Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 1 February 2023 to Thursday 9 February 2023
&
Friday 2 June 2023 (in-camera)
&
Wednesday 11 October 2023 to Thursday 12 October 2023 (in camera)
&
Wednesday 27 March 2024 to Thursday 28 March 2024

Virtual Hearing

Name of Registrant:	Mary Frank Bukuru
NMC PIN	97Y0270O
Part(s) of the register:	Registered Nurse – Adult Nursing
Relevant Location:	Gwynedd
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant member) Dr Robert Cawley (Lay member) Janet Fitzpatrick (Registrant member)
Legal Assessor:	David Swinstead (Days 1 – 10) Breige Gilmore (Days 11 – 12)
Hearings Coordinator:	Max Buadi (Days 1 – 7) Philip Austin (Day 8) Amie Budgen (Days 9 – 10) Dilay Bekteshi (Days 11 – 12)
Nursing and Midwifery Council:	Represented by Silas Lee, Case Presenter (Days 1 – 8) Represented by David Claydon, Case Presenter (Days 9 – 12)
Mrs Bukuru:	Not present and not represented (1 February

	2023 and morning of 2 February 2023). Present and Represented by Angela Namkumba (afternoon of 2 February 2023) Present and represented by Prince Mutalemwa (morning of 8 February 2023) and Angela Namkumba (afternoon of 8 February 2023) Present and represented by Prince Mutalemwa (morning of 9 February 2023) and Angela Namkumba (afternoon of 9 February 2023) Present and represented by Simon Holborn (11-12 October 2023)
Facts proved:	Charges 1c, 1di, 1dii, 1g in part, 1j, 2a, 2ci, 3b, 3c, 3d, 3e and 3f
Facts not proved:	Charges 1a, 1b, 1e, 1f, 1g in part, 1h, 1i, 2cii, 2ciii and 3a
Fitness to practise:	Impaired
Sanction:	Conditions of practice (1 year)
Interim order:	Interim conditions of practice order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Bukuru was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 13 December 2022.

Mr Lee, 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 Mrs Bukuru's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Bukuru 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 Mrs Bukuru

The panel next considered whether it should proceed in the absence of Mrs Bukuru. It had regard to Rule 21 and heard the submissions of Mr Lee. He informed the panel that the NMC had taken steps to contact Mrs Bukuru regarding her attendance its attention to correspondence sent by the NMC Case Officer.

Two emails had been sent by the NMC Case Officer on 19 and 31 January 2023 enquiring as to whether Mrs Bukuru will be attending and if she is represented. Mrs Bukuru had not responded to either email.

Mr Lee also informed the panel that the Hearings Coordinator had tried to contact Mrs Bukuru this morning via telephone and had not received a response.

Mr Lee reminded the panel of the public interest in the expeditious disposal of this hearing. He also reminded the panel that witnesses are due to give evidence at this hearing and adjourning could inconvenience them.

Mr Lee submitted that there is no reason to believe that an adjournment would result in Mrs Bukuru's attendance as she has not provided a reason for her non-attendance.

Mr Lee submitted that there is always a degree of unfairness in proceeding in the absence of a registrant. He reminded the panel that Mrs Bukuru has not made any admissions to any of the charges. He further submitted that by not attending Mrs Bukuru cannot provide her account of the matters raised. He drew the panel's attention to a letter, dated 12 August 2020, from Mrs Bukuru within the NMC bundle. He informed the panel that this was her local response to the matters raised and submitted that by not attending Mrs Bukuru cannot cross examine any of the witnesses and cannot test the NMC's evidence.

Mr Lee invited the panel to proceed in Mrs Bukuru's absence.

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 Mrs Bukuru. In reaching this decision, the panel has considered the submissions of Mr Lee 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:

- All reasonable attempts had been made to contact Mrs Bukuru by the NMC and the Hearings Coordinator this morning;
- No application for an adjournment has been made by Mrs Bukuru and concluded that she had chosen voluntarily to absent herself;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- 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 Mrs Bukuru in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, Mrs Bukuru has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. 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 Mrs Bukuru's 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 Mrs Bukuru. The panel will draw no adverse inference from her absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Lee to amend the date in the heading of charge 1.

The proposed amendment was to change the date in the heading of charge 1. He said that it is accepted that 11 August 2020 is the date in question. It was submitted by Mr Lee that the proposed amendment would provide clarity and more accurately reflect the evidence. He also submitted that there is no injustice caused to Mrs Bukuru as she knows that the date of the incident was 11 August 2020.

That you, registered nurse:

1) On 11 ~~October~~ **August** 2020 in respect of Patient A:

After observations were made by the legal assessor, Mr Lee proposed to make a further amendment. He submitted that to provide further clarity and reflect that all the alleged incidents described in the charges occurred on 11 August 2020, the date should be moved to the overall heading of the charges.

That you, a registered nurse **on 11 August 2020**:

1) ~~On 11 August 2020~~ In respect of Patient A:

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Bukuru and no injustice would be caused to either party by the proposed amendment being allowed. It

was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge

That you a registered nurse, on 11 August 2020:

1) In respect of Patient A:
   a) Did not provide medication when requested
   b) Did not de-escalate and / or attempt to deescalate the situation when PRN was refused
   c) Attempted to close the door when he tried to access the nurses station
   d) Applied pressure to the door of the nurses station that:
      i) Was not appropriate
      ii) Caused him to become unstable and fall
   e) Did not call a GP soon enough and / or at all
   f) Did not call an ambulance
   g) Did not conduct observations / checks
   h) Did not conduct risk assessment following the fall
   i) Did not provide care for the injuries he sustained
   j) Engaged in a further argument with him after the fall

2) Did not document in Patient A's notes:
   a) The incident with the nurses station door
   b) The fall at the nurses station
   c) That the following had not been conducted following the fall:
      i) Observations
      ii) Checks
      iii) Risk assessments

3) Displayed an inappropriate attitude towards the patient in that:

a) You stated you were ‘fed up’ with him
b) You stated he ‘done this on purpose’
c) You stated he had done this for attention
d) You told carers they should ‘drag’ him back to his room by his feet
e) You called him a ‘a really horrible, wicked man’
f) You asked Colleague A to listen in to the call he made to his wife

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

Decision and reasons on application to amend the charge

The panel heard a further application made by Mr Lee, on behalf of the NMC, to amend the wording of charge 3a.

The proposed amendment was to remove the letter ‘a’ before the quote within the charge. It was submitted by Mr lee that this was a typographical error and the proposed amendment would provide clarity and more accurately reflect the evidence.

3) Displayed an inappropriate attitude towards the patient in that:
   e) You called him ~~a~~ ‘a really horrible, wicked man’

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

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

Details of charge (as amended)

That you a registered nurse, on 11 August 2020:

1) In respect of Patient A:
    a) Did not provide medication when requested
    b) Did not de-escalate and / or attempt to deescalate the situation when PRN was refused
    c) Attempted to close the door when he tried to access the nurses station
    d) Applied pressure to the door of the nurses station that:
        i) Was not appropriate
        ii) Caused him to become unstable and fall
    e) Did not call a GP soon enough and / or at all
    f) Did not call an ambulance
    g) Did not conduct observations / checks
    h) Did not conduct risk assessment following the fall
    i) Did not provide care for the injuries he sustained
    j) Engaged in a further argument with him after the fall

2) Did not document in Patient A's notes:
    a) The incident with the nurses station door
    b) The fall at the nurses station
    c) That the following had not been conducted following the fall:
        i) Observations
        ii) Checks
        iii) Risk assessments

3) Displayed an inappropriate attitude towards the patient in that:
    a) You stated you were 'fed up' with him
    b) You stated he 'done this on purpose'
    c) You stated he had done this for attention

d) You told carers they should ‘drag’ him back to his room by his feet
e) You called him ‘a really horrible, wicked man’
f) You asked Colleague A to listen in to the call he made to his wife

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

Background

Mrs Bukuru was an agency nurse on a medium to long term contract at Meddyg Care Home (‘the Home’). The Home was for residents with dementia and it housed between 38 to 40 residents and the home was at full capacity. Residents at the Home had varying level s of capacity, many had complex needs.

The incident occurred on the night shift of 11 August 2020 and involved Patient A who had complex care needs. Patient A had dementia and complications due to suffering a stroke. Healthcare Assistants (‘HCA’), present at the relevant time and giving evidence today, will say that on occasion Patient A will become anxious, aggressive or exhibit aggressive behaviour and use racist language.

On the night shift of 11 August 2020, Patient A for pain relief medication. It is alleged that the NMC refused to give that pain relief medication immediately as she was fed up of Patient A and did not want to provide care to him at that point.

It is further alleged that Patient A spoke to Mrs Bukuru later that evening and had an argument. Mrs Bukuru, allegedly, did not escalate the matter and her actions further agitated Patient A. As the incident progressed, while you were in the nurses’ station, you allegedly tried to close the door. Patient A allegedly used his zimmer frame to push the door to keep it open. It is alleged that when you let go of the door Patient A fell down hard and hit his head causing injuries and bleeding. This was noticed by one of the carers.

