Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 11 March – Monday 18 March 2024

Virtual Hearing

Name of Registrant:	**Teresa Bacon**
NMC PIN:	08D0451E
Part(s) of the register:	Registered Nurse - Sub part 1 RNA: Adult nurse, level 1 (31 March 2008)
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	John Penhale (Chair, lay member) Pauline Esson (Registrant member) Robert Cawley (Lay member)
Legal Assessor:	Patricia Crossin
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Ms Bacon:	Not present and unrepresented at the hearing
Facts proved:	All charges
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Bacon was not in attendance and that the Notice of Hearing letter had been sent to Ms Bacon's registered email address by secure email on 8 February 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates, that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Bacon'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 Ms Bacon's 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 Ms Bacon

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

Ms Da Costa submitted that there had been no engagement at all by Ms Bacon with the NMC in relation to these proceedings despite multiple emails and phone calls and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Ms Bacon;
- Ms Bacon has not engaged with the NMC and has not responded to any of the emails and telephone calls to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses will attend on the first day to give oral evidence and five others are due to attend over the course of the next three days of the hearing;
- Not proceeding may inconvenience the witnesses, their employer and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- Given the nature of the allegations, there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Bacon in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered

address. She has made no response to the allegations. 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 Ms Bacon'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 Ms Bacon. The panel will draw no adverse inference from Ms Bacon's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On or around 28 April 2019:

    a. Did not respond in a timely manner when it was reported to you that Patient A was having breathing difficulties;

    b. Did not record in Patient A's notes your rationale for giving Patient A a nebuliser;

    c. Did not escalate Patient A's condition to a senior nurse or doctor before going on your break;

    d. Went on your break when you knew that Patient A was experiencing breathing difficulties.

2. On one or more dates in or around May 2019 recorded that you had administered Patient B's anti-coagulant medication when you had not.

3. Your conduct at charge 2 was dishonest in that you recorded that you had administered the medication when you knew that you had not in fact administered the medication to Patient B.

4. On one or more unknown dates in or around May 2019:

    a. Shouted at Patient B;
    b. Were rude to Patient B;
    c. Said to Patient B words to the effect of ‘tears don’t work for me Patient B’;
    d. Did not change Patient B’s dressings;
    e. Did not give Patient B her pain relieving medication when it was requested by Patient B.

5. On one or more unknown dates you acted unprofessionally in that you:

    a. Consumed food whilst in the ward area of the hospital;
    b. Discussed your private life with unknown patients;
    c. Asked an unknown patient to get a coffee for you;
    d. Shouted at an unknown patient words to the effect of ‘you will eat’.

6. On one or more unknown dates you consumed food that was provided by the hospital for patients on the ward.

7. Your conduct at charge 6 lacked integrity in that you consumed food that did not belong to you.

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

Application for Rule 32(2)

Ms Da Costa made an application for Rule 32(2) in respect of Patient B [PRIVATE].

Ms Da Costa submitted that Patient B is willing to give evidence over the telephone. [PRIVATE].

[PRIVATE].

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

[PRIVATE]. The panel determined that Patient B would be allowed to give evidence by telephone.

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

Ms Da Costa, on behalf of the Nursing Midwifery Council (NMC), made a request that part of this hearing be held in private on the basis that proper exploration of [PRIVATE]. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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(2) states that a hearing which relates solely to an allegation concerning Patient B's health must be conducted in private.

[PRIVATE].

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Da Costa to allow the written statement of Ms 1 dated 14 May 2022 into evidence without formal proof. However, she said that the NMC had made sufficient efforts to ensure that this witness was present.

Ms Da Costa submitted that the NMC were informed [PRIVATE]. She submitted that another witness, [PRIVATE]. Ms Da Costa referred the panel to the email dated 9 March 2024 in which Ms 1 stated:

[PRIVATE].

Ms Da Costa submitted that the NMC has taken reasonable steps to secure the attendance of Ms 1. Ms Da Costa referred the panel to the factors set out in *Thorneycroft v NMC* [2014] EWHC 1666 (Admin).

