Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 27 – Friday 30 August 2024 &
Wednesday 4 – Friday 6 September 2024

Virtual Hearing

Name of Registrant:	**Katie Evans**
NMC PIN:	14G0028W
Part(s) of the register:	Registered Nurse – RNA Adult Nursing - September 2014
Relevant Location:	Swansea
Type of case:	Misconduct
Panel members:	Ashwinder Gill (Chair, Lay member) Janet Fitzpatrick (Registrant member) Paula Charlesworth (Lay member)
Legal Assessor:	Ian Ashford-Thom (27 – 30 August 2024) Robin Ince (4 – 6 September 2024)
Hearings Coordinator:	Khadija Patwary Samara Baboolal (5 September 2024)
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Miss Evans:	Not present and unrepresented
Facts proved:	Charges 1), 2), 3)a) and 3)b)
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Evans was not in attendance and that the Notice of Hearing letter had been sent to Miss Evans' registered address by recorded delivery and by first class post on 24 July 2024.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Evans

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

Ms Da Costa provided the panel with a brief background as to the substantive hearing that was listed regarding this matter in January 2024 but was postponed due to the NMC's hearing capacity and Miss Evans' adjustment requests at the time. She submitted that the NMC case officer had attempted to contact Miss Evans several times since 29 February 2024 with reasonable adjustments having been offered. However, the NMC did not receive a response. Ms Da Costa further submitted that there had been no engagement at all by Miss Evans with the NMC in relation to these proceedings since January 2024 and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Miss Evans;
- Miss Evans has not engaged with the NMC since 29 February 2024 and has not responded to any of the emails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses have been scheduled to give oral evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in November and December 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

Details of charge (as amended)

That you a registered nurse:

1) On 27 November 2019 said to a colleague in respect of Patient A “put a pillow over her head and when she stops moving you will know she’s dead” or words that effect. **(proved)**

2) On 28 November 2019 said to a colleague “she doesn’t want anyone to punch/smack/slap her in the face, she wants you to fucking do it”. **(proved)**

3) On 30 December 2019:
   a) Said “She can fucking lay in it then” or “fuck her then she can sit in it”, or words to that effect; **(proved)**
   b) Failed to provide Patient A care within a reasonable time, in that you did not assist colleague/s with changing Patient A who was soiled. **(proved)**

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

Decision and reasons on application to admit Witness 5's written statement

The panel heard an application made by Ms Da Costa under Rule 31 to allow the written statement of Witness 5 into evidence. She referred the panel to a letter dated 9 July 2024 in which the NMC case officer informed Miss Evans that the NMC do not propose to call Witness 5 to give live evidence at this hearing. She submitted that Miss Evans was asked to respond to this letter by 18 July 2024, but the NMC have not received a response from her.

Ms Da Costa submitted that Witness 5's role was that she was a senior general manager at Barchester Healthcare at the time that the alleged incidents occurred and that she was the chair of the internal disciplinary hearing. She submitted that Witness 5 was not a direct witness to the allegations. On this basis, Ms Da Costa advanced the argument that there was no lack of fairness to Miss Evans in allowing Witness 5's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the factors 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 gave the application in regard to Witness 5 serious consideration. The panel noted that Witness 5's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered whether Miss Evans would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 5 to that of a written statement. The panel noted that Miss Evans had been provided with a copy of Witness 5's statement and that the NMC informed her of this by letter dated 9 July 2024. It determined that as Miss Evans had chosen to voluntarily absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel was of the view that Witness 5's evidence is not the sole and decisive evidence in the case, she did not provide any direct evidence in relation to the allegations and acted as the Chair of the disciplinary hearing exhibiting the notes from that hearing.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 5 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Da Costa, on behalf of the NMC, to amend the wording of charge 2).

Ms Da Costa submitted that having heard evidence from Witness 4 and in response to the panel's questions prior to the short break, Witness 4 clarified in oral evidence that it was stated by Miss Evans "*she doesn't want anyone to slap her in the face, she wants you to fucking do it*."

The proposed amendment was to reflect the evidence that was given by Witness 4. It was submitted by Ms Da Costa that this does not introduce any new allegation, but the application is simply being made in the interests of justice to correct the position to accurately reflect the evidence.

