view in respect of this application and that whether this evidence is admitted is a matter for the panel.

The panel heard and accepted the legal assessor's advice in which he referred the panel to Rule 31 of the Rules and to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel had regard to the NMC Guidance on *'Evidence'* (Reference: DMA-6 Last Updated 30/08/2024), and in particular the section entitled *'Admissibility of evidence'* and *'Hearsay'*. The panel noted the following:

'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'

The panel also had regard to the following principles set out in the case of *Thorneycroft*:

1. *Whether the statements were the sole and decisive evidence in support of the charges;*
2. *The nature and extent of the challenge to the contents of the statements;*
3. *Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
4. *The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;*
5. *Whether there was a good reason for the non-attendance of the witnesses;*
6. *Whether the [the NMC] had taken reasonable steps to secure the attendance of the witness;*
7. *The fact that [the registrant] did not have prior notice that the witness statements were to be read.*

The panel considered that the evidence of Mr 2 was not the sole or decisive evidence in support of the charges. It noted that the evidence produced by Mr 2 was collected as part of a local investigation into the allegations. The panel was of the view that the evidence provided by Mr 2 appeared to be objective, and he was not a direct witness to any of the events that led to the charges. Given the objective nature of his evidence and that it was collected as part of a local investigation, the panel determined that there was no suggestion that Mr 2 had any reason to fabricate his evidence. The panel appreciated that the charges you face are serious, and adverse findings may have a detrimental effect on Miss Gilmartin's career as a registered nurse.

The panel noted that Mr 2 no longer works for the Trust, and that the NMC have instructed a third party to locate him, but these efforts have been unsuccessful. Whilst the panel heard no information from Mr 2 about why he has disengaged with the NMC, it found that the NMC had taken all reasonable steps to secure his attendance in the circumstances. The panel noted that you were made aware of this application and that

Mr Baron, on behalf of Colleague A, did not oppose this application.

The panel determined that the evidence of Mr 2 is clearly relevant as it was collected as part of a local investigation into the allegations made by Patient A. Balancing all of the above factors, the panel decided that it was fair to admit the evidence of Mr 2 as hearsay. Once it has heard all of the evidence in this case, the panel will decide what weight should be attached to it when it carries out its assessment of all of the evidence.

Background

The charges arose whilst Miss Gilmartin was employed by Bradford District Care NHS Foundation Trust (the Trust) as a Band 7 Specialist Nurse for Care Leavers. Miss Gilmartin was employed in this role from July 2002. As part of this role, Miss Gilmartin worked autonomously and was responsible for planning her own workload, which included undertaking risk assessments. Miss Gilmartin had a discretion within her role to seek any supervision above the mandatory supervision requirements via her team leader.

Patient A was a child in care whose care had, at the relevant time, been recently been transferred to the Leaving Care team of nurses. Patient A had a history of reported involvement in [PRIVATE].

Patient A had been under the care of Children in Care Nurses since November 2019. Patient A was transferred to Leaving Care Nurses in June 2021 and to Colleague A’s caseload on 14 July 2021 until September 2021. From October 2021 Patient A was

transferred to Miss Gilmartin's caseload but Colleague A remained involved in their care.

On 8 March 2022, the NMC received a referral from Patient A who alleged that Miss Gilmartin had breached professional boundaries, failed to report safeguarding incidents and abused her position of trust when she was providing care between July 2021 and March 2022.

Decision and reasons on facts

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

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

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:

- Patient A: Service user of Looked After Children and Care Leavers.

- Ms 1: Named Nurse for Children in Care, Care Leavers and Youth Justice within Bradford District Care NHS Foundation Trust (the Trust).

The panel also heard evidence from Colleague A who was a Band 7 Specialist Nurse for Care Leavers.

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

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

Professional boundaries

In determining the question of whether professional boundaries had been breached, the panel had regard to the Trust's Safeguarding Policy in which it states:

> *'The rapport that staff develop with service users should be on a professional footing. Engaging in enjoyable activities and using humour can be therapeutic but it can be harmful if this progresses into exchange of personal comments or jokes.'*

The panel also had regard to the NMC Guidance on the Standards for competence for registered nurses, in particular, the following:

> *'[All nurses must] use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.'*

The panel was also mindful of the *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'* (the Code) which sets out that nurses must *'stay objective and have clear professional boundaries at all times with people in [their] care.'*

Charge 1)a)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

   a) On one or more occasions gave Patient A greetings cards and/or an Amazon gift card and/or cash.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 1 and to the evidence of Colleague A.

The panel had sight of Patient A's witness statement in which they stated the following:

> *'At the Wednesday clinics, Ms East gave me gifts. This included money (I do not recall the exact value but it happened often), Easter themed chocolate (I think this must have been available in the supermarket even though it was not Easter at the time), Amazon gift cards, candles and toiletries sets. The value of the Amazon gift card was always £15, and I received a gift card two or three times…'*

The panel also had regard to Patient A's oral evidence.

In her witness statement to the NMC dated 26 June 2023, Ms 1 stated the following:

> *'Patient A added that professional boundaries had been crossed significantly. This included receiving gifts in the form of case / vouchers or gift cards and other trivial things such as chocolate and candles…*
>
> *Patient A raised in their complaint that* [Colleague A] *had given them gifts. Prior to the Covid Pandemic, the Team would do bake sales to raise money to provide all patients a present around Christmas time. The presents would be given by the whole team, not an individual nurse. The presents would typically be toiletries,*

hats or gloves, and chocolate selection boxes. Post Covid, this practice stopped. Previously at Christmas time, the wider organisation did a shoebox appeal and the whole cohort of patients the Team saw received a box, rather than individuals. We do not have a policy within the Trust for giving gifts. I have not seen any actual gifts given, however, a picture of a gift tag on a gift bag suggests there were items given to Patient A at Christmas.'