Ms Da Costa submitted that Ms 1's evidence is relevant, reliable and not sole or decisive. She submitted that Ms 1 has referred to matters that are referred to by other witnesses.

Ms Da Costa submitted that this does not impact the fairness in this case as Ms Bacon is not in a position to challenge Ms 1's evidence as she is not in attendance.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application and referred the panel to the Guidance in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1666 (Admin).

The panel noted there is no suggestion of fabrication or inconsistencies in the evidence of Ms 1. Although the panel noted that Ms 1's evidence is not sole or decisive and there is corroborating evidence from other witnesses. The panel considered that Ms 1 has a cogent reason for not attending.

The panel noted that Ms Bacon had been provided with a copy of Ms 1's statement in advance of the hearing and has raised no issues in respect of its contents. There were also public interest issues that needed to be explored in respect of the allegations. The panel reminded itself that it would determine the appropriate weight to place on the evidence in this statement in due course.

In these circumstances, the panel came to the view that the evidence of Ms 1 is relevant, and it would be fair to accept into evidence the written statement and exhibits of Ms 1.

Background

Ms Bacon was referred to the NMC on 1 May 2020 by a Divisional Director of Nursing for Medicine and Emergency Care, East Lancashire Hospitals NHS Trust. These regulatory concerns relate to incidents that took place whilst Ms Bacon was working as a Band 5 Nurse on the Digestive Diseases ward at Royal Blackburn Hospital, East Lancashire Hospitals NHS Trust ('the Trust').

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Bacon.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Matron for Digestive Disease Directorate and Specialist Services at East Lancashire Hospitals NHS Trust
- Witness 2: Band 6 Sister at Royal Blackburn Hospital
- Witness 3: Band 7 Nurse at Royal Blackburn Hospital

- Witness 4: Health Care Assistant at Royal Blackburn Hospital
- Witness 5: Health Care Assistant at Royal Blackburn Hospital
- Witness 6: Patient B

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

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

Charge 1a

1. On or around 28 April 2019:

    a. Did not respond in a timely manner when it was reported to you that Patient A was having breathing difficulties;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 4's witness statement which stated:

> *"[…] [Witness 5] then went to [Ms 1] for help getting the breathless patient from his chair into bed. Again, [Witness 5] went running back to Teresa for help. Again, Teresa was off-hand with [Witness 5]; she gave [Witness 5] the impression that she couldn't be bothered, and not to disturb her. [Ms 1] stayed with the man who was breathless, so me and [Witness 5] could attend to the*

other patient who'd had the accident. [Witness 5] and I were in the side room for about ten minutes assisting this patient – no longer than ten minutes."

The panel noted Ms 1's witness statement which stated:

"[Witness 5] went to find Teresa and Teresa mentioned she was carrying out a controlled drug and we had to wait. That specific shift wasn't any busier than usual. Teresa was asked more than once to come assist the patient as he was having difficulty breathing. Teresa did not seem interested to help. Teresa did briefly come over and placed a mask over the patient. At the point I wasn't in the bay as I attended another patient that pressed the buzzer."

The panel took into account the evidence that Ms Bacon did not respond in a timely manner when she was told that Patient A had breathing difficulties. The panel had sight of the multi-disciplinary progress notes ('care notes') for Patient A and noted there was no written record of Patient A's breathing difficulties or any action recorded in Ms Bacon's retrospective handwritten documentation at 13.25 on 28 April 2019.

The panel noted on the balance of probabilities, that Ms Bacon did not respond in a timely manner when it was reported to her that Patient A was having breathing difficulties.

This charge is therefore found proved.

Charge 1b

b. Did not record in Patient A's notes your rationale for giving Patient A a nebuliser;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted the evidence of Witness 3 and Witness 4 who stated that they had observed a nebuliser mask in place on Patient A's case. The panel took into account the care notes for Patient A dated between 26 and 28 April 2019. It noted that there is evidence that the rationale for giving Patient A a nebuliser was not recorded by Ms Bacon. This evidence was corroborated by Witness 3's oral evidence where she said that the application of a nebuliser was not recorded in the care notes for Patient A.