> *"That you a registered nurse:*
>
> 2) *On 28 November 2019 said to a colleague "she doesn't want anyone to* ***slap*** ~~*punch/smack*~~ *her in the face, she wants you to fucking do it".*
>
> *AND in light of the above, your fitness to practise is impaired by reason of your misconduct."*

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

The panel considered this application. However, it determined to amend the wording of charge 2) of its own volition to read "*on 28 November 2019 said to a colleague "she doesn't want anyone to punch/smack/slap her in the face, she wants you to fucking do it*." The panel considered that this amendment will not change the overarching nature of the allegations.

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Miss Evans and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Da Costa under Rule 31 to allow the hearsay evidence of Ms 1, namely her local statement that is signed and dated 16 December 2019, into evidence. She further invited the panel to allow the hearsay evidence which was the interview notes from Ms 3's and Ms 1's interviews both dated 31 December 2019 into evidence. She submitted that both of these exhibits were referred to by Ms 2 during her oral evidence.

Ms Da Costa submitted that the local statement dated 16 December 2019 was provided to Witness 1 during the internal investigation. The panel granted the NMC time to undertake enquiries as to why Ms 1 and Ms 3 had not been called upon to give evidence.

Ms Da Costa submitted that the case lawyer was on annual leave until 2 September 2024 so another lawyer at the NMC was tasked to investigate further into this matter. She submitted that there is no information as to why there are no witness statements from Ms 1 and Ms 3. She further submitted that the case officer was unable to find any communication between these two individuals and the NMC. Ms Da Costa submitted that the evidence contained within those three exhibits is highly relevant and that it would be fair to admit this evidence.

Ms Da Costa submitted that Ms 1 is the nurse who is referred to as assisting Patient A. The information she has provided in her local statement and interview notes covered matters that are very relevant to the allegations and to matters that the panel would be making a determination on. In relation to Ms 3, Ms Da Costa submitted that her evidence is relevant as she was present at one of the incidents where Miss Evans had alleged to have made the comment about putting a pillow over Patient A's face.

Ms Da Costa submitted that the NMC does concede Ms 1 and Ms 3 have not attended to give live evidence and what they have stated in the exhibits cannot be cross-examined or challenged today. Ms Da Costa invited the panel to consider all the evidence in this case in particular, the interview notes in relation to Miss Evans own interview with Ms 2. She submitted that the panel would note that Miss Evans accepts some of the allegations and most importantly she accepts the allegation of making a comment about putting a pillow over Patient A's face. Ms Da Costa submitted this was stated by Miss Evans on 16 January 2020 in her interview notes.

Ms Da Costa submitted that the exhibits are not the sole and decisive evidence and that they are corroborated by witnesses who have provided the panel with oral evidence.

The panel accepted the advice of the legal assessor. The panel was referred to the principles within the authority of *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

In relation to Ms 1's local statement dated 16 December 2019; the panel determined to not admit this as hearsay evidence.

The panel was of the view that Ms 1's local statement was relevant to the allegations, as it related to charge 2, setting out what Witness 4 and other unknown staff reported to Ms 1 about this incident.

The panel went on to consider whether it would be fair to admit this local statement and bore in mind the principles in Thornycroft. It determined that it was not the sole and decisive evidence relating to this charge, as Witness 4 provides evidence relating to this allegation. Miss Evans in her interview stated that she could not recall this incident and at her disciplinary hearing stated she may have repeated back the phrase that was reported to her, but she denied swearing. The panel therefore determined that there would be challenge to the context of this hearsay evidence.

When considering whether there was any reason to suggest the witness had fabricated the local statement, the panel noted that Miss Evans had raised concerns that her colleagues were making local statements against her and *'had got it in for me'. These concerns were raised to Witness 1, during her local interview and during her disciplinary hearing.* However, the panel noted that she had not raised specific concerns relating to Ms 1. The panel therefore concluded that there was not any specific evidence that Ms 1 had fabricated her local statement.

The panel considered that this is a serious allegation and noted that the NMC's sanction bid is a strike-off. The panel noted that there has been no evidence provided by the NMC regarding Ms 1's non-attendance and there is no NMC witness statement provided by Ms 1. The panel further noted that it was not provided with information of any steps being taken by the NMC to secure Ms 1's attendance, that the local statement does not have a declaration of truth, is a brief statement and was not created for the purpose of this hearing. There would therefore be no opportunity to test the evidence contained in the local statement.