The panel had sight of a number of photographs, which included images of a number of cards that were given to Patient A by Miss Gilmartin and Colleague A. The panel noted the following that was written in a birthday card to Patient A:

'To [Patient A]
On your 18th birthday

All grown up and still full of mischief. Hope you're having it LARGE (not sex, drugs or rock n roll).

A large cup of tea is in order.

You won't forget us when you're rich and famous we will be in your back garden.

Much love Liz and [Colleague A] xxxx.'

The panel also had regard to a Christmas card in which the following was written:

'To [Patient A]

Happy Christmas
Hope 2022 is a good year for you
KEEP GOING – you're doing WELL
Love from Liz (AKA your EARTH MOTHER)
And [Colleague A] (…)
Xxxx'

The panel heard evidence from Colleague A that she had no part in writing these cards and that they were written by Miss Gilmartin.

The panel was of the view that whilst sending approved gifts and Christmas or Birthday cards may be appropriate in some circumstances, given the content of the cards it was inappropriate. The panel found that referring to *‘sex, drugs and rock n roll’* and stating *‘you won’t forget us when you’re rich and famous we will be in your back garden’* is also inappropriate and went beyond building rapport. The panel also considered that signing cards *‘love’* from *‘your EARTH MOTHER’* and with *‘Xxxx’* was unprofessional, blurred the lines of your professional relationship with Patient A and breached professional boundaries. The panel therefore found this charge proved.

Charge 1)b)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    b) Gave Patient A a cake.

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A, Ms 1 and to the evidence of Colleague A.

In their evidence, Patient A told the panel that they received a birthday cake from Colleague A and you for their 18th birthday.

In Colleague A’s evidence, she told the panel that her and Miss Gilmartin had bought a cake for Patient A’s 18th birthday. She said that she and Miss Gilmartin bought a small cake to mark Patient A’s birthday and that acts of kindness like this were common in this service where patients were vulnerable and often on their own. Colleague A told the

panel that she did not purchase the cake with her own money and that the Trust had a fund to use for occasions such as this.

The panel had sight of Miss Gilmartin's reflective statement in which she stated the following:

> *'We purchased the cake for Service user A for the occasion of his 18th birthday-when myself and my colleague had planned to meet with [them] at Social Services Central Office. My colleague purchased the cake, with my full approval, from the funds we had leftover from Christmas.(approximate value £2.00).'*

The panel noted that it was not disputed that Miss Gilmartin bought a birthday cake for Patient A. Having regard to all of the evidence before it, the panel was satisfied that this was accepted practice within the team and provided for by the Trust. The panel therefore found that this was not a breach of professional boundaries and found this charge not proved.

Charge 1)c)

That you, a Registered Nurse:

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    c) Bought and sent a book to Patient A entitled 'The Secret To Teen Power'

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A and to the reflective statement of Miss Gilmartin.

In Patient A's witness statement to the NMC dated 11 August 2023, the following was stated:

> *'In addition, Miss Gilmartin also sent me a book from Amazon to my home address, from their personal Amazon account… This book was, called 'The Secret to Teen Power' and is about the law of attraction.'*

The panel had sight of the local investigation meeting notes in which it stated that Miss Gilmartin admitted to having sent Patient A this book. The panel also had regard to the audio recording and transcript of a call between Miss Gilmartin and Patient A on 8 January 2022. In this call, Miss Gilmartin referred to the book and said that she would send it as she thought it would help Patient A.

The panel considered that in sending a patient a self-help book using her own funds, Miss Gilmartin's actions went beyond that expected of a professional relationship and breached professional boundaries. The panel also considered that providing material that was not pre-approved by the MDT to Patient A was potentially harmful and went beyond providing therapeutic care. The panel therefore found this charge proved.

Charge 1)d)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    d) Engaged in one or more inappropriate conversations during telephone calls with Patient A, as set out in Schedule 1 below.

    <u>Schedule 1</u>

    17 September 2021
    6 December 2021
    13 January 2022

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A and Ms 1. It also had regard to Miss Gilmartin's written reflective statement.

The panel heard audio recordings and read a number of transcripts of telephone calls that took place between Miss Gilmartin and Patient A during the time period in question, and on the dates specified in Schedule 1. The panel had particular regard to the following parts of the transcript:

> *'[Colleague A] It's only cos we care about you, we want you do to well so you can look after us when we are old biddies, that's why we do it…*
>
> *…[Patient A][Mr 3] is a nonce and he make me sick thinking about him…*
> *…[Miss Gilmartin] Slimeball that is the only way to describe the animals unfortunately…*
>
> *…[Miss Gilmartin] He doesn't like me [Mr 2] let me tell you, he knows that I know what he is and I can't be in the same room as him I want to fucking kill him…*
>
> *…[Miss Gilmartin] Yeah, well don't ever give me a AK47 trust me there will be nobody left standing up there.'*

The panel also noted that the tone of these conversations was unprofessional and swear words were used by Miss Gilmartin.

The panel had sight of Miss Gilmartin's reflective statement in which she stated the following:

> *'I deeply regret both the content and context of most of these calls, during which I discussed other members of staff known to Service user A and used derogatory and inflammatory language.*

Replaying the conversations was difficult. I sounded very angry and aggressive in them, which Was not my usual demeanour at work.

I was very frustrated by some of the claims made by subject A, and was not in a position to deal with them, as they were external to my own organisation.

I was generally extremely stressed, and this was exemplified by Subject A's presentation.

I had very little self awareness at the time, and obviously deeply regret this now.'

