Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 16 September 2024 – Thursday, 10 October 2024

Virtual Hearing

Name of Registrant:	Christopher Hinch
NMC PIN	01E0438E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing – 8 May 2004
Relevant Location:	Derbyshire
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, lay member) Patricia Ford (Registrant member) Angela Kell (Lay member)
Legal Assessor:	Robin Hay (16 – 17 September 2024) John Donnelly (18 September 2024 -10 October 2024)
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Neair Maqboul, Case Presenter
Mr Hinch:	Present and represented by Jim Olphert, instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charge 4
No case to answer:	Charges 1a, 1b and 5
Facts proved:	Charges 2a, 2b, 2c, 2d, 2e, 2f and 3
Facts not proved:	N/A

Fitness to practise:	Impaired
Sanction:	**Suspension order (9 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse

1. On or around 23 April 2022, whilst working at the '[*PRIVATE*]' were abusive and/or rude and/or uncaring and/or dismissive towards Resident A in that you

    a. Admonished Resident A for using their call bell too much

    b. Tapped Resident A on the head on one or more occasions

2. On the nightshift 07 - 08 June 2022, whilst working at *'[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

    a. Closed or threatened to close Resident B's bedroom door

    b. Called Resident B '*a baby'* or words to that effect

    c. Told Resident B that Resident B was '*wasting your time'* or words to that effect

    d. Removed Resident B's call bell/buzzer from them and /or placed Resident B's call bell/buzzer such as it was not accessible to them

    e. Pushed medication in to Resident B's mouth

    f. Threatened to unplug one or more resident's call bell/buzzer(s)

3. On the nightshift 08-09 June 2022, whilst working at *‘[PRIVATE]’*, after Resident D had suffered a fall, you ‘drag lifted’ them from the floor

4. On 09 June 2022 whilst working at *‘[PRIVATE]’*, recorded in medical notes in relation to Resident E *‘seattled well. all care needs met’* (sic) but Resident E had passed away on 08 June 2022

5. Your conduct at Charge 4 above was dishonest in that you created a medical record that recorded information that you knew was not true

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Maqboul, on behalf of the Nursing and Midwifery Council (NMC), to admit the following into evidence:

1. The account of Resident A, with respect to charges 1a and 1b, contained in the witness statement of Witness 5 and its associated exhibits.
2. The account of Resident B, with respect to charges 2a, 2b, 2c, 2d, 2e and 2f, contained in the witness statements of Witnesses 2 and 3 and their associated exhibits.
3. The local statement of Mr 1

Ms Maqboul referred the panel to Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules) and submitted that it is an established fact that a panel could determine the evidence it allows before it subjects to the test of relevance and fairness. She further referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He highlighted that this case laid out the following factors to be considered in admitting hearsay evidence:

(i) *'Whether the statements are the sole or decisive evidence in support of the charges*

(ii) *The nature and extent of the challenge to the contents of the statements*

(iii) *Whether there was any suggestion that the witnesses had reasons to fabricate their allegations*

(iv) *The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career*

(v) *Whether there is a good reason for the non-attendance of the witness*

(vi) *Whether the NMC have taken reasonable steps to secure attendance*

(vii) *Whether the Registrant had prior knowledge that the witness statements were to be read'*

Ms Maqboul further referred the panel to the cases of *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) and *El Karout v NMC* [2019] EWHC 28 (Admin).

Ms Maqboul provided the following written submissions with regards to the hearsay application:

'***The Charges***

1. *Charge 1- On or around 23 April 2022, whilst working as a nurse at 'The Meadows' you were abusive and/or rude and/or uncaring and/or dismissive towards Resident A in that you*

   a Admonished Resident A for using their call bell too much;

   b- Tapped Resident A on the head on one or more occasions.

2. *The NMC relies on the evidence of …(*Witness 5*)… in respect of both limbs of charge one.*

3. *…..(Witness 5)… describes that on 24 April 2022, Resident A disclosed to her and another member of staff, (Ms 1)- who is not giving evidence in these proceedings) that the Registrant had told her off for using her buzzer too much and had tapped her on the head three times.*

4. *When considering the 'Thorneycroft criteria', it is respectfully submitted that the evidence of (Witness 5) is admissible in circumstances where:*

   i. *Although (Witness 5) is the only witness to this charge, she describes that the allegations of abuse made by Resident A were disclosed to her on the day shift of 24 April 2022; the shift following that of the Registrant. She describes at paragraph 13 of her witness statement (pg 17):*

      "the same day, (Ms 1) and I wrote a statement together of what Resident A had said:

   ii. *That contemporaneous account is found at page 28 of the exhibit bundle. It was made shortly after Resident A had raised what had happened, rather than months or weeks later. Questions regarding the taking of the statement can properly be put to this witness, particularly in circumstances where there is no suggestion of coercion, and in fact the Resident voluntarily made the disclosure;*

   iii. *A wholesale challenge is noted on behalf of the Defence. The Registrant does not lose the opportunity to put his case and provide his account to the panel. The panel must weigh the evidence of (Witness 5) and test it against all other evidence.*

   iv. *There is no suggestion that the witness had reason to fabricate the allegation. (Witness 5) confirms at paragraph 6 of her witness statement that she had never worked with the Registrant. There is therefore no history between them to speak of.*

   v. *Unfortunately, Resident A passed away on 17 March 2023, within 12 months of the allegations having been made. There is no suggestion she*

was unwilling to cooperate, particularly in circumstances where she herself informed staff of the treatment received from the Registrant.

vi. *Whilst the charge is serious, the mere fact of the evidence being admissible does not mean it ought to be given weight automatically. That is a separate consideration, to be viewed through the lens of the evidence as a whole.*

5. *Charge 2- On the nightshift 07-08 June 2022, whilst working as a nurse at '[PRIVATE]' you were abusive and/or rude and/or uncaring and/or dismissive towards one or more residents under your care in that you*
   - *a- Closed or threatened to close Resident B's bedroom door;*
   - *b- called Resident B a baby or words to that effect;*
   - *c- Removed Resident B's call bell / buzzer from him and/or placed Resident B's call bell/buzzer such as it was not accessible to them;*
   - *d- Pushed medication into Resident B's mouth;*
   - *e- Threatened to unplug one or more resident's call bell/buzzer*

6. *The NMC seeks to rely on the evidence of (Witness 2) and (Witness 3) in respect of charge 2.*

7. *Resident B has not provided a witness statement specifically for these proceedings, but did provide an account to (Witness 3), (day centre manager) who communicated the allegations to (Witness 2) (Deputy Home Manager).*

8. *…..*

9. *Following the Registrant's night shift on 7 June 2022, Resident B disclosed to staff at his daycare centre, that the Registrant had spoken to him in a derogatory manner, called him a baby, threatened to close his bedroom door, removed his call bell and pushed medications into his mouth. The centre*

communicated the concerns to (Witness 2), who notified the Registrant's employment agency.

10. *On application of the Thorneycroft criteria below, it is submitted that the evidence of (Witness 2) and (Witness 3) should be admitted:*

    i. *Resident B provided a full and detailed account during a police interview. This account was given in a formal setting, where Resident B was subject to a number of live questions.*

    ii. *Resident B also voluntarily disclosed details of the treatment he had received. There is no suggestion of any coercion by members of staff;*

    iii. *(Note of Disclosure by Resident B) not only provides an outline of events, but a detailed timed chronology as to the next steps taken by the daycentre which provides a sense of the importance placed on the need for accurate recording on the part of the day centre;*

    iv. *Within the police interview Resident B referred to all of the allegations contained within charge 2- he described feeling scared, his bedroom door being closed, the ramming of tablets down his throat as well as the switching off and removal of the buzzer.*

    v. *Resident B's account to (Witness 3) is consistent with the account he provided to the police;*

    vi. *The above are not the sole and decisive pieces of evidence in respect of charge 2. The Registrant himself, in his local statement (page 26 exhibit bundle) says*

    > *"…I explained he was pressing the buzzer as he was dozing so I suggested placing the buzzer next to his pillow. On doing this he started screaming and shouting" (chg 2c) "At that point I left his room and closed the door". (Chg 2a)*

    vii. *Further, in his police interview (pg 11 line 17) the Registrant describes Resident B as having the buzzer in his hand, which he*

then removes by pinning it to the pillow. He also accepts he closed Resident B's bedroom door.

viii. *(Witness 4) provides direct evidence as to the Registrant's threat of removal of the call bell (charge 2f)(pg 21 w/s para 13–*

> *"Christopher said that he had told the residents in rooms 42 Resident B and 43 (I cannot recall his surname) that if they continued to buzz for no reason, he would unplug the buzzers.*

ix. *The MAR chart recordings against tablet medications on 7th June 2022 at 22:00hrs are marked as N (offered) (charge 2e).*

x. *(Note of Disclosure by Resident B) is a direct account of Resident B's disclosure, which (Witness 3) wrote down contemporaneously as he conveyed the treatment he had experienced;*

xi. *There is no suggestion of any reason for fabrication on the part of the witnesses; indeed, the Registrant's own account aligns in part with what the witnesses report;*

xii. *The panel is asked to consider the hearsay bundle, which demonstrates the very careful consideration given to Resident B's engagement with this hearing. He is now unfortunately deemed to be end of life and therefore unable to participate. He did all he could to ensure his active engagement both with the police and (Witness 3) before the serious decline in his health;*

11. *Finally the NMC seeks permission to rely on the written local statement of (Mr 1) (page 42 exhibit bundle)*

12. *His account relates to charge 2c.*

13. *It is not the sole and decisive piece of evidence. (Witness 4) also provides evidence on this point.*

14. *His evidence is neutral but helpful by way of context.*

15. *It is unclear what (if any) attempts have been made to secure his attendance by the NMC, and I am unable to confirm anything further in this regard.'*

Mr Olphert, on your behalf, provided the following written submissions with regards to the hearsay application:

1. *'The NMC seek to admit the evidence of Resident A and Resident B as hearsay evidence to prove the allegations in charges 1 and 2. There is also an application to rely on the evidence of (Mr 1). The issue in respect of his statement will be dealt with separately.*

2. *In respect of charge 1, the 'statements' which the NMC seek to admit are the comments made by (Witness 5) in her statement regarding what Resident A had said to her and other ((Ms 1) - from whom there is no statement) and the contents of exhibit ….(Exhibits p.29) which is a handwritten note.*

3. *In respect of charge 2, the 'statements' which the NMC seek to admit are the comments in (Witness 3)'s witness statement, and the relevant contemporaneous note, produced in their final redacted form on the morning of Day 1 as an on-table. They also seek to admit the police interview with Resident B and the comment on that evidence from the statements of (Witness 1), (Witness 2) and (Witness 1).*

4. *The above gives an immediate sense, it is submitted, as to how pervasive the hearsay is in this case, with nearly all of the live evidence in some way repeating the hearsay accounts and passing comment upon it.*

5. *It is submitted on behalf of the Registrant that the NMC should not be permitted to rely on the accounts of absentee witnesses to substantiate the bulk of the allegation which any panel will ultimately be asked to adjudicate.*

6. *The Registrant submits that by their non-attendance, he is effectively robbed of the opportunity to explore or challenge the central evidence in this case in respect of the most serious allegations.*

7. *In this case, the matter is complicated, as I will come on to in due course, by the fact that the NMC will doubtless seek to advance in their case that the fact that two like offences are before the panel makes it more likely that both are true.*