Balancing all of these factors, the panel determined that it would not be fair to accept into evidence Ms 1's local statement. Therefore, the panel refused this application.

In relation to Ms 1's interview notes dated 31 December 2019, the panel concluded to not admit this as hearsay evidence for the same reasons as above as it relates to Ms 1's evidence.

In relation to Ms 3's interview notes dated 31 December 2019, the panel determined to not admit this as hearsay evidence.

The panel was of the view that Ms 3's interview notes were relevant to the allegations, as it related directly to charge 1. The panel was also of the view that Ms 3's interview notes were not the sole and decisive evidence. It noted that Miss Evans appears to accept that she said words to the effect of what is stated in charge 1). However, in Miss Evans'

interview she does not reference "*…when she stops moving you will know she's dead*", which is evidence that is provided by Ms 3 in her interview, who is a direct witness to this charge. The panel therefore noted that this evidence would likely be challenged. The panel further noted that it was not provided with any strong evidence that this exhibit contained a fabricated account, as despite raising concerns about her colleagues, Miss Evans does not provide any information specifically relating to Ms 3.

The panel considered that this is a serious allegation and noted that the NMC's sanction bid is a strike-off. The panel noted that there has been no evidence provided by the NMC regarding Ms 3's non-attendance and there is no NMC witness statement provided by Ms 3. The panel further noted that it was not provided with information of any steps being taken by the NMC to secure Ms 3's attendance, that the interview notes do not contain a declaration of truth, the interview is brief and lacks detail, and this document was not created for the purpose of this hearing. There would therefore be no opportunity to test the evidence contained in Ms 3's interview notes.

Balancing all of these factors, the panel determined that it would not be fair to accept into evidence Ms 3's interview notes. Therefore, the panel refused this application.

Background

The charges arose whilst Miss Evans was employed as a registered nurse by Awel Y Mor Care Home (the Home). It is alleged that between 27 November and 30 December 2019, Miss Evans made several inappropriate comments regarding Patient A, who was in her care. It is specifically alleged that Miss Evans made comments to staff about putting a pillow over the head of Patient A who was frequently buzzing for help. Further it is alleged that Miss Evans suggested that Patient A should be left to lie in their own faeces and failed to provide timely care to her.

Decision and reasons on facts

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

The panel has drawn no adverse inferences from the non-attendance of Ms Evans.

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

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

- Witness 1: Registered Nurse and General Manager at the Home at the time of the allegations;
- Witness 2: Registered Nurse and Deputy Manager at the Home at the time of the allegations;
- Witness 3: Care Assistant at the Home at the time of the allegations;
- Witness 4: Care Assistant at the Home at the time of the allegations.

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

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

Charge 1)

1) On 27 November 2019 said to a colleague in respect of Patient A “put a pillow over her head and when she stops moving you will know she’s dead” or words that effect.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3’s, Witness 4’s and Witness 1’s witness statements and oral evidence. It also took into account Witness 3’s investigation notes dated 31 December 2019, Witness 4’s investigation notes dated 31 December 2019 and 29 January 2020, Witness 4’s letter raising concerns dated 15 December 2019, Witness 1’s handwritten statement dated 16 December 2019 and Miss Evans’ interview notes dated 16 January 2020.

The panel considered Witness 3’s witness statement in which she stated that “*I recall that one night during late 2019 Miss Evans made a comment about a resident at the Home, saying to “take a pillow and put it over her face”. At first, I did not understand what she meant and I think that I may have asked another colleague to clarify. Once I understood what Miss Evans meant, I took her comment as a joke*.” The panel noted that this was corroborated by Witness 3’s interview notes dated 31 December 2019. The panel was of the view that Witness 3 was a reliable witness and that she was consistent in her oral evidence and interview.