The panel considered that the telephone conversations that took place between Miss Gilmartin were inappropriate. In the call set out above, Miss Gilmartin took the lead, she was speaking in derogatory language about colleagues and said that she wanted to *"fucking kill"* Mr 3. The panel determined that this kind of conversation is highly inappropriate and unprofessional, exacerbated by the fact that she engaged in these subjects with a vulnerable patient. The panel also noted that in a telephone conversation with Patient A, Miss Gilmartin disclosed very personal details about a date she went on at the weekend to give Patient A a *"giggle"*.

Having reviewed all of the communications between Miss Gilmartin and Patient A, the panel considered that it was apparent that the relationship progressed and became less professional in time. The panel found that the relationship between Miss Gilmartin was over-familiar and lead to Patient A feeling as though they were friends. The panel determined that Miss Gilmartin's inappropriate telephone conversations with Patient A went beyond that to be expected of a therapeutic relationship. It determined that Miss Gilmartin's behaviour on these calls and sharing of personal information was harmful to Patient A and breached professional boundaries. The panel therefore found this charge proved.

Charge 1)e)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

   e) On one or more occasions sent a text message to Patient A referring to yourself as 'Earth Mother' and/or 'Mother'

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A and Mr 2. It also had regard to the evidence of Miss Gilmartin

The panel had sight of Patient A's witness statement to the NMC in which the following was stated:

> *'Miss Gilmartin asked me to call them "Earth Mother" from our first meeting at the annual health assessment on 14 July 2021. They said to me "I'd really love it if you'd call me that", or words to that effect. I remember thinking it was quite weird. Miss Gilmartin said it turned them on to have someone call them "earth mother"…*
>
> *Miss Gilmartin said that the purpose of this nickname was that I did not have a birth mother, but now I had an earth mother, and they would guide me…*
>
> *This name would be used the whole time we would talk.'*

The panel had sight of a text message sent by Miss Gilmartin to Patient A dated 20 September 2021 in which she stated the following:

> *'Glad you've gone to college Your mother is pleased.'*

On 22 September 2022 Miss Gilmartin wrote the following in a text to Patient A:

‘Make your mother proud ha’

On 23 September 2021 Miss Gilmartin wrote the following to Patient A:

‘…Just wanted you to know your [Colleague A] and your new mother be missing you…’

On 1 January Miss Gilmartin wrote the following in a message to Patient A:

‘Happy new year
Hope 2022 is good
Ur earth mother is watching out for you x…

… Hope ur ok
Your earth mother checking in’

In Miss Gilmartin’s reflective statement, she stated the following:

Service user A claimed that I made [them] refer to me as “Earth Mother.”

This was his nickname for me, and within the context of my role, many of our teenagers referred to us by nicknames that they had given us-not always with respect, however often just in fun.

I never asked [Patient A]/or demanded that [Patient A] used this title nor assumed or attempted to assume the role of [Patient A’s] mother. [Patient A] said at the time, that [they] called me this as I had on occasion texted [Patient A] to tell [Patient A] to get up and get ready for college. [Patient A] said I “nagged [Patient A]” but [Patient A] also said this was a positive, particularly as [Patient A] was approaching [their] last year in sixth form and was struggling with competing

demands. [Patient A] also said [they] had part time work, which we often discussed within the phone calls.'

The panel found that on a number of occasions you sent text messages to Patient A referring to yourself as *"Earth Mother"* or *"Mother"*. The panel considered that in referring to herself in this way and encouraging Patient A to use these maternal nicknames for her, Miss Gilmartin went beyond building rapport and that this was neither therapeutic nor professional, blurred boundaries and was potentially harmful. The panel therefore determined that this breached professional boundaries and found this charge proved.

Charge 1)f)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

   f) On one or more occasions sent a text message referring to Patient A as '[PRIVATE]' and/or '[PRIVATE]'

This charge is found proved.

In reaching this decision the panel regard to all of the evidence before it. It had particular regard to the evidence of Patient A and had sight of screenshots of text messages.

The panel had sight of a text message from Miss Gilmartin to Patient A on 14 September 2021 in which she wrote the following:

'That's [PRIVATE]
Good [PRIVATE]'

On 15 September 2021 Miss Gilmartin wrote the following in a text message to Patient A:

‘Good [PRIVATE…
…That’s [PRIVATE]’

On 16 September 2021 Miss Gilmartin sent the following text to Patient A:

‘OK [PRIVATE]’

On 21 September 2021 Miss Gilmartin sent the following text to Patient A:

‘That’s [PRIVATE]’

The panel found that on a number of occasions you sent text messages to Patient A referring to Patient A as “[PRIVATE]” or “[PRIVATE]”. The panel considered that in referring to Patient A in this way, Miss Gilmartin went beyond building rapport and that this was neither therapeutic nor professional, blurred boundaries and was potentially harmful. The panel therefore determined that this breached professional boundaries and found this charge proved.

Charge 1)g)i)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    g) Failed to record significant information disclosed by Patient A in their records including:

        i) a failure by Notre Dame college to safeguard the patient

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A, Ms 1 and the audio recording and transcript of a call between Miss Gilmartin and Patient A.

The panel noted that in the telephone call between Miss Gilmartin and Patient A, the following was stated:

> *'[Patient A] Yea but do you know what it is. They don't realise that I could go on a full rampage now and tell you everything that college have done to fail to safeguard me and you could just put in a report against them so they better watch where they are going with this because.*
>
> *[Miss Gilmartin] No because they are so busy doing fucking inquiries on the safeguarding [inaudible], it better not be recorded because I will get the facts [inaudible] however [inaudible] [inaudible] and making referrals [inaudible] instead of marking the papers.'*

In Ms 1's witness statement to the NMC she stated the following:

> *'Allegations against people who work with children must be taken seriously and can cover a wide range of circumstances. There is no documentation in any records to suggest that Miss Gilmartin reported this, or made a written record of the information hared by Patient A and/or immediately reported this to Safeguarding, myself or the team leader as would be expected under safeguarding policies.'*

The panel had sight of the Care Leaver Nurse job description in which sets out the following:

> *'Input into clinical electronic systems such as SystmOne and RiO as well as ICS (Local Authority) and the Leaving Care nursing paper records ensuring that an accurate and contemporaneous record for the young person's journey within the Leaving Care System is maintained and readily available for reference.'*

The panel had regard to the witness statement of Mr 2 in which he stated the following:

'Miss Gilmartin stated in interview that they were not always sure what to record as they were unclear whether Patient A had told them was true or a fantasy. However, as per the policy, it is not for Miss Gilmartin to determine which information was potentially significant. Everything should be recorded, even if it was considered to be untrue.'