8. *The potential unfairness caused by witnesses whose accounts are said to be further bolstered by other hearsay needs little in the way of expansion. The risk where a statement of someone we cannot challenge, is said to also be corroborated by someone we also cannot challenge is clear.*

9. *Both <u>Nursing and Midwifery Council v Ogbonna [2010] EWCA Civ 1216</u> and latterly <u>El Karout v Nursing And Midwifery Council [2019] EWHC 28 (Admin)</u>*

make clear that in the context of regulatory proceedings it is essential that the admissibility of evidence, not simply the weight to be attached to it, is assessed by a panel. The NMC's guidance echoes this sentiment, stating in the relevant section of DMA-6:

> *"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." (emphasis added)*

10. *The central issue here then, is whether it is fair to admit that evidence upon which NMC rely to effectively prove their case in whole. It is submitted on behalf of Mr Hinch that there can be no greater unfairness than not being able to properly challenge the case which you face. Without being able to do so, Mr Hinch is effectively forced to defend these allegations with one hand tied behind his back.*

11. *As the Court of Appeal stated in Ogbonna:*

> *"In that context, the NMC should perhaps be reminded that it was seeking to adduce Miss Pilgrim's statement as the sole evidence supporting the material parts of charge 1 when it knew that evidence was roundly disputed and could not be tested by cross-examination. It was, moreover, seeking to adduce it in support of a case that it was promoting, whose*

outcome could be (as in the event it was) the wrecking of Mrs Ogbanna's career as a midwife, a career which had lasted over 20 years. I should have thought it was obvious that, in the circumstances, fairness to Mrs Ogbonna demanded that in principle the statement ought only to be admitted only if she had the opportunity of cross -examining Miss Pilgrim upon it." (emphasis added)

12. *Andrew Thomas QC (as he then was) sitting as a Judge of the High Court, set out the principles in Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin) which ought to be applied:*

"45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these:

1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.

In my judgment, unless the Panel is given the necessary information to put the application in its proper context, it will be impossible to perform this balancing exercise."

13. *The evidence in the present case is plainly sole or decisive and that evidence on which the NMC seek to reply is neither demonstrably reliable nor is there any proper means of testing its reliability.*

14. *There is no documentary corroborative evidence in respect of the allegations of Resident A or Resident B. The panel, in an ordinary case, would be doubtless cautioned as to the approach to witness testimony consistent with the case of* R (Dutta) v General Medical Council [2020] EWHC 1974 (Admin) *which sets out*

the strengths and weaknesses of oral testimony and the value of considering it as against the documentary record, and being able to test it.

15. *Here we have no documentary record in respect of the allegations linked to Resident A or Resident B which can form a basis for known probable facts, and to compound the issue, no means to test the witness evidence either, if the panel consent to admitting the evidence of Residents A and B.*

16. *Again, per the judgment in* <u>*Thorneycroft*</u> *which I have already outlined, there can be no certainty that the account is inherently reliable, and with no other independent evidence no means of testing the reliability of that evidence as a foundation for the allegations which the NMC seek to litigate.*

17. *Indeed, a short analysis of the accounts given by Resident B to (Witness 3) in (the note of disclosure by Resident B) and the police interview demonstrate that the account cannot be considered inherently reliable. One such example is that Resident B initially suggests the giving of the medication is in the morning in (the note of disclosure by Resident B), then says it is in the evening in his interview. He is said to have said they were pushed into his mouth in (the note of disclosure by Resident B), and then in his police interview (pp.37-38 of the exhibit bundle) that in fact the way they were administered was how they would normally be given (by use of a small pot) but that Mr Hinch may have done so in a less compassionate way.*

18. *Not only has his account altered which it is submitted must give some concern regarding inherent reliability, but also the softening of his position speaks to exactly why being able to challenge and explore that evidence would be so important in a case such as this.*

19. *The 2019 case of El Karout v Nursing And Midwifery Council [2019] EWHC 28 (Admin) went further still than the Court in Thorneycroft reiterating that the focus in the first instance should be on admissibility rather than weight, and that in particular where hearsay is the sole evidence as to a particular charge which may have the effect of, to quote Spencer J in El Karout, "jeopardise the appellant's whole career" it must be approached with extreme caution.*

20. *In the present case, the core elements are as follows:*

    1. *The evidence is both sole and decisive, there is no evidence in respect of a number of the allegations, but for the evidence of the two absent witnesses. The live evidence which the panel will hear can only repeat that hearsay evidence.*

    2. *There is no means to test that evidence at all, let alone in a manner which would allow for a fair challenge to it.*

Reasons for the Absence of the Witnesses

21. *The NMC doubtless seek to persuade you that the circumstances of the absence of the witnesses is central to your consideration of the issues, and whilst of course the reason for the absence of both in understandable, it does not mitigate against the fact that without them the hearing would be unfair. The reason for their absence is but one factor, and it is outweighed in the present case by the core issue of fairness, as is reflected in the NMC guidance cited above.*

22. *The inclusion of the reasons for a witness' absence as a criterion by Andrew Thomas QC in Ogbonna was, it is submitted, because where a witness voluntarily choses to absent themselves, it should militate against their evidence being admitted. The fact that there is a good reason for their absence does not and should not have a bearing on the central question of fairness.*

Format of the Evidence

23. *It is accepted that in respect of Resident B there is a police interview with him, which is plainly a more formal type of evidence than an informal discussion with him, but it is not an account which the police sought to challenge or probe, and so cannot be viewed through that lens and – as has been explored above, it differs from the previous first account. In any event, even if it were the case that his evidence had been tested by the police fully, the absence of live evidence would still not allow Mr Hinch to properly and fairly challenge that account and explore it.*

24. *The situation with Resident A is even less clear. The second hand evidence is in the form of a short account from a someone at the home. As the learned Judge stated in El Karout:*

> *"There is a world of difference between, on the one hand, an off-the-cuff response to a question about medication amid general conversation in a welfare call and, on the other, a considered response to a very specific request for information, ensuring that the patient knew and understood the importance of the consequences of her answer."*

25. *Whilst the circumstances are not perfectly analogous – plainly they rarely are as each case differs – it is right to say that an imperfect note of what was said without any of the formal protections of an interview or similar, is not sufficient for the panel to be able to resolve the questions of inherent reliability or that otherwise there is a means of testing that evidence.*

26. *Again, it is submitted that this evidence cannot be said to be inherently reliable. Resident A appears only to have gestured that Mr Hinch has tapped her on the head, and the circumstances are not explored with Resident A either contemporaneously or after the fact. Indeed, all we are told by (Witness 5) is that Resident A tapped her colleague and then said that is what had happened to her. This account is, it is submitted, simply too vague to be considered demonstrably reliable and far too basic to form a proper basis to form the basis*

of a charge which could jeopardise Mr Hinch's entire career, per the authorities above.

<u>Risk of False Corroboration with Multiple Hearsay Accounts</u>

27. *Finally, as is highlighted at the start of these submissions, the risk of 'false' corroboration, where the evidence of one hearsay witness reinforces that of another, is per <u>El Karout</u> (para 132) "a consequential risk that the panel will rely on the accumulated evidence, without challenge, in a way which would render their approach to the other allegations unfair". This is plainly a live issue in the present case as I have already said, because the NMC would doubtless seek to rely on the similarity of allegations in proving their case.*

<u>Evidence of Andrew Parks</u>

28. *The below paragraphs are a short note setting out the position in respect of (Mr 1)'s handwritten statement (bundle p.42).*

29. *The NMC seek to admit his statement as hearsay. It does not appear that any significant efforts were made to secure his attendance, but the Registrant's position is that the panel's decision should be guided by their decision on Residents A and B and so should follow their decision in respect of those witnesses.*

30. *This is so because on the face of it, given the nature of the statement and the absence of any effort to take a formal statement, it would fall fowl of the same issues in the line of authorities cited above as the others, save – it is accepted – that the evidence is not sole and decisive as it is with Resident A or B. On that basis it ought to be excluded.*

31. *However, were the panel to decide to admit the evidence on Resident B following careful deliberation, then it is likely that the Registrant would seek to rely on the evidence of (Mr 1) to assist in some small way in contradicting the account of Resident B and so may be agreed by admission.*

III CONCLUSION

32. *For the above reasons the panel are invited to carefully consider the statements in this case, and reach a determination that the evidence of Residents A and B should not be admitted.'*

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

The panel considered the hearsay application.

With respect to the account of Resident A contained in the witness statement of Witness 5 and its associated exhibit, the panel took into account that the internal statement written by Witness 5 and Ms 1 on behalf of Resident A was made contemporaneous to the date of

the alleged incidents in charges 1a and 1b. The panel noted that the statement details Resident A's account of the alleged incidents which form the basis of charges 1a and 1b. Thus, the panel decided that the witness statement of Witness 5 and its associated exhibit are potentially relevant to the charges.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the evidence of Witness 5 is the sole and decisive evidence with respect to charges 1a and 1b. The panel took into account that the account of Resident A was not supported by any other documentary evidence or witness evidence in this case. It noted that although Witness 5 and Ms 1 had recorded Resident A's account of the alleged incidents together, Ms 1 was not scheduled to give evidence as a witness in this case. The panel therefore decided that the evidence of Witness 5 is the sole and decisive evidence with respect to charges 1a and 1b.

The panel noted that the NMC had notified you that the witness statement of Witness 5 and its associated exhibit would be tendered into evidence. The panel took into account that you had challenged the evidence of Witness 5 as you had denied the allegations. However, the panel was satisfied that there was no suggestion that Resident A had any reason to fabricate the allegations or for Witness 5 to falsify the account of Resident A in her witness statement.

The panel considered that although the charges were not so serious, any adverse finding could have a negative impact on your nursing career. The panel noted that there is a good reason for the non-attendance of Resident A as it considered that Witness 5 had confirmed in her witness statement that Resident A had passed away.

The panel considered whether it would be fair to admit the hearsay witness statement of Witness 5 and its associated exhibit into evidence. The panel took into consideration that in the internal statement written by Witness 5 and Ms 1 on behalf of Resident A, there was no direct reference made to you as the subject of the allegations as reference was instead

made to '*the agency night nurse'*. The only time a direct reference was made about you was in the witness statement of Witness 5 which was written eleven months after the alleged incident. The panel also took into consideration that sufficient context of the alleged incidents was not provided by Resident A. Furthermore, the panel noted that the account of Resident A seemed to have been recorded as a mere report of what Resident A had stated as there was no further probing or challenge of Resident A by either Witness 5 or Ms 1 to test the veracity of her account.

Having considered these factors including the fact that the evidence of Witness 5 is the sole and decisive evidence, the panel determined that it is not fair to admit the hearsay witness statement of Witness 5 and its associated exhibit into evidence. Although Witness 5 could be questioned by you and the panel regarding the account of Resident A, the panel concluded that this would not be sufficient to mitigate the unfairness posed to you. Accordingly, the hearsay application with respect to charges 1a and 1b is refused.