The panel noted that Ms Bacon did not offer an explanation when given the opportunity to do so when she was interviewed by Witness 1 as part of the Trust investigation.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1c

c. Did not escalate Patient A's condition to a senior nurse or doctor before going on your break;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 3's statement which stated:

> *"[PRIVATE]. I couldn't believe she had just gone to break. It was a completely incorrect action to take. If the patient was in my care, I would have been checking their observations and staying with them to monitor their breathing; I would have called a doctor. I'm not sure if Theresa asked the HCA to monitor while she was on break. I would have told my HCA I was going on my break, and if there were any changes, to come and get me. She should have done that. By leaving them with the nebuliser and going to break, [PRIVATE] – it was that serious."*

The panel took into account that there was no evidence to suggest that Ms Bacon had attempted to escalate Patient A's condition to a senior nurse or doctor prior to taking her break. The panel noted that no escalation was recorded in the care notes.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1d

d. Went on your break when you knew that Patient A was experiencing breathing difficulties.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 3's statement which stated:

> *"I don't recall the shift on 24 April 2019 being busier than usual – it was a busy shift anyway. I would have started my day shift at about 7:30am if it was a full day (we generally work 12 hour shifts). Around lunch time, I recall that Teresa had gone on her break. I was doing my day to day job when one of the HCAs informed me that one of Teresa's patients was feeling unwell and Teresa had given the patient a nebuliser. This was standard procedure, but it was not standard procedure to go on your break while a patient was having difficulty breathing."*

Witnesses 3, 4 and 5 confirmed in their oral evidence that it would have been expected that a nurse should prioritise patients with breathing difficulties and that Ms Bacon took her break in the knowledge that Patient A was experiencing breathing difficulties. The panel noted that Ms Bacon had to be called from her break when it was discovered that Patient A was not breathing.

The panel noted the consistency in the evidence of witnesses in relation to this allegation.

The panel determined that Ms Bacon went on her break when she knew that Patient A was experiencing breathing difficulties.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2

2. On one or more dates in or around May 2019 recorded that you had administered Patient B's anti-coagulant medication when you had not.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel heard telephone evidence from Patient B and found their evidence to be clear and consistent. Patient B gave evidence that they were as *"sure"* as they could be, even though the events took place five years ago. The panel also took into account that Patient B accepted that they did not like Ms Bacon, but this was due to the care that they received from her during their long stays in Hospital. However, in cross examination Patient B confirmed that their dislike of Ms Bacon had not influenced their memory or the truthful account of the incidents they gave in written and oral evidence. [PRIVATE].

The panel noted Patient B's letter dated 31 May 2019 which stated:

> *"On several times a day, [PRIVATE]. This has happened several times, not only to me, but to other patients as well."*

The panel noted that Patient B's letter is consistent with their witness statement and oral evidence. The panel noted that Patient B was firm in their evidence [PRIVATE].

The panel noted the evidence of Witness 2 that Ms Bacon approached them and indicated that Patient B was raising an issue as regard the failure to [PRIVATE]. Ms Bacon told Witness 2 that she had administered the injection. The panel also noted the Drug Chart recorded Ms Bacon having signed [PRIVATE].

However, the panel preferred Patient B's evidence. It found their evidence to be cogent with a clear recall of the incident. In preferring this evidence, the panel noted Patient B's letter of 31 May 2019 which provided a contemporaneous account of what happened and was consistent with their written and oral evidence provided to the panel.

The panel therefore found this charge proved on the balance of probabilities.

Charge 3

3. Your conduct at charge 2 was dishonest in that you recorded that you had administered the medication when you knew that you had not in fact administered the medication to Patient B.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel took into account parts of Witness 2's written statement:

> *"The incident I was involved in in May 2019 concerned Patient B making an allegation that Theresa had not given her an injection she was due. At the time of the incident I was in the 10 bed bay at bottom, looking after the male patients. It was a late shift, later in the day at roughly tea time. Teresa came done and said Patient B had accused her of not giving her the injection while she was asleep. Teresa said she had given Patient B the injection and did not say that Patient B was asleep at the time. I said to Teresa that I would go to*

that bay and see to Patient B. I asked Teresa to document everything Patient B had said to her."