The panel also considered Witness 4's witness statement in which she stated that "*There was another incident with Miss Evans involving the same resident and a comment about a pillow. I cannot recall all the details but I think that the resident's bowels had opened. Staff answered the buzzer and then told Miss Evans that her bowels had opened, but she did not want Miss Evans to change her. Myself and another member of staff helped the resident, whose mood was still very low at this point. Miss Evans remarked to me that "she can just lay in it then" and also made a comment about putting a pillow over the resident's head until she stopped breathing. I was very disgusted and shocked by these comments*." The panel noted that it is suggested by Witness 4 that the incidents took place on the same date however, it is referenced in the charges that these incidents took place on two different dates. The panel also noted that this comment was not mentioned in Witness 4's letter raising concerns dated 15 December 2019 or in either of her two interview notes dated 31 December 2019 and 29 January 2020. The panel was of the view that Witness 4 may have been mistaken and in relation to this charge she was not reliable in her recollection regarding this charge during her oral evidence.

The panel further considered Witness 1's witness statement in which she stated that "*Miss Evans came to see me about an incident that had occurred. She told me that she thought some staff would give me statements about some comments that she had made. Miss Evans explained to me that the comments were said as a joke but that some of the staff had taken the comments seriously. She admitted that she had made the comments but that they had been made as she had found the shift to be stressful. Miss Evans was afraid that she might lose her job. She told me that one of the residents had been buzzing for help frequently and she made a comment to a carer to "put a pillow over her head and once she stops moving, you will know she is dead*"." The panel noted that this was corroborated by Witness 1 in her oral evidence. The panel considered Witness 1's

handwritten statement dated 16 December 2019 and it was noted that this was created by Witness 1 on the same date that Miss Evans had reported the matter to her. The panel was of the view that Witness 1 was a reliable witness and that she was consistent in her oral and written evidence.

The panel considered Miss Evans' interview notes dated 16 January 2020 in which she accepted that "*…staff were saying what can we do about it and I said for a joke put a pillow over her head*." The panel noted that Miss Evans was not specifically asked about the last part of the phrase that is alleged in the charge.

Overall, the panel was satisfied on the balance of probabilities that on 27 November 2019, Miss Evans said to a colleague in respect of Patient A "*put a pillow over her head and when she stops moving you will know she's dead*" or words that effect.

In light of the above, the panel therefore finds charge 1) proved.

Charge 2)

2) On 28 November 2019 said to a colleague "she doesn't want anyone to punch/smack/slap her in the face, she wants you to fucking do it".

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's statement and oral evidence. It also took into account Witness 4's letter dated 15 December 2019, Witness

4’s interview notes dated 31 December 2019, Miss Evans’ interview notes dated 16 January 2020 and the record of her disciplinary hearing dated 28 January 2020.

The panel considered Witness 4’s interview notes dated 31 December 2019 in which she references this incident, her account between her letter raising concerns dated 15 December 2019 and her interview notes is broadly consistent, albeit the word used changes from “*punch*” to “*smack*.” The panel also considered Witness 4’s oral evidence in which she is broadly consistent but the word changes to “*slap*.”

The panel considered Witness 4’s witness statement in which she stated that “*There was a student nurse also present when the resident made this comment, however I cannot remember their name due to how much time has passed. I asked the student nurse to get a registered nurse to help with dealing with the resident. Miss Evans then entered the room and asked what the matter was. The resident told Miss Evans what was wrong, who then said a comment in front of the resident and myself about being smacked in the face. Miss Evans did not help at all. Another nurse then came into the room and talked to the resident, calming her down. She was not without help for very long as I think that the other nurse entered the room just after Miss Evans exited*.” The panel noted that this was corroborated by Witness 4’s letter raising concerns dated 15 December 2019, in her oral evidence and interview notes dated 31 December 2019.

The panel was of the view that when looking at the inconsistencies in relation to the words being used by Witness 4, it was satisfied that these words refer to a similar type of action, referencing harm to the face, but that it was just a different way of describing it. The panel was satisfied that it was not a material inconsistency, and it does not change the nature of the comment.

The panel further considered Miss Evans’ interview notes dated 16 January 2020. When she was asked by Ms 2 *“do you recall a shift when Patient A was unwell in November and a Carer had called you for advice as Patient A was asking to be punched in the face?”,*

Miss Evans replies "*no*". However, she then appeared to change her position by saying "*I vaguely remember someone saying she said that but I couldn't say who it was*." when subsequently asked *"do you remember being called into her room for this?"* The panel also considered the record of Miss Evans' disciplinary hearing dated 28 January 2020 in which she was able to recall more detail of the incident and accepts "*I may have repeated what was said to me but I wouldn't have sworn*." The panel noted that Miss Evans also accepts that she does use swear words in certain circumstances.