With regards to the account of Resident B contained in the witness statements of Witnesses 2 and 3 and their associated exhibits, the panel took into account that the Note of Disclosure and the Safeguarding Referral were made contemporaneous to the date of the alleged incidents in charges 2a, 2b, 2c, 2d, 2e and 2f. The panel noted that both documents detail Resident B's account of the alleged incidents that are the basis of charges 2a, 2b, 2c, 2d, 2e and 2f. Thus, the panel decided that the witness statements of Witnesses 2 and 3 and their associated exhibits are potentially relevant to the charges.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the evidence of Witnesses 2 and 3 is the sole and decisive evidence with respect to charges 2a, 2b, 2c, 2d, 2e and 2f. The panel took into account that there is other evidence which had been presented by the NMC in support of the charges in question, including the safeguarding referral dated 10 June 2022, the Police Interview with Resident B dated 24 June 2022, the Police Interview with you dated 2 July 2022, your account of the night in question as detailed in the Statement of the Registrant and the witness statement of Witness 4. The

panel therefore decided that the evidence of Witnesses 2 and 3 is not the sole and decisive evidence with respect to charges 2a, 2b, 2c, 2d, 2e and 2f.

The panel noted that the NMC had notified you that the witness statements of Witnesses 2 and 3 and their associated exhibits would be tendered into evidence. The panel took into account that you had challenged the evidence of Witnesses 2 and 3 as you had denied the allegations. However, the panel was satisfied that there was no suggestion that Resident B had any reason to fabricate the allegations or for Witnesses 2 and 3 to falsify the account of Resident B in their witness statements.

The panel considered the charges to be serious as any adverse finding could have a negative impact on your nursing career. The panel noted that there is a good reason for the non-attendance of Resident B due to his current health status as confirmed by the NMC.

Having considered these factors, the panel determined that it is relevant and fair to admit the account of Resident B, with respect to charges 2a, 2b, 2c, 2d, 2e and 2f, contained in the witness statements of Witnesses 2 and 3 and their associated exhibits into evidence. It was of the view that although the nature and contents of their evidence were challenged by you, it is a matter for the panel to compare and evaluate evidence from the NMC and you and attach any weight it may deem fit. The panel was also of the view that given that Witnesses 2 and 3 are scheduled to give oral evidence in this case, you would have the opportunity to question and challenge their evidence.

With respect to the local statement of Mr 1, the panel was of the view that although the statement is ambiguous and vague as it did not make any direct reference to you as the nurse in question nor the date on which the described alleged incident occurred, Mr 1 was a direct witness to the alleged incidents contained in charge 2. . Thus, the panel decided that the local statement of Mr 1 is potentially relevant to the charge 2.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel considered whether the local statement of Mr 1 is the sole and decisive evidence with respect to charge 2. The panel took into account that there is other evidence which had been presented by the NMC in support of charge 2, including the safeguarding referral dated 10 June 2022, the Police Interview dated 2 July 2022 and the witness statement of Witness 4. The panel was of the view that the local statement of Mr 1 provides an eyewitness alternative account of the alleged incident. The panel therefore decided that the local statement of Mr 1 is not the sole and decisive evidence with respect to charge 2.

The panel noted that the NMC had notified you that the local statement of Mr 1 would be tendered into evidence. The panel was also satisfied that there was no suggestion that Mr 1 had any reason to fabricate his account of the alleged incidents.

The panel considered the charges to be serious as any adverse finding could have a negative impact on your nursing career. The panel noted that there was no explanation provided by the NMC for the non-attendance of Mr 1 nor was there any evidence provided to demonstrate any reasonable steps taken by the NMC to secure his attendance at the hearing.

The panel considered whether it would be fair to admit the local statement of Mr 1 into evidence. It took into consideration that Mr Olphert had invited the panel to admit the local statement of Mr 1 into evidence if the panel had determined to admit the hearsay statement with respect to charges 1 and 2 into evidence, as you intend to rely on Mr 1’s evidence. Given the submissions of Mr Olphert, the panel determined that it is relevant and fair to admit the local statement of Mr 1 into evidence. The panel would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Decision and reasons on application for special measures/reasonable adjustments

The panel heard an application made by Ms Maqboul for the provision of a special measure/reasonable adjustment for Witness 4. The application was made pursuant to Rule 23 (1) (f) of the Rules.

Ms Maqboul submitted that Witness 4 has indicated that she would not be comfortable to give her evidence in your presence. Ms Maqboul stated that, given that this was a virtual hearing, Witness 4 had requested that your camera and audio should be turned off throughout the duration of her evidence. Ms Maqboul submitted that the panel should therefore grant her request as the special measure was necessary in order to enable Witness 4 give the best evidence to the panel.

Mr Olphert did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel decided to grant the application. The panel therefore directed that you should turn off your camera and audio throughout the duration of Witness 4's evidence, in order to enable her to give the best evidence in these proceedings. It was satisfied that no injustice would be posed to you by such special measure.

Background

On 20 June 2022, the NMC received a referral from Derbyshire Police about you. The referral arose as a result of your work placements, obtained through an employment agency [PRIVATE] (the Agency) at the following care homes: [PRIVATE] (Home 1) and [PRIVATE] (Home 2). The incidents outlined within the charges were alleged to have occurred at both Homes between April and June 2022, while you were working as an agency night nurse.

With respect to the alleged incident at Home 1, Resident A reported to a care assistant that on 24 April 2022, you had allegedly told her off for pressing the buzzer too much and you had allegedly tapped her on the head.

With respect to the alleged incident at Home 2, following your night shift between 7 - 8 June 2022, Resident B made a disclosure to staff at his Edmund Street Activity Centre ('the Day Centre') and raised the following allegations against you: that you had spoken to him in a derogatory manner; called him a baby; threatened to close his bedroom door; removed his call bell and pushed medications into his mouth. The Day Centre communicated the concerns to Witness 2, the deputy manager at Home 2, who notified the Agency.

It was also alleged that on your nightshift between 8 - 9 June 2022 at Home 2, after Resident D had suffered a fall, you had drag lifted them from the floor. Additionally, it was alleged that during your shift on 9 June 2022 at the Home, you had recorded in medical notes in relation to Resident E that she had slept well however Resident E had passed away on 08 June 2022.

The alleged incidents were reported to the Agency and you were no longer allocated shifts at Home 1 and Home 2.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Olphert that there is no case to answer in respect of charges 1a, 1b, 2b, 2c, 2d, 2e and 5. This application was made under Rule 24(7).

Mr Olphert provided the following written submissions below:

> 5. *'The charges against which the application is made are as follows:*
>   a. *Charge 1 entirely;*

b. Charges 2b, 2c, 2d, 2e; and

c. Charge 5

6. The basis of the application differs in respect of different charges and so the relevant submissions in respect of each are set out below.

II SUBMISSIONS

Charge 1

7. It is submitted that Charge 1 should be dismissed in its entirety at this stage.

8. The panel, by its decision at the outset of the hearing determined that the hearsay evidence which formed the sole evidence on which Charge 1 as founded ought not be admitted. It follows that the second-hand account given by [Witness 5] *of the actions of the Registrant in respect of Resident A are not before the panel in an admissible form.*

9. The NMC have produced no further evidence in support of this allegation.

10. It would not be proper to reach a conclusion on this charge absent any evidence, and it is not within the panel's gift to infer that any conduct can be made out on the basis of an unrelated incident in respect of Resident B.

11. On the basis of the above, the panel are faced with no evidence on which to base this charge, and following the authority of Galbraith this charge should be dismissed in its entirety.

Charges 2b, 2c, 2d and 2e

12. The Registrant also submits that the above charges should properly be dismissed at this stage on the basis of the 'second limb' of the Galbraith test.

13. *It is acknowledged that in respect of Charges 2a and 2f there is other corroborative evidence, including that given by live witnesses and as such it would not be proper to make an application in respect of those charges.*

14. *It is, however, submitted that the four charges highlighted above are susceptible to an application at this stage.*

15. *The Registrant's submissions in respect of each are as follows:*

    a. *General observations – Resident B did not formally identify who was responsible for some or all of the conduct. Whilst there is reference to an agency worker, there is also reference in his initial account to* [Mr 1] *and a 'new started'.* [Witness 3] *records in her safeguarding that the Resident reported that he was attended by a male and female.* [Witness 4] *records that only 3 staff were on shift with the Registrant, and only two female staff alongside* [Mr 1]*. She was on residential downstairs and the other agency care worker was allocated to the dementia unit and as far as she was aware neither she nor the agency worker assisted with Resident B's care.*

    b. *Charge 2b – In Resident B's initial account, which* [Witness 3] *conceded were rough notes recorded by a colleague, it is suggested that the Registrant called Resident B a baby. Later on in the same statement it is suggested that it was babyish. It is unclear whether Resident B meant that the Registrant called him a baby or spoke to him like a baby. This was further explored in Resident B's police interview. In that interview he begins by saying that the Registrant called him babyish, or childish before taking the buzzer away. When the officer explored this further (p.4 Police Interview) Resident B described an incident about the buzzer being taken away but did not expand further. On the basis of the hearsay accounts alone, it is submitted that the evidence is sufficiently vague or unclear that it ought properly to be dismissed.*

c. *Charge 2c – This charge stems from a brief bullet point note at the very end of the rough notes recorded by* [Witness 3]*'s colleague. It is unclear if this phrase was actually used because of the format of the notes. In the police interview this is repeated (p.6 Police Interview) but not expanded upon. It is unclear in what circumstances this was said. On the basis of the hearsay accounts alone, it is submitted that the evidence is sufficiently vague or unclear that it ought properly to be dismissed.*

d. *Charge 2d – the circumstances of this allegation are unclear. In his initial account Resident B suggests that his buzzer was taken. In the police interview this matter was explored further, and Resident B alleges that the Registrant took his buzzer away for '15 minutes' because he looked at his clock and that he then 'chucked' it at Resident B from about 6-7 inches away. He is clear that the buzzer was taken 'outside' (p.4 Police Interview). Those details are not contained within the accounts recorded in either the notes or the initial safeguarding referral, or the referral by* [Witness 2] *which appears to suggest that in fact Resident B was simply told by the Registrant that he would move his call bell. Further, we know from* [Witness 4] *that the call bells were activated frequently that night, and the statement of* [Mr 1] *– who we know from* [Witness 4] *was the staff carer who was allocated to the nursing unit – makes clear that at all times to his recollection the door to Resident B's room was open and the buzzer was plugged in. The charge avers in the alternative that the buzzer was placed such that it was not accessible, however this is not consistent with what Resident B says, who suggests that the buzzer was unplugged and taken away for 15 minutes. Indeed, even if it were placed in an alternative location, the care plan at* [Resident B's Care Plan] *simply states that the buzzer needed to be placed within reach and not in his hand as the staff have suggested. The evidence of Resident B on this allegation is unclear, has shifted with differing accounts and is inconsistent with the little other*

evidence which we have by which to evaluate it. It is therefore so tenuous or inconsistent that it ought to be dismissed.

e. *Charge 2e – As with 2d above, the evidence in respect of this allegation varies significantly. Resident B initially reports that the medications were 'pushed' into his mouth, and that it took place in the morning (per the* Note of Disclosure by Resident B and the Police Interview*).* Witness 1 *in her evidence stated that as far as she could recall, Resident B had said that the medications were 'rammed down his throat'. However, at the police interview, Resident B's explanation of events differs. He initially says they were 'stuffed down his throat' (p.2 Police Interview), however he at this stage says that the conduct happens at night, not after he has woken up in the morning. He also explains that it is just one tablet. He then says that the individual administering the medication 'put the pot up to me mouth' (p.3 Police Interview) and 'bumped it into me mouth' and that there may have been some water with it. When asked how nurses normally do it he explains 'like that but in a more compassionate way' (p.4 Police Interview). It is submitted that this speaks to the fact that in fact the medications were administered in the ordinary way. It is submitted that the accounts of Resident B are inconsistent and shift over time, and that they do not support the allegation that the medications were pushed into the Resident's mouth. The hearsay evidence is therefore so tenuous and inconsistent that the charge ought to be dismissed.*

