Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Wednesday, 20 March 2024 – Wednesday, 27 March 2024

Virtual Hearing

Name of Registrant:	Deborah Jayne Cank
NMC PIN	87Y2448E
Part(s) of the register:	RN3: Mental health nurse, level 1 (08 April 1999) RN4: Mental health nurse, level 2 (01 November 1989)
Relevant Location:	Wigan Metropolitan
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Tracey Chamberlain (Registrant member) Susan Laycock (Lay member)
Legal Assessor:	Joseph Magee (20-22 March 2024) Nicholas Baldock (25-27 March 2024)
Hearings Coordinator:	Taymika Brandy
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter
Miss Cank:	Not present and unrepresented (Special Counsel Mary-Teresa Deignan, instructed by the NMC on Miss Cank's behalf, in attendance on 21 March 2024 for the Ground Rules hearing only)
Offer of no evidence:	Charges 4),5),6),7),8),9) and 10)
Facts proved:	Charges 1) 2) and 3) (in their entirety) and

Charges 11), 12) and 13)

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Cank was not in attendance. Mr Kewley, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the customer receipt, confirming that the Notice of Hearing letter had been sent to Miss Cank's registered address by recorded delivery and by first class post on 12 February 2024.

In addition, Mr Kewley referred the panel to screenshot of the Royal Mail 'online Track and trace' service which states '*we're unable to confirm the status of your item'*. Mr Kewley explained that the status of this item remains unavailable to date. However, he submitted that the Rules do not require confirmation of delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Mr Kewley explained that in a telephone call of 13 October 2020, Miss Cank had said that she was having difficulty opening documents sent to her via the Egres system and had asked for paperwork to be sent to her registered postal address instead.

For these reasons, Mr Kewley submitted that the NMC 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 had regard to the screenshot of the Royal Mail 'online Track and trace' service, and the customer receipt confirming that the Notice of Hearing letter had been sent to Miss Cank's registered address by recorded delivery and by first class post on 12 February 2024. The panel noted whilst the delivery status of the Notice of Hearing remains unavailable, it bore in mind that the Rules do not require confirmation of delivery, and that

it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

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

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

Decision and reasons on proceeding in the absence of Miss Cank

The panel next considered whether it should proceed in the absence of Miss Cank. It had regard to Rule 21 and heard the submissions of Mr Kewley who invited the panel to continue in the absence of Miss Cank. He submitted that Miss Cank has voluntarily absented herself.

Mr Kewley submitted that there has been limited engagement from Mrs Cank with these NMC proceedings and referred the panel to the following attempts made by an NMC Case Officer to contact Miss Cank, prior to this hearing (as contained in the bundle):

- An email dated 1 April 2020. This email was to explain that calls made to Miss Cank's registered telephone numbers regarding the initial NMC referral were unsuccessful and to get in contact with her NMC Case Officer as a matter of urgency;

- An email dated 1 April 2020. This email acknowledged that Miss Cank had responded from her registered email address and it confirmed that another

unsuccessful call had been made to her registered telephone number;

- A telephone call noted dated 13 October 2020, which confirmed the call was successful. It records that Miss Cank confirmed her registered address that the NMC held was correct and expressed her feelings towards the proceedings and the nature of the referral;

- A telephone noted dated 7 December 2023, which confirmed the call was successful, however, that the call disconnected after the NMC Case Officer introduced themself; and

- Further emails dated 29 November 2023, 5 December 2023, 4 March, 2024 and 8 March 2024. Regarding the schedule of this hearing, the relevant documentation, to confirm Miss Cank's attendance and receipt of the documentation served for this hearing.

In addition, Mr Kewley explained that final attempts were made by the NMC Case Officer to contact Miss Cank on 19 March 2024 via her registered telephone number on three occasions. The telephone call notes confirm that the calls made were unsuccessful.

Mr Kewley submitted that Miss Cank has not engaged with the NMC since 2020. He submitted that Miss Cank has made no application for an adjournment and there is no reason to suppose that adjourning would secure her attendance at some future date.

Further, Mr Kewley submitted that two witnesses are due to attend to give oral evidence in this hearing, one of which is considered a vulnerable witness. He submitted that not proceeding may inconvenience the witnesses and their employer. Finally, he submitted that there is a strong public interest in the expeditious disposal of the case and outlined the steps that can be taken to mitigate the disadvantages to Miss Cank non-attendance at this hearing.

Mr Kewley invited the panel to proceed in the absence of Miss Cank for the reasons set out above.

The panel accepted the advice of the legal assessor which included reference to the cases of *R v Jones* [2002] UKHL 5, *General Medical Council v Adeogba* [2016] EWCA Civ 162 and *NMC v Visvardis* [2016] EWCA Civ 162.

The panel has decided to proceed in the absence of Miss Cank. In reaching this decision, the panel has considered the submissions of Mr Kewley and the advice of the legal assessor. It has had regard to the factors set out in the decision of *R v Jones, Adeogba,* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Miss Cank has voluntarily absented herself;
- The Notice of Hearing had been sent to the same registered email that Miss Cank had sent an email from on 1 April 2020 and, also to her registered address. Miss Cank has a duty to notify the NMC of any changes to her contact details.
- No application for an adjournment has been made by Miss Cank;
- Miss Cank has not engaged with the NMC since 2020 and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are due to attend to give live evidence; and not proceeding may inconvenience the witnesses and their employer(s);
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- The allegations in the case are serious; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Cank in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, 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 Miss Cank's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kewley, to amend the wording of charge 10.

The proposed amendment was to correct an administrative error in the charge regarding what Miss Cank is alleged to have stated. Mr Kewley submitted that the proposed amendment would accurately reflect the evidence in this case. He further submitted that the proposed amendment would not change the nature of the misconduct alleged or result in any injustice or unfairness to Miss Cank.

Proposed amendment

10) On 17 October 2019, in response to Colleague B attempting to explain why she had raised her voice to a resident, put your hand in front of Colleague B's face and told her to ~~be quiet~~ ***get out*** *or said words to that effect.*

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

The panel took into account Mr Kewley's submissions, noting that the NMC witness statement of Colleague B makes reference to the wording as set out above, in the proposed amendment. The panel was satisfied that there would be no prejudice to Miss Cank and no injustice would be caused to either party by the proposed amendment being allowed. Further, that this amendment would properly reflect the evidence in this case. It therefore granted the application to amend the charge as applied for.