Overall, the panel was satisfied on the balance of probabilities that on 28 November 2019, Miss Evans said to a colleague "*she doesn't want anyone to punch/smack/slap her in the face, she wants you to fucking do it*".

In light of the above, the panel therefore finds charge 2) proved.

Charge 3)a)

3) On 30 December 2019:
    a) Said "She can fucking lay in it then" or "fuck her then she can sit in it", or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's and Witness 4's statements and oral evidence. It also took into account Witness 3's interview notes dated 31 December 2019 and 29 January 2020, Witness 4's interview notes dated 31 December 2019 and 29 January 2020, Miss Evans' interview notes dated 16 January 2020 and 29 January 2020 and the record of her disciplinary hearing dated 28 January 2020.

The panel considered Witness 3's interview notes dated 31 December 2019 which state:

> *"Q: in relation to [Patient A] having her bowels open?*
> *A: Patient A had her bowels open but two were on break but I said I could ask [Miss Evans] to help us Patient A said no I don't want [Miss Evans]. I asked her why as [Miss Evans] is very nice. She said something after that but I didn't understand her.*
> *Q: Did you talk to [Miss Evans] about it?*
> *A: Yes*
> *Q: What did she say?*
> *A: She just said, ok if that's what she wants."*

In Witness 3's interview notes dated 29 January 2020 in which she references the comments being made by Miss Evans in the charge, when asked what Miss Evans' response was, Witness 3 replied *"she laughed first and said she will have to stay like that in poo until the team come back."*

The panel noted that Witness 3 does not mention this incident in her witness statement but in her oral evidence she confirmed to the panel that words to that effect were stated. The panel further noted that although there was some absence about the alleged comments in her witness statement and her interview dated 31 December 2019, the panel was satisfied that Witness 3 was a reliable witness as her interview notes dated 29 January 2020 and her oral evidence was consistent.

The panel also considered Witness 4's interview notes dated 31 December 2019 in which she refers to an incident *"last night*", stating *"we asked [Miss Evans] to help but Patient A*

refused [Miss Evans] to help. [Witness 3] told [Miss Evans] this and she said "fuck her then she can sit in it" that was just after 6;30pm."

The panel further considered Witness 4's witness statement in which she stated that "*There was another incident with Miss Evans involving the same resident and a comment about a pillow. I cannot recall all the details but I think that the resident's bowels had opened. Staff answered the buzzer and then told Miss Evans that her bowels had opened, but she did not want Miss Evans to change her. Myself and another member of staff helped the resident, whose mood was still very low at this point. Miss Evans remarked to me that "she can just lay in it then" and also made a comment about putting a pillow over the resident's head until she stopped breathing. I was very disgusted and shocked by these comments."*

The panel noted that although there were some inconsistencies regarding the exact words allegedly used by Miss Evans, this was not a material difference as the nature of the comment was the same.

The panel considered Miss Evans' interview notes dated 16 January 2020 in which she does not accept swearing but does not deny making the comment. It further considered Miss Evans' interview notes dated 29 January 2020, where she accepts making the comment but not swearing. It also considered Miss Evans' disciplinary hearing dated 28 January 2020 where she admits making the comment but not swearing. However, the panel also noted that Miss Evans accepted during other interviews that she sometimes swore.

Overall, the panel was satisfied on the balance of probabilities that on 30 December 2019, Miss Evans said "*she can fucking lay in it then*" or "*fuck her then she can sit in it*", or words to that effect.

In light of the above, the panel therefore finds charge 3)a) proved.

Charge 3)b)

3) On 30 December 2019:
    b) Failed to provide Patient A care within a reasonable time, in that you did not assist colleague/s with changing Patient A who was soiled.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's, Witness 2's, Witness 3's and Witness 4's written statements and oral evidence. It also took into account Witness 3's interview notes dated 29 January 2020, Witness 4's interview notes dated 31 December 2024 and 29 January 2020 and Miss Evans' interview notes dated 29 January 2020.

The panel noted there was no dispute that this incident occurred during a time when some staff members were on their break.