16. *The panel have, following their decision on hearsay now had the benefit of hearing the remainder of the NMC's case, which it is submitted has not materially altered the position in respect of Resident B's evidence. Overall, the panel is invited to dismiss the above charges.*

Charge 5

17. *The NMC have pleaded dishonesty in the present case. The exact nature of the dishonesty is framed in the charge as "in that you created a medical record that recorded information that you knew was not true".*

18. *The only evidence which the NMC have adduced in respect of this allegation relates to the fact that the record was entered on the care plan for Resident E incorrectly. The Registrant has, by admission, accepted that this was an incorrect entry.*

19. *The NMC have not produced any evidence which supports or underpins the suggestion that the Registrant gained, or had anything to gain from this entry. He plainly took proper steps on the same record to notify the NHS of Resident E's passing, and having done so could not be materially advantaged by this entry.*

20. [Mr 1]*'s entries following the passing of Resident E were explained by* [Witness 2] *as final care, but the freetext entries suggesting that the Resident required a 'lot of help' suggest that in fact these entries had also been made erroneously.* [Witness 4] *confirmed that the thumbnails of the patients are small and hard to see.*

21. *The NMC's guidance on charging dishonesty (PRE-2e) suggests that: "Dishonesty describes a state of mind rather than a course of conduct, and the nurse, midwife or nursing associate's acts or omissions will only be considered to be dishonest if they demonstrate they were intentionally seeking to mislead or wrongly take advantage of another person."*

22. *There is no evidence in the present case to support that assertion and it is submitted that absent any clear evidence, no panel could properly conclude that the entry was made dishonestly.*

23. For those reasons this charge should be dismissed.

III CONCLUSION

24. The panel are invited to dismiss the above charges at half-time.'

Ms Maqboul provided the following written submissions below:

'Charge 1: On or around 23 April 2022, whilst working as a nurse at '[PRIVATE]' you were abusive and/or rude and/or uncaring and/or dismissive towards Resident A in that you

a. Admonished Resident A for using their call bell too much;

b. Tapped Resident A on the head on one or more occasions.

2. *The NMC is neutral as to whether or not there is a case to answer and leaves it to the panel to determine.*

3. *It is submitted that the charges addressed below fall into an entirely disparate category to those contained in charge 1, and the application of no case to answer (charges 2b, 2c, 2d, 2e and 5) should therefore be dismissed.*

Charge 2: On the nightshift 07-08 June 2022, whilst working as a nurse at '[PRIVATE]' you were abusive and/or rude and/or uncaring and/or dismissive towards one or more of the residents under your care in that you:

b. Called Resident B a baby or words to that effect

4. *The panel has now heard the evidence on behalf of the NMC in respect of all charges.*

5. [Witness 2] *confirmed the evidence she had provided in her witness statement. There was no deviation or inconsistency between her written statement and her oral evidence.*

6. *The provenance of her evidence, (or indeed any of the witnesses' evidence) which was addressed in the earlier hearsay application is not a matter to be considered at this stage. Issues of 'weight' to be attached to a witnesses evidence is to be considered at the end of stage 1.*

7. [Witness 2] *was not specifically probed as to the veracity of her evidence on this point by the Defence, nor was exhibit [*Witness 2's email to the Agency] *put to her.*

8. *Both* [Witness 1] *and* [Witness 2] *gave clear evidence that Resident B knew all of the regular members of staff working at the Home. In his police interview, Resident B is clear the person he makes the allegations of is a nurse, from an agency, who has worked at the home 4-5 times previously. Mr Hinch was the only nurse on duty on 7, 8 and 9 June.*

9. [Witness 1] *in her oral evidence confirms Resident B later named Mr Hinch as the person responsible for his mistreatment.*

10. *None of the limbs within **Galbraith** are therefore engaged.*

2c. Told Resident B that Resident B was wasting your time or words to that effect

11. *The same submissions made in respect of charge 2b are made in respect of this charge.*

12. *Resident B in his police interview also states "…he said I were wasting his time…"(page 40 exhibit 3).*

13. *It is respectfully submitted there is case to answer in respect of this charge*

<u>2d. Removed Resident B's call bell/buzzer from him and/or placed Resident B's call bell/buzzer such as it was not accessible to him</u>

14. *The same submissions are repeated here.*

15. *Both* [Witness 1] *and* [Witness 2] *gave clear evidence that Resident B had told them his call bell had been removed.* [Witness 2] *accepted that the phraseology in the care plan could have been drafted a little clearer, but she did not suggest the call bell had not been moved.*

16. *Further, Mr Hinch himself states within his police interview (page 11 line 17) that Resident B had the buzzer in his hand, which he then removed as a consequence of pinning it to the pillow.*

17. *It is therefore submitted there remains a case to answer in respect of this charge.*

<u>2e. Pushed medication into Resident B's mouth</u>

18. *The oral evidence of* [Witness 1] *and* [Witness 2] *did not deviate from their written evidence.*

19. [Witness 1] *provided further oral evidence as to the process by which medication was administered to Resident B- this would generally be given with a teaspoon, and Resident B would nod or show the contents of his mouth to demonstrate his agreement to having the medication administered, and to confirm it had been taken.*

20. *Mr Hinch in his police interview describes none of these actions whilst administering medication. Resident B in his police interview is clear that Mr Hinch was '…aggressive…and pushing them down his throat.." (pg 36)*

21. *The evidence with respect to this charge is therefore neither lacking nor tenuous. The panel is asked to dismiss the application.*

<u>Charge 5- Your conduct at charge 4 was dishonest in that you created a medical record that recorded information that was not true</u>

22. [Care Record for Resident E] *clearly shows that the registrant had recorded an entry with respect to Resident E, who sadly passed away on 8 June 2022.*

23. *The entry made suggest that the Resident had actively received care from the Registrant.*

24. *In those circumstances, it is submitted the Registrant must have known (owing to the fact the Resident was deceased) that he had not in fact provided any care to Resident E.*

25. *Whilst it has been asserted on behalf of the Defence that this was an 'error', that cannot be considered as evidence at this stage in the proceedings. The Registrant has not yet opened his case, and any assertion put on his behalf cannot be considered as 'evidence'.*

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

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved in relation to charges 1a, 1b, 2b, 2c, 2d, 2e and 5 and whether you have a case to answer in this regard.

The panel had regard to the test set out in the case of *R v Galbraith* [1981] 1 WLR 1039. In *Galbraith*, Lord Lane set out the following test:

'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

> *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
>
> *(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses' reliability or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury…There will of course as always in this branch of the law be borderline cases. They can safely be left to the discretion of the judge.'*

In considering whether there was sufficient evidence to enable the panel to find the facts in relation to charges 1a, 1b, 2b, 2c, 2d, 2e and 5 proved, the panel carefully considered the evidence before it.

With respect to charges 1a and 1b, the panel bore in mind that it had earlier determined that the sole evidence which supports these charges was inadmissible hearsay evidence. The panel further noted that the NMC has not provided any further evidence in support of these charges. In the absence of any evidence to support these charges, the panel determined that there is no case to answer in respect of these charges.

In relation to charge 2b, the panel considered the oral evidence and respective witness statements of Witnesses 1, 2 and 3. The panel also took into account the Note of Disclosure by Resident B, the Safeguarding Referral by Witness 3, the email from Witness 2 to the Agency dated 10 June 2022 as well as the Police Interview with Resident B dated 24 June 2022. The panel was of the view that the evidence is clear and consistent with each other that you had allegedly called Resident B a baby or stated that he acted in a childish manner. The panel was therefore satisfied that the evidence with respect to this charge, when taken at its highest, could lead to the charge being proved. It therefore concluded that there is a case to answer in relation to this charge. The panel would attach any weight it deems fit to the evidence with respect to this charge, in the facts finding stage.

With regard to charge 2c, the panel took into account the oral evidence and witness statements of Witnesses 2 and 3, the Note of Disclosure by Resident B, the Safeguarding Referral by Witness 3, the email from Witness 2 to the Agency dated 10 June 2022 as well as the Police Interview with Resident B dated 24 June 2022. The panel was of the view that there is consistency in the NMC evidence that you had allegedly told Resident B that he was wasting your time or words to that effect and there was no ambiguity in this regard. The panel was therefore satisfied that the evidence with respect to this charge, when taken at its highest, could lead to the charge being proved. It therefore concluded that there is a case to answer in relation to this charge. The panel would attach any weight it deems fit to the evidence with respect to this charge, in the facts finding stage.

With respect to charge 2d, the panel took into account the oral evidence and respective witness statements of Witnesses 1, 2 and 3. The panel further considered the Note of Disclosure by Resident B, the respective safeguarding referrals made by Witnesses 2 and 3, the email from Witness 2 to the Agency dated 10 June 2022, Resident B’s care plan as well as the Police Interview with Resident B dated 24 June 2022. The panel was of the view that the NMC evidence with respect to this charge is clear and consistent with each other. The panel was therefore satisfied that the evidence with respect to this charge,

when taken at its highest, could lead to the charge being proved. It therefore concluded that there is a case to answer in relation to this charge. The panel would attach any weight it deems fit to the evidence with respect to this charge, in the facts finding stage.

In relation to charge 2e, the panel considered the oral evidence and respective witness statements of Witnesses 1, 2 and 3. The panel also took into account the Note of Disclosure by Resident B, the respective safeguarding referrals made by Witnesses 2 and 3, the email from Witness 2 to the Agency dated 10 June 2022, Resident B's care plan, Resident B's Medication Administration Record (MAR) charts as well as the Police Interview with Resident B dated 24 June 2022. The panel noted that there were some inconsistencies in terms of the time the medication was allegedly administered to Resident B by you and also that there is some ambiguity in the words used to describe the alleged manner in which the medication was administered to Resident B by you. Nevertheless, the panel was of the view that the mischief in this charge is that you had administered medication to Resident B in an alleged abusive or uncaring manner. In this regard, the panel was satisfied that there is sufficient evidence which could support a finding in relation to charge 2e. It therefore concluded that there is a case to answer in relation to this charge. The panel would attach any weight it deems fit to the evidence with respect to this charge, in the facts finding stage.

With regard to charge 5, the panel bore in mind that the standard test for determining dishonesty was laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

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

In considering whether there is sufficient evidence to enable the panel to draw inference as to your actual state of knowledge/belief as to the facts in relation to charge 4, the panel carefully considered all the evidence before it. The panel sought to determine whether it

could draw inference of your alleged dishonesty and/or of your state of mind from this evidence.

The panel took into account that there were no previous concerns raised about your nursing practice until the alleged incidents, which demonstrates evidence of previous good character. The panel examined the NMC evidence before it and noted that there is no direct evidence that could demonstrate your state of mind at the time of the incident and that the only contemporaneous evidence to the incident is the Entry in care record for Resident E on 8 June 2022. The panel took into consideration that both Witnesses 1 and 2 had stated that there can be human errors in recordkeeping at Home 2 although errors should not be made. Witness 2 further confirmed that aside from the error stated in charge 4, there was no other error you had made in your recordkeeping during your shifts at the Home from 7- 9 June 2022. The panel further considered the context of the incident. It noted that you were an agency nurse who may have not been fully familiar with the practice at Home 2 and that the incident had occurred during a night shift, which may have affected your concentration at that time.