Details of charge (as amended):

That you, a registered nurse, whilst employed by Lakeside Nursing and Residential Home as the home manager,

1) Failed to send to the CQC:

    a) Statutory notifications for 15 resident deaths from September - December 2019.
    b) An action plan required to be submitted in December 2019**. [PROVED IN ITS ENTIRETY]**

2) In February 2020, told Colleague A that you had sent statutory notifications in respect of one or more of the resident deaths referred to at charge 1 to:

a) The CQC
b) The local authority. **[PROVED IN ITS ENTIRETY]**

3) Your conduct at charge 2 was dishonest in that you knew you had not sent the statutory notifications in respect of one or more of the resident deaths referred to at charge 1 to:

a) The CQC and
b) The local authority. **[PROVED IN ITS ENTIRETY]**

4) On 4 October 2019, in relation to Resident B:

a) Gave the wrong insulin. **[NO EVIDENCE OFFERED]**
b) Failed to record the administration of the wrong insulin. **[NO EVIDENCE OFFERED]**

5) With regard to the medication error at charge 4, told Colleague B on one or more occasions:

a) To 'keep her mouth shut and not say anything' or said words to that effect. **[NO EVIDENCE OFFERED]**
b) Instructed Colleague B to take Resident B's blood measurement (BM) but not record it. **[NO EVIDENCE OFFERED]**

6) Your conduct at charge 4b) was dishonest in that you were intentionally seeking to cover up the medication error you made. **[NO EVIDENCE OFFERED]**

7) Your conduct at charge 5a) and 5b) lacked integrity in that you were attempting to influence Colleague B to assist you in covering up the medication error you had made. **[NO EVIDENCE OFFERED]**

8) On 17 October 2019, alleged that Colleague B caused a bruise to Resident C.

[NO EVIDENCE OFFERED]

9) Your conduct at charge 8 were -

a) Dishonest in that you knew that Resident C had been bruised before Colleague B came on shift, or in the alternative;

[NO EVIDENCE OFFERED]

b) Lacked integrity in that you did not consult Resident C's care records to ascertain when the bruise had first been noted prior to accusing Colleague B of having caused it.

[NO EVIDENCE OFFERED]

10) On 17 October 2019, in response to Colleague B attempting to explain why she had raised her voice to a resident, put your hand in front of Colleague B's face and told her to get out or said words to that effect.

[NO EVIDENCE OFFERED]

11) On 8 November 2019, when Colleague C raised a safeguarding concern, failed to document and / or investigate this. **[PROVED]**

12) On or around 9 November 2019, told Colleague C that he was a "*shit stirrer*" for raising the safeguarding concern referred to at charge 11 or said words to that effect. **[PROVED]**

13) Your conduct at charge 12 was intended to bully and / or intimidate Colleague C for having reported a safeguarding concern. **[PROVED]**

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

Background

Miss Cank joined the NMC Register in 1989. The NMC received a referral on 19 February 2020, from a former colleague at Lakeside Nursing Home ('the Home'), part of Millennium Care UK.

At the time the alleged concerns arose, Miss Cank was employed as the Registered Home Manager at the Home. It is alleged that various concerns arose between October 2019 – February 2020, including a failure to fulfil her legal requirement as Registered Manager, to notify the Care Quality Commission ('CQC') and the relevant authorities of residents deaths at the Home. It is further alleged that Miss Cank acted dishonestly, had not investigated safeguarding concerns raised by a member of staff, and that she had bullied and/or intimidated colleagues at the Home. Furthermore, it is alleged that Miss Cank made a medication error, which she failed to record and also attempted to influence a colleague to cover it up.

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

During the course of the preliminary applications, Mr Kewley made an application that parts of the case be held in private due to reference made to [PRIVATE]. The application was made pursuant to Rule 19 of the '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(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, third-party or by the public interest.

Having heard there will be reference made to [PRIVATE] in this case, the panel determined to into private session, as and when such issues are raised in order to protect their right to privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Kewley, pursuant to Rule 31 to admit the witness statements and exhibited documents of Colleague B and Colleague D.

In respect of Colleague D, Mr Kewley explained that at the material time, she was employed as the Clinical Lead at the Home. He explained that her evidence consists of one witness statement and documentation exhibited therein.

Mr Kewley outlined the correspondence between Colleague D and the NMC. He explained that following the NMC sending Colleague D a formal Notice of this hearing on 20 February 2024, confirming the dates which Colleague D was required to give evidence, the NMC received a telephone call from Colleague D's relative stating [PRIVATE].

Mr Kewley submitted that Colleague D's evidence is relevant to charge 1) a) and that it is fair to admit her hearsay material into evidence. Further, he submitted that her witness statement created for the purpose of this hearing, was signed and included a declaration of truth.

Mr Kewley submitted that there is other evidence before the panel that it can use to test the reliability of Colleague D's witness statement, namely, the documentary evidence she exhibits and the evidence of Colleague A. He also submitted that there does not appear to be any history of animosity between Colleague D and Miss Cank and therefore, nothing to suggest that she would fabricate the allegations against Miss Cank. He accepted that Miss

Cank will be unable to cross examine the witness. However, in all the circumstances, he submitted that admitting this hearsay material into evidence would not result in any real unfairness to Miss Cank.

In respect of Colleague B, Mr Kewley explained that her evidence consists of one witness statement and a supplementary witness statement. He explained that [PRIVATE].

In addition, Mr Kewley explained that an NMC Public Support Officer ('PSO') had contacted Colleague B via telephone and Colleague B had advised that [PRIVATE].

Mr Kewley accepted that Colleague B's hearsay material is the sole evidence in respect of charges 4), 5), 6), 7) and 10). However, he submitted that it is important evidence and without it, the NMC would be unable to proceed with a number of charges. He submitted that Colleague B has a good and cogent reason for not attending the hearing to give evidence. Further, he invited the panel to take into account the contemporaneous nature of Colleague B's handwritten notes in respect of charge 4) and submitted that the panel are able to test Colleague B's evidence, using the account of other witnesses in this case. He submitted that the panel can attach what weight it deems appropriate to Colleague B evidence, in its later considerations.