[PRIVATE]. Patient B was well-informed as to their medication needs and their evidence was clear and consistent. The panel noted the evidence from Witness 2 was consistent with the evidence from Patient B.

The panel noted the evidence that Ms Bacon knew Patient B well and was familiar with her treatment, [PRIVATE]. Ms Bacon, as an experienced nurse on this high-dependency ward, would have been aware of the importance of administering anti-coagulation medication.

The panel found that Ms Bacon had not administered Patient B's anti-coagulation medication and accepted Patient B's consistent evidence on this allegation. Ms Bacon would have been aware of her duty to do so and the risk to Patient B. Therefore, in not administering the medication and falsely recording she had done so, she would have been well aware that her behaviour was dishonest.

The panel considered that in these circumstances, this was dishonest behaviour, and would be viewed as dishonest by ordinary decent people.

The panel therefore found this charge proved on the balance of probabilities.

Charges 4a and 4b

a. Shouted at Patient B;
b. Were rude to Patient B;

These charges are found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Patient B's witness statement where they stated:

"Teresa would frequently shout at me for no reason. There were other times when she was fine and then she would just turn. [PRIVATE] there was no reason to be mean and rude."

It also noted parts of their letter dated 31 May 2019 where Patient B stated:

"I have been on Ward C2 since 17th May 2019. I have been treated by staff nurse Theresa several times. Each time I feel like I have been patronised, shouted at, ignored…she humiliates patients.
…
She is rude and unprofessional. [PRIVATE]."

The panel noted that Patient B wrote the letter dated 31 May 2019 in closer to the time when the event took place. The panel further took into account Patient B's evidence that Ms Bacon frequently shouted at them, and that Patient B considered Ms Bacon to be rude.

The panel therefore found this charge proved on the balance of probabilities.

Charge 4c

c. Said to Patient B words to the effect of 'tears don't work for me Patient B';

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Patient B's letter dated 31 May 2019 where she stated:

[PRIVATE].

The panel noted that Patient B's oral evidence was consistent with their letter and witness statement and that they were open and honest about disliking Ms Bacon. The panel noted its previous findings that Patient B's dislike of Ms Bacon did not influence their memory of events and the truthfulness of the evidence. The panel therefore accepted their evidence on this allegation.

The panel therefore found this charge proved on the balance of probabilities.

Charge 4d

d. Did not change Patient B's dressings;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Patient B's letter dated 31 May 2019 where they stated:

> *"This nurse came on the night shift [PRIVATE]. I asked Teresa to change the dressing earlier in the shift but she said she was too busy. I was asking her to change it for over six hours until the night nurse came on. The nurse changed my dressings and then talked to Teresa and told her she couldn't keep neglecting me…Over the several days that Teresa was my nurse she never changed my dressings and it was always the night nurses who had to change it as Teresa refused to. [PRIVATE] I was fully reliant on Teresa during the shifts she was my nurse."*

It also took into account parts of Witness 1's statement where she said:

> *"In this case Ms Bacon perceived Patient B as being aggressive towards [them] and just didn't change the dressing…Ms Bacon stated that [they] had apologies to Patient B when has not been able to get [them] to change the dressing."* [sic]

The panel noted that Witness 1's statement and oral evidence were consistent as regard to the allegation of the dressing not being changed by Ms Bacon. Patient B in their oral evidence was very clear in describing what the dressing was for, where it was located and how it felt when it was not changed. Patient B gave evidence to the panel that a nurse on another shift had to change the dressing.

The panel therefore found this charge proved on the balance of probabilities.