Having carefully considered the evidence with respect to charge 4, the panel was of the view that it was difficult to draw any inference as to your state of knowledge/belief or your motivation with regard to charge 4. The panel concluded, having regard to its assessment of the evidence, that a properly directed panel could not find the facts of charge 5 proved. The panel therefore determined there was no case to answer in respect of this charge, in its entirety.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Olphert, who informed the panel that you made full admissions to charge 4.

The panel therefore finds charge 4 proved in its entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Maqboul and those made by Mr Olphert.

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

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

- Witness 1: Home Manager of Home 2 at the time of the incidents.
- Witness 2: Deputy Home Manager of Home 2 at the time of the incidents.
- Witness 3: Day Service Manager at the Day Centre at the time of the incidents .
- Witness 4: Care Assistant at Home 2 at the time of the incidents.

The panel also heard evidence from you under oath.

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

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

Charge 2a

2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

    a. Closed or threatened to close Resident B's bedroom door

This charge is found proved.

In reaching this decision, the panel took into account that Resident B's care plan provided that: *'Resident B likes to have his door to his room to remain open and a door guard is in place to hold the door open…'*

The panel took account of the Note of Disclosure by Resident B. It noted that on 9 June 2022, Resident B had disclosed to Witness 3 and her colleague at the Day Centre that you had threatened to shut his door and actually shut his door, during your night shift between 7 – 8 June 2022. The panel took into consideration that this incident was thereafter reported in the Safeguarding Referral by Witness 3 and in the email from Witness 2 to the Agency dated 10 June 2022. The panel further noted that Resident B repeated the same allegation during his police interview dated 24 June 2022.

The panel took into consideration that you denied the allegation and stated that you were not aware that Resident B liked his door open. You stated during your oral evidence that although you had swung the door, you never intended to close the door.

However, the panel took into account that you acknowledged that you closed Resident B's door, during your night shift between 7 – 8 June 2022, in your statement of the incidents via the Agency, in your police interview dated 2 July 2022 and, in your reflection, dated August 2024. The panel also noted that Resident B was clear and consistent in his account of the incident. It bore in mind that Resident B was questioned and probed about the incident, by the police during his police interview dated 24 June 2022. Resident B also

had no apparent motivation to fabricate the allegation, and therefore the panel accepted the account of the incident by Resident B.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had closed Resident B's door.

The panel considered the context of the incident. It noted that at the time of the incident, Resident B was distressed and, in your words, was '*shouting and screaming'*. The panel therefore considered your conduct to be uncaring, rude and dismissive, given the vulnerable condition of Resident B and the context of the incident. The panel did not regard your conduct to have reached the threshold of an abuse. The panel therefore found charge 2a proved on the balance of probabilities.

Charge 2b

> 2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you
>
>   b. Called Resident B '*a baby'* or words to that effect

This charge is found proved.

In reaching this decision, the panel took account of the Note of Disclosure by Resident B. It noted that on 9 June 2022, Resident B had disclosed to Witness 3 and her colleague at the Day Centre that you had called him a baby and stated that he acted in a childish manner, during your night shift between 7 – 8 June 2022. The panel took into consideration that this incident was thereafter reported in the Safeguarding Referral by Witness 3 and in the email from Witness 2 to the Agency dated 10 June 2022. The panel further noted that Resident B repeated the same allegation and provided more context to the incident, during his police interview dated 24 June 2022.

The panel took into consideration that you denied the allegation and stated that you always treated residents with respect and dignity.

However, the panel took into account that in your statement of the incidents via the Agency, you stated that you told Resident B that he is an adult and should behave in such manner. You also stated in your police interview dated 2 July 2022 that Resident B had said to you '*you are talking to me like a child'*. You further stated during your oral evidence to the panel that you had told Resident B to have an adult-to-adult conversation with you to resolve the issue about his buzzer. The panel was of the view that your various statements implied that Resident B was behaving like a child.

The panel noted that Resident B was clear and consistent in his account of the incident. It bore in mind that Resident B was questioned and probed about the incident, by the police during his police interview dated 24 June 2022. The panel therefore accepted the account of the incident by Resident B.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had called Resident B a baby or words to that effect.

The panel considered the context of the incident. It noted that Resident B was vulnerable, completely dependent on you and other carers for meeting his basic needs and that he felt that he was a burden on people. The panel therefore considered your conduct to be uncaring, rude and dismissive of Resident B's needs and wishes. The panel further considered your conduct to be abusive as such words are emotionally cruel and belittling to a very vulnerable person with high care needs. The panel therefore found charge 2b proved on the balance of probabilities.

Charge 2c

2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

   c. Told Resident B that Resident B was '*wasting your time'* or words to that effect

This charge is found proved.

In reaching this decision, the panel took account of the Note of Disclosure by Resident B. It noted that on 9 June 2022, Resident B had disclosed to Witness 3 and her colleague at the Day Centre that you had told him that he was wasting your time, during your night shift between 7 – 8 June 2022. The panel took into consideration that this incident was thereafter reported in the Safeguarding Referral by Witness 3 and in the email from Witness 2 to the Agency dated 10 June 2022. The panel further noted that Resident B repeated the same allegation and provided more context to the incident, during his police interview dated 24 June 2022.

The panel took into consideration that you denied the allegation and stated that you would not speak to any resident in that manner.

However, the panel noted that Resident B was clear and consistent in his account of the incident. It bore in mind that Resident B was questioned and probed about the incident, by the police during his police interview dated 24 June 2022. The panel therefore accepted the account of the incident by Resident B. The panel was of the view that given the context of the incident, it was indicative of the pattern of your behaviour in the manner you treated Resident B at the time of the incidents.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had told Resident B that he was '*wasting your time'* or words to that effect.

The panel considered the context of the incident. It noted that your role at the home was to provide professional and compassionate care to the residents. The panel therefore considered your conduct to be uncaring, rude and dismissive, given Resident B's dependency on others to meet his basic needs. The panel did not regard your conduct to reach the threshold of an abuse. The panel therefore found charge 2c proved on the balance of probabilities.

Charge 2d

2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

    d. Removed Resident B's call bell/buzzer from them and /or placed Resident B's call bell/buzzer such as it was not accessible to them

This charge is found proved.

In reaching this decision, the panel took into account that Resident B's care plan provided that: *'I am unable to mobilise independently and require a nurse call buzzer to be connected, in working order and within my reach prior to me being unattended in my bedroom'.*

The panel took account of the Note of Disclosure by Resident B. It noted that on 9 June 2022, Resident B had disclosed to Witness 3 and her colleague at the Day Centre that you had removed his call bell/buzzer from him, during your night shift between 7 – 8 June 2022. The panel took into consideration that this incident was thereafter reported in the

respective safeguarding referrals made by Witnesses 2 and 3, and in the email from Witness 2 to the Agency dated 10 June 2022. The panel further noted that Resident B repeated the same allegation during his police interview dated 24 June 2022. The panel bore in mind that Resident B was questioned and probed about the incident, by the police during his police interview dated 24 June 2022.

The panel took into consideration that you denied the allegation. You stated in your reflection dated August 2024 that:

> *'During the following shift, Resident B continued to use his buzzer more frequently that most of the residents. He also had his TV on very loudly late into the night. Resident B was in room 41, and the terminally ill resident was next door in room 41. I suggested to Resident B that he turn his TV volume down and try to get some sleep. I explained to Resident B that he was pressing the buzzer without meaning to when he was dosing as he kept it in his hand all the time, and so I suggested that he put the buzzer next to his pillow to avoid this happening. If he had taken my advice, he would still have been able to reach the buzzer and use it if he needed it, but it would have stopped him pressing it accidentally. Resident B screamed and shouted at me for this suggestion, so I left his room and closed his door'*

You further stated during your police interview dated 24 June 2024 that you had removed the call bell/buzzer and pinned it to the left side of Resident B's pillow, in order to prevent him from pressing it accidentally whilst he slept. During your oral evidence to the panel, you explained how much arm movement Resident B had. You stated that you had pinned it to the right side of his pillow and that you believed that Resident B could access his call bell/buzzer from where you had pinned it. However, when further questioned by the panel, you confirmed that you had not checked with Resident B as to whether he could reach the call bell/buzzer.

The panel was of the view that, given that Resident B had screamed and shouted at you when you made the suggestion of pinning his call bell/buzzer to his pillow, Resident B did

not accept your suggestion and would not have behaved in such manner if the call bell/buzzer was easily accessible to him. The panel therefore accepted the account of the incident by Resident B.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had removed Resident B's call bell/buzzer from them and placed it such as it was not accessible to them.

The panel considered the context of the incident. It noted that at the time of the incident, Resident B was distressed and was shouting at you for removing his call bell/buzzer. You did not agree with Resident B on where to place his call bell/buzzer and disregarded his objection at placing it on his pillow. The panel therefore considered your conduct to be uncaring and dismissive as it was your duty as a registered nurse to attend to the care needs of residents under your care. The panel did not regard your conduct to be rude or to reach the threshold of an abuse given the context of the incident as your intention was to prevent Resident B from pressing his call bell/buzzer accidentally while he slept. The panel therefore found charge 2d proved on the balance of probabilities.

Charge 2e

2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

    e. Pushed medication in to Resident B's mouth

This charge is found proved.

In reaching this decision, the panel took account of the Note of Disclosure by Resident B. It noted that on 9 June 2022, Resident B had disclosed to Witness 3 and her colleague at the Day Centre that you had pushed his medication into his mouth when he woke up in the

morning. The panel took into consideration that this incident was thereafter reported in the respective safeguarding referrals made by Witnesses 2 and 3, and in the email from Witness 2 to the Agency dated 10 June 2022. The panel further noted that Resident B repeated the same allegation and further stated that you had rammed the medication into his mouth with the medication pot, during his police interview dated 24 June 2022.

The panel took into consideration that you denied the allegation and stated that you had assisted Resident B to take his medication using a spoon because he was unable to pick the tablets from a medicine pot. You stated that it was the standard and normal procedure for the administration of medication by nurses.

The panel had sight of the MAR charts and noted that the medication was recorded to have been administered to Resident B by you during your night shift between 7 – 8 June 2022. The panel further noted that there was some ambiguity in the words used by Resident B to describe the manner in which you had administered medication to him and also as to the timing of the incident. Nevertheless, the panel bore in mind that it had earlier determined that the ambiguities were not material to the charge, given that the mischief in this charge is that you had administered medication to Resident B in an abusive, rude, uncaring or dismissive manner.

The panel noted that Resident B was clear and consistent in his account of the incident. The panel did acknowledge that Resident B had varied within his statement the timing of the incident but noted that when probed with very specific questioning about the timing of the incident by the police during his police interview dated 24 June 2022, he was very clear that it was given at night, which is in alignment with the documentary evidence provided by the MAR chart.

The panel noted that Resident B had been taking medication for a long period of time at Home 2 and therefore would be able to recognise when medication is not administered in a compassionate manner. The panel was also of the view that given the context of the incident, it was indicative of the pattern of your behaviour in the manner you treated

Resident B at the time of the incidents. The panel therefore accepted the account of the incident by Resident B.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had pushed medication into Resident B's mouth.