Mr Kewley submitted that whilst Miss Cank has not made a substantive response to the allegations, there is limited evidence of her response to the allegations. He referred the panel to a telephone note detailing a call from an NMC Case Officer to Miss Cank on 13 October 2020. This states: *'[Miss Cank] said she can't believe that they tell so many lies'*. He also acknowledged that there does appear to be some animosity between Miss Cank and Colleague B. However, he submitted that the panel can fairly submit Colleague B's hearsay material into evidence, on the basis that there are ways of testing its reliability.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to the NMC cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin).

In reaching its decision, the panel had regard to the principles set out in the case *Thorneycroft* at paragraphs 45 and 56, it also took into account the submissions made by Mr Kewley.

In respect of Colleague D, the panel noted that her hearsay material is relevant to the charges and that it was not the sole and decisive evidence in support of the charges. The panel bore in mind that Miss Cank was not in attendance, therefore it was unable to ascertain whether she challenged any of Colleague D's evidence. However, it did take into account the telephone note 13 October 2020, where Miss Cank expressed that lies had been told. The panel noted that there appeared to be no animosity between Colleague D and Miss Cank, and at the material time, they had a close working relationship.

The panel acknowledged the seriousness of the charges that Colleague D gives evidence in respect of, however it also had regard to its overarching responsibility to protect the public. Given [PRIVATE], the panel was of the view that there was a compelling and cogent reason for her nonattendance. [PRIVATE].

The panel took into account that notice of this application and the hearsay bundle before the panel had also been served on Miss Cank, albeit at short notice on 19 March 2024. The panel was of the view that Colleague D's hearsay material was relevant and that it was able to test the reliability of her evidence. In all the circumstances the panel granted the hearsay application in respect of Colleague D's evidence and determined that it will

attach the appropriate weight to her evidence at its later consideration of the facts of this case.

In respect of Colleague B, the panel considered that her hearsay material was the sole or decisive evidence in support of a large number of charges. The panel bore in mind that Miss Cank was not in attendance, therefore it was unable to ascertain whether she challenged any of Colleague B's evidence. However, it did take into account the telephone note 13 October 2020, where Miss Cank expressed that lies had been told. It also took into account the underlying context to these incidents, including that there was clear animosity between Miss Cank and Colleague B. Further, the panel bore in mind the seriousness of the charges alleged and the adverse effect it would have on Miss Cank if these were proven.

The panel was provided with information regarding the attempts the NMC had made for Colleague B to come and attend the hearing and give oral evidence. [PRIVATE]. However, it was of the view that the NMC had not properly explored this with the witness. [PRIVATE].

Whilst the panel had regard to the contemporaneous nature of some of Colleague B's evidence, it could not be satisfied that this evidence was demonstrably reliable or alternatively that there was some means of testing its reliability. The panel was of the view that admitting this hearsay material into evidence would be unfair and prejudicial to Miss Cank given the reasons set out above. In all the circumstances, the panel did not accede to this application in respect of Colleague B.

Decision and reasons on application for special measures

Mr Kewley made an application for special measures in respect of Colleague C, he submitted that in accordance with Rule 23 (1) (c), Colleague C should be treated as a vulnerable witness [PRIVATE].

Mr Kewley explained that NMC had instructed Communicourt, an independent court intermediary service, for an intermediary to support Colleague C in giving evidence at this hearing. He further explained that a member of the NMC Public Support Service team would also be present to also support the witness. He referred the panel to a report dated 2 November 2023, from a Communicourt intermediary, [PRIVATE]

Mr Kewley explained that prior to Colleague C giving evidence, the intermediary will be invited to the hearing, to establish ground rules to clarify appropriate communication style and for all parties to agree strategies to be used throughout Colleague C's evidence. He submitted that the intermediary can also answer any questions in respect of the report before the panel.

Mr Kewley also referred the panel to a document titled 'Equal Treatment the Bench Book' (last updated April 2023) which give guidance regarding the assistance of an intermediary in civil proceedings.

The panel accepted the advice of the legal assessor who advised that under Rule 23 (2), the panel may adopt measures it considers necessary to enable it to receive evidence from vulnerable witnesses.

The panel was satisfied that the criteria set out under Rule 23 (1) (c) had been met in this instance. Given Colleague C's [PRIVATE]. Further, it noted that the assistance of an intermediary would support Colleague C to give his best evidence and that the panel can establish an appropriate communication style and agreed strategies to be used throughout Colleague C's evidence at the preliminary ground rules hearing.

The panel considered that allowing this application would not cause any unfairness to Miss Cank, and it determined that in the circumstances of this case, it was both fair and proportionate to grant the application for special measures in respect of Colleague C.

Decision and reasons on application to offer no evidence

Mr Kewley made an application to offer no evidence in respect of the charges 4),5),6),7),8), 9) and 10). He provided the panel with the following written submissions in this regard:

'1. These are the written submissions on behalf of the Nursing and Midwifery Council ("NMC") in respect of an application to offer no evidence on a number of charges in the proceedings concerning Deborah Cank ("the Registrant").

2. The case against the Registrant commenced on 20 March 2024 before the panel.

3. On day one of the hearing the panel considered a number of preliminary applications which included a hearsay application under Rule 31(1) in respect of witness [Colleague B].

4. The panel refused the hearsay application in respect of [Colleague B] and the Chair provided an oral summary of the panel's reasoning.

5. As a result of the panel's refusal decision, the NMC seeks to offer no evidence on charges 4, 5, 6, 7, 8, 9 and 10 on the basis that the evidence of [Colleague B] was sole and decisive on those charges and there is no longer a realistic prospect of those charges being found proved.

Approach

6. The panel's attention is drawn to the NMC's publicly available guidance on offering no evidence – guidance DMA-3. 2

7. The guidance sets out three circumstances in which the NMC will apply to offer no evidence. In this case, the application is made under the second limb which states: 'where there is no longer a realistic prospect of some or all of the factual allegation being proved'.

8. The guidance provides examples of situations where they may no longer be a realistic prospect of proving the charge which includes the following: 'the charge relies on the evidence of a witness who cannot attend a hearing, and an application to rely on their statement as hearsay evidence has been rejected'

9. The guidance further states: 'when we ask a panel to do this and the case is at a hearing, we will open our case and fully explain the background, and our reasons for offering no evidence.'