Mrs Bukuru allegedly proceeded to shout at Patient A while he was on the floor and used inappropriate language.

A number of HCAs attended to offer care to Patient A when he was on the floor. One HCA allegedly told Mrs Bukuru to call for an ambulance. It is alleged that she refused to do this, did not conduct observations or a risk assessment following Patient A's fall. The NMC state that Mrs Bukuru did not provide the care she was required to provide while she was on shift.

The next day, Mrs Bukuru resigned from her position at the Home. Mrs Bukuru stated that she was scared of Patient A and had been securing herself in the nurses' station to protect herself. She stated that Patient A lost his balance and fell on his own.

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

As Ms Namkumba was informing the panel of your circumstances, she raised [PRIVATE]. The panel, of its own volition made a request that those parts of the case be held in private. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Lee indicated that he supported the application.

Ms Namkumba also supported the application.

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

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

Registrant attends the hearing

As Mr 4 was giving evidence, the Hearing Coordinator was contacted by Ms Namkumba, [PRIVATE], stating that you wanted to participate in the hearing going forward.

Ms Namkumba provided the panel with the update on your position. She stated that she has managed to acquire a legal representative for you, however he would not be available until 8 February 2023 due to the short notice. She said that regardless of what happens, she would like time to prepare documentation for your case. She said that there is a lot of material she wants to submit to the panel like character references, your own witness statement, a reflective statement and evidence of training undertaken.

Mr Lee submitted that the immediate issue is that the panel is halfway though Mr 4's evidence. He reminded the panel that adjourning until 8 February 2023 would cause the hearing to go part heard.

Ms Namkumba accepted that you should have been more prepared. [PRIVATE].

[PRIVATE].

Mr Lee submitted that this is a difficult situation as the hearing has to proceed fairly but fairness goes both ways. He reminded the panel that it did decide to proceed in your absence. He also reminded the panel that there are no more witnesses after Mr 4 and the NMC's case will close.

You said that you would like a legal representative to represent you.

The panel adjourned briefly to give Ms Namkumba time to prepare questions for Mr 4.

Decision and reasons on application to adjourn

The panel heard an application made by Ms Namkumba to have this hearing adjourned until 8 February 2023. She reminded the panel that you had joined the hearing on the second day, and you were not aware of the day it was to start, and Ms Namkumba made you aware.

[PRIVATE].

Ms Namkumba said that you had been doing care assistance work [PRIVATE].

[PRIVATE].

Ms Namkumba said that she went through your correspondence and stated that you have not been in contact with your legal counsel for a long time. She said in the last correspondence from your former legal counsel it appeared that they were not sure when this hearing was due to start. She referred to the emails sent to you on 31 January 2023 by the Hearings Coordinator and the NMC Case Officer. She said that you did not know when the hearing started and Ms Namkumba had to check your correspondence for you.

Ms Namkumba said that in the interest of fairness, the panel should provide you with the opportunity to present your case with legal representation.

In response to a question from the legal assessor, Ms Namkumba said that she has exchanged email correspondence with the new legal representative, Mr Welch. She said that he has verbally confirmed his attendance on 8 February 2023.

The legal assessor said that the panel need to be reasonably assured that Mr Welch will attend the hearing, on your behalf, on 8 February 2023.

Mr Lee opposed the application and submitted that it would be fair to proceed with the hearing. He submitted that it is in the public interest to proceed and have the hearing concluded expeditiously. [PRIVATE]

Mr Lee submitted that this is a matter for the panel, but he opposed the application. He submitted that it would be fair to proceed and there is a public interest in the hearing concluding expeditiously. [PRIVATE].

Mr Lee informed the panel that you had legal representation, Thompsons Solicitors, early this year and on 6 January 2022 the NMC received an email stating that your legal representation was withdrawing from the case. He submitted that your legal representative would have been informed of the date of the hearing.

Mr Lee submitted that there is a duty on you to engage your legal representative and maintain it until the hearing commences. He submitted that it is not clear why Thompsons Solicitors are no longer representing you.

Mr Lee informed the panel have heard from all the NMC's witnesses. He submitted that if the panel decide to adjourn until 8 February 2023, then it may hear two applications that could take up most of the day and then it might hear your case the following day on 9 February 2023 which means that this hearing will go part heard.

Mr Lee submitted that it is not in the public interest to adjourn a case of this nature. He further submitted that there must be cogent reasons as to why this information regarding legal representation was not shared ahead of this hearing and why there was not an application to adjourn when Thompsons Solicitors withdrew.

Mr Lee submitted that this is a matter for the panel.

Ms Namkumba informed the panel that she did not know why Thompsons Solicitors withdrew from the case.

The panel accepted the advice from the legal assessor which included reference to Rule 32 which stated:

> *32.(1) The Chair of the Practice Committee may, of her own motion, or upon the application of a party, postpone any hearing of which notice has been given under these Rules before the hearing begins.*
>
> *(2) A Practice Committee considering an allegation may, of its own motion or upon the application of a party, adjourn the proceedings at any stage, provided that:*
>
> > *(a) no injustice is caused to the parties; and*
> > *(b) the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor.*

The panel took account of the submissions of Ms Namkumba and Mr Lee.

The panel bore in mind that [PRIVATE] you had not been able to attend the first day of the hearing. It also bore in mind that it has heard from most of the NMC witnesses before you appeared at this hearing.

The panel bore in mind that there is a public interest in the expeditious disposal of this case and bore in mind that the earliest the NMC can reschedule this hearing is around July 2023.

However, in light of the circumstances the panel considered that, in the interest of fairness, you need an opportunity to present your best case. It was of the view that, while [PRIVATE] Ms Namkumba has done the best she can to represent you in these circumstances, you would be better served with legal representation to help you present your case.

The panel also considered that it is in the public interest for the panel to make a sound and reasonable decision regarding your fitness to practice.

The panel determined there to be no injustice caused to either party to adjourn until 8 February 2023.

Decision and reasons on application to admit written statement of Mr 5 and Patient A

The panel heard an application made by Mr Lee under Rule 31 to allow the written statement of Patient A into evidence.

Mr Lee reminded the panel that the test is fairness and it should not admit any evidence that is unfair to you. He submitted that you will not be able to cross-examine Patient A but the panel must decide if the reliability of the evidence be tested without Patient A being present. He referred the panel to the guidance in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Mr Lee submitted that in a case where the evidence will be sole and decisive, the panel should proceed with caution. He submitted that where the evidence merely adds support to evidence heard live or documentary evidence then this will amount to hearsay and can be admitted on grounds of fairness.

Mr Lee referred the panel to the witness statement of Patient A which references his Alzheimer disease and outlines the incident. It also stated that he had to be told the date of the incident and describes it as strange.

Mr Lee, within Patient A's witness statement, drew the panel's attention to the incident regarding the door at the Home. He submitted that Patient A's evidence in this regard is sparse as Patient A stated that he was talking with you and does not know how he ended

up on the floor. He also submitted that Patient A does not remember the other nurses' names.

Mr Lee submitted that Patient A is clear on some issues and not clear on others. He submitted that if the panel feel that it cannot rely on Patient A's witness statement, then it is not fair to admit it into evidence. He submitted, however, that the panel may consider that Patient A's evidence is substantiated by other evidence and corroborated by Ms 1, Ms 2 and Ms 3.

Mr Lee submitted that Patient A's witness statement is not sole and decisive and is corroborated by other evidence.

Mr Lee also confirmed that initially, Patient A did not have the capacity to attend the hearing due to his health condition. However, it was later confirmed to the NMC that Patient A had passed away.

Mr Mutalemwa, on your behalf, opposed the application. He said that the evidence of Patient A cannot be used due to his health condition. He said that Patient A cannot discern between what is real and what is not real, and his account is "all over the place."

Mr Lee moved on to make an application under Rule 31 to allow the written statement of Mr 5 into evidence. He submitted that the reasons for the non-attendance of Mr 5 is not clear. He informed the panel that the NMC spoke to one of his colleagues and was told that Mr 5 was on holiday, however there is no confirmation of this.

Mr Lee submitted that Mr 5 was informed of the hearing and engaged with the NMC but for whatever reason he has not attended or replied to emails sent regarding his attendance. Mr Lee submitted that there is no good reason that he can put before the panel for Mr 5's non-attendance.

Mr Lee said that he does not submit that it would be fair to admit Mr 5's witness statement in absence of Mr 5 being available to give oral evidence.

Mr Lee submitted that Mr 5, in his witness statement, provides a lot of information about the incident but he was not present for it. He submitted that Mr 5 cannot be cross-examined and put forwards Mr 5's witness statement as "multiple hearsay".

Mr Lee invited the panel to accept paragraphs 1, 2 and 6 of Mr 5's witness statement. He submitted that paragraphs 1 and 2 describes Mr 5's role at the Home, who he is and a summary of his responsibility. He submitted that paragraph 6 refers to photographs he took at 09:00 following the incident. Mr Lee submitted that the photographs are inherently reliable and are of Patient A's injuries which are corroborated by Ms 1, Ms 2 and Ms 3.

Mr Mutalemwa opposed this application. He said that the photographs were taken ten hours after the time of the incident.