The panel considered the context of the incident. The panel considered your conduct in pushing medication into Resident B's mouth to be uncaring as it is the duty of registered nurses to provide compassionate care to residents under their care. However, the panel did not regard your conduct to be rude, abusive or dismissive as there is no evidence of such behaviour. The panel therefore found charge 2e proved on the balance of probabilities.

Charge 2f

2. On the nightshift 07 - 08 June 2022, whilst working *at '[PRIVATE]'* you were abusive and/or rude and/or uncaring and/or dismissive towards one of more residents under your care in that you

    f. Threatened to unplug one or more resident's call bell/buzzer(s)

This charge is found proved.

The panel took account of the witness statement of Witness 4 dated 11 April 2023, in which she stated:

> *'During the shift, I recall Christopher coming downstairs and said that it was not normal for buzzers to be going off that much. From what I recall, it was a particularly busy night. Christopher said that he had told the residents in rooms 42*

(Resident B) and 43 (….I cannot recall his surname) that "if they continued to buzz for no reason that he would unplug the buzzers".'

The panel also took into account the Internal Statement written by Witness 4 dated 8 June 2022 in which Witness 4 had reported that you had threatened to unplug Resident B's call bell/buzzer. The panel noted that this statement was made contemporaneously to the time of the incident.

The panel took into consideration that you denied the allegation and stated that you could not have made such threat given that unplugging the call bell/buzzer would be counterproductive as residents would be unable to alert you to their care needs.

The panel took into account that Witness 4 was clear and consistent in both her documentary and oral evidence that you had threatened to unplug Resident B's call bell/buzzer. You had also admitted to being frustrated by the constant use of the call bell/buzzer by Resident B. The panel was of the view that there was no reason for Witness 4 to fabricate her account of the incident and given the context of the incident, it was indicative of the pattern of your behaviour in the manner you treated Resident B at the time of the incidents. Therefore, the panel accepted Witness 4's account of the incident.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 7 - 8 June 2022, you had threatened to unplug Resident B's call bell/buzzer.

The panel considered the context of the incident. It noted that it is the duty of registered nurses to attend promptly to the care needs of residents under their care when they are alerted by residents with the aid of call bell/buzzer. The panel therefore considered your conduct to be uncaring, rude and dismissive, given the vulnerable condition of Resident B and the context of the incident. The panel further considered your conduct to be abusive as such threat amounted to emotional abuse of Resident B, given his reliance on his call

bell/buzzer to draw attention of care staff to his care needs and his anxiety about this. The panel therefore found charge 2f proved on the balance of probabilities.

Charge 3

3. On the nightshift 08-09 June 2022, whilst working at *'[PRIVATE]'*, after Resident D had suffered a fall, you 'drag lifted' them from the floor.

This charge is found proved.

The panel took account of the witness statement of Witness 4 dated 11 April 2023, in which she stated:

> *'At around 07:30 Resident D fell in her room….When Christopher arrived, he asked if she had hit their head or was in any pain. Resident D responded that she had not hit her head and was not in any pain. As soon as she said this, Christopher wrapped his arms around shoulders and lifted her to her feet very quickly. This is known as a drag lift…'*

The panel also took into account the Internal Statement written by Witness 4 dated 8 June 2022 in which Witness 4 had made a similar allegation. The panel noted that this statement was made contemporaneously to the time of the incident. The panel also had sight of the Care Note for Resident D and the Safeguarding Referral for Resident D made by Witness 2 on 10 June 2022, in which it was reported that you had drag lifted Resident D when she had a fall.

The panel took into consideration that you denied the allegation. The panel noted that in your statement of the incidents via the Agency, you stated that you '*then lifted her to her feet and supported her until she got her balance. The HCA then gave her a walking frame. One HCA said "oh we are doing it like that" and the nurse said she would do her observations'.*

However, in your reflection dated August 2024, you stated that *‘I brought a chair over and placed it in front of her. I asked her to place her hands on the chair and to put one then the other flat on the floor into a standing position. I supported Resident D as she did this. Once she was standing, I removed the chair and gave her back her walking frame so she could walk back to her chair…’.* Furthermore, in your oral evidence to the panel. you stated that you assisted Resident D to her feet with the aid of her walking frame.

The panel took into account that Witness 4 was clear and consistent in both her documentary and oral evidence that you had drag lifted Resident D when she had a fall. The panel was of the view that there was no reason for Witness 4 to fabricate her account of the incident. The panel further noted there were various significant inconsistencies in your accounts of the incident as to how you assisted Resident D when she had a fall. In view of these inconsistencies, the panel accepted Witness 4’s account of the incident.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on the nightshift 8 - 9 June 2022, after Resident D had suffered a fall, you ‘*drag lifted’* them from the floor. The panel therefore found charge 3 proved on the balance of probabilities.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Ms Maqboul 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'*

Ms Maqboul submitted that when considering the issue of misconduct, mere negligence is not sufficient and what must be proved is that the conduct would be considered deplorable by fellow practitioners. She further referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) where the High Court stated that depending on the circumstances, a single act or omission, if particularly grave, could be categorised as misconduct.

Ms Maqboul submitted that your conduct, in charges 2, 3 and 4, was a serious departure from the standards expected of a registered nurse and such departure was sufficiently serious as to warrant a finding of misconduct in this case. She submitted that your conduct breached the following sections of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2018' ("the Code"): 1, 2, 3, 4, 6, 7, 8, 10 and 20.

Ms Maqboul submitted that, with respect to charge 2, your conduct demonstrated a pattern of behaviour or a course of conduct, over two-night shifts at the Home, towards Resident B. She highlighted that Resident B was both vulnerable and infirm and he required a high level of care. She stated that Resident B relied heavily on those who cared for him to administer proper care and to do so respectfully. She submitted that [PRIVATE] was Resident B's home, and you created a level of apprehension and fear in Resident B in his own home, such that he felt unable to disclose within the proximity of his home, the poor level of care that had been afforded to him by you. Resident B further disclosed to the Daycare Centre staff, a reluctance to return to [PRIVATE] as a result of your actions.

Ms Maqboul submitted that each of the sub charge contained within charge 2 is a serious departure from what one would expect of a registered nurse and amounts to misconduct.

In relation to charges 3 and Resident D, Ms Maqboul highlighted that witnesses had confirmed during evidence that there are approved moving and handling techniques that should be utilised when a resident has suffered a fall and two specific techniques were identified, both of which you failed to utilise. She stated that Resident D was a vulnerable service user, reliant upon those around her to administer safe, professional and effective care. Ms Maqboul submitted that the panel should consider the context of the incident as you gave evidence to the extent that you were frustrated when you attended to Resident D. She submitted that, in looking at your evidence in isolation, it is clear that you expected staff who were not on duty to carry out work that was your responsibility. Notwithstanding this, you proceeded to execute a drag lift on Resident D, which is not only a dangerous technique but also a technique which has the risk of causing serious injury and is completely contrary to approved moving and handling techniques.

Ms Maqboul submitted that the panel should consider that, during your cross examination, you not only refused to accept the deficiencies of your decision, but also refused to accept that the way in which you lifted Resident D was not an approved moving and handling technique, and clearly there were concerns raised by other members of staff about it.

With regard to charge 4 and the documentary error relating to Resident E, Ms Maqboul submitted that you demonstrated a lack of care in detail and that you had treated the documentation as a tick box exercise, when it required proper care and attention, particularly in the circumstances that Resident E was deceased. She submitted that it should have been clear to you, having looked at all the other entries that came before your entry, that Resident E was deceased.

In conclusion, Ms Maqboul invited the panel to find that your actions in charges 2, 3 and 4 amounted to misconduct.

Mr Olphert referred the panel to the case of *R* (*Shaw) V General Osteopathic Council* [2015] EWHC 2721 (Admin), where the High Court noted that misconduct did refer to some degree of moral blameworthiness, and that there was an implication of that and the degree of opprobrium likely to be conveyed to the ordinary and intelligent citizen.

Mr Olphert submitted that, in assessing misconduct, the panel ought to assess each allegation in term and indeed determine whether each alone could amount to misconduct. He stated that it is accepted that personal mitigation is, as a general rule, not something which the panel should have regard to when considering misconduct or current impairments, as indicated by the Court of Appeal in the case of Campbell v GMC [2005] EWCA Civ 250. Mr Olphert however submitted that this should be distinguished from that evidence, which is directly relevant to the particular circumstances in which the registrant found themselves at the time, and indeed their clinical practice, which must plainly be relevant to the issues of both misconduct and impairment. He submitted that the bar for misconduct is a high one and requires a finding that the conduct is serious and may be regarded as deplorable by fellow practitioners, as set out in the case of *Nandi v GMC* [2004] EWHC 2317 (Admin).

With respect to charge 4, Mr Olphert submitted that, given the absence of dishonesty in respect of this allegation, one record keeping error, in circumstances where it was clear that the entry was simply placed on the wrong resident record which could in theory have

happened to anyone, is not sufficient to reach the threshold of serious professional misconduct. He asserted that your conduct was clearly an act of absent mindedness rather than some intentional act. Mr Olphert submitted that, in such circumstances and in the absence of a pattern of record keeping errors, there is insufficient evidence to conclude that your conduct in charge 4 demonstrates serious misconduct that could be considered deplorable by other professionals.

In relation to charge 3, Mr Olphert submitted that your conduct was not done with malice but as a result of the circumstances at the time of the incident. He submitted that your conduct in relation to the drag lift is not so serious as to warrant a finding that the conduct is deplorable nor that it attracts any kind of moral blameworthiness or opprobrium. He asserted that although your conduct was haphazard, it does not amount to serious professional misconduct.

With regard to charge 2, Mr Olphert stated that you accepted the panel's findings on facts with respect to your actions and that they are within the framework of the charges, very serious. He further stated that you accepted that some of your actions, contained in charge 2, amount to serious professional misconduct. However, he asserted that this does not apply to all of the sub charges and the panel should undertake a careful consideration of whether your conduct in each sub charge amount to misconduct.

Submissions on impairment

Ms Maqboul highlighted that although there is no legal definition of impairment, at this stage, the panel should consider whether the nurse or midwife can practise kindly, safely and professionally. She submitted that, in the circumstances of this case, the resounding answer to that question is 'no'. Ms Maqboul submitted that it is the position of the NMC that your fitness to practise is currently impaired, as a result of your misconduct, on both public protection and public interest grounds.

Ms Maqboul submitted that you acted in such a way that placed both Residents B and D at an unwarranted risk of harm, you have demonstrated a complete lack of insight into your conduct, and therefore, there is a high likelihood that you might repeat your behaviour if a finding of impairment is not made in this case.

Ms Maqboul submitted that your conduct towards Resident B had such an impact on him in that he was so distressed that he could only disclose the incident when he was not within the premises of Home 2. She submitted that you displayed a complete disregard for both Residents B and D, and you did not demonstrate any insight into your failings, during the course of giving your evidence.

Ms Maqboul highlighted that your response as to what you would have done differently was that you should have delegated some of your responsibilities to another staff member to attend to the respective needs of both Residents B and D. She further highlighted that you stated that there were systemic issues at Home 2. However, Ms Maqboul submitted that your evidence in this case is at odds with your police interview, and it is the position of the NMC that you only raised these issues as a result of the criticisms of your conduct at Home 2.