10. The requirement to open the case fully was set out clearly in the judgment of Laing J in PSA v X & NMC [2018] EWHC 70 (Admin) at [47]:

> *'I consider that it is especially important, if the NMC considers that it is appropriate to offer no evidence, that it fully opens the case, so that the Committee is able to make a decision, informed by a sufficient knowledge the facts, whether it is appropriate for the NMC to offer no evidence, or whether it should require the NMC to reconsider that view, and try and obtain more evidence.'*

11. It is important to note that this application is made in circumstances where the panel has (a) received a full written opening on all of the charges and (b) has received and read all of the evidence in the case contained within the witness statement bundle and the exhibits bundle.

Panel's own powers

12. It is important to recognise that unlike a criminal trial, a professional disciplinary panel acting with an overarching objective of protecting the public is expected to play a more proactive role that a judge presiding over a criminal trial.

13. In X the judge referred to the following at [47]: '

> *'Mr Bradly also drew my attention to paragraph 80 of Ruscillo in which the Court of Appeal said that the disciplinary body should 'play a more pro-active role than a judge presiding over a criminal trial in making sure that the case is properly presented and the relevant evidence is placed before it'*

14. This point was also repeated in the often cited case of PSA v Jozi & NMC [2015] EWHC 764 (Admin).

15. The panel's attention is drawn to the NMC's publicly available guidance on directing further investigation during a hearing – Guidance DMA-5.

16. The guidance states:

> *'In every case that goes to the Fitness to Practise Committee we need to make sure that we have given the panel all the relevant evidence. The panel needs to understand the background including the context in which the incident occurred, consider all the relevant facts and make a fair and fully informed decision that best protects the public.*
>
> *If this hasn't happened, and there is important evidence available, that is missing, or that we haven't put before the panel, the panel can direct us to get that further evidence. The panel should not consider itself to be 'bound' by that lack of the evidence to find a charge not proved, it should take a more proactive role than a judge in a criminal trial, and where necessary*

intervene to make sure that cases are properly presented, and request the further evidence.

The panel can use its powers to require people to attend hearings or produce relevant documents1, or its powers to adjourn the case, as it needs to.'

Submissions

17. The following submissions are made in support of the application:

a. Without the evidence of [Colleague B] there is no longer a realistic prospect of the charges being found proved;

b. The witness has told the NMC that she will not give evidence at the hearing;

c. [PRIVATE].

d. [PRIVATE].

18. In those circumstances, the NMC offers no evidence on these charges.'

In addition to his written submissions, Mr Kewley made oral submissions in respect of charges 8) and 9).

Mr Kewley submitted that whilst Colleague A's evidence appears to support these charges, his evidence is repetition of what Colleague A had subsequently learnt from concerns raised by members of staff at the Home. He submitted that Colleague A had not been present at the Home on the date of the alleged incident and therefore, he cannot

provide any direct evidence in this regard. Further, as Colleague B's contemporaneous note dated 17 October 2020 was deemed inadmissible, there is no longer any direct evidence in respect of these charges.

The panel accepted the advice of the legal assessor which included reference to the case of *Professional Standards Authority v NMC and X* [2018] EWHC 70 (Admin) and Rule 22 (5) and the NMC guidance titled 'Offering no evidence'(Reference: DMA-3) ('the Guidance').

In reaching its decision, the panel took into account Mr Kewley's submissions and his earlier submissions in respect of the hearsay evidence application. The panel also had regard to the NMC Guidance. The panel carefully considered the chronology of events and the contextual background of the case so that it could make an informed decision whether or not to accept the NMC's proposal to offer no evidence in relation to those charges affected by the hearsay ruling.

The panel had regard earlier findings regarding the hearsay application, in that the NMC had not properly [PRIVATE] by Colleague B and considered its power to direct the NMC to conduct further investigations. The panel took into account that Colleague B's sole or decisive evidence supports a large number of the charges that are subject to this application. The panel also bore in mind its duty to make a fair and fully informed decision that protects the public and fulfils its overarching duty in a fair and proportionate way.

For these reasons, the panel directs the NMC to provide further information in respect of Colleague B's ability to give evidence at this hearing and, to fully apprise Colleague B of all supportive measures that can be offered to support Colleague B to give her best evidence. It noted that the NMC Guidance titled 'Supporting people to give evidence in hearings' (ref: CMT-12) (last updated 1 August 2023) provides a non-exhaustive list of the support that can be offered. The panel determined that it will revisit this application once the NMC has obtained further information.

Following the panel's direction, Mr Kewley advised the panel that a NMC Public Support Service Manager contacted Colleague B via telephone on 22 March 2024. Mr Kewley submitted that in the NMC's view, it has taken all reasonable steps to secure this witnesses attendance. He provided the panel with the following note of the telephone call:

'[PRIVATE].'

The panel was of the view that the NMC had made Colleague B sufficiently aware of the support available to her, and given [PRIVATE] there is no realistic prospect of her giving evidence.

The panel noted that the NMC Guidance that offering no evidence will be appropriate if:

'*…the charge relies on the evidence of a witness who cannot attend a hearing, and an application to rely on their statement as hearsay evidence has been rejected …'*

The panel was of the view that, taking all of the above circumstances into consideration, there was not a realistic prospect that it would find charges 4),5),6),7),8),9) and 10) proved, given that Colleague B's inadmissible hearsay material was the sole and decisive evidence in respect of those charges. The panel concluded that the overarching objectives of public protection and maintaining public confidence in the profession can still be achieved by its consideration of the remaining allegations.

Accordingly, the panel acceded to the NMC's application to offer no evidence in respect of 4),5),6),7),8),9) and 10).

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 Kewley.

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:

- Colleague C: [PRIVATE]
- Colleague A: Managing Director for Millennium Care UK, at the time of the allegations.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included reminding the panel of the test for determining dishonesty as set out in the case of *Ivey v Genting Casinos [UK] Ltd* [2017] UKSC 67. The legal assessor also gave advice in respect of the legal definition of intent. The panel having admitted hearsay evidence accepted the legal assessor's advice as to how to determine the weight that should be accorded to it.

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

Charge 1) a)

1) Failed to send to the CQC:

    a) Statutory notifications for 15 resident deaths from September - December 2019.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleagues A and D and the documentary evidence before it.