Charge 4e

e. Did not give Patient B her pain relieving medication when it was requested by Patient B.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Patient B's witness statement which stated:

> *"For the pain medication she needed a second person to sign for it for her to give it to me but she would just go and say that she was busy and didn't get the second person for a long time. [PRIVATE] and I would constantly be asking her for my medication."*

The panel noted Patient B's oral evidence that they would often have to remind Ms Bacon to administer their pain relief medication and that someone else would have to get the medication for them. The panel noted that their oral evidence was consistent with their witness statement.

The panel therefore found this charge proved on the balance of probabilities.

Charge 5a

5. On one or more unknown dates you acted unprofessionally in that you:

    a. Consumed food whilst in the ward area of the hospital;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Patient B's witness statement which stated:

> *"But I saw her just standing in the corner a lot eating and drinking. She never seemed busy. I know other nurses complained that Teresa wasn't doing any work and was just sitting at the nurse's station."*

The panel noted that Patient B's evidence as regard to this allegation, was supported by the evidence from the witnesses who confirmed that Ms Bacon was often seen consuming food in the ward area whilst on shift.

The panel therefore found this charge proved on the balance of probabilities.

Charge 5b

    b. Discussed your private life with unknown patients;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 5's statement where she stated:

> *"Teresa would also spend a lot of time in the middle bay which consisted of [PRIVATE]. I believe her manner was overly friendly towards these patients.*

While I never heard her say anything of a sexual nature, Teresa would speak about her private life with the male patients, and I felt like it was crossing a professional boundary."

It also noted Witness 4's witness statement where she stated:

"On a professional level I often felt like I couldn't approach Teresa, like she was too busy and didn't want to know. On a personal level, she did try to get on with the staff sometimes. [PRIVATE]. She would tell this to patients as well, which was quite inappropriate – especially considering some patients on the ward [PRIVATE]. She would try to be overly friendly with patients and their families sometimes, and tell them she'd been rushed off her feet all day."

The panel noted that there was consistent evidence in relation to Ms Bacon sharing her private life with patients. The panel determined, as a result of Witness 4 and 5's evidence, that Ms Bacon shared with patients' personal information which was both inappropriate and unprofessional.

The panel therefore found this charge proved on the balance of probabilities.

Charge 5c

c. Asked an unknown patient to get a coffee for you;

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 5.

The panel noted Witness 5's statement where she stated:

"I have also witnessed Teresa asking a patient to go and fetch her a costa coffee while she was on shift. I did not witness any exchange of money. This is not how I expect a Registered Nurse to behave. It was just Teresa,

everyone knew what she was like [PRIVATE] but she was very vocal when asking for it and she was not discreet. This was very unprofessional."

Witness 5 confirmed in her oral evidence that Ms Bacon would regularly *"drink Costas"* and would ask patients to get her coffee. The panel noted Witness 5 in her oral evidence also said that it was known the Hospital policy was not to ask for anything from patients. She further gave evidence that staff were there to care for patients and not the other way round. She told the panel that no other nurse would do this. The panel found this evidence convincing that this aspect of Ms Bacon's behaviour was unprofessional.

The panel therefore found this charge proved on the balance of probabilities.

Charge 5d

d. Shouted at an unknown patient words to the effect of 'you will eat'.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 5's statement where she stated:

"On another shift, [PRIVATE]. This patient had been on the ward for a while. [PRIVATE]. Teresa approached the bed and shouted "You will eat" in front of everyone in the bay. [PRIVATE]. I think an Incident report form was done by the Nurse in Charge, but I can't remember if it was [Ms 2] or [Witness 6]. At that time they didn't encourage HCAs to fill out the incident forms, it was more for a Nurse. If something like that happened now I would fill out an incident form."

The panel noted that Witness 5's evidence was helpful in understanding the context of this alleged incident. The panel heard evidence that [PRIVATE]. Witness 5 also said that Ms Bacon was pressuring the patient to eat [PRIVATE].

As noted above, the panel found Witness 5's evidence to be convincing.