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. He also referred the panel to the guidance in *Thorneycroft*.

The panel took account of the submissions of Mr Lee and Mr Mutalemwa and the guidance in *Thorneycroft.*

Patient A's witness statement

With regards to the witness statement of Patient A, the panel was very cautious in its approach when considering this application. It bore in mind that Patient A was allegedly the victim of neglect by you and has since passed away. It considered *Thorneycroft* and determined the following:

(1) whether the statement was the sole or decisive evidence in support of the charge;

The witness statement was not the sole and decisive evidence in support of the charge.

(2) the nature and extent of the challenges to the contents of the statement;

There are some challenges to the content of the statement, namely the capacity for Patient A to recall the incident.

(3) whether there was any suggestion that the witness had reason to fabricate their allegations;

Witnesses have confirmed that Patient A had a difficult rapport with you and had issues with your ethnicity.

(4) the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;

The allegations are very serious and could have an adverse impact on your nursing career.

(5) whether there was a good reason for the non-attendance of the witness;

There is a good reason for the non-attendance of Patient A.

(6) whether the NMC had taken reasonable steps to secure the attendance;

This is not applicable given the circumstances of Patient A's non-attendance.

(7) the fact that the registrant did not have prior notice that the witness statement was to be read.

You had prior notice that the witness statement was to be read.

The panel bore in mind that Ms 1, Ms 2 and Ms 3 all confirmed that Patient A used racist language towards you and as a result, viewed his witness statement with some scepticism. It also bore in mind that Patient A had dementia and was of the view that it would never know if his condition caused him to be this way.

However, in reading Patient A's witness statement, it noted that it appeared incoherent and had contradictions. Further, the panel noted that it was clear Patient A did not like you and he raised a number of issues that are not related to the charges. As a result, it questioned his ability to provide an objective account.

The panel bore in mind Mr Mutalemwa's opposition to the application based on Patient A's dementia potentially impacting his ability to give evidence. However, it determined that this did not make Patient A's witness statement inadmissible. It determined that it was its incoherence and the fact that it raised concerns not pertaining to the charges. Further, it also concluded that the witness statement of Patient A does not provide the panel with any additional evidence that it does not already have from Ms 1, Ms 2 and Ms 3 relating to the incident.

In these circumstances the panel refused the application.

Mr 5's witness statement

The panel considered *Thorneycroft* and determined the following:

(1) whether the statement was the sole or decisive evidence in support of the charge;

The witness statement was not the sole and decisive evidence in support of the charge.

> *(2) the nature and extent of the challenges to the contents of the statement;*

There are some challenges to the photographic evidence, namely that they were taken ten hours after the incident and when the injuries were alleged to have been sustained.

> *(3) whether there was any suggestion that the witness had reason to fabricate their allegations;*

There is no evidence to suggest that Mr 5 has a reason to make any fabrications.

> *(4) the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

The allegations are very serious and could have an adverse impact on your nursing career.

> *(5) whether there was a good reason for the non-attendance of the witness;*

The reasons for Mr 5's non-attendance are unknown.

> *(6) whether the NMC had taken reasonable steps to secure the attendance;*

The NMC took reasonable steps to secure the attendance of Mr 5.

> *(7) the fact that the registrant did not have prior notice that the witness statement was to be read.*

The panel nor you have had no prior notice that this application.

The panel bore in mind that the NMC only want to admit paragraphs 1, 2 and 6 of Mr 5's witness statement. It noted that paragraph 6 speaks to the photographs in the exhibit bundle. While the panel accept that the photographs were taken ten hours after the incident, it was of the view that they demonstrate that an injury to Patient A occurred.

In light of the above, the panel decided that it would be fair and relevant to admit paragraphs 1, 2 and 6 of the witness statement of Mr 5. In due course the panel will determine what weight, if any, to attach to it.

Decision and reasons on facts

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

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 who, at the time of the alleged events, were employed in the following roles:

- Ms 1: At the relevant time, an HCA at the Home;

- Ms 2: At the relevant time, an HCA at the Home;

- Ms 3: At the relevant time, an HCA at the Home;

- Mr 4: At the relevant time, an pre-registered nurse at the Home.

The panel also heard evidence from you under affirmation.

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

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

Charge 1a

1) In respect of Patient A:
   a) Did not provide medication when requested

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 1, Ms 2 and Ms 3.

You told the panel that Patient A had been given all of the medication that he was due for. However, in their oral evidence, the HCAs that testify to charge 1a all claim that a medication due to be given to Patient A was missed by you. The panel noted that it was not clear what medication Patient A had allegedly requested from the evidence before it. There was some suggestion that Patient A was asking for additional PRN medication, but this was not confirmed. The panel noted that there is no Medication Administration Records ("MAR") chart within the paperwork.

The panel was not satisfied that the alleged mischief in charge 1a could be made out, due to the vagueness and the lack of clarity from the evidence. Whilst there was an account provided by Patient A in relation to this incident, the panel did not consider this to be particularly clear in what it was he had allegedly asked you for. The panel was aware that Patient A suffered from dementia, so it was of the view that it could only place a limited amount of weight on his evidence without any other credible evidence to support this.

The panel was of the view that there was no tangible evidence to suggest that you had not given medication to Patient A when requested, or that you had indeed missed administering medication that he should have received. Therefore, it decided that the NMC had been unable to discharge its burden of proof in demonstrating that you did not provide medication to Patient A when requested.

The panel found charge 1a not proved.

Charge 1b

1) In respect of Patient A:
    a) Did not de-escalate and / or attempt to deescalate the situation when PRN was refused

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 1, Ms 2 and Ms 3.

In considering charge 1b, the panel noted that it is intrinsically linked to charge 1a, in that your alleged inaction was in response to a situation where PRN was refused. It was of the view that it was not the panel's function to compartmentalise the charge; the panel had to consider it insofar as a situation where you had refused to administer PRN medication to Patient A.

The panel reminded itself that it did not find proved that you had not given PRN medication to Patient A when requested. Therefore, the panel was not satisfied that you did not de-escalate and / or attempt to de-escalate the situation when PRN was refused, as it had not found that PRN medication was refused. Whilst there was evidence which suggested an incident had occurred, the panel could not be satisfied that this was specifically linked to PRN medication being refused to Patient A.

Therefore, the panel did not find charge 1b proved.

Charge 1c

1) In respect of Patient A:
    c) Attempted to close the door when he tried to access the nurses station

This charge is found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 1 and Ms 3.

The panel had regard to Ms 3's NMC witness statement, in which it was said:

> "*As we came out of the room, I could hear something going on at the Nurse's station. I could see the [Patient A] wit* [sic] *his Zimmer frame. He was between the door and I saw that he was being pushed out. I did not see who was pushing him out of the Nurse's station. I can't remember if I heard [Patient A] shouting when I came out of the room.*
>
> *I think that it was Mary who was pushing him out as she was the only person in the Nurse's station…*

Then suddenly, I heard a bang. I didn't see [Patient A] fall. I just heard the bang. When [Ms 2] and I arrived by the Nurse station, [Patient A] was on the floor…I noticed the when [sic] *on the Zimmer frame had been broken which I think was broken by the door…*"

You also appeared to admit that you had closed the door of the nurse's station on Patient A. You told the panel that you were frightened of Patient A based on his harsh tone so you ran to close the office door, did so, and then heard a bang outside.

In taking account of the above, the panel was satisfied that you attempted to close the door when Patient A tried to access the nurses' station.

Therefore, the panel found charge 1c proved.

Charge 1d

1) In respect of Patient A:
    d) Applied pressure to the door of the nurses station that:
        i) Was not appropriate
        ii) Caused him to become unstable and fall

These charges are found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 2 and Ms 3.

The panel had regard to Ms 2's NMC witness statement, in which it was stated:

"*…We were in the corridor and we heard all this noise. We could see the doctor pushing the door to the Nurse's station. I can't recall that he said anything to Mary. I saw him pushing the door and her pushing back. It was a good battle with the door.*

He is pushing the Zimmer frame in the door and she was a largish lady. It got pretty rough…".

The panel also had regard to Ms 3's NMC witness statement, in which she said:

"*…As we came out of the room, I could hear something going on at the Nurse's station. I could see [Patient A] with his Zimmer frame. He was between the door and I saw that he was being pushed out. I did not see who was pushing him out of the Nurse's station. I can't remember if I heard [Patient A] shouting when I came out of the room…*

I think that it was Mary who was pushing him out as she was the only person in the Nurse's station. Mary was the only person allowed in the Nurse's station…

Then suddenly, I heard a bang. I didn't see [Patient A] fall. I just heard the bang. When [Ms 2] and I arrived by the Nurse's station, [Patient A] was on the floor…".

The panel noted that you do not appear to dispute that it was you in the nurses' station at the time, however, you deny continuously applying pressure to the door to keep Patient A out. The panel found your evidence to be confusing and unclear on this point, so it preferred the consistent evidence of the NMC witnesses. It considered that you applying pressure to the door would have been the most likely response in the particular circumstances of this case. You appeared to be the person in the nurses' station, Patient A was seen trying to enter said Nurse's station, and witnesses attest to seeing a 'battle' between you and Patient A.