The panel also had sight of the Bradford District Care NHS Foundation Trust safeguarding children policy and procedure dated 15 February 2021 and the Bradford District Care NHS Foundation Trust safeguarding adults policy and procedure dated 22 July 2020. The panel determined that Miss Gilmartin was under a duty to record significant information which would have included Patient A's disclosure that their college had failed to safeguard them.

The panel noted that there was no record of Patient A's disclosure and considered that Miss Gilmartin omitted from doing so because of the nature of their relationship. It noted that earlier in the telephone conversation, Miss Gilmartin stated that she would not record certain things without having Patient A's consent which was not in accordance with policy. The panel considered that in telling Patient A that she would only record information with their consent, Miss Gilmartin's breached professional boundaries as this was blurring the lines of their relationship and Patient may have raised it with her as they needed help. The panel therefore found that Miss Gilmartin's omission to record this disclosure a breach of professional boundaries and found this charge proved.

Charge 1)g)ii)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    g) Failed to record significant information disclosed by Patient A in their records including:

        ii) a discussion about MASH (multi-agency safeguarding hub)

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A, Ms 1 and the audio recordings and transcript of a call between Miss Gilmartin and Patient A.

The panel considered the audio recordings and transcript of a telephone conversation that took place between Patient A and Miss Gilmartin and in particular the following:

> *'[Miss Gilmartin] …How weird is that but anyway so yeah the other thing as well [Patient A] without writing all this down, I have never written it down because I think there is certain things that without your permission I wouldn't want on your file so the whole discussion about the [inaudible] MASH police that has not gone on your file, that is between us. If you say to me literally the [inaudible] MASH police if this happens to me again ring the MASH police [inaudible] what I didn't realise was if anything had had [sic] happened to you that information would have been passed on to whoever it as going to but if nothing happened here as the case was because you didn't do what you were planning to do or imagined you were going to plan to do the information stayed safe, it didn't go anywhere so there was no reason for me to ring the [inaudible] police at that point. Honestly [Patient A] if anything did happen do [sic] you I would still have to ring them anyway wouldn't I.'*

The panel had sight of the Care Leaver Nurse job description in which sets out the following:

> *'Input into clinical electronic systems such as SystmOne and RiO as well as ICS (Local Authority) and the Leaving Care nursing paper records ensuring that an accurate and contemporaneous record for the young person's journey within the Leaving Care System is maintained and readily available for reference.'*

The panel also had sight of the Bradford District Care NHS Foundation Trust safeguarding children policy and procedure dated 15 February 2021 and the Bradford

District Care NHS Foundation Trust safeguarding adults policy and procedure dated 22 July 2020.

The panel determined that Miss Gilmartin was under a duty to record any discussions about MASH and other agencies and she did not. The panel noted that Miss Gilmartin only recorded some of what was discussed with Patient A and that she told Patient A that she does not write everything in their notes. The panel considered that this may have been confusing for Patient A and blurred professional boundaries. The panel was of the view that in not recording the discussion about MASH in Patient A's records breached professional boundaries. Accordingly, the panel found this charge proved.

Charge 1)h)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:

    h) Told Patient A to dispose of their prescribed medication without clinical justification.

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A and it had regard to Colleague A's evidence.

The panel had sight of Patient A's witness statement to the NMC in which they stated the following:

> *'With regard to conversations about* [PRIVATE], *I used to take seritaline, circadin (melatonin) and mirtazapine, and Miss Gilmartin talked to me about the side effects with regards to* [PRIVATE]*, essentially saying they were worried about me* [PRIVATE]. *I do not believe this conversation was recorded in any of the recordings that have been transcribed, as it must not have recorded, as above.*

They used to tell me to not take my medication because of the impact on my [PRIVATE]*.'*

The panel had no objective evidence to support Patient A's evidence and they were unable to recall any specific details about this during panel questions. The panel therefore found that the NMC had not discharged its evidential burden and found this charge not proved.

Charge 1)i)

1) Between 13 July 2021 and 4 March 2022 breached professional boundaries in that you:
   i) On one or more occasions contacted Patient A by telephone and/or text message outside of working hours without clinical justification.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A and Mr 2. The panel also had regard to Miss Gilmartin's responses during the local investigation meeting.

In Patient A's witness statement to the NMC, they stated the following:

'Miss Gilmartin used to contact me at varied times of the day, a lot of times in the evening. This is often when we would discuss inappropriate topics, as above, and about organised crime, as below. I know they were also calling others out of hours as they would often tell me during our calls that they had just been speaking to other clients.

We used to talk a lot outside of working hours, which I believed were 09:00 to 17:00. Miss Gilmartin mostly worked from home and they would often call for no particular reason, and we would often talk about things Miss Gilmartin should not have been talking about, such as sex, crime and drugs…

…I used to contact Miss Gilmartin outside of working hours as I felt this was okay, given that Miss Gilmartin would be happy to speak to me at these times. Miss Gilmartin became a massive part of my life, and it felt like a relationship between friends rather than patient and nurse.'