The panel considered Witness 3's interview notes dated 29 January 2020 in which she stated that she told Ms Evans:

> *"…Patient A has buzzed, she has had a poo, and because people are on break and only me and my partner and the nurse. I said I would call the nurse, she asked me who the nurse was, I said [Miss Evans], she said no I don't want [Miss Evans]…*
>
> *…What was [Miss Evans'] response when you told her?*

She laughed first and said she will have to stay like that in poo until the team come back, she seemed surprised by it".

Witness 3 in her oral evidence was unable to assist with how much time had lapsed between informing Miss Evans that Patient A had soiled herself and Patient A being changed, this was due to the passage of time since this incident occurred. Witness 3 stated, however, that her account at the time of her local interview was accurate. The panel noted that in her interview dated 29 January 2020, and therefore closer in time to the date of the interview, Witness 3 stated that Patient A was changed at "*7 ish as we needed the other group [of carers] to help*".

The panel considered Witness 4's witness statement in which she stated "*I do not think that the resident was left for long without being changed after having opened her bowels. The incident happened during break time in the evening, perhaps around 18:00-19 :00, but I cannot recall exactly what time it happened*." Witness 4 in her interview note dated 31 December 2024 stated that they asked for Miss Evans' help just after 6.30pm. Further, in her interview note dated 29 January 2020 she stated that first break was "*around 6ish*" and second break "*6.30*" and went on to state in relation to when Patient A was changed "*I can't remember honest, I can't recall the order*".

The panel considered Miss Evans' interview notes dated 29 January 2020 in which she stated "*I said she can lay in it then as the others would be back soon as it was only 6.20ish and they would be back in a few minutes…[Ms 2]: Did you go in and see Patient A [Miss Evans]: No, I didn't want to upset."* Later in that interview Miss Evans stated that she asked the Carers who were returning from break *"if they could give the girls a hand as she didn't want me in there."* When asked whom she spoke to she said that this may have been Witness 4, however the panel noted that Witness 4 does not corroborate this.

The panel noted that Witness 3, Witness 4 and Miss Evans in their local interviews stated that Patient A had skin integrity issues. Witness 3 in her oral evidence stated that when residents have problems with their skin and they soil themselves, staff normally change residents "*straight away*".

The panel considered Witness 2's written statement in which she stated *"…telling a carer to leave the resident lying in their faeces could result in moisture lesions or further damage*."

The panel further considered Witness 1's witness statement in which she stated "*Usually a nurse would go in regardless to change a resident. I understand that [Miss Evans] then said that the resident can "just fucking lay in it then" and did not try to correct the situation. In my clinical opinion as a registered nurse, I think that [Miss Evans] should have dealt with the resident regardless of their relationship. In a nursing career, it is likely to come across patients who you may not get on with but you still have a duty to provide them with care*."

Witness 1 in her oral evidence told the panel that in circumstances where a patient had refused care from Miss Evans, she would expect Miss Evans to get help from another member of staff, and when staff were on break there were other nurses in the building, as the home is split into two units, whose assistance Miss Evans could have sought. Witness 1 stated that she would not expect Miss Evans to make a derogatory comment. If there was no one available, she would still expect Miss Evans to deliver care especially as this resident had soiled herself and you do not want her to lie in faeces for a prolonged period of time. She went on to tell the panel that there was a risk in causing Patient A distress and risk to skin integrity if prolonged.

Having considered all the evidence the panel determined that Miss Evans had a duty to care for Patient A as she was the only nurse on the floor at that time and that she made no attempt to see or speak to Patient A after being appraised by Witness 3 of the situation. Instead, Miss Evans laughed and made a derogatory comment about Patient A remaining

in her faeces. The nature of the comment made indicates that Miss Evans did not intend to provide care to Patient A. The panel also considered that it was known to staff, including Miss Evans, that Patient A had skin integrity issues and therefore should be changed quickly. Therefore, although the panel could not determine precisely how long Patient A had remained without being changed, it was satisfied on a balance of probabilities that there was an unreasonable delay caused by Miss Evans' failure to act.

Overall, the panel was satisfied on the balance of probabilities that on 30 December 2019, Miss Evans failed to provide Patient A care within a reasonable time, in that she did not assist colleague/s with changing Patient A who was soiled.

In light of the above, the panel therefore finds charge 3)b) proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The NMC code of professional conduct: standards for conduct, performance and ethics (2015)' (the Code) in making its decision.