In considering whether it was appropriate for you to apply pressure to the door of the nurses' station, the panel took account of the context of the situation. Patient A had allegedly behaved in an agitated and intimidating manner towards you, and there was also some evidence to suggest that Patient A was historically abusive towards you, which other witnesses had confirmed. You told the panel that Patient A was irate and screaming racist

abuse at you at the time of this incident. Whilst you had stated in your reflective piece that you were scared of Patient A, you had insisted in your oral evidence that you were not scared of Patient A on at least two occasions, before your representative prompted you, and you then changed your answer.

The panel noted that Patient A was a vulnerable, elderly, dementia patient who was at a high risk of falls, and that you would have been aware of this at the time of the incident. It was of the view that as part of your role, you would have been expected to perform a rapid risk assessment, weighing up the risk of harm exposed to yourself and the risk of harm to Patient A. The panel determined that applying pressure to the nurses' station door was likely to expose Patient A to a higher risk of harm and, based on the evidence before it, the panel did not consider this to be appropriate in the circumstances. It decided that there would have to have been extenuating circumstances for this type of behaviour to have been appropriate, and these were not present here. The panel noted that whilst there may be contextual factors which give rise to a large amount of mitigation, your primary role is to safeguard the patients that you are supposed to be caring for. This, on the face of it, appears to be the opposite of what you did.

Nonetheless, the panel determined that any mitigation would be considered at a later stage in proceedings. At the facts stage of the hearing, the panel is merely determining whether the charge happened as alleged.

In taking account of the above, the panel was satisfied that it was not appropriate for you to apply pressure to the door of the nurses' station.

In considering whether applying pressure to the door of the nurses' station caused Patient A to fall and become unstable, the panel was of the view that it was more likely than not that you '*battling*' with Patient A in this way was likely to cause him to fall over, having regard to his heightened risk of falls. The panel received evidence to suggest that Patient A was already agitated, and it did not consider you to have de-escalated the situation in the manner that you should have as the registered nurse in a position of responsibility. To

the contrary, you engaged in behaviour that made the situation more volatile, exposing Patient A to a higher risk of becoming unstable and falling.

In taking account of the above, the panel was satisfied that you applying pressure to the door of the nurses' station caused Patient A to fall and become unstable.

Therefore, the panel found charges 1d(i) and 1d(ii) proved.

Charge 1e

1) In respect of Patient A:
    e) Did not call a GP soon enough and / or at all

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 2

The panel noted that the majority of the NMC witnesses that speak to this charge allege that they had asked you to call the General Practitioner (GP), but you did not. To the contrary, you told the panel that you did call the GP, and the evidence of Ms 2 also appeared to confirm this.

The panel had regard to Ms 2's NMC witness statement, in which it was said:

> "*I noticed Mary on the phone, she was phoning an ambulance or an out of hours GP. I don't know what time this was but it was after the girls put him in his room. It was not long after he was in his room.*
>
> *Mary said she called the out of hours but it was way too late though…*"

In taking account of the above, the panel was satisfied that you had made a telephone call to the GP at some point after the incident, despite there being nothing to suggest that a GP did actually attend the nursing home.

The panel then moved on to consider whether the telephone call you made to the GP was within a reasonable timeframe of the incident. It noted that Mr Lee took you through this particular situation in your oral evidence, and appeared to be intimating that an appropriate time for you to call the GP would have been when Patient A was on the floor at the nurses' station.

In having regard to the context of this incident, the panel did not consider there to be a significant delay between Patient A falling over and you calling the GP. It determined that a lot appeared to be happening at the time of the incident, and it would have been illogical for you to have left a patient on the floor in discomfort whilst you went and telephoned a GP.

Furthermore, Patient A had initially insisted on speaking to his wife on the telephone after his fall. The panel was informed that there only appeared to be one telephone on the unit, so you would have had to wait for Patient A to finish speaking to his wife before making a telephone call to the GP. The system in place at the Home appeared to suggest that you had made an entry at 23:36 hours on the day of Patient A's fall, indicating that you had spoken to 111 who had assessed the case as requiring referral to the GP in the morning. Given this outcome, the panel did not consider there to have been a pressing need for Patient A to be referred to the GP as a matter of urgency. The panel determined that you had telephoned the GP within a sufficient period of time in light of the above advice.

Therefore, the panel was not satisfied that you did not call a GP soon enough and / or at all for Patient A.

The panel found charge 1e not proved.

Charge 1f

1) In respect of Patient A:
   f) Did not call an ambulance

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Mr 4.

The panel had sight of the 'Falls management policy and procedure' at the Home, specifically bullet point four of the section titled 'Falls Procedure' which states:

> "*If, on initial assessment, no serious injuries are found, and the individual appears to be unaffected by the incident:*
>
> - *Complete a risk assessment to decide upon the appropriate action; call 111 for professional advice and guidance to inform the risk assessment and decision-making process*
> - *Decide the action that needs to be taken following the risk assessment; this may include the use of moving and handling techniques or equipment according to the individual care home policy...*".

Furthermore, the panel also had regard to the section titled 'Falls and the Ambulance Service' which states:

> "*…Risk assessments will be undertaken for all manual handling and incidents of falls. Where an individual is injured or medically unwell, the emergency services will be contacted. If the individual has fallen, has capacity and is not injured but cannot get up, Meddyg Care will identify mechanisms to safely assist the individual from the floor…*".

The panel noted that the ‘red flag assessment’ completed by you indicated that the above criteria had not been met. Therefore, in according to the Home’s policy, you would not have been required to call an ambulance.

The panel determined that it had no other evidence before it to indicate that you should have called an ambulance for Patient A. Even after having spoken to 111, the advice you received was to contact the GP in the morning. There was nothing to suggest that this was an emergency situation which required an ambulance being called.

Therefore, the panel was not satisfied that you were under a duty to call an ambulance for Patient A in these particular circumstances.

The panel found charge 1f not proved.

Charge 1g

1) In respect of Patient A:
    g) Did not conduct observations / checks

This charge is found proved in respect of observations, but not proved in respect of checks.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 1, Ms 2 and Ms 3.

In considering whether you did not conduct observations, the panel noted that, through your representative Ms Namkumba, you provided a partial admission to charge 1g, in that you admit failing in your responsibility to complete observations of Patient A. The panel considered you to have been aware that there would have been a duty imposed on you to

complete your observations, as you were the registered nurse on shift. This is also supported by the 'Falls management policy and procedure at the Home'.

In considering whether you did not conduct 'checks' of Patient A, the panel had regard to the fact that you had completed a 'red flag assessment'. The panel was not clear on what other 'checks' you were required to complete in respect of Patient A and it had not received any specific evidence on this point. Whilst the 'Falls management policy and procedure' at the Home referred to "*repeated observations*" needing to be carried out, there was nothing that indicated that this needed to be completed half hourly, as proposed by the NMC witnesses. The panel noted that this could be down to you not having completed baseline observations, so you would not have been able to determine how often you would have needed to complete other 'checks'.

In any event, whilst you had admitted to not completing observations, the panel was satisfied that you had completed a required 'check' by way of a 'red flag assessment', and this was recorded as you having done so. The panel was not provided with any evidence to indicate what other 'checks' you should have carried out.

In taking account of the above, the panel found that you had not conducted any observations after Patient A's fall. It found charge 1g proved in this respect. However, the panel did not find that you did not conduct any checks of Patient A after his fall, so it found charge 1g not proved in relation to that limb.

Charge 1h

1) In respect of Patient A:
    h) Did not conduct risk assessment following the fall

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Ms 1, Ms 2, Ms 3 and Mr 4.

The panel noted that it had found you to have completed a 'red flag assessment' in respect of Patient A's fall so it was satisfied that you had conducted some sort of risk assessment in this regard. You told the panel that you had conducted a risk assessment of Patient A whilst he was on the floor at the nurses' station.

The panel had sight of the 'Falls management policy and procedure' at the Home which, in the panel's view, would have specified what risk assessments you would have needed to have carried out on Patient A. However, from this policy, the panel was not clear on what other 'risk assessment' you were required to complete in respect of Patient A. In the absence of any other evidence to the contrary, the panel considered you to have conducted the risk assessment of Patient A as required.

In taking account of the above, the panel was not satisfied that you did not conduct a risk assessment following Patient A's fall.

Therefore, the panel found charge 1h not proved.

Charge 1i

1) In respect of Patient A:
    i) Did not provide care for the injuries he sustained

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Mr 5.

The panel considered this charge to have a wide remit, as it had not been specified what is meant by the words ‘provide care’ in this scenario.

The panel noted from the photographs provided by Mr 5 that these appeared to show that Patient A had suffered some sort of head injury. These photographs were taken by Mr 5 the same day as Patient A’s fall at around 09:00 hours.