The panel had regard to Miss Gilmartin's reflective statement in which she stated the following:

'I made a large number of phone calls and texts to Service user A during the time he was known to me. Many of these were out of hours. This was not unusual practice within the context of my work, as many young people would contact myself or my colleague as their named Leaving Care nurse if distressed or in crisis. Some of the calls and texts were regarding Service user A's emotional wellbeing, and as time went on he became increasingly demanding of my time and attention. I was anxious to maintain a rapport with [Patient A], until [Patient A] was able to access therapeutic services. [Patient A] had frequently been offered counselling, but waiting lists locally were long and [Patient A] was reluctant to access services where [they] would be seen 2 to 1…'

The panel had sight of Patient A's call log and text messages received from Miss Gilmartin during the period in question. The panel noted that Miss Gilmartin engaged in communication with Patient A late in the evening, early in the morning and on weekends which was outside of her working hours. Having examined the content of the text messages and the recordings of telephone calls, the panel concluded that whilst Miss Gilmartin stated that her contact was therapeutic, it was not clinically justified.

The panel was of the view that Miss Gilmartin's contact with Patient A went beyond building a professional relationship, was personal and blurred professional boundaries. By contacting Patient A outside of working hours, the panel determined that this blurred professional boundaries and resulting in Patient A feeling like that their relationship with Miss Gilmartin was a friendship. The panel therefore found this charge proved.

Charge 2)

2) On 23 February 2022 provided Patient A with a list of people you wanted to be harmed.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it which included the evidence of Patient A and Colleague A.

In her evidence, Colleague A admitted to having provided a list of names to Patient A. There is no evidence that Miss Gilmartin provided Patient A with a list of names. The panel therefore found that this charge is not proved.

Charge 3)a)

3) In relation to Patient A:

a) On an unknown date did not make a referral to Patient A's social worker when they told you they were being [PRIVATE].

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A.

The panel heard audio recordings and had sight of a transcript of a telephone conversation that took place between Patient A and Miss Gilmartin on 8 January 2022. The panel noted the following:

'[Miss Gilmartin] [inaudible] what have you been up to?

[Patient A] Just being doing stupid things as per usual.

[Miss Gilmartin] [inaudible] what when you say its stupid what do you mean, do you mean naughty [inaudible]

[Patient A] Well, one of the guys that's been messaging me for ages and I've been saying no, no, no, no, no

[Miss Gilmartin] So you said yes.

[Patient A] Yeah, he carried on messaging me like yesterday night and like today he kept on saying can I come, can I come and I said no and then he just sent me a message to say I'm outside.

[Miss Gilmartin] Ohhh, oh bloody hell.

[Patient A] [inaudible] now like he's just gone now so he wouldn't leave like half an hour I did say oh come on you need to get off now then he goes oh I wanna fuck yer and

[Miss Gilmartin] [inaudible]

[Patient A] So I just said to him oh well erm I don't really want to stamp to that if I'm honest.

[Miss Gilmartin] Right.

[Patient A] And then he just said ah you need something to cheer you up don't you. And then

[Miss Gilmartin] Well maybe not that if you're not in the mood.

[Patient A] And then erm, he said oh god I've never seen you so down erm

[Miss Gilmartin] Does he, do you know him?

[Patient A] Mm well I know him from my past yes

[Miss Gilmartin] Right

[Patient A] So not my best mate

[Miss Gilmartin] Right

[Patient A] [inaudible] he's an awful awful [inaudible] person to be fair

[Miss Gilmartin] Is he

[Patient A] Yeah I mean, so yeah [PRIVATE]*.'*

The panel considered that after Patient A disclosed this information to her, Miss Gilmartin had a duty to refer this to Patient A's social worker and she did not. The panel therefore found this charge proved.

Charge 3)b)

3)In relation to Patient A:
b) On 8 January 2022 did not make a referral to the crisis team and/or Patient A's social worker when they read you [PRIVATE].

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A, Ms 1, Mr 2 and the audio recording and transcript of a telephone conversation that took place between Miss Gilmartin and Patient A on 8 January 2022.

The panel heard audio recordings and head sight of a transcript of a telephone conversation that took place between Patient A and Miss Gilmartin on 8 January 2022. It noted that during this call, Patient A disclosed to Miss Gilmartin that [PRIVATE].

The panel had regard to the evidence of Ms 1 and noted the following in her witness statement to the NMC:

> *'Should a patient make disclosures of this nature, I would expect a nurse to ensure this is documented in the patient's records and make onwards referrals to specialist agencies as required. I would also expect that local safeguarding policies are followed (Child or Adult dependant on the patient's age)… I would expect Miss Gilmartin to have directed Patient A to Accident and Emergency or made a referral to the crisis team to give Patient A the support they required. Miss Gilmartin could also have contacted social care to speak with Patient A's social worker.'*

The panel noted that Ms 1, who carried out the local investigation, found no evidence that Miss Gilmartin had escalated this disclosure.

The panel had sight of Miss Gilmartin's response during the local investigation meeting:

> *'because [Patient A had] already turned 18 at that point, the only people that would go and get [Patient A] were the police. But [Patient A] was already allegedly involved with the police and it had an incident where they allegedly turned up at [Patient A's] house. And so it was not just straightforward ring the police to go do a welfare check. In hindsight, yes, of course I should have done that…'*

The panel also had sight of Miss Gilmartin's reflective statement in which she wrote the following:

> *'Service user A contacted me by phone, to inform me that [they] had been sitting on the train tracks for a long period of time, the night previously and during that*

time [PRIVATE]*. [Patient A] sent me a copy of* [PRIVATE]*. I discussed [their] current state of mind, and [their] mood seemed positive.*

[Patient A] informed me that [they] had already contacted the out of hours mental health team in the city where [they were] residing.