Ms Maqboul submitted that there is no evidence to demonstrate that you have strengthened your nursing practice. She submitted that there has been no further information received from your current employer as to your current practice. She stated that you currently work independently, which is similar to how you worked in Home 2 and this is very concerning, particularly in circumstances where the panel had found that your conduct amounted to emotional abuse of Resident B. Ms Maqboul submitted that your impairment bundle demonstrates that there is a complete lack of insight, remorse and remediation on your part. She asserted that you did not undertake any training to address the specifics of the concerns over and above mandatory training. She invited the panel to take into consideration that there is no testimonial evidence from fellow professionals, despite your over twenty years of experience as a registered nurse.

Ms Maqboul submitted that registered nurses care for the most vulnerable people in society and therefore, a finding of impairment on public protection grounds is required to address a potential risk to those individuals.

In terms of public interest, Ms Maqboul submitted that you breached numerous tenets of the nursing profession through your conduct and have brought the profession into disrepute. She asserted that a fully informed member of the public would be seriously concerned by your conduct in this case, such that it would result in a lack of trust and confidence in the nursing profession. She submitted that members of the public have an expectation that health professionals will act impartially and with the best interests of a patient in mind, and your conduct risks undermining that reasonable and important expectation. She therefore concluded that finding of impairment is necessary to maintain the public confidence in the profession and in the NMC as a regulator in upholding professional standards.

Mr Olphert referred the panel to the case of *Meadow v GMC* [2006] EWCA Civ 1390 in which Sir Anthony Clark MR stated:

> *'In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings, but to protect the public against the acts and omissions of those who are not fit to practise. The fitness to practise panel thus looks forward and not back. However, in order to form a view as to the fitness to practise of a person today, it is evident that they will have to take account of the way in which a person concerned has acted or failed to act in the past.'*

Mr Olphert submitted that the above statement is particularly pertinent in this case. He stated that the panel's primary concerns are public protection and ensuring that the public interest is protected. This is summarised by Mrs Justice Cox's comments in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin).

Mr Olphert further referred the panel to the case of *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) where the Court, in considering the issue of rejected defence, set out the following principles:

1) *'Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.*

2) *Denial of misconduct is not a reason to increase sanction.*

3) *It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.*

4) *However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.*

5) *The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant.'*

Mr Olphert submitted that, given that the panel has found two allegations proved which you denied, the principles laid down in Sayer case is clearly relevant, particularly the third principle.

Mr Olphert submitted that it is evident that you plainly understand the gravity of your conduct and it is also notable that there have been no further concerns raised regarding your nursing practice. He told the panel that you are currently in a role where you feel supported and you have moved away from agency work because of your reflection on your time as an agency nurse. He submitted that you have demonstrated that you are currently fit to practise as a registered nurse based on your recent practise.

Mr Olphert submitted that although your numerous training certificates were undertaken in the course of your employment, they demonstrate that you are a safe and effective practitioner. He submitted that in response to Ms Maqboul's submissions on your testimonials, the panel should consider that you have practised as a night nurse at various care homes for a significant number of years. He highlighted that you were often the only nurse on those shifts and as an agency nurse, you could not build relationships with fellow practitioners. Mr Olphert therefore asserted that it is therefore unrealistic to expect nursing practitioners to be able to provide references on your behalf.

Mr Olphert highlighted that you have provided several testimonials which speak glowingly about your overall personal conduct, but more significantly, that you have practised as a registered nurse without concern.

Mr Olphert submitted that your conduct, in the charges found proved, is limited to isolated incidents on a handful of shifts within one or two days. He asserted that such isolated incidents cannot be demonstrative of a wider attitudinal issue in this case, given your previously unblemished twenty-year nursing career and the fact that no further concerns have been raised about your current nursing practice.

Mr Olphert submitted that the concerns in this case were plainly out of character for you and the panel can have confidence that you are now a safe and compassionate nurse who has continued to act in the best interest of patients under your care and there is no likelihood that you would repeat any of the concerns in future. He highlighted that for example, you had made a referral to the Care Quality Commission (CQC) about a previous employer, given your perceived safeguarding risks to patients at your previous workplace.

Mr Olphert submitted that, in light of this, you do not pose a risk of harm to the public and a finding of impairment on public protection ground is therefore not required. He further submitted that a finding of impairment on public interest ground is also not required as a

fully informed member of the public, aware of all of the facts, including the passage of time, your otherwise unblemished career and your current safe practice, would not be appalled or surprised to learn that no finding of impairment is made.

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

Decision and reasons on misconduct

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

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

> ***'Prioritise people***
> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*
>
> ***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*
1.5 *respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 *work in partnership with people to make sure you deliver care effectively*
2.2 *recognise and respect the contribution that people can make to their own health and wellbeing*
2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

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

Practise effectively
You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

8 Work cooperatively

To achieve this, you must:

8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
8.2 *maintain effective communication with colleagues*

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

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

To achieve this, you must:

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

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

With respect to charge 2a, the panel took into account that you stated that, at the time of the incident, Resident B was shouting and screaming, and that your conduct was as a result of your attempt to deescalate the situation. Nevertheless, the panel considered your conduct to be unacceptable and that it fell short of the standard of care expected from a registered nurse. The panel noted that Resident B was a vulnerable person who was dependent on you and other carers for meeting his basic needs and that his care plan had clearly stated that he likes to have his room door open. The panel therefore considered your conduct in walking away from a resident who was clearly distressed to be unkind and dismissive of Resident B's care needs. Accordingly, it found your actions in charge 2a to amount to misconduct.

In relation to charge 2b, the panel considered your conduct to amount to an emotional abuse of Resident B as such words are belittling and degrading to a vulnerable person with high care needs. The panel noted that your conduct apparently caused emotional and psychological distress to Resident B given that he highlighted three times that you called him a baby or that he acted like a child, during his disclosure to Witness 3. The panel therefore found your conduct to be extremely serious and unprofessional, and that it would be seen as deplorable by other members of the profession and members of the public. Accordingly, the panel determined that your actions in charge 2b amounts to misconduct.

With regard to charge 2c, the panel took into account that at the time of the incident, you were working as an agency nurse in a busy night shift with various residents requiring your attention and care. Nevertheless, the panel was of the view that, as an experienced nurse,

you were expected to organise your time efficiently to appropriately attend to residents' needs. The panel considered that your conduct apparently made Resident B to feel unimportant and that his care needs were irrelevant. The panel therefore determined that, as a result of your conduct, you failed to respect and uphold the dignity of Resident B. It found that your conduct fell short of the fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel decided that your conduct in charge 2c amounts to misconduct.

With respect to charge 2d, the panel took into account that you stated that your intention at the time of the incident was to prevent Resident B from pressing his call bell/buzzer accidentally while he slept. However, the panel noted that Resident B had screamed and shouted at you when you made the suggestion of removing and pinning his call bell/buzzer to his pillow. Given Resident B's dependency on and anxiety about the location of his call bell/buzzer, the panel considered your conduct to be wholly unacceptable and inappropriate. It noted that registered nurses are expected to work in partnership with persons under their care and to consider their preferences whilst providing care to them. Therefore, your conduct in removing Resident B's call bell/buzzer and not checking with him whether he was happy with your decision or whether he could reach it, fell short of the standard of care expected from a registered nurse. Accordingly, the panel decided that your conduct in charge 2d amounts to misconduct.

In relation to charge 2e, the panel took into account that you were an agency nurse who was not very familiar with the residents at Home 2. The panel determined that although your conduct was uncaring and amounted to poor practice, it did not meet the threshold of seriousness as to amount to misconduct.

With regard to charge 2f, the panel noted that Resident B was a vulnerable person who depended on his call bell/buzzer to draw attention of care staff to his care needs and had an associated anxiety in relation to it. The panel therefore considered your conduct to amount to an emotional abuse of Resident B and a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to

maintain. Accordingly, it determined that your conduct in charge 2f amounts to misconduct.

With respect to charge 3, the panel was of the view that, given your experience as a registered nurse, you should have employed a more appropriate method to assist Resident D after her fall, rather than a drag lift. In this regard, you failed to work with and communicate effectively with your colleagues, at the time of the incident, in order to ascertain the best approach to assist Resident D after her fall. Nevertheless, although your conduct amounted to poor practice, the panel determined that it did not meet the threshold of seriousness on its own as to amount to misconduct.

In relation to charge 4, the panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession and that your incorrect entry in Resident E's record clearly fell short of this. However, the panel considered that this was an isolated incident and that at the time of the incident, you were an agency nurse working on a busy night shift and may have not been well acquainted with the record-keeping system at Home 2. Therefore, the panel was of the view that your conduct was a careless error on your part. Accordingly, it determined that your conduct in charge 4 is not sufficiently serious as to amount to misconduct.

Consequently, having considered all the charges individually and as a whole, the panel determined that your actions in charges 2a, 2b, 2c, 2d and 2f did fall significantly 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, your fitness to practise is currently impaired.

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional standards. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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 first considered whether any of the limbs of the Grant test were engaged in the past. The panel noted that, at the time of the incidents, your actions, as contained in charges 2a, 2b, 2c, 2d and 2f, caused apparent emotional and psychological distress to Resident B. The panel was of the view that the nature of your misconduct was such that it had the potential to discourage Resident B from further seeking/accessing appropriate clinical care as he was reported to have been hesitant to return to Home 2 from the Day Centre on 9 June 2022. The panel therefore determined that your misconduct had placed Resident B at an unwarranted risk of harm and caused actual harm to him in terms of emotional and psychological distress.

The panel determined that your misconduct constituted a serious breach of the fundamental tenets of the nursing profession as you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

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

The panel next considered whether the limbs of the *Grant* test are engaged in the future. In this regard, the panel considered the case of *Cohen v GMC* where the court addressed the issue of impairment with regard to the following three considerations:

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

b. *Has it in fact been remedied?*

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

In this regard, the panel also considered the factors set out in the NMC Guidance on insight and strengthened practice (FTP-15).

The panel first considered whether your misconduct is capable of being addressed. The panel was of the view that your misconduct could be addressed through a process of insightful reflections, retraining in the areas of concern and evidence of recent good practice. Therefore, the panel determined that your misconduct is capable of remediation.

The panel then went on to consider whether the concerns has been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed? (FTP-15b). The panel also considered the context of the misconduct. It noted that, at the time of the incidents, you were an agency nurse working on a busy night shift and this may have affected your behaviour at that time. However, the panel was of the view that, given your experience as a registered nurse working within care home settings, you should have respected and upheld the dignity of Resident B and managed the issues professionally. The panel was of the view that your conduct did not arise from any unique circumstances. Care homes are generally busy given the vulnerable nature of their residents.

Regarding insight, the panel took into account your reflective statement and your oral evidence. The panel noted that you sought to provide justifications for some of your actions and at various times, blamed the Home's management system for your failings. The panel was concerned that you failed to demonstrate sufficient understanding of the

seriousness of your misconduct and that you also failed to demonstrate any insight into the impact of your conduct on Resident B, the nursing profession and the wider public. The panel therefore determined that you failed to demonstrate sufficient insight into your misconduct.

The panel took into account the various positive testimonials made on your behalf and the several training courses you had completed. However, the panel attached limited weight to them as they were not particularly relevant to the areas of concern.