The panel considered there to be conflicting evidence as to when the wounds seen in the photographs were created, as there was some suggestion that Patient A had suffered a previous fall earlier that day and sustained a previous head injury from that. It was unclear whether this particular incident involving you was the cause of the entirety of the wounds seen, or the significance of the impact, as it did not have any comparators. No photographs had been provided of Patient A’s injury after his initial fall; only his subsequent one. In any event, from the photographic evidence, the panel noted that Patient A’s head injury had become somewhat perturbed as it had started to bleed again. However, the panel was aware that the extent of the bleeding appeared to vary from person to person in oral evidence, in addition to when the source of the bleeding occurred.

The panel was in no doubt that Patient A clearly had injuries to his head, as shown in the photographs, but it considered it to be impossible for it to determine when the extent of these injuries truly occurred. Therefore, without knowing when the extent of these injuries occurred, the panel was not able to determine what care should have been provided and when. For example, had the majority of the injuries seen in the photographs occurred after Patient A’s initial fall, the requirement of you to provide more urgent care would have been less due to the lapse in time.

In your oral evidence and your reflective statement, you told the panel that “*I told the doctor that there were no major injuries, but I reported a small scab which did not require any dressing*”. The panel had no evidence before it to dispute that what you had said was incorrect.

The panel had found you to have completed a ‘red flag assessment’ which it determined was a form of ‘care’ provided by you. You had also assessed Patient A whilst he was on the floor at the Nurse’s station and had telephoned a GP to seek advice on what care should be provided in the aftermath of the incident, with follow-up advice given and recorded. The panel was of the view that some form of ‘care’ had been provided by you to Patient A in the wake of the injuries he had sustained.

In taking account of the above, the panel was not satisfied that you did not provide care for the injuries Patient A sustained. It determined that the NMC had not been able to discharge its burden of proof, as it was unclear when Patient A had sustained the extent of the injuries shown in the photographs.

Therefore, the panel found charge 1i not proved.

Charge 1j

1) In respect of Patient A:
    j) Engaged in a further argument with him after the fall

This charge is found proved.

In reaching this decision, the panel took account of the evidence from Patient A, Ms 1, Ms 2 and Ms 3, as well as your own evidence.

The panel noted that the evidence the NMC has called in support of this charge suggests that the patient was verbally abusive to you after his fall and that you retorted to him in some way. In particular, the panel had regard to Ms 2’s witness statement, in which it was stated:

"*…When I came back, Mary and the doctor were arguing again. Mary was shouting and pointing with her finger at him. She said that she "had enough of him" and kept repeating this. She said that she wanted the doctor out of her sight.*

The doctor was lying flat on the floor at the time. I cannot remember what he said to her. She was saying to him, "you are a really horrible, wicked man. You are a horrible, horrible man". She was irate at the time. I think she swore at him but I did not hear this…".

The panel considered this to be similar to what Ms 3 recalls, as she states:

"*She was saying that she's had enough of him. She had enough of the way that he was treating her as his Nurse. She was calling him names, calling him a "bastard" and things*".

Patient A himself also partly remembers this incident, despite having no recollection of how he ended up on the floor, as he states:

"*…There were a couple of Nurses by this time but I can't remember any names. They were upset at the reaction and the physical assault that had taken place…*".

The panel was of the view that there was significant corroborative evidence to indicate that an altercation of sorts had occurred after Patient A had fallen. Three of the NMC witnesses attested to seeing Patient A on the floor and that you had continued to engage in an argument with him from this position. The NMC witnesses said they remember this incident specifically because it felt that this was such a departure from the expected standards set.

In your oral evidence, you denied all of the allegations against you in relation to this charge. You said that you did not blame Patient A for falling over, you did not argue with him, and you did not swear at him. In your documentary evidence, you told the panel that

Patient A had been racist towards you by telling you to "*go back to Africa*", but you did not explain what actions you took in the aftermath of this. The panel was aware that it would move on to consider any potential mitigation at a later point in this hearing.

In taking account of the above, the panel preferred the consistent and corroborative evidence of the NMC witnesses to that of your own evidence in relation to this charge. The panel found the NMC witness evidence to be compelling in relation to this charge, to the extent that you had engaged in a further argument with Patient A after his fall.

Therefore, the panel found charge 1j proved.

Charge 2a

2) Did not document in Patient A's notes:
   a) The incident with the nurses station door

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence of Mr 4.

The panel had sight of Patient A's medical notes in which it was clear that the incident relating to the nursing station door was recorded at 23:36 hours on 11/08/2020:

> *"…he decided to come very near to me at the door and started to verbally abusing* [sic] *me for no reason. i went to close the door as i new* [sic] *he will continue to abuse me. he then suddenly banged the door with his zimmer to prevent me from closing it…"*

In addition to this, the panel noted that in his submissions, Mr Lee appeared to concede that the incident involving the nurses' station door was documented in Patient A's notes.

Therefore, the panel found charge 2a not proved.

Charge 2b

2) Did not document in Patient A's notes:
   b) The fall at the nurses station

This charge is found NOT proved.

In reaching this decision, the panel took account of the evidence of Mr 4.

The panel had sight of Patient A's medical notes in which it was clear that the incident relating to the nursing station door was recorded at 23:36 hours on 11/08/2020: [sic]

> *"…as i* [sic] *was already closed he lost his balance and fell backwards. he continued to verbally abusing* [sic] *me though he was on the floor. he demanded to talk to his wife. he was able to lift his neck up to see what was happening. he refused to be lifted with the camel. staff managed to get him up. he was able to walk to his room with the zimmer frame. he spoke to his wife. she is aware about the fall. spoke to out of hours doctor. advised to keep an eye on him. to refer to his own GP mane* [sic]*…"*

In addition to this, the panel noted that in his submissions, Mr Lee appeared to concede that the incident involving Patient A's fall was documented in Patient A's notes.

Therefore, the panel found charge 2b not proved.

Charge 2c

2) Did not document in Patient A's notes:
   c) That the following had not been conducted following the fall:

i) Observations
ii) Checks
iii) Risk assessments

This charge is found proved in respect of observations, but not proved in respect of checks and risk assessments.

In reaching this decision, the panel took into account your and Mr 4s evidence.

In respect of charge 2c(i), the panel considered there to have been a duty imposed on you to conduct observations following Patient A's fall as his named registered nurse on that shift. It would have been your primary role to safeguard the patients that you were responsible for.

The panel had regard to its findings in charge 1g and noted that you had admitted not conducting observations on Patient A and that you would have been under a duty to do so. You had told the panel that Patient A was asleep and you did not want to wake him. The panel was of the view that you should have documented in Patient A's notes that it was not possible to conduct observations, as this would have provided an indication to staff at the Home of future care that may/may not have needed to be delivered.

In respect of charge 2c(ii), the panel had regard to its findings in charge 1g and noted that it did not find that you did not conduct checks on Patient A following his fall. It had sight of the Falls management policy and procedure at the Home and it considered this to be relatively vague in relation to what checks you were needed to perform on Patient A.

In the absence of any conclusive evidence, the panel was not satisfied that there was a duty imposed on you to perform checks on Patient A. The panel determined that the NMC had not been able to adduce any evidence to confirm what you were supposed to have done by way of checks in this instance.

In respect of charge 2c(iii), the panel considered that the evidence provided was indicative of you needing to perform a 'red flag assessment', namely, a post falls risk assessment. As found in charges 2a and 2b, the panel had found that you did indeed record a post falls risk assessment in Patient A's notes. It was not clear on what other risk assessments you should have conducted on Patient A after he had fallen.

The panel found that you had not conducted any observations after Patient A's fall, in accordance with charge 2c(i). However, the panel did not find charges 2c(ii) or 2c(iii) proved, in respect of you not conducting checks or a risk assessment of Patient A after the fall.

Therefore, the panel found charge 2c(i) proved, but charges 2c(ii) and 2c(iii) not proved.

Charge 3a

3) Displayed an inappropriate attitude towards the patient in that:
    a) You stated you were 'fed up' with him

This charge is found NOT proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 1, Ms 2 and Ms 3.

The panel was of the view that had you said you were '*fed up*' with Patient A, this would have constituted you displaying an inappropriate attitude. However, none of the NMC witnesses that were called to give evidence could categorically confirm that you had stated that you were '*fed up*' with Patient A. The panel noted that the majority of the NMC witnesses appeared to suggest in their oral and documentary evidence that you were presenting in a manner that appeared to suggest that you were '*fed up*' with Patient A.

For example, the panel had regard to Ms 2's witness statement, in which it was stated:

"*On 11 August 2020…I went and told Mary that the doctor wanted pain relief. She was standing in the Nurse's office, drying medicine pots. She told me to tell the doctor that she was busy. She didn't tell me what she was busy with. She was fed up with him. She was standing in the Nurse's station…*".

Ms 3, in her witness statement, states:

"…She was shouting at him while he was on the floor. She was saying that she's had enough of him. She had enough of the way that he was treating her as his Nurse…".

The panel considered the wording of the charge to be specific. Therefore, the panel was not satisfied that, specifically in respect of charge 3a, you displayed an inappropriate attitude towards Patient A. It had no evidence to suggest that you had stated that you were '*fed up*' with him.

Therefore, the panel found charge 3a not proved.

Charge 3b

3) Displayed an inappropriate attitude towards the patient in that:
    b) You stated he 'done this on purpose'

This charge is found proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 1 and Ms 3.