We discussed a contact to the police to undertake a welfare check, but [Patient A] refused, as [their] response to police coming to [their] door was always negative (in [their] opinion).

I made a significant error of judgement in not making the call and requesting a police welfare check, regardless of [Patient A's] wishes (as I have done several times, when concerned regarding the health and safety of other vulnerable young people in my care, and it would have been best practice to do so).

I should have telephoned the out of hours crisis team in both my own city as he was a service user of health services in Bradford, but residing in a neighbouring city, following [Patient A's] call to me, and documented all of the above.'

The panel had regard to Miss Gilmartin's responses to Patient A's disclosure [PRIVATE] and in particular the following:

'[Miss Gilmartin] You've not, good. Well I need you to hang in for a bit, till Monday for me to speak to your doctor, think you can do that?

[Patient A] Mm

[Miss Gilmartin] Yeah, I need you to read this book as well, its only short. But if I send it Monday you're not going to get it until Tuesday or Wednesday, so you'll have to hang on until then won't yer? See what I can get from yer doctor.'

Having regard to all of the evidence, the panel determined that on 8 January 2022, after Patient A read Miss Gilmartin a [PRIVATE], she was under a duty to make a referral to

the crisis team and/or Patient A's social worker and she did not. The panel therefore found this charge proved.

Charge 3)c)

> 3)In relation to Patient A:
> c) On 9 January 2022 did not make a referral to the crisis team and/or Patient A's social worker when they sent you a text message at 18:33 hours telling you they had [PRIVATE] earlier that day.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Patient A, Ms 1 and Mr 2. The panel also had regard to Miss Gilmartin's reflective statement.

The panel had sight of a text message sent by Patient A to Miss Gilmartin on 9 January 2022 at 18:33 in which the following was stated:

> *'Earlier today, I was still feeling how I was when I spoke to you on Saturday, in crisis and that there was only one way out and I took myself on a wonder and sat by the bridge near the train tracks. After a while sitting there something hit me and said if I go there would be non one to fight for change in the care system, no one with the skills to tackle the issues this sector faces. I took myself off and came back home. Was one of the most scariest things sitting next to the bridge in desperation* [PRIVATE]*.'*

The panel had sight of Miss Gilmartin's response on 10 January at 09:31 in which she stated the following:

> *'Hi [Patient A] Well that was a brave decision And I'm very relieved but I do need to talk to you Have worried all weekend and I think you need a safety plan in place But I can ring you this am Or you ring me when you're up and about'*

The panel had regard to the evidence of Ms 1 and Mr 2 and noted that following a local investigation, there was no record of Miss Gilmartin making a referral to the crisis team or Patient A's social worker following the text message that was sent by Patient A at 18:33 on 9 January 2022.

The panel had regard to Miss Gilmartin's written reflective statement in which she stated the following:

> *'I did call the crisis team the following day, and spoke to a member of staff, who informed me that Service user A was known to them, had referred [themself] at the time of crisis, and that [Patient A] would be receiving a follow up visit or phone call that day from the crisis team. I failed to document this.*
>
> *I failed to do this, in the mistaken belief that [Patient A] was both safe and well, as I had spoken to [Patient A] on the phone, and [Patient A] had informed me that [they were] safe and well, which was completely inadequate, in hindsight.'*

Having regard to all of the above the panel found that Miss Gilmartin did not make a referral to the crisis team or to Patient A's social worker after receiving the text on 9 January 2022 at 18:33. The panel therefore found this charge proved.

Charge 3)d)

> 3)In relation to Patient A:
>
> d) Did not record any or all of the information disclosed as specified in charges 3 a) to c) in the patient's records.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before. It had particular regard to the evidence of Ms 1 and Mr 2. The panel also had regard to Miss Gilmartin's reflective statement.

The panel had sight of Ms 1’s witness statement to the NMC in which she stated the following:

‘As a result of no records, I am not aware of any action taken by Miss Gilmartin following the disclosure by Patient A to them. Documentation in health records is fundamental to effective patient care and a means of effective communication when sharing information. Information sharing is important to promote effective safeguarding, assessment, analysis, and risk management where there are safeguarding concerns.’

The panel also had sight of Mr 2’s witness statement in which he stated the following:

‘No conversations dated 8 January 2022 or 9 January 2022 were recorded in Patient A’s notes.’

In Miss Gilmartin’s reflective statement in which she accepted that she failed to document the information disclosed to her by Patient A and that she failed to document that she had spoken to the crisis team on 9 January 2022.

Having regard to all of the above, the panel determined that Miss Gilmartin did not record any information disclosed as specified in charges 3 a) to c) in the patient’s records. Accordingly, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Gilmartin's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel 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 Gilmartin's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

The panel had regard to the terms of the Code in making its decision. Mr Edenborough identified the specific standards that were relevant and where, in his submission, your actions amounted to misconduct.

Mr Edenborough submitted that Miss Gilmartin's breach of professional boundaries was serious and extremely inappropriate in view of Patient A's degree of vulnerability. He submitted that Miss Gilmartin's relationship and breach of professional boundaries with

Patient A caused a pattern of *"unthinking"* behaviour which placed Patient A at risk and fell far below the standards expected. Mr Edenborough referred the panel to the charges found proved and submitted that Miss Gilmartin's actions and omissions in respect of these was serious and amounted to misconduct.

Submissions on impairment

Mr Edenborough 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.