Ms Da Costa identified the specific, relevant standards where Miss Evans's actions amounted to misconduct.

Ms Da Costa submitted that the actions and failings of Miss Evans are a serious departure from what is expected from a registered nurse. She submitted that Miss Evans put Patient A at a risk of harm and that actual harm was caused. Ms Da Costa submitted that Miss Evans delayed in changing Patient A who had soiled herself and was suffering from skin integrity issues, and referred to the witness evidence heard throughout this hearing that delaying in changing Patient A can cause harm. Ms Da Costa further submitted that Patient A heard one of the comments made by Miss Evans and was in distress.

Ms Da Costa submitted that there is misconduct given the serious nature of the concerns in this matter. She submitted that she failed to treat Patient A with kindness, respect and compassion, and failed to deliver Patient A's treatment, assistance or care without undue delay.

Submissions on impairment

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

Ms Da Costa submitted that, if this misconduct was repeated, there is a real risk of harm to patients in Ms Evans's care. Ms Da Costa submitted that Miss Evans's conduct caused harm to Patient A and given that there is no information to suggest remediation on part of Miss Evans, there is a high risk of repetition.

Ms Da Costa submitted that at this time, there is nothing before the panel that indicates that Miss Evans has insight into her actions. She submitted that there does not seem to be any evidence of remediation provided by Miss Evans.

Ms Da Costa submitted that the issues raised in this matter seem to be attitudinal, which is difficult to remediate, and that Miss Evans has not demonstrated any remorse for her actions.

Ms Da Costa submitted that there is a risk of harm to the public if Miss Evans were allowed to continue practising without a finding of impairment and restriction on her practice. She submitted that a finding of impairment is necessary on the ground of public interest, in order to uphold public confidence and trust in the nursing profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*

1.4 avoid making assumptions and recognise diversity and individual choice

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively
2.6 recognise when people are anxious or in distress and respond compassionately and politely

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

4 Act in the best interests of people at all times

8 Work co-operatively

To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.4 Take all reasonable personal precautions necessary to avoid any potential health risks to [….] people receiving care […]

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

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

*Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions**.'***

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

In its deliberation, the panel was mindful that Miss Evans was not in attendance at these proceedings nor has she provided any submissions, and therefore carefully examined the wider context surrounding the comments made to Patient A. It considered Witness 3's evidence, that Miss Evans was a good nurse, that at the time of the incidents patient A was buzzing for help often and may have buzzed for help approximately 200 times in a day, that it was very hard for all of the staff to answer the buzzer, and when Miss Evans made the comment set out in charge 1) '*everyone was laughing, it was a joke'*. However, the panel concluded that, despite the context surrounding the charges Miss Evans' conduct fell far short of the of the standards of conduct expected of a registered nurse. In reaching its decision the panel took into account the deplorable nature of the comments she made about Patient A. One comment was made in Patient A's presence and Miss Evans failed to provide fundamental care to Patient A within a reasonable time when she had soiled herself and Patient A's vulnerabilities. The panel determined that Miss Evans' conduct would be viewed by both nursing professionals and general members of the public as deplorable.

The panel found that Miss Evans' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct on all three charges proved.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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 act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel determined that all three limbs of the Dame Janet Smith’s test were satisfied. Miss Evans’s conduct put Patient A at a real risk of significant harm and, for instance, her conduct resulted in actual harm to Patient A in that she was distressed upon hearing one of Miss Evans’ comments and leaving Patient A in her faeces may have resulted in aggravation to her skin complaint and further distress.

The panel determined that Miss Evans’ actions did bring the medical profession into disrepute, as her actions were serious and related to the treatment, care and dignity of a vulnerable patient in her care.

The panel further determined that Miss Evans’s actions were very serious and breached fundamental tenets of nursing.

The panel, in light of all of the information heard over the course of these proceedings, concluded that Miss Evans cannot currently practise kindly, safely and professionally.