On each of these occasions as set out at charge 5a-d, the panel found that Ms Bacon's behaviour was unprofessional. The panel noted that as a registered nurse, there is a duty to act professionally. The panel concluded that Ms Bacon's behaviour [PRIVATE], that she was inappropriate with her behaviour and language and potentially put patients at risk of harm.

The panel therefore found this charge proved on the balance of probabilities.

Charge 6

6. On one or more unknown dates you consumed food that was provided by the hospital for patients on the ward.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted Witness 5's witness statement in which she stated:

> *"Teresa would also regularly take food from the patient trays and eat it herself. She would always have pockets full of food. I have seen her look for her keys in her pockets, and take out all the patient food she has stored in them before finding her keys. Teresa would rarely help give out patient trays for meal times. I recall instances where Teresa would act like she was helping us with the trays to access cakes off of them.*

On one occasion, we were just about to give out the food trays to the patients as it was dinner time. I started to serve the first bay to start off, which Teresa was working on. She helped to serve the trays too. I recall pulling out the food tray for bed sixteen. The food was definitely there. I continued serving the trays to the bays, and when I got around to giving bed sixteen their tray, their pudding had disappeared. The only other person who was there was Teresa. When I moved on to serve the next bay, Teresa stopped helping me serve the food. I found this strange. Soon after the cake disappeared, I saw Teresa eating a cake across from the Nurse's station. I went straight to the medication room to speak to [Witness 2] about what had happened. Later, [Witness 2] pulled me to the side and said she had spoken to Teresa. Teresa told [Witness 2] she hadn't eaten anything.

It's policy that staff have to supply their own lunch. Patients are served lunch daily and fill in a menu each day to select their choice. One meal is allocated per patient, so there are no more than 24 meals served. Occasionally there might be spare food when a patient is discharged, but its policy that we aren't to eat patient food. Despite this, Teresa would regularly do so."

It also noted Ms 1's witness statement which stated:

"There were numerous occasions where I had witnessed Teresa eating food off the trolley. All the patients were given their meals first and whatever was left on the trolley, Teresa would eat. I don't recall any complaints from patients.

The policy is that staff should not touch or eat any food off the trolley as this was for the patients. There was a 'no food on ward' rule however I witnessed Teresa eating on the ward on numerous occasions. Staff could bring their own food in or purchase food from the canteen. However any food needed to be consumed in the staff room or within the canteen."

The panel noted that Witness 5's evidence was consistent with the evidence from Ms 1. The panel accepted her evidence that staff would often consume left over food

from the trolley after patients had been fed. Witness 5 in her oral evidence said that food would only go missing when Ms Bacon was there and explained that she had caught her once eating the exact cake that had gone missing from one of the patient's meal trays. She told the panel that no nurse would take food from patients prior to them eating as that would have the effect of them missing out.

The panel therefore found this charge proved on the balance of probabilities.

Charge 7

7. Your conduct at charge 6 lacked integrity in that you consumed food that did not belong to you.

This charge is found proved.

In reaching this decision, the panel took into account all of the oral evidence, written statements and documentary exhibits.

The panel noted its findings at charge 6. The panel considered that Ms Bacon's consuming of food, which was provided for patients, evidenced unethical behaviour and demonstrated a lack of integrity.

The panel found that Ms Bacon's behaviour was deliberate in that she would pretend to serve patients' meals with the intention of removing food for her own consumption. The panel also found Ms Bacon consumed food intended for patients who may have had specific dietary requirements. Her actions amounted to a lack of integrity and is not the behaviour expected of a registered nurse.

The panel therefore found this charge proved on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so,

whether Ms Bacon's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct.

Ms Da Costa identified the standards she submitted were relevant to where Ms Bacon's actions amounted to misconduct. She referred the panel to parts of the Code, specifically sections 1, 2, 3, 4, 8, 10, 16, 17, 19 and 20.

Ms Da Costa submitted that Ms Bacon's conduct fell far short of the Code and what would have been expected of a registered nurse.