The panel was of the view that had you stated that Patient A had '*done this on purpose*', referring to him falling over, this would have constituted you displaying an inappropriate attitude towards him.

The panel had regard to Ms 1's witness statement, in which it was stated:

> *"…Mary was standing over him and shouting. She kept saying that he had done this on purpose and that he had not really hurt himself…"*.

The panel noted that this was also corroborated by Ms 3's statement provided at a local level. In addition to this, you also admitted during your oral evidence that you had said to Patient A that he had '*done this on purpose*'.

In taking account of the above, the panel was satisfied that you did display an inappropriate attitude towards the patient in that you accused him of falling over on purpose.

The panel found charge 3b proved.

Charge 3c

3) Displayed an inappropriate attitude towards the patient in that:
    c) You stated he had done this for attention

This charge is found proved.

In reaching this decision, the panel took account of Ms 1's evidence.

The panel was of the view that had you stated that Patient A had '*done this for attention*, referring to him falling over, this would have constituted you displaying an inappropriate attitude towards him.

The panel had regard to Ms 1's witness statement, in which it was stated:

> *"…She said that he had done this for attention…"*

Ms 1 also confirmed in her oral evidence that you had repeatedly stated that he had fallen over on purpose and that he had done this for attention.

The panel placed a significant amount of weight on the evidence of Ms 1 in relation to this charge. It found her to have been consistent, credible and reliable in her account to the panel.

The panel did not consider Ms 1 to have borne any ill-will towards you in giving her evidence, to the contrary, it considered her to be fair and balanced in what she had to say about you. The panel noted that Ms 1 spoke positively of your all-round nursing practice, as she stated in her oral evidence that you were "*absolutely a good nurse when it came to it*" and that she could rely on you in an emergency situation to help at any time. Ms 1 said that she was not sure whether the pressure of the shift just got to you on this particular occasion.

In taking account of the above, the panel was satisfied that you did display an inappropriate attitude towards the patient in that you accused him of falling over for attention.

The panel found charge 3c proved.

Charge 3d

3) Displayed an inappropriate attitude towards the patient in that:
    d) You told carers they should 'drag' him back to his room by his feet

This charge is found proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 1, Ms 2 and Ms 3.

The panel was of the view that had you told carers they should ‘drag’ Patient A back to his room by his feet, this would have constituted you displaying an inappropriate attitude towards him.

The panel had regard to Ms 2’s witness statement, in which it was stated:

> *“…I didn’t know why they got him up but they told me that they had no choice. Mary had told them to drag the doctor out by his feet to his room and they did not want to do this, so they got him up and put him in a wheelchair…”*.

The panel also had sight of a record of conversation between Ms 3 and Ms 2’s regarding the incident on 11 August 2020, which had been compiled for the Trust investigation. In this record of conversation, it is stated:

> *“…Mary told both [Ms 2] and [Ms 3] to get him up and both refused on numerous occasions, Mary did not phone out of hours or ambulance. Doctor also wanted to phone his wife.*
>
> *By this time [Ms 6] had arrived and Mary wanted [Ms 6] and [Ms 3] to drag him out by his legs but they refused…”*.

In Ms 3’s witness statement, it was stated:

> *“…Mary told me and [Ms 6] to move [Patient A] dragging his legs” We refused to do this…”*.

The panel considered the oral accounts provided by Ms 1, Ms 2 and Ms 3 to corroborate with their documentary evidence. Whilst you denied that you told the carers they should 'drag' Patient A back to his room by his feet, the panel preferred the consistent and convincing evidence of the NMC witnesses to that of your own evidence.

In taking account of the above, the panel was satisfied that you did display an inappropriate attitude towards Patient A in that you told carers they should 'drag' him back to his room by his feet.

The panel found charge 3d proved.

Charge 3e

3) Displayed an inappropriate attitude towards the patient in that:
   e) You called him a '*a really horrible, wicked man*'

This charge is found proved.

In reaching this decision, the panel took account of your evidence, along with the evidence of Ms 1, Ms 2 and Ms 3.

The panel was of the view that had you called Patient A '*a really horrible, wicked man*', this would have constituted you displaying an inappropriate attitude towards him.

The panel had regard to Ms 2's witness statement, in which it was stated:

> *"…The doctor was lying flat on the floor at the time. I cannot remember what he said to her. She was saying to him, "you are a really horrible, wicked man. You are a horrible, horrible man". She was irate at the time…"*.

Ms 2 also said in her oral evidence that you were '*absolutely irate to the point that you were screaming*'.

The panel preferred the evidence of Ms 2 to that of your evidence. You had told the panel in your oral evidence that you did not lose your temper, but you did feel overwhelmed by the situation. However, the panel considered the account of Ms 2 to be more plausible, taking account of the background context.

A number of the NMC witnesses had attested to how you were behaving towards Patient A at this point, and the panel considered it to be consistent with you demonstrating an inappropriate attitude towards Patient A. Whilst the panel acknowledged that there may be mitigation involved in this incident, it was of the view that this should be considered at a later point in proceedings.

In taking account of the above, the panel was satisfied that you did display an inappropriate attitude towards Patient A in calling him '*a really horrible, wicked man*'

The panel found charge 3e proved.

Charge 3f

3) Displayed an inappropriate attitude towards the patient in that:
    f) You asked Colleague A to listen in to the call he made to his wife

This charge is found proved.

In considering this charge, the panel took account of the evidence provided by you, as well as Ms 1.

The panel was of the view that had you called Patient A '*a really horrible, wicked man*', this would have constituted you displaying an inappropriate attitude towards him.

The panel had regard to Ms 1’s witness statement, in which it was stated:

> “*We followed him back to his room we got him sat down on his chair and by this time, Mary phoned his wife, so that she could be informed that [Patient A] had had a fall. Mary pulled me to one corner and asked me to listen to the conversation between [Patient A] and his wife. She wanted me to tell her what [Patient A] had said to his wife on the phone…*”.

The panel also had sight of Ms 1’s local statement, which corroborated her NMC witness statement. Ms 1 had stated “*When the nurse had handed the phone to [Patient A], the nurse had asked me to listen to the conversation and let the nurse know what was said…*”.

The panel noted that during your oral evidence, you also appeared to accept that you had told Ms 1 to listen in to the telephone call between Patient A and his wife. You told the panel that you had given this instruction as you needed to know what was said in case something needed to be mentioned in the patient’s notes.

The panel was of the view that whilst this could have been an appropriate instruction in some circumstances, this situation was not one of them. There was no specific instruction from you as to what Ms 1 should listen out for. For example, if you had asked Ms 1 to listen out for signs of distress, then this might have been appropriate. However, the panel considered this to be more of a ‘fishing expedition’ in getting Ms 1 to report back anything that was said that she may consider to be relevant.

The panel considered you to have attempted to invade Patient A’s privacy by asking Ms 1 to carry out this instruction. You would not normally be privy to a private conversation between a patient and their spouse. The panel determined that the nature of this telephone call should have had no bearing on what entries you should have made in Patient A’s notes. You should have documented what had happened from your perspective and any other information you considered to be relevant in the patient’s notes.

In taking account of the above, the panel was satisfied that you had instructed Ms 1 to listen in to a telephone conversation between Patient A and his wife. It determined that it was inappropriate for you to ask Ms 1 to listen in to the telephone call.

Therefore, the panel found charge 3f 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 amounted 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, recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there was no burden or standard of proof at this stage, and it 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 then go on to decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect,*

involving some act or omission which falls short of what would be proper in the circumstances.'.

The panel heard your oral evidence under oath.

You told the panel that you have carefully reflected on the charges found proved in this case and said that you are not proud of them. You said that you admit that on the day of the incident with Patient A, your actions were '*not nice'*, and you understand the seriousness of the charges before you. You said that you behaved unprofessionally and as if you are not a caring nurse, and you regret your actions *'from the bottom of your heart'.*

You told the panel that whilst you are not making excuses for your actions, there were circumstances which you believe made you act out of character. You said that you received frequent racial, verbal abuse from Patient A who disliked you from the day they were admitted to the Home. You said they were abusive towards you, and you reported this to the Home manager who told you that they would speak with Patient A. You trusted them to do this, but they did not.

You told the panel that Patient A was being verbally abusive to you for the entire night shift [PRIVATE] and prevented you from completing handover the morning after. Another colleague spoke to your manager and told them that Patient A was not treating you fairly. Your manager told your colleague that they would speak with Patient A again and failed to after this was escalated a second time.

With regard to your overall relationship with Patient A, you said that when you had to administer medication to Patient A you were very scared. You told the panel that Patient A then told you that you '*work hard, were the best nurse in the Home and should be paid more'* which was the only time they had spoken to you nicely.

You told the panel that regardless of this, you still regret your actions even though it came from a place of fear. You said that you understand the seriousness of the case, are not proud of your actions and have learnt from your mistakes. You explained that you have completed further relevant training, assured the panel that the matters set out in the charges found proved will never occur again and you are deeply sorry.