The panel first considered whether Miss Cank had a duty to send the CQC Statutory notifications in respect of resident deaths at the Home.

The panel noted Colleague D's witness statement:

> *'[…] It is the home manager's job to escalate concerns to the CQC, but they can delegate this to whom they feel is fit to do a statutory notification.'*

The panel also noted Colleague A's witness statement:

> *'Debbie was the Registered Manager of the Home […]*
>
> *2) It was ensuring system safety through a process of governance in accordance with the legislation and NMC code of conduct, and […]'*

The panel took into account Colleague A's oral evidence, he informed the panel that Miss Cank's duties included; managing the Home's staff of up to 60 people, and having general oversight of the day-to-day operations. Further, he explained that sending statutory notifications of resident deaths to the CQC was the responsibility of Miss Cank and that the notifications were required to be submitted as a matter of urgency.

The panel also took into account the notes of Miss Cank's local investigation meeting dated 12 February 2020 into the concerns, which state:

> *'[Colleague A]: As a Registered Manager are you aware of your legal duty and responsibility to submit statutory notifications to the CQC?*
>
> *[Miss Cank]: Yes*

[…]'

The panel was mindful that the notes of the local investigation had not been signed. However, it noted that this evidence was more contemporaneous than the witness statements before it and Miss Cank had not challenged the records of this meeting. The panel therefore accepted this evidence in respect of this charge.

In addition, the panel acknowledged that whilst the witness statement of Colleague D was considered hearsay evidence, it noted that it was supported by the evidence of Colleague A, who had also confirmed in his evidence that Miss Cank was responsible for sending statutory notifications to the CQC regarding resident deaths. The panel therefore attached weight to Colleague D's evidence in this regard. In all the circumstances, the panel was satisfied that the evidence before it established a responsibility upon Miss Cank, as the Registered Manager at the Home to send statutory notifications to the CQC regarding resident deaths. The panel then considered whether Miss Cank had failed to do so.

The panel had regard to the contextual evidence of this allegation. The panel noted Colleague A and D's evidence that there had been initial concerns regarding Miss Cank allegedly not submitting a statutory notification regarding Resident A's death. This had been brought to the Home's attention by a CQC inspector in an email dated 21 January 2020. This subsequently led Colleague D on Colleague A's instruction to investigate further into whether other notifications had been submitted.

The panel noted Colleague D's witness statement:

'[Colleague A] asked me to check that all other notifications had been sent to CQC as he was concerned that there could be more. […]

[…] I checked the CQC portal and there were no notifications on there since September 2019. When I looked into this, I found out that the notification for the

resident's death had not been done. I subsequently submitted the notification on 22 January 2020 [PRIVATE], when the resident passed away on 13 December 2019. […]

Around 22 January 2020, [Colleague A] asked if I could check if other notifications had been done. I went on the CQC portal and noticed that nothing had been sent since September 2019. I looked into it by checking the file for CQC notifications, emails and the CQC portal, and nothing had been sent. We had quite a few deaths, about 17, since September 2019 and when I backtracked there should have been 14 notifications sent for expected deaths in the Home. I had not been asked to do these notifications at the time and had assumed that they had been done [by Miss Cank]'

The panel also noted Colleague D's more contemporaneous account of this allegation, dated 18 February 2020, which states:

'I can confirm that from September 2019 notifications which were required to be submitted to CQC have not been completed by Debbie Cank – Home Manager I have checked the CQC Portal as Debbie was still logged in and also her emails which confirmed that nothing had been sent since September At no point in time did she ask me to complete these notifications. She informed me that as I did not have access to the CQC Portal she had to complete them. This statement is true and factual'

In his oral evidence, Colleague A confirmed to the panel that he too had checked the CQC portal, the files and had obtained access to Miss Cank's emails via IT, but was not able to find any evidence of the notifications being sent.

The panel also noted that Colleague A had sent three emails to Miss Cank, requesting the notification schedule, dated 6 February 2020, 7 February 2020 and 10 February 2020, which Miss Cank had not responded to. The panel had regard to the Home's CQC

notification log and noted that the last recorded resident death notification was recorded 20 September 2020.

The panel noted that during the local investigation meeting Miss Cank had stated the reason why the notification schedule had stopped at 20 September 2020 was because '*they had been archived'*. She also stated that there were hard copies of the notifications that could be found in the archive box. However, the panel found that Miss Cank's account was not supported by the documentary evidence before it. In addition, when questioned regarding any archived paper documentation, Colleague A confirmed that none had been found in the Home's files regarding the 15 missing CQC notifications.

In all the circumstances, the panel accepted the evidence of Colleagues A and D as it found it to be consistent with the documentary evidence before it. Further, it found their evidence cogent and compelling. The panel concluded that it was more likely than not, that Miss Cank had failed to send the CCQ statutory notifications for 15 resident deaths from September - December 2019.

Accordingly, the panel finds this charge proved.

Charge 1) b)

1) Failed to send to the CQC:

b) An action plan required to be submitted in December 2019.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and the documentary evidence before it.

The panel first considered whether it was Miss Cank's responsibility to submit the action plan. The panel noted that during Colleague A's oral evidence, he stated that Miss Cank would be responsible for creating and submitting the required action plan to the CQC. Colleague A's witness statement also states:

> *'[…] as part of that breach there was a requirement for the Registered Manager to complete an action plan (regulation 17 plan (exhibit OH/5)) and submit it to the CQC; the deadline for this was 20 December 2019*.'

The panel found that whilst Miss Cank, as the Registered Manager was required to submit this action plan, this was a joint responsibility with other nominated individuals/provider of the Home, namely, the nominated individual, which was confirmed to be Colleague A. Having established this duty, the panel went on to consider whether Ms Cank had failed to send the action plan to the CQC required to be submitted in December 2019.

The panel noted Colleague A's witness statement:

> *' […] Debbie had not submitted it; despite conversations we had about this and being assured of the otherwise. Then the CQC contacted me on 21 January 2020 [PRIVATE] to say they had not received the action plan, to our surprise. We subsequently acted on this and shared the action plan on the regulatory breach to the CQC directly […]'*

The panel also noted an email from the CQC inspector, dated 21 January 2020. As follows:

> *' I am chasing up the action plan post the inspection at Lakeside and the report, it was due 20 December 2020.[…]*
>
> *Please can both pieces of information be submitted as required as soon as possible.'*

The panel accepted Colleague A's evidence in relation to Miss Cank's alleged failure to submit the action plan to the CQC, which was supported by the email above.