Submissions on impairment

Ms Da Costa moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included

reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Da Costa submitted that Ms Bacon is currently impaired due to her failings having involved a serious departure from the standards expected of a registered nurse. She submitted that Ms Bacon is likely to cause a risk of harm to patients in the future. Ms Da Costa submitted that there is nothing put before the panel to indicate that there has been any insight or remediation into her conduct.

Ms Da Costa submitted that a number of the charges relate to an attitudinal issue that is not easily remediable and difficult to put right. She submitted that Ms Bacon has not addressed these issues. Ms Da Costa submitted that all four limbs of the Grant test are engaged, and that Ms Bacon is impaired on both public protection and public interest grounds.

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, Dey v GMC 2001 UKPC 44 and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel had regard to the terms of ''The Code: Professional standards of practice and behaviour for nurses and midwives (2018' (the Code) in making its decision.

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 Ms Bacon's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Bacon's actions amounted to a breach of the 2018 Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
>
> ***4 Act in the best interests of people at all times***
> *4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*
>
> ***8 Work co-operatively***
> *8.2 maintain effective communication with colleagues*
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

15 Always offer help if an emergency arises in your practice setting or anywhere else
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly
16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.3 keep to and promote recommended practice in relation to controlling and preventing infection
19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
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.

In taking all of the sub charges in charge 1 together, the panel determined that in taking a break during a period [PRIVATE], Ms Bacon's actions constituted misconduct. The panel took into account that Ms Bacon did not respond to the request in a timely manner to attend Patient A who had breathing difficulties, failed to escalate or identify the issues and document them in the care notes appropriately, in circumstances where a patient died. The panel determined that there were serious failings on Ms Bacon's part and that charge 1 in its entirety amounted to misconduct.

In respect of charges 2 and 3, the panel took into account that Ms Bacon knowingly did not give the medication to Patient B and signed the drug chart that she had. The panel noted that Ms Bacon was dishonest in that she falsified the record. The panel also noted that Ms Bacon put Patient B at risk of harm by not administering their medication. The panel determined that there were serious failings on Ms Bacon's part and that charges 2 and 3 amounted to misconduct.

The panel determined that the failings it had found in charge 4 constituted serious attitudinal concerns arising from Ms Bacon's practise. Ms Bacon was not doing what was expected of a registered nurse by treating patients without care and compassion. Ms Bacon did not administer the required treatment to Patient B; did not administer pain relief and did not change dressings when there was a clinical

need to do so. The panel determined that these were serious failings on Ms Bacon's part and that the entirety of charge 4 amounted to misconduct.

In respect of charge 5, the panel took into account that it had found that Ms Bacon repeatedly acted in an unprofessional manner in the period covered by the charges. The panel considered that any nurse would find Ms Bacon's behaviour deplorable. The panel determined that there were serious failings in Ms Bacon's behaviour and dealings with patients. The panel considered that individually, each of the sub charges might not amount to misconduct. However, the panel determined that when taken together, charge 5 amounted to misconduct.

In respect of charges 6 and 7, the panel took into account that Ms Bacon lacked care and compassion towards patients as she had acted selfishly, with a lack of integrity and without due regard of the care of her patients. The panel noted that Ms Bacon could have caused harm to patients due to them potentially not receiving the proper nutrition. The panel determined that charges 6 and 7 amounted to misconduct.

The panel found that Ms Bacon's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

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

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Ms Bacon's misconduct. Ms Bacon's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession

would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel was of the view that Ms Bacon failed to address the impact of her actions on patients, colleagues, the wider profession or the public as a whole. The panel therefore determined that Ms Bacon had demonstrated no insight. The panel had no information before it to assist it in understanding whether Ms Bacon had strengthened her practice or developed her insight during the intervening period.

The panel bore in mind that dishonesty is often more difficult to remediate than clinical concerns. The panel took into account the Ms Bacon had serious attitudinal issues. The panel did not have any evidence before it that Ms Bacon has taken steps to strengthen her practice. The panel could not be satisfied, in the absence of any evidence, that Ms Bacon understands and appreciates the seriousness of her failings and her dishonesty.