Mr Holborn asked you how you would respond differently if you were to find yourself in a similar situation again. You said you would seek extra help from your colleagues and ask somebody to speak with the resident, ensure that the manager is aware and if they do not take further action, you would escalate to more senior management. Further, you would try to de-escalate the situation and remain calm when engaging with the resident/patient so that you can help them. You said that this could include having a calm conversation with residents, offering them a drink to comfort them and seeking help from another colleague if you could not diffuse the situation.

You said that you have completed training to strengthen your practice for when you work as a registered nurse again and the training has taught you how to manage the situation if you were faced with a similar situation. You said you are currently working as an HCA and do not feel undermined in any way, you are passionate about caring for your patients. You described how you work very hard to deliver holistic care to every patient and take your work very seriously.

You said that you always escalate situations if they do not feel right. Further, you confirmed that your reflective pieces were written by you and provided an honest account of how you would respond differently if faced with a similar situation whilst working as a registered nurse in the future.

You said that you have reflected with your family members on the incident and the charges found proved were not in your nature. You said that you have worked as a registered nurse for over 25 years and had an unblemished career up until you were referred to the NMC for this incident.

Mr Claydon referred you to the *'Caring for People with Dementia'* certificate dated 24 September 2023, asking you how long this course lasted. You said it was a one-hour online course covering topics such as 'what is dementia', the types of dementia and how to look after patients/residents with this condition who present with challenging behaviour. You said that from this training, you have learnt that when someone has dementia, they may behave out of character. You said that during your career, you have looked after many elderly patients with dementia and have seen how family members can be affected by their relative's behavioural changes.

You said that you accept that the charges found proved were *'never events'* (meaning that they should never have happened). You said that in relation to the charge 3f, you asked a colleague to listen to a private phone call between Patient A and his wife, so that you could report the conversation at handover. You admitted that you also did this because you were aware that you may get into trouble for your actions in the incident with Patient A.

During panel questioning, you said that you produced the contents of your reflective pieces; the first reflective piece was written before the hearing in February 2023 and the second reflective piece was written after the last hearing in September 2023.

In relation to charge 3e, you told the panel that you do not remember speaking to Patient A in this manner but because the incident occurred very fast, you do not deny that you may have said this. You said you take full responsibility for what happened on the day of the incident.

In relation to charge 2, you told the panel that you lost control of the situation which resulted in your poor language towards Patient A. You said at the time of the incident, you did not leave to seek help but admit you should have escalated the incident. You said that you have since reflected on this, carried out training and would now respond differently if a similar occasion occurred.

When asked how you feel your actions during the incident with Patient A would have affected your junior colleagues and the HCAs involved. You said that you believe that they would have lost trust in you as a senior colleague and questioned your ability to deliver good quality care to residents. Further, that they may have been hesitant to seek your help in the future.

[PRIVATE].

The panel referred you to the *'Health Education England, Skills for Care and Skills for Health'* certificate and asked you to clarify what the training course covered. You said that this was a one day long, face-to-face training course for HCAs, which covered the following:

- Medication administration;
- Moving and handling;
- Food hygiene;
- End of life care; and
- Safeguarding.

You told the panel that when you were working at Meddyg Care there were a lot of concerns which you raised with the manager prior to this incident. You realised that this was not as effective at the time as you would have liked. Further, that since the incident occurred, you have worked more on your communicational skills with colleagues, members of the multi-disciplinary team and residents in your care.

The panel asked you how you believe you should have communicated with Patient A in hindsight. You told the panel that you would sincerely apologise to Patient A and their family, assure them that you would not make the same mistake in your actions again and aim to gain back their trust. Further, you would apologise to and reassure the junior

colleagues involved that you have strengthened your practice so that they would not be put in the same position by you again.

You said that you feel the impact of your actions on Patient A would be that they would be scared, angry and very confused that someone they trusted to care for them would behave in this manner and would understand if Patient A would not want to receive care from you again.

You said that you understand that your actions do not reflect well on the nursing profession and could have reduced the public's trust in you as a healthcare professional.

You said you wanted to reassure the panel that you have reflected on your actions, carried out training and continued to work in a healthcare setting as an HCA to strengthen your practice.

Mr Claydon invited the panel to take the view that the facts found proved amount to misconduct. He invited the panel to have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)' (the Code) in making its decision.

Mr Claydon invited the panel to identify the specific, relevant standards that he submitted you had breached, which would lead to your actions amounting to misconduct and he referred the panel to the NMC's published guidance on impairment.

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

Mr Claydon submitted that three limbs of the *Grant* test were engaged. He submitted that limb 'd' is not engaged as the charges found proved do not relate to dishonesty.

Mr Claydon invited the panel to consider that your fitness to practice is impaired on the grounds of public protection and is also in the wider public interest.

In relation to public protection, Mr Claydon submitted that the incidents were serious in nature, relating to a lack of proper conduct which led to direct, unwarranted harm to Patient A. Mr Claydon invited the panel to consider whether you are liable to repeat the conduct, which was found proved. He submitted that you have made admissions to the charges found proved and have provided the NMC with evidence which can demonstrate your remorse and insight. However, he submitted that you have only recently accepted the charges found proved and you are at the start of your journey to remediation. Mr Claydon submitted that, therefore, there is a risk of repetition of the charges found proved and invited the panel to consider that your fitness to practise is impaired on the ground of public protection.

Mr Claydon submitted a finding of impairment is also in the wider public interest as a well-informed member of the public would be concerned to learn that you were continuing to work as a registered nurse without any form of restriction in place in light of the seriousness of the charges found proved. He submitted that your actions breached the Code and have brought the profession into disrepute and, therefore, your fitness to practise is also impaired on public interest grounds.

Mr Holborn, on your behalf, submitted that you have taken numerous measures to demonstrate your remorse, strengthen your practice and to remediate. Mr Holborn invited the panel to consider your oral evidence, your reflective pieces, the relevant mandatory training you have completed, the positive testimonials from your colleagues and relatives of the patients for whom you have cared. He submitted that all of the evidence can be viewed to have mitigated the risk of repetition in your misconduct.

Mr Holborn submitted that you have demonstrated significant remorse and insight into your actions, acknowledging that you breached the Code at the time, but have learnt from these mistakes and have taken sufficient measures to strengthen your practice so that you can now practice safely in accordance with the Code. He submitted that your confidence and competence have improved in your new role. Further, that you have taken responsibility in escalating any concerns you have to senior members of staff as part of your reflection of the incident.

Mr Holborn invited the panel to consider the circumstances around the incident. Mr Holborn submitted that the charges found proved were tied to an isolated incident and you have had an otherwise unblemished career as a registered nurse for 25 years. Further, he submitted that at the time of the incident, you had been subject to regular racial, verbal abuse from Patient A [PRIVATE]. Mr Holborn submitted that however, you accept that you should handle these situations differently despite the circumstances and will do so in the future.

In relation to the wider public interest, Mr Holborn invited the panel to consider that well-informed members of the public would appreciate that you have not tried to undermine the seriousness of the charges found proved but have instead admitted and learnt from your mistakes. He submitted that a member of the public would be reassured by the extensive measures you have taken to remediate and strengthen your practice.

Mr Holborn submitted that in all the circumstances your fitness to practise is not impaired.

Decision and reasons on misconduct

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Meadow v General Medical Council* [2006] EWCA Civ 1390.

In reaching its decision on misconduct, the panel considered your oral evidence, that of the witnesses, the written testimonials, your written reflective pieces and the certificates of the training you have completed. Further, the panel considered the submissions of Mr Holborn and Mr Claydon.

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:

'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.

1.5 respect and uphold people's human rights.

5 Respect people's right to privacy and confidentiality.

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times.

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code.

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that the breaches of the Code were a serious departure from the standards expected of a registered nurse and concluded that each of the charges and sub charges found proved amounted to misconduct.

Decision and reasons on impairment

The panel went on to decide if as a result of the misconduct, your fitness to practise is currently impaired. The panel was aware that the NMC guidance as to whether a nurse's fitness to practise is impaired can be answered by considering whether the nurse can practice kindly, safely and professionally (NMC guidance on Impairment DMA-1).

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional conduct. 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 the trust in the profession of both patients and the public.

The panel first considered the context of the incident. It considered your oral evidence in which you stated that you had been subject to verbal, racial abuse from Patient A, and the oral evidence from Ms 1 who stated the following:

> *'In my opinion, Mary is a good nurse…'*

Further, the panel considered the oral evidence from Ms 2, who stated the following:

> *'When I started, Mary would do the things I asked of her. It seemed now, that she didn't want to be there. [PRIVATE]. She was not tolerating the people very well and she was losing her patience'.*

The panel considered seriously your oral evidence, in which you told the panel you had been frequently racially abused by Patient A on several previous occasions leading up to the incident. The panel also noted the comments by your colleagues as set out above. The panel considered that these matters formed the background to and were part of the context in which this incident occurred.

However, the panel also bore in mind that Patient A was living with dementia at the time of the incident. On balance, having considered all these matters, [PRIVATE], and setting that against the context of Patient A's dementia diagnosis and vulnerability, the panel concluded that these matters could not outweigh the seriousness of your actions. Further, the panel had regard to the fact that it had found that the charges found proved amounted to misconduct.