Accordingly, the panel finds this charge proved.

Charge 2)

2) In February 2020, told Colleague A that you had sent statutory notifications in respect of one or more of the resident deaths referred to at charge 1 to:

   a) The CQC
   b) The local authority.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A and the documentary evidence before it.

The panel noted Colleague A's witness statement:

> *'On six occasions I had asked for the schedule and a copy of the notification schedule. On 6, 7 and 10 February 2020 [PRIVATE], I contacted Debbie, via email, and we had conversations prior to and shortly after. She did not respond and shrugged them off. This made us even more concerned. She said she had done the notification via email to the CQC and local authority […]'*

The panel also noted the oral evidence of Colleague A, in which he explained the importance of sending statutory notifications to external authorities so that they may carry out any external investigation, if required.

The panel was not provided with a response from Miss Cank in respect of this allegation. However, it noted Miss Cank had stated during the local investigation meeting that she had sent a notification to the CQC, but had not informed the safeguarding authorities as '*we haven't had full notification on it.'* The panel did not have any evidence before it to support Miss Cank's assertion.

In all the circumstances, the panel accepted the evidence of Colleague A as credible, noting that his oral evidence was consistent with his witness statement. Taking into account the evidence above, the panel finds this charge proved.

Charge 3)

3) Your conduct at charge 2 was dishonest in that you knew you had not sent the statutory notifications in respect of one or more of the resident deaths referred to at charge 1 to:

   a) The CQC and
   b) The local authority.

This charge is found proved.

In reaching this decision, the panel had regard to its findings in respect of charges 1) and 2) and the legal test for dishonesty as set out in *Ivey v Genting Casinos*. The panel bore in mind that it must first ascertain the actual state of the individual's knowledge or belief as to the facts. Once this has been established, the question of whether the conduct was honest or dishonest is to be determined by applying the objective standards of ordinary and decent people.

The panel noted the local investigation meeting minutes, in which Miss Cank had confirmed she had sent statutory notifications to the CQC. However, the panel bore in mind that Miss Cank was not present at this hearing, therefore the panel had no evidence

from her, that would assist it in ascertaining her state of knowledge or belief as to the facts. In Colleague A's oral evidence, he told the panel that Miss Cank had confirmed during a conversation that she had sent a notification to both authorities, in respect of Resident A, this was also consistent with his witness statement.

The panel determined that as an experienced Nurse and Registered Manager of the Home, Miss Cank would have been aware of the procedures and the importance for submitting statutory notifications for resident deaths at the Home. The panel noted that Miss Cank had advanced several reasons for why these notifications may have not been successfully submitted, such as; issues with the CQC portal used for submitting notifications and that she had sent them via email, but had not received a response from the CQC.

The panel noted its earlier findings, in that Miss Cank had failed to send statutory notifications to the CQC on 15 occasions. She also confirmed that she had not sent a notification to the local safeguarding authorities in respect of Resident A, yet she had informed Colleague A she had. The panel concluded that Miss Cank would have been aware that she had not submitted these notifications at the material time.

The panel determined that Miss Cank's conduct at charge 2) was dishonest and that her conduct would be regarded as dishonest according to the standards of ordinary decent people.

Accordingly, this charge is found proved.

Charge 11)

11) On 8 November 2019, when Colleague C raised a safeguarding concern, failed to document and / or investigate this.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleagues A and C and the documentary evidence before it.

The panel noted the contextual evidence in relation this allegation set out in Colleague C's witness statement, regarding him witnessing two senior carers, allegedly taking a resident out of a wheelchair into an armchair using an inappropriate method.

Colleague C's witness statement states:

> *'On the same day [8 November 2019] I witnessed the drag lifting incident, I think I sent message I sent Debbie a message on Facebook messenger say I needed to speak to her about something and she sent something back to clarify what I was saying. [….] I asked if I could ring her. Debbie and I had a phone call over Facebook Messenger (I am not sure who phoned who) and told her what happened. […]'*

The panel also noted that in Colleague C's witness statement he explains that a meeting was held in the morning of following day (9 November 2019), Colleague D was present with Miss Cank. His witness statement states:

> *'During this meeting, they both asked me what happened with the drag lifting incident, and I told them. When they were asking me questions it was horrible, as it was like being in a court room and having people firing questions at you and trying to make out what you are saying is not true. I remember [Colleague D] saying to me that is not true that is not what they would do.'*

However, the panel was of the view that this meeting did not amount to an investigation meeting, rather an informal conversation.

The panel also took into account the minutes of the local investigation. When Miss Cank was asked if she had investigated this matter specifically with Colleague C, she stated '*No I did not'*. Miss Cank also stated that she '*failed to put in a safeguarding'*.

The panel also noted Colleague A's witness statement, as follows:

> *'[Miss Cank] failing to take seriously a whistleblowing allegation. She had not made any efforts to investigate the matter in which an allegation of abuse had been made. We would have expected her to investigate the matter formally with a view to suspending any staff for whom an allegation had been made against or prior to that, starting to take formal witness statements.[…]'*

And:

> *'[…] Debbie should have acknowledged [Colleague C] was coming to her with a whistleblowing concern and that he was exercising his right to do this. Debbie should have handled this sensitively, confidentially and given [Colleague C] assurances that it would be investigated and taken seriously. […] Debbie should speak to people without delay, she did not do this. If it transpired from the investigation that it was a safeguarding concern, she would need to do a safeguarding investigation.'*

In addition to his witness statement, Colleague A had also confirmed in his oral evidence that there was no documentation found in the residents' files and the staff files regarding the safeguarding concern raised by Colleague C.

The panel accepted the evidence of Colleagues A and C in respect of this allegation as it was supported by the documentary evidence before it. In all the circumstances the panel found that Miss Cank had failed to document and / or investigate the safeguarding concern raised by Colleague C on 8 November 2019.

Accordingly, the panel finds this charge proved.

Charge 12)

12) On or around 9 November 2019, told Colleague C that he was a “shit stirrer” for raising the safeguarding concern referred to at charge 11 or said words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleagues A and C and the documentary evidence before it.