In light of this, the panel was not satisfied that any of the concerns had been remediated nor had you strengthened your nursing practice. Accordingly, the panel determined that your misconduct is highly likely to be repeated and limbs a, b and c of the *Grant* test are engaged in the future.

The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection.

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

The panel had regard to the serious nature of your misconduct and the public protection issues it had identified. It determined that public confidence in the profession, particularly as the misconduct involved the emotional abuse of a vulnerable resident, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that your 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 suspension order for a period of nine months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Ms Maqboul reminded the panel that in considering sanction, the proper approach is to consider the full range of sanctions, starting with the least restrictive order and apply the principle of proportionality. She submitted that, given the panel’s findings of serious misconduct and impairment as well as the severity of the charges found proved, it is the NMC’s position that the appropriate sanction in this case is a striking-off order.

Ms Maqboul submitted that in terms of the aggravating factors, the panel should consider that you were the most senior member of staff on duty on those two-night shifts and were responsible for the care of Resident B, but you abused the position of trust with respect to Resident B who was highly vulnerable. She submitted that you demonstrated an abject lack of insight into your failings and there is a clear absence of remorse, notwithstanding what has been said about the fact that these were denied charges. She asserted that your actions demonstrated a pattern of misconduct over two-night shifts, and this placed residents at risk of suffering harm.

Ms Maqboul submitted that in terms of mitigating factors, the only real mitigation is that there was no physical harm suffered by Resident B, although, as the panel noted in its findings, your actions caused emotional distress to him.

Ms Maqboul submitted that, although the panel had noted that the misconduct in this case is capable of remediation, it should consider whether ingrained attitudinal concerns, which your misconduct demonstrates, are capable of remediation. She asserted that since 2022 when the incidents occurred, you have failed to demonstrate any insight into the impact of your conduct on others and the only thing that you stated you could have done differently was to have delegated your duties. Ms Maqboul submitted that there will likely not be any change in the level of your insight if you are given another twelve months to reflect on your conduct.

Ms Maqboul highlighted that there was no testimonial from your current employer and there was nothing to prevent you or your representative from taking steps to provide such document in order to assure the panel about your current conduct in your workplace. She further highlighted that you generally work in relative isolation and the panel may consider this factor when making its decision in this case.

In conclusion, Ms Maqboul invited the panel to consider the NMC Guidance on Considering sanctions for serious cases (SAN-2), in particular, Abuse or neglect of children or vulnerable people, which states:

> *‘When considering sanctions in cases involving the abuse or neglect of children or vulnerable adults, panels will, as always, start by considering the least severe sanction first and move upwards until they find the appropriate outcome. However, as these behaviours can have a particularly severe impact on public confidence, a professional’s ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register. If the panel decides to impose a less severe sanction, they will need to*

make sure they explain the reasons for their decision clearly and carefully. This will allow people who have not heard all of the evidence in the case, which may include those directly affected by the conduct in question, to properly understand the decision.'

Mr Olphert referred the panel to the NMC Guidance on Factors to consider before deciding on sanctions (SAN-1) which states:

> *'Being proportionate means finding a fair balance between the nurse, midwife or nursing associate's rights and our overarching objective of public protection. We need to choose a sanction that doesn't go further than we need to meet this objective. This reflects the idea of right-touch regulation, where the right amount of 'regulatory force' is applied to deal with the target risk, but no more.'*
>
> *'To be proportionate, and not go further than it needs to, the Committee should think about what action it needs to take to protect the public and address the reasons why the nurse, midwife or nursing associate is not currently fit to practise.'*

Mr Olphert submitted that your conduct should be considered within its proper context, particularly, that the conduct found proven involves one resident on one shift in the course of twenty years of your career as a registered nurse. However, he stated that you do not seek to downplay the seriousness of the concerns in this case.

Mr Olphert submitted that your conduct does not demonstrate any ingrained attitudinal issue as it was only an isolated incident within the context of hundreds of patients which you had treated within the course of your long career. He submitted that the panel should also consider the principles on rejected defences set out in the case of *Sawati v General Medical Council* [2022] EWHC 283 (Admin), when making its decision on sanction.

Mr Olphert reminded the panel that it had earlier found that your misconduct is capable of remediation. He submitted that, in light of that finding, the proportionate approach is to

impose a sanction which allows for a process of insightful reflection, retraining and further evidence of good practice to purge the impairment in this case. He asserted that a striking-off order would be very disproportionate as it would impede any potential for growth, self-reflection, learning and development on your part. He submitted that, given the panel's findings on impairment, this is not a case where your conduct is simply incompatible with continued registration.

Mr Olphert went on to highlight the mitigating factors in this case. He highlighted that you had told the panel that nursing is a core part of your identity as a person. [PRIVATE]. [PRIVATE]. Mr Olphert submitted that you did not seek to rely on those factors as any kind of apologism and this was why it was not explored during your evidence. Nevertheless, the panel may consider those factors as relevant personal mitigation on your part.

Mr Olphert submitted that although your training certificates and testimonials may not be relevant at the impairment stage, they are directly relevant at the sanction stage. He submitted that there were no deficiencies in your clinical practice, and you had demonstrably passed all mandatory training courses and that your previous employer had praised your approach with patients, noting your compassion and patient centred care.

Mr Olphert submitted that it is evident from your testimonials that you are predisposed towards helping others through charitable endeavours. He told the panel that you currently volunteer at charities [PRIVATE]. You also provide direct support to veterans to ensure that they are able to attend events, and you ensure that they are supported throughout such events. You also volunteer at an organisation [PRIVATE], which assist persons with traumatic brain injuries, and you provide additional holistic rehabilitation to such persons to assist their reintegration into the society.

Mr Olphert submitted that you no longer work for agencies, and you currently have full support and oversight in your current workplace. He invited the panel to take into consideration that with further reflection, retraining and evidence of continued good practice, you are capable of purging the impairment in this case.

In conclusion, Mr Olphert invited the panel to impose a lesser sanction than a striking-off order, which would enable you to continue practising as a registered nurse, albeit, with some restrictions.

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

Decision and reasons on sanction

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

The panel identified the following aggravating features:

- Your actions demonstrated an abuse of your position of trust as a registered nurse.
- Your lack of insight into the impact of your misconduct on Resident B, the nursing profession and the wider public.
- Your conduct placed Resident A at risk of physical harm and caused actual harm in terms of emotional and psychological distress.
- Resident B was a very vulnerable person who was dependent on you for meeting his basic needs at the time of the incidents.

The panel also identified the following mitigating features:

- Your actions were isolated incidents over an otherwise unblemished career as a registered nurse
- Your previous good character and unblemished history

The panel had regard to the NMC Guidance on Serious concerns which are more difficult to put right (FTP-3a). It also had regard to the NMC Guidance on Considering sanctions for serious cases (SAN-2), in particular, Abuse or neglect of children or vulnerable people. The panel considered the definition of vulnerable people in the footnote of the Guidance which states:

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

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

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that there remains a risk of repetition, that you had breached fundamental tenets of the nursing profession, and your misconduct would undermine the public's confidence in the nursing profession if you were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your nursing 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 decided that your 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 therefore determined that a caution order would neither protect the public nor be in the public interest.

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

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *No evidence of harmful deep-seated personality or attitudinal problems;*
> - *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
> - *No evidence of general incompetence;*
> - *Potential and willingness to respond positively to retraining;*
> - *……*
> - *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
> - *The conditions will protect patients during the period they are in force; and*
> - *Conditions can be created that can be monitored and assessed.'*

The panel bore in mind that it had found that your misconduct is capable of remediation. However, the panel was of the view that your conduct towards Resident B is suggestive of attitudinal concerns albeit not deep-seated. It noted that your misconduct amounted to emotional abuse of Resident B and a failure to respect and uphold his dignity. The panel was also of the view that the nature of your misconduct was such that it could discourage members of the public from seeking/accessing appropriate care when required for themselves or their vulnerable relations. Family members might well be reluctant to place their vulnerable relations, with high care needs, in the care of healthcare providers if they

felt that they might be exposed to emotional abuse or that their dignity might be compromised in some way.

The panel therefore determined that given the seriousness of the concerns, its attitudinal nature and your lack of sufficient insight into the severity and impact of your actions on Resident B, the nursing profession and the wider public, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, and this poses a risk of harm to patients' safety and the public. Consequently, the panel decided that a conditions of practice order would not protect the public nor be in the public interest.

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

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

The panel had found that your misconduct in terms of the emotional abuse of Resident B and your failure to respect and uphold his dignity amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It noted that you failed to demonstrate insight into the severity and impact of your misconduct on Resident B, the nursing profession and the wider public. The panel also found that your misconduct was a serious breach of the fundamental tenets of the nursing profession which brought the nursing profession into disrepute.

Notwithstanding this, the panel took into account that this was one episode of misconduct over the course of two shifts during a twenty-year career as a registered nurse, and that there is no evidence of repetition of behaviour since that episode. The panel was of the view that although the concerns are attitudinal in nature, there was no evidence before it to indicate any harmful deep-seated attitudinal problems in this case.

The panel carefully considered the submissions of Ms Maqboul in relation to the imposition of a striking-off order in this case. It also considered following paragraphs of the SG (SAN-3e) with respect to imposing a striking-off order:

- *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 bore in mind that the misconduct in this case is capable of remediation and that this was one episode of misconduct over the course of two shifts during a twenty-year career as a registered nurse. It was also of the view that the abuse in this case is at the lower end of that spectrum. Therefore, in taking account of all the evidence before it, the panel concluded that a striking-off order would be disproportionate.

Although your misconduct raises questions about your professionalism, it was, in the panel's view, not to the extent that required your removal from the register. There was evidence, since the incidents, of you practising safely and effectively such that the panel was content that a striking-off order would be unduly punitive and disproportionate, and therefore, not the appropriate sanction. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in this case to impose a striking-off order. It was of the view that a striking-off order could deprive the public of a

registered nurse who has the potential to return to nursing practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Consequently, the panel was satisfied that, in this case, the misconduct is not fundamentally incompatible with remaining on the register and that public confidence in the nursing profession could be maintained if you were not removed from the register.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of nine months would provide you with an opportunity to demonstrate evidence of sufficient insight into your misconduct and that your fitness to practise is no longer impaired. The panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse.

The panel noted the hardship such an order will inevitably cause you, however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

Before the end of the period of suspension, another panel will review the order. At the review hearing, the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- An updated reflective statement demonstrating sufficient insight into the severity and impact of your misconduct on Resident B, the nursing profession and the wider public. Your reflective statement should also address the following areas, and where possible, describe how you have strengthened your practice in those areas:

    a) Providing compassionate and dignified care to vulnerable persons especially those with mental health issues.
    b) Your professionalism and impact of your conduct on your patients and colleagues.
    c) Communication and working cooperatively with your colleagues.

- Any updated references or testimonials commenting on your general conduct and attitude, in whatever role, paid or unpaid, subsequent to this hearing.

- Evidence of up-to-date relevant training courses undertaken in the areas of concern including in managing challenging behaviours, safeguarding of vulnerable adults and in respecting and upholding dignity of patients.

- Your engagement and attendance at any future review hearing.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Maqboul. She submitted that given the panel's findings on sanction, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. She further submitted that the reference provided by your current employer, on your behalf, did not make any substantial difference to this decision.

Mr Olphert invited the panel to consider that an interim suspension order could have a significant impact on you in view of your current employment.

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

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.

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