The panel went on to consider 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.'*

The panel next had regard to paragraph 76, where Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. has in the past and/or is liable in the future to be dishonest.'

The panel considered that limbs '*a'* to *'c'* were engaged. It determined that limb *'d'* was not engaged as the charges found proved were not related to dishonesty.

The panel considered the factors set out in the case of *Cohen* and considered whether your misconduct is such that it could be remedied. The panel took into account all of the evidence before it, including your oral evidence, your written reflective pieces in relation to the incident that occurred at the Home, the testimonials and the oral evidence of the witnesses. The panel also had regard to the submissions made by Mr Holborn and Mr Claydon, when determining whether you have addressed your misconduct.

The panel determined that Patient A was put at an unwarranted risk of harm as a result of your misconduct. It determined that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel concluded that confidence in the nursing profession would be undermined if a finding of impairment was not made.

In relation to insight, the panel considered that you have demonstrated some understanding of how your actions could have put Patient A at an unwarranted risk of serious harm, an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession.

However, the panel noted that you did not accept the charges until after the facts were found proved by the panel, when you apologised for your actions. The panel was of the view that you have only just started to demonstrate that you have insight and remorse into your actions. The panel determined that it was only in your oral evidence, given in respect of submissions at the misconduct and impairment stage, that you have begun to

demonstrate how you would handle the situation differently in the future. Furthermore, the panel determined that you had yet to develop comprehensive strategies to prevent such behaviour from reoccurring, should similar circumstances arise. The panel concluded that your present strategies centred around escalating or passing responsibility for situational management that belonged to a nurse to others, including junior colleagues.

In all the circumstances, the panel determined that this demonstrated that you have developing, but not yet sufficiently developed, insight into the seriousness of your misconduct.

The panel took into account that you have engaged with the NMC proceedings, and provided two written reflective pieces, and evidence of the additional, relevant training you have undertaken to strengthen your practise.

The panel noted that you have made attempts to strengthen your practice, however, given you have only recently accepted the matters which have led to the finding of misconduct, you cannot yet have been found to have reached a point in your journey towards remediation where the panel could be satisfied that there is no risk of repetition. Therefore, the panel is of the view that there is a risk of repetition of the charges found proved. Consequently, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required due to the risk of repetition of the charges found proved and the consequential risk of harm to patients/residents in your care. In addition, the panel concluded that public

confidence in the profession would be undermined if a finding of impairment was not made in this case in light of the seriousness of the charges found proved, and therefore the panel found that your fitness to practise is also impaired on the ground of the wider public interest.

Having regard to all of the above, the panel has determined that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of one year. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Your evidence on sanction

You gave evidence under oath.

You expressed your enthusiasm for returning to work in a field that you love, specifically nursing. Despite reaching out to several nursing homes and securing interviews, you faced challenges due to restrictions on your practice. This resulted in disappointments, but you said you remained hopeful about upcoming interviews through agencies. You said your goal is to demonstrate to the panel that you are a safe and capable nurse.

You emphasised the difficulty of the ongoing investigations into your practice and expressed distress about the situation. Acknowledging the past incident, you expressed

remorse and mentioned your unblemished record as a nurse over the years. Additionally, you expressed apologies towards the resident's family, and your colleagues for the events that transpired.

During cross-examination by Mr Claydon, you detailed your online and in-person courses, particularly focusing on topics like developing resilience and wellbeing. You discussed the assessments, study responsibilities, and decision-making processes in different nursing scenarios. You also outlined the learnings from courses related to resilience in challenging situations.

Regarding specific questions from the panel, you emphasised the importance of avoiding assumptions and highlighted your understanding of patients with dementia. Furthermore, you clarified your understanding of the impact of dementia on a person's ability to be responsible for their actions. You discussed your reflection on the significant impact of your actions on the resident within your care, demonstrated your deep regret, informed the panel that you had learned from this incident and stated that you would never engage in such behaviour again. Rather, that you would maintain your composure when confronted with challenging behaviour and would always make a resident's care, safety and needs your paramount priority as a nurse.

Submissions on sanction

Mr Claydon referred the panel to the NMC guidance on sanctions, emphasising that they should serve a purpose rather than solely be punitive. He invited the panel to view sanctions in an ascending order and submitted that any imposed sanction should be necessary to protect the public and satisfy the public interest. Mr Claydon addressed the panel on the aggravating and mitigating factors.

Mr Claydon said that in respect of the available sanctions, taking no action or imposing a caution order would not be appropriate due to the gravity of the misconduct and would not adequately safeguard the public or uphold the public interest.

Regarding a conditions of practice order, he submitted that the concerns are very serious and are compounded by clinical and attitudinal misconduct in the treatment of Patient A. While conditions of practice might suit purely clinical matters, he submitted that this order would be insufficient in this case, where both clinical and attitudinal concerns were present.

Mr Claydon suggested that a suspension order should be considered if the seriousness of the case warrants temporary removal from the NMC register. He highlighted the importance of ensuring no evidence of deep-seated harmful attitudes exists. Regarding a striking-off order, he left it to the panel to deliberate on whether a lesser sanction would be inadequate. He detailed the multifaceted nature of the incident, involving an altercation, observational failures, inappropriate comments, and improper instructions to staff. Given the gravity of the charges found proved, he submitted that a striking-off order might be the only suitable measure in this instance.

Mr Holborn submitted that the incident was an isolated and one-off situation. He submitted that you have expressed remorse and the awareness of the need to rectify the concerns at hand and that your 20-year tenure as a dedicated and well-regarded nurse demonstrates your commitment to patient care and wellbeing.

Considering the ongoing efforts to strengthen your practice, Mr Holborn submitted that punitive measures such as a suspension order or a striking-off order might not align with the progress already made. Mr Holborn also accepted that a caution order may not be appropriate at this stage.

Mr Holborn emphasised your passion for nursing and your dedication to your profession, suggesting that a conditions of practice order would be appropriate in allowing you to further strengthen your practice. He argued against a suspension order and striking-off order, citing their potential hindrance to your ongoing remedial journey and professional growth.

Reflecting on the mitigating factors, Mr Holborn highlighted your self-reflection, evident strides in remediation, and comprehensive understanding of the implications of your actions. He therefore invited the panel to impose a conditions of practice order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct that caused Patient A harm and put them at further risk of harm.
- Involved a resident made more vulnerable by the fact of their dementia.
- Acting as a poor role model for junior staff behaving in the way you did and instructing them to participate in misconduct.

The panel also took into account the following mitigating features:

- You have strongly expressed remorse.
- Demonstrated reflection and adequately developed insight through the regulatory process.
- You had experienced racial abuse by the resident which caused you to be frightened and act out of character.

The panel noted the substantial length of time that had elapsed since the prior impairment decision was made in October 2023. It carefully reviewed the subsequent evidence

demonstrating your dedication to remediation and deepening insight. The panel commended the notable shift from minimal remorse and understanding to a significantly heightened level of insight and genuine remorse.

The panel then went on to consider the appropriate sanction in this case.

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

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *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.*

In considering the panel's decision on impairment, the panel found some attitudinal issues but indicated that they were not deep-seated. The panel concluded that as your misconduct took place over a single shift, and was within the context of you experiencing repeated racial abuse, additionally when considering your present remorse and reflection, that there was no evidence of a longitudinal/deep-seated attitudinal concern.

The panel also identified specific aspects of your practice that could benefit from retraining. With targeted training, the panel was of the view that the outstanding concerns can be effectively addressed. Moreover, considering your lengthy career and the lack of evidence of general incompetence, the panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings in this case.

The panel considered your journey in enhancing insight and remediation through the regulatory process. The panel commended your use of support systems like 'buddy systems' offered by NMCwatch as a positive step towards actively engaging in your return to practice and enriching your understanding. Furthermore, the panel acknowledged your efforts to secure a nursing role while under an interim conditions of practice order as a testament to your commitment to re-entering the profession. Based on your demonstrated insight, remediation and dedication to the nursing profession, the panel determined that a conditions of practice order would satisfy the public interest and assist in successfully reintegrating a reformed nurse back into practice.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel considered a suspension order but was of the view that it was not the least restrictive option available to it. It also determined that as you had adequate insight, a period of suspension would serve no useful purpose and would not be required in terms of public interest. The panel therefore determined that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must work for a single substantive employer for the length of the conditions of practice order.
>
> 2. In-person participatory training to be undertaken in three areas:
>   - Care of patients or people living with dementia
>   - Managing incidents and injuries
>   - Conflict resolution training
>
> 3. Supervision notes from an employer which paid regard to your competency on these three areas of that training.

4. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

5. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

7. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.

c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for one year.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the next hearing.
- A testimonial from a current or recent employer.

Interim order

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

Submissions on interim order

Mr Claydon invited the panel to impose an interim order in the same terms as the substantive order and should be imposed for a period of 18 months on the basis that it is necessary for the protection of the public and otherwise in the public interest. He submitted that the interim order is to provide for the gap between the making of any

substantive order and closure of the statutory appeal window or any actual appear. Should no appeal be lodged, or an appeal be resolved, that interim order would fall away.

Mr Holborn raised no objections.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.