Mr Edenborough submitted that Miss Gilmartin's conduct and breach of professional boundaries caused emotional harm to Patient A and placed them at a real risk of unwarranted harm on a number of occasions over a significant period of time. Mr Edenborough submitted that whilst Miss Gilmartin has provided some written responses, there is no evidence that she has addressed the concerns and strengthened her practice. Mr Edenborough submitted that Miss Gilmartin's conduct needs to be marked and invited the panel to find that Miss Gilmartin's fitness to practice is currently impaired on public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments, which included the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

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 Gilmartin’s actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

1.1 *treat people with kindness, respect and compassion*

1.2 *make sure you deliver the fundamentals of care effectively*

1.3 *avoid making assumptions and recognise diversity and individual choice*

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 *work in partnership with people to make sure you deliver care effectively*

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

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

3.3 *act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

3.4 *act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 *balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 *make sure that any information or advice given is evidence-based including information relating to using any health and care products or services*

8 Work co-operatively

To achieve this, you must:

8.5 *work with colleagues to preserve the safety of those receiving care*

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

> ***10.1*** *complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> ***10.2*** *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

> ***13.1*** *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
>
> ***13.2*** *make a timely referral to another practitioner when any action, care or treatment is required*

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

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

__20.3__ be aware at all times of how your behaviour can affect and influence the behaviour of other people

__20.5__ treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

__20.6__ stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved individually, and cumulatively, amounted to serious professional misconduct.

The panel considered that breaching professional boundaries with a particularly vulnerable patient was serious. The panel was of the view that giving greeting cards with inappropriate content, sending unapproved books using her own money, engaging in highly inappropriate conversations with Patient A and contacting them outside of working hours Miss Gilmartin blurred professional boundaries which led to Patient A interpreting their relationship to be that of a friendship. The panel considered that this was exacerbated by Miss Gilmartin's use of, and encouragement of the use of, familial and maternal nicknames given Patient A's history and vulnerabilities. The panel also considered that Miss Gilmartin's failure to record significant disclosures about Patient A's College and MASH team was serious.

The panel determined that Miss Gilmartin's failure to escalate Patient A's disclosure was very serious. The panel also determined that Miss Gilmartin's failure to act when Patient A disclosed that he was having suicidal thoughts was extremely serious and could have had catastrophic consequences.

Having regard to all of the above, the panel determined that Miss Gilmartin did not prioritise Patient A, practise effectively, preserve Patient A's safety or promote professionalism and trust. The panel therefore found that Miss Gilmartin's actions fell 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 Gilmartin's fitness to practise is currently impaired.

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

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

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

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

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

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

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

The panel found limbs a, b and c engaged in this case.

The panel considered that in breaching professional boundaries with Patient A, Miss Gilmartin put them at risk of unwarranted harm. As a result of the breach of professional boundaries, Patient A viewed the relationship as a friendship, rather than a professional relationship. The panel was of the view that this breach had caused Patient A emotional harm.

In engaging in inappropriate conversations with Patient A in which Miss Gilmartin undermined her colleagues and other healthcare professionals the panel found that this placed Patient A at risk of harm. Miss Gilmartin's actions had the potential to influence Patient A's willingness to access other services which could have negatively impacted on the care they received and caused harm. The panel was of the view that in using maternal and familial terms, given Patient A's history and vulnerabilities, this placed them at risk of harm.

The panel determined that Miss Gilmartin did not act in the best interests of Patient A, and by *"gatekeeping"* information and not by not appropriately referring, she deprived Patient A of specialist support which could have been detrimental to their mental health. Furthermore, Miss Gilmartin's lack of referring ands escalating might have caused Patient A to lose confidence in the profession and prevented them from disclosing potentially relevant information about their health which could have led to harm.

The panel found Miss Gilmartin's failure to escalate that Patient A was being [PRIVATE] and that they were [PRIVATE] to be extremely serious and could have had catastrophic consequences for Patient A.

The panel was of the view that in breaching professional boundaries, being involved in a highly inappropriate telephone conversation with a colleague and vulnerable patient and failing to refer and record significant information, Miss Gilmartin's conduct brought the profession into disrepute. The panel considered that maintaining professional boundaries and prioritising patient care are fundamental tenets of the profession and that Miss Gilmartin's conduct breached these.

The panel went on to consider whether the misconduct in this case is capable of remediation. It had regard to the case of *Cohen* and the NMC Guidance entitled *'Can the concern be addressed?* (Reference FTP-15a Last Updated 27/02/2024), in particular the following:

> *'Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *…*
> - *inappropriate personal or sexual relationships with people receiving care or other vulnerable people or abusing their position as a registered nurse, midwife or nursing associate or other position of power to exploit, coerce or obtain a benefit.'*

Whilst Miss Gilmartin formed an inappropriate relationship with Patient A and breached professional boundaries, the panel determined that this was not done with the intention to exploit, coerce or obtain a benefit. However, the panel was of the view that breaching professional boundaries is attitudinal in nature and therefore inherently difficult to remediate. The panel considered that the breach of professional boundaries in this case was not at the lower end of the spectrum of seriousness as it involved a vulnerable patient, it occurred over a sustained period of time and caused actual harm. The panel determined that whilst it may be difficult for Miss Gilmartin to remediate her practice, it would not be impossible in these circumstances.

In considering whether Miss Gilmartin has remediated the concerns, it had regard to all of the information before it. The panel had sight of Miss Gilmartin's letter of resignation to the Trust and her written reflective statement in which she stated the following:

‘Conclusion

I have had a great deal of time to reflect on my relationship with Service user A, [their] behaviour towards myself and my behaviour in the events leading up to [their] complaints.

I deeply regret my own actions, however never intended to do any harm to Service user A or cause offence to other members of staff discussed in the telephone conversations.

In my efforts to approach this case differently, and to encourage Service user A to achieve [their] potential, I completely lost sight of [their] [PRIVATE]*, and any attendant risks, allowing my professional boundaries to become blurred. I mistakenly believed that service user A could achieve [their] goals and escape the stereotype endured by so many of our young people from care backgrounds.*

This was not my remit, and I should have adhered to well established professional boundaries, and the Code of Professional Conduct, which would have ensured my own safety, and protected my professional integrity.