Therefore, in having regard to the above, the panel considered there to be insufficient evidence to demonstrate that Ms Bacon had remediated her misconduct. The panel took into account that Ms Bacon showed a lack of integrity and breached the fundamental tenants expected of a registered nurse. The panel considered there to be a risk of repetition of Ms Bacon's dishonesty and a risk of unwarranted harm to patients in her care, should adequate safeguards not be imposed on her nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious and includes dishonesty. It was of the view that a fully informed member of the public would be concerned by

its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Therefore, in having regard to all of the above, the panel was satisfied that Ms Bacon's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

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

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

Submissions on sanction

Ms Da Costa informed the panel that in the Notice of Hearing, dated 8 February 2024, the NMC had advised Ms Bacon that it would seek the imposition of a striking off order if it found Ms Bacon's fitness to practise currently impaired. She submitted that a sanction should be proportionate and is not designed to have a punitive effect. She submitted that it should protect the public, maintain public confidence in the profession and declare and uphold proper standards of conduct and performance.

Ms Da Costa identified what she considered to be the aggravating features in this case which includes dishonesty, clinical and conduct concerns and a lack of insight.

Ms Da Costa took the panel through the sanctions available to it. She submitted that given the circumstances of this case, and taking into account the SG, it should lead to a finding that a striking off order is the only appropriate sanction.

Ms Da Costa submitted that the facts show a failure to treat patients in a kind, caring and compassionate manner which resulted in direct harm. She submitted that Patient B, who was a vulnerable patient with a number of health conditions, has stated they do not feel comfortable being treated in a hospital anymore. Ms Da Costa submitted that Ms Bacon has shown attitudinal concerns towards patients during her shifts.

Ms Da Costa further submitted that Ms Bacon has not taken any steps to strengthen her practice and that there is a high risk of repetition. She submitted that Ms Bacon's actions raise fundamental concerns surrounding her professionalism and the treatment of vulnerable patients.

In closing, she submitted that a striking off order would ensure that confidence and trust in the profession is maintained and would mark the profound seriousness of the behaviour in this case.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings

- Continued pattern of misconduct over several weeks
- Conduct which patients at actual physical harm
- Dishonesty
- Clinical and conduct concerns
- Other patients were put at risk of harm
- Lack of engagement

The panel found no mitigating features. The panel noted that Ms Bacon reported [PRIVATE]. However, no evidence was presented to the panel in support of this.

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 Ms Bacon's 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 Ms Bacon's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Bacon's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the panel's findings. Key aspects of the misconduct identified in this case (namely attitudinal concerns and dishonesty) were not something that can be easily addressed through retraining alone or through supervision of her practise. Furthermore, the panel concluded that the placing of

conditions on Ms Bacon's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel's findings evidenced a series of concerns that were not one off in nature. The panel found evidence of deep-seated attitudinal problems. The panel found no evidence of insight by Ms Bacon into her unprofessional behaviour and found her actions were uncaring and lacked compassion. In addition, the panel found Ms Bacon's actions caused harm to patients and put patients at risk of harm. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Bacon's actions is fundamentally incompatible with Ms Bacon remaining on the register without restriction.

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

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

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

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

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel found Ms Bacon's actions deplorable, caused actual harm and that the behaviour seriously undermined public confidence in the profession. The panel determined that the appropriate and proportionate sanction is that of a striking-off order. The panel weighed the public interest consideration against the effect of the order would have on Ms Bacon. The panel considered that the public interest outweighs Ms Bacon's interest in this matter. Having regard to the effect of Ms Bacon's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

This will be confirmed to Ms Bacon in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, or after any appeal that has been lodged has concluded, 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 is in Ms Bacon's own interests until the striking-off sanction takes effect.

Submissions on interim order

Ms Da Costa submitted that an interim suspension order for 18 months was necessary to protect the public and was otherwise in the public interest until any appeal that may be lodged has concluded.

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

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 reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and uphold the public interest. It determined that an 18-month period was necessary to allow sufficient time for any appeal that may be lodged to conclude.

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

That concludes this determination.