The panel noted Colleague C witness statement, as follows:

> *‘[…] things started to change. The issue with this came when Debbie said “You’re a shit stirrer” in the meeting. When Debbie called me a ‘shit stirrer’, I burst out saying “I’m not a shit stirrer”.’*

The panel also noted Colleague C’s email sent to Miss Cank on 12 January 2020. In this email he states:

> *‘[…] Regarding the safeguarding report I made, I wanted to know why you took the approach you did by saying I am shit stirring, because in my own mind, I don’t cause trouble […]’.*

Colleague C had also sent an email to Colleague A on 19 Janauy 2020. In this email he states:

'I called Debbie to explain and she thanked me and told me she will deal with it, unfortunately, for some reason, "dealing with it" consisted of myself […] in the office whilst I was called a "shit stirrer"[…]'

The panel was not provided with a substantive response from Miss Cank regarding this allegation. However, the panel took into account the notes of the investigation meeting on 6 February 2020, in which Miss Cank was asked whether she had called Colleague C a '*shit stirrer'*. Miss Cank states: *'He was never called a shit stirrer[…]'.*

The panel noted that Colleague C's evidence in respect of this allegation had been consistent, in that he had raised this matter with Colleague A, the Director of the Home and challenged Miss Cank directly for referring to him in this way. The panel was of the view that there was no evidence before it to suggest that Colleague C had reason to fabricate this allegation, given his previously good working relationship with Miss Cank, which he had outlined in his evidence. For these reasons, the panel accepted the evidence of Colleague C and found that, on a balance of probabilities, Miss Cank had called Colleague C a "*shit stirrer*" for raising the safeguarding concern referred to at charge 11.

Accordingly, the panel finds this charge proved.

Charge 13)

13) Your conduct at charge 12 was intended to bully and / or intimidate Colleague C for having reported a safeguarding concern.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C, the documentary evidence before it and its findings in respect of charge 12).

The panel had regard to the NMC's guidance on bullying (ref: FTP-3 last updated 27 February 2024) which states:

> *'Bullying can be described as unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls. Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.'*

The panel noted that in his email to Colleague A on 19 January 2020, Colleague C reported to have felt '*degraded*' following Miss Cank calling him a '*shit stirrer'*. The panel also accepted that Miss Cank, as Colleague C's manager, would have been aware of the issues he was facing at the material time pertaining to [PRIVATE]. The panel also took into account that Miss Cank had referred to Colleague C in this way in front of colleagues, following him raising a safeguarding complaint. The panel was of the view that Miss Cank's conduct was intimidating to Colleague C, a junior member of staff. Further, the panel bore in mind the evidence before it regarding the working environment and the challenges Colleague C was already facing at work. The panel found Miss Cank's conduct was unwanted and intended to humiliate Colleague C. Taking into account the NMC Guidance on bullying, the panel was satisfied that Miss Cank's conduct did amount to bullying. The panel also found that Miss Cank was well aware of the effect her conduct would have on Colleague C and therefore intent was made out.

Accordingly, the panel finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Cank'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, Miss Cank's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Mr Kewley invited the panel to take the view that the facts found proved are sufficiently serious as to amount to misconduct and were in breach of The Professional standards of practice and behaviour for nurses and midwives (2018) ("the Code"). He then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, Miss Cank's actions amounted to a breach of those standards.

In respect of charge 1) a), Mr Kewley submitted that Miss Cank, as the Registered Manager of the Home failed to submit statutory notifications in respect of resident deaths

at the Home. He submitted that Miss Cank was aware of this legal obligation, as there is evidence before the panel that she had submitted notifications previously.

Mr Kewley submitted that by not notifying the CQC and the local authority of the resident deaths, Miss Cank deprived both authorities the opportunity to identify any potential issues regarding resident deaths. Mr Kewley referred the panel to the witness statements of Colleagues A and D in support of his submission.

In relation to charge 1) b), Mr Kewley submitted that there was a partial responsibility on Miss Cank to submit the action plan to the CQC by the required submission date. He submitted that Colleague A had informed the panel in his oral evidence of a specific conversation between himself and Miss Cank, where Miss Cank had provided reassurance that she was completing the report. As a result of Miss Cank's failure, Mr Kewley submitted Colleague A had to step in and submit the report himself. Mr Kewley submitted that the purpose of providing this report to the CQC was to fulfil the Home's regulatory duties and to assist the CQC in assessing improvement in relation to concerns identified at the August 2019 inspection.

In relation to charges 2) and 3), Mr Kewley submitted that Colleague A had asked Miss Cank directly about whether she had submitted the statutory notifications and Miss Cank had failed to tell the truth. Further, he submitted that it was a reasonable expectation for Colleague A to rely on this information given to him by Miss Cank, the Registered Manager of the Home.

Mr Kewley submitted that given Miss Cank's senior position at the Home, she was responsible for ensuring that she was transparent, honest and accountable. He submitted that Miss Cank's dishonesty was directly linked to her professional practice and particularly serious, as it was connected with reporting resident deaths to external agencies.

Regarding charges 11) 12) and 13), Mr Kewley submitted that these charges relate to Miss Cank's failure to investigate the safeguarding concern raised by Colleague C. He submitted that the safeguarding concern alleged a serious safeguarding incident regarding an inappropriate lift of a resident in the Home. He submitted that irrespective of whether this concern was substantiated, it should have been investigated by Miss Cank.

Mr Kewley submitted that Miss Cank's subsequent conduct in calling Colleague C a '*shit stirrer*' is particularly serious, as this is the type of behaviour that prevents people from speaking up and raising alleged concerns that they have observed. He submitted that this promoted a closed culture where people do not raise concerns.

Mr Kewley submitted that Miss Cank's actions in all the charges found proved are sufficiently serious as to amount to misconduct and were in breach of The Code.

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

Mr Kewley submitted that statutory notifications of resident deaths and required action plans following CQC inspection, contribute towards maintaining and improving the safety of service users who are in the Home. He submitted that in the NMC's view, Miss Cank's actions had the potential to increase the risk of harm to service users.