The panel determined that Miss Evans had demonstrated some limited insight at the time of the incident as she had reported the comment set out in charge 1), to Witness 1, her manger. Miss Evans told Witness 1 that her comment was *'an awful thing to have said'* and Witness 1 described Miss Evans as *'crying and upset at this point'*. However, the panel noted that this initial demonstration of insight was limited in nature and only related to charge 1). Although the panel considered that Miss Evans' conduct was remediable, there was no evidence before the panel of any further or detailed reflection by Miss Evans on her conduct, or its impact on Patient A, her colleagues, the nursing profession and the wider public. The panel noted that there was also no evidence of remorse or remediation before the panel. The panel therefore determined that there is a risk of repetition. The panel 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold or protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was also required. A well-informed member of the public would lose trust and confidence in the nursing profession if they learned that a nurse who had treated a patient in the manner that Miss Evans had treated Patient A, which included remarks and comments of a disdainful nature which resulted in real harm, was not made subject to restrictions on her practice.

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

Sanction

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

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

Submissions on sanction

Ms Da Costa invited the panel to consider a striking-off order. She identified that the first aggravating factor is that there was more than one incident relating to the comments which were made by Miss Evans and that these demonstrate attitudinal concerns. She further submitted that Patient A was a very vulnerable patient who had mental health difficulties at the time and that Miss Evans' conduct caused further anguish and may have caused deterioration to Patient A's mental health.

Ms Da Costa submitted that the third aggravating factor is that Miss Evans' conduct may have affected the culture within the Home and could have influenced junior colleagues that she was working with during those shifts. She submitted that the comments made by Miss Evans could have been overheard by relatives or other patients within the Home itself.

Ms Da Costa submitted that in relation to a mitigating factor, the shift of 27 November 2019 was a difficult shift for Miss Evans and the other witnesses which the panel have heard from, particularly given that it is said that Patient A must have pressed her buzzer for an estimated 200 times. She submitted that the NMC does take that to be a mitigating factor as the shift was difficult. Finally, Ms Da Costa submitted that there is no insight from Miss Evans nor any reflection or remediation from her.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Patient A was a vulnerable patient due to her physical and mental health issues;
- Miss Evans' conduct which put Patient A at risk of actual harm;
- Miss Evans' attitudinal concerns which may have influenced junior colleagues in the Home;
- The incidents were repeated and occurred on three separate dates, albeit over a short period of time; and
- Miss Evans' lack of insight, although the panel notes she demonstrated some limited insight when she initially reported the matter.

The panel also took into account the following mitigating features:

- The difficult shift of 27 November 2019 as Patient A had pressed the buzzer a significant number of times; and
- No previous NMC referrals.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Evans' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Evans' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Evans' registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be easily addressed through training as it was attitudinal in nature. Furthermore, the panel concluded that the placing of conditions on Miss Evans' registration would not adequately address the seriousness of this case and would not protect the public.

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

- *No evidence of harmful deep-seated personality or attitudinal problems; and*
- *No evidence of repetition of behaviour since the incident.*

Although the panel considered that Miss Evans exhibited attitudinal problems, it did not find them to be deep-seated. However, the panel noted (from the NMC Guidance SAN-3d) that it had to "*look at how far the nurse…fell short of the standards expected of them*". The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered that Ms Evans' actions amounted to serious breaches of fundamental tenets of the profession, such as nurses treating people with kindness, respect and compassion, which the panel found to be particularly serious.

The panel was of the view that Miss Evans' has limited insight into her conduct and therefore cannot be satisfied that there is no risk of repetition. Equally, due to the lack of any evidence from her regarding remediation the panel was not able to assess or conclude that Miss Evans' had strengthened her practice.

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

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

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

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

The panel also took into account the following:

- The lack of evidence from Miss Evans or any reflective piece commenting on the impact of her actions on her colleagues and the public's confidence in the nursing profession;
- The impact upon public confidence which may lead to members of the public avoiding using health and care services;
- Lack of testimonials and references; and
- The lack of any evidence that Miss Evans has taken steps to remediate the failings.

The panel determined that, notwithstanding that it considered Miss Evans' conduct to be remediable, by failing to engage with these proceedings or even provide some evidence of developing insight and remorse, Miss Evans was, in effect, indicating that she had no intention of remediating her failings. Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Evans' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

Interim order

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

Submissions on interim order

The panel considered the submissions made by Ms Da Costa that an interim suspension order should be made to cover the appeal period. She submitted that an interim order is necessary to protect the public and in the public interest. Ms Da Costa invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public and in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It concluded that not to impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

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

This will be confirmed to Miss Evans in writing.

That concludes this determination.