I have paid a high price for my actions; I have lost my career of almost 40 years; which has always been fulfilling and the role which I had valued most of all for the last 15 of those years. I have now completely retired from nursing and would not wish to return under any circumstances.

[PRIVATE].

I am deeply saddened that a client or any other professionals would view my care as a betrayal of trust. As a nurse, that was never my intention.’

The panel considered that Miss Gilmartin has expressed some remorse for her actions. However, her insight into her conduct is insufficient. The panel noted that Miss Gilmartin

has indicated that she had retired from the nursing profession and as a consequence, there is no evidence of strengthened practice. Having regard to all of the above, the panel considered that there is a risk of repetition of the conduct. The panel therefore determined that a finding of impairment was required on public protection grounds.

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.

Given the seriousness of the breach of professional boundaries, the disregard for the health and wellbeing of Patient A and the actual emotional harm caused and the potential for serious harm, the panel was of the view that public confidence in the profession would be undermined if a finding of impairment was not made. The panel therefore found Miss Gilmartin’s fitness to practice impaired on the grounds of public interest, to uphold proper professional standards and maintain confidence in the profession and its regulator.

Having regard to all of the above, and to the question of whether Miss Gilmartin is currently able to practise kindly safely and professionally, the panel determined that her fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

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

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

Submissions on sanction

Mr Edenborough submitted that the NMC sanction bid is that of a striking-off order. He referred the panel to Patient A's Witness Impact Statement and invited the panel to take into the account the impact of Miss Gilmartin's misconduct on Patient A. Mr Edenborough submitted that given the seriousness of Miss Gilmartin's misconduct, a striking-off order is required on public protection and public interest grounds.

Decision and reasons on sanction

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

The panel had regard to the NMC Guidance on *'Factors to consider before deciding on sanctions'* Reference: SAN-1 Last Updated 30/08/2024, in particular the following:

The panel took into account the following aggravating features:

- Miss Gilmartin failed to safeguard Patient A on a number of occasions over a significant period of time which placed them at a risk of harm.
- In breaching professional boundaries with Patient A, Miss Gilmartin placed them at a risk of harm and caused actual emotional harm.
- Miss Gilmartin's misconduct persisted over a significant amount of time and manifested in a number of different ways.
- Miss Gilmartin has a lack of insight into her conduct.

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

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 attitudinal concerns and the risks to patient safety identified. The panel decided that it would not protect the public and 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, the public protection and attitudinal concerns identified, an order that does not restrict Miss Gilmartin's practice would not protect the public or 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 Gilmartin's misconduct was not at the lower end of the spectrum. The panel decided that a caution order would not mark the seriousness of the case and would not be sufficient to satisfy the public interest, uphold proper professional standards and maintain confidence in the profession or regulator.

The panel next considered whether placing conditions of practice on Miss Gilmartin's registration would be sufficient and proportionate. The panel was of the view that whilst some elements of Miss Gilmartin's misconduct is clinical in nature and therefore capable of being addressed through retraining, there is a pattern of extremely unprofessional and concerning conduct which the panel considered could not be addressed through a conditions of practice order. The panel therefore determined that a

conditions of practice order would not be sufficient to protect the public and it would not be in the public interest.

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;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *...*

The panel found that the misconduct in this case occurred over a significant period of time and Miss Gilmartin's lack of professionalism and breach of professional boundaries manifested in a number of forms. The panel was of the view that Miss Gilmartin's misconduct and her behaviour is indicative of a deep-seated attitudinal problem. The panel had sight of Miss Gilmartin's letter of resignation to the Trust in which she stated that she had retired and that she would not return to nursing. Whilst the panel had no information that Miss Gilmartin had repeated the behaviour, the panel considered that there was no evidence that she has worked without incident since these charges arose. Having found that there is a deep-seated attitudinal problem, and that there is no evidence of strengthened practice or insight, the panel was of the view that there is a high risk of repetition of the conduct.

Having regard to all of the above, the panel determined that whilst temporary removal would protect patients while it is in force, it would not adequately meet the public interest considerations of this case given the seriousness of Miss Gilmartin's misconduct.

In considering a striking-off order, the panel had regard to the following guidance set out in the SG:

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

The panel considered that Miss Gilmartin's conduct was a serious and significant departure from the standards expected of a registered nurse. Maintaining professional boundaries, professionalism and prioritising patient care are fundamental tenets of the profession.

The panel was of the view that Miss Gilmartin's conduct raises fundamental questions about her professionalism. The panel considered that the public would be deeply concerned to hear about Miss Gilmartin's breach of professional boundaries and the highly inappropriate conversations she had with a vulnerable patient in her care. The panel also considered that the public would be extremely concerned to hear about Miss Gilmartin's failure to safeguard Patient A, and in particular, her failure to respond appropriately when they [PRIVATE]. This unprofessional and harmful behaviour is, in the panel's view, fundamentally incompatible with Miss Gilmartin remaining on the Register.

The panel determined that Miss Gilmartin's misconduct was so serious, to allow her to continue practising would undermine public confidence in the profession, and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Gilmartin's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should

conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that a striking-off order was necessary to protect the public and 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.

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 Gilmartin's own interests until the striking-off order 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 Edenborough who invited the panel to impose an interim suspension order for 18 months to cover the appeal period. He submitted that an interim suspension order was necessary for the protection of the public and is otherwise in the public interest.

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 its 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. Having already determined that a striking-off order is necessary to protect the public and to satisfy the public interest in this case, to not impose an interim suspension order to cover the appeal period would be inconsistent with its earlier findings. The panel therefore imposed an interim suspension order for a period of 18 months to cover any appeal period.

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

That concludes this determination.

This will be confirmed to Miss Gilmartin in writing.