Mr Kewley submitted that some of the concerns in this case are attitudinal in nature, both in respect of the dishonesty and Miss Cank's conduct towards Colleague C. He referred the panel to the NMC guidance titled 'Serious concerns which are more difficult to put right' (Ref: FTP-3a) (Last Updated 01/07/2022) which states:

> *'[…] breaching the professional duty of candour to be open and honest when things go wrong, […] hindering a colleague or member of the public who wants to raise a*

concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care;[…]'

Mr Kewley submitted that Miss Cank's behaviour contributed to a culture which suppresses openness about the safety of care in this case.

Mr Kewley explained that Miss Cank has disengaged from these NMC proceedings and has not been in contact with the NMC since 2020, for reasons that are unknown. He reminded the panel that it must not draw adverse inference from Miss Cank's non-attendance at this hearing. However, he submitted that as a result of Miss Cank's disengagement, there is no evidence of insight or reflection on the allegations before the panel. Further, he submitted that there is no evidence of remediation or steps taken to strengthen her practice. He submitted that for these reasons, the panel may consider that there remains a risk of repetition of the facts found proved.

Mr Kewley submitted that it is the NMC's view that Miss Cank's fitness to practise is currently impaired on public protection grounds.

Mr Kewley submitted that a finding of current impairment is also necessary on public interest grounds. He submitted that Miss Cank is a senior nurse and was the Registered Manger of the Home, who acted dishonestly in connection with her responsibilities and in a way that suppressed the culture of openness. In addition, Miss Cank has acted in a bullying and intimidatory manner towards Colleague C, a junior member of staff. He submitted that the concerns in this case would have the potential to undermine the public's trust and confidence that they place in the nursing profession. He submitted that Miss Cank's conduct also has the potential to damage the reputation of the nursing profession.

For the reasons set out above, Mr Kewley invited the panel to find Miss Cank's fitness to practise is currently impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to the case of *Roylance v General Medical Council* (No. 2) [2000] 1 AC 311.

Decision and reasons on misconduct

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

The panel, in reaching its decision, had regard to the protection of the public and the wider public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Miss Cank's actions amounted to a breach of the Code. The panel considered that the following sections of the Code had been breached in this case:

> ***'8 Work co-operatively To achieve this, you must:***
>
> *[…]*
>
> *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 This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:***

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

[…]

16 Act without delay if you believe that there is a risk to patient safety or public protection To achieve this, you must:

[…]

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

[…]

20 Uphold the reputation of your profession at all times To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

[…]

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went on to consider whether Miss Cank's actions, both individually and collectively, amounted to misconduct.

In determining whether Miss Cank's actions in charge 1) a) amounted to misconduct, the panel considered the importance of sending statutory notifications of resident deaths to the relevant authorities. Further, the panel took into account how such notifications allow these authorities to identify any potential issues, that may require further external investigation. The panel noted that Miss Cank had failed, on 15 occasions to submit these statutory notifications during September - December 2019. The panel took into account that this was not an isolated incident, but, rather, a course of conduct over four months. The panel bore in mind that Miss Cank was an experienced Registered Manager and Nurse, who was aware of her responsibilities and had previously submitted timely statutory notifications for resident deaths at the Home. The panel was not provided with any clear explanation for why these notifications had not been submitted by Miss Cank.

Regarding charge 1) b), the panel considered that following a CQC inspection in August 2019, Miss Cank had failed to submit a required action plan. The panel understood that the purpose of this action plan was to ensure that the service was safe and to demonstrate what actions had been taken to improve the service. Whilst the panel acknowledged that this was a shared responsibility with the registered provider, it bore in mind Miss Cank's duties as the Registered Manager and that she had been in direct communication with the CQC inspector who had requested this.

The panel concluded that Miss Cank's actions fell far below such standards expected of a registered nurse, and that members of the public and fellow professionals would consider her behaviour deplorable. The panel determined that Miss Cank's actions at charges 1)a) and 1) b) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Miss Cank's actions in charges 2) and 3) amounted to misconduct, the panel considered that Miss Cank had dishonestly told Colleague A that she had sent statutory notifications in respect of one or more of the resident deaths. The panel was of the view that Miss Cank had sought to mislead Colleague A, by telling him she had submitted these notifications when she knew she had not.

The panel considered that Miss Cank's actions may have prevented external investigation from the relevant authorities. The panel considered that patients, fellow practitioners, and members of the public expect nurses to act with honesty and integrity at all times and that Miss Cank's dishonest conduct was at the higher end when considering seriousness. It concluded that Miss Cank's actions fell far below such standards expected of a registered nurse, and that members of the public and fellow professionals would consider her behaviour deplorable. The panel determined that Miss Cank's actions at charges 2) and 3) breached the Code and were sufficiently serious to amount to misconduct.

In determining whether Miss Cank's actions in charge 11) amounted to misconduct, the panel considered there was a duty on Miss Cank to investigate the serious alleged safeguarding concern and that she had failed to do so. The panel was of the view that irrespective of whether this concern could be substantiated she should have investigated it to ensure there was no risk of actual harm having been caused to the resident.

In determining whether Miss Cank's actions in charge 12) amounted to misconduct, the panel considered that Miss Cank's behaviour towards Colleague C, in calling him a '*shit stirrer'* after he raised the alleged safeguarding concern, was inappropriate and discouraging. The panel bore in mind Colleague C's [PRIVATE] and that he had initially

felt confident about raising the alleged concern to Miss Cank. The panel accepted the submission made by Mr Kewley, in that Miss Cank's behaviour in this regard, contributed to a culture which suppresses openness about the safety of care in this case.

In determining whether Miss Cank's actions in charge 13) amounted to misconduct, the panel considered that Miss Cank had used the inappropriate language set out in charge 12) with the intention to bully and intimidate Colleague C. The panel considered the impact this had on Colleague C, it also bore in mind the impact bullying can have on the culture of a workplace and on patient care. It considered that Miss Cank was in a senior position at the Home where she was best placed to encourage an environment safe and free from bullying. Yet, the panel found that Miss Cank intentionally abused her position of seniority to intimidate and bully Colleague C and that her behaviour was attitudinal in nature.

In all the circumstances, the panel concluded that Miss Cank's actions fell far below such standards expected of a registered nurse, and that members of the public and fellow professionals would consider her behaviour deplorable. The panel determined that Miss Cank's actions at charges 11) 12) and 13) breached the Code and were sufficiently serious to amount to misconduct.

The panel therefore determined that Miss Cank's actions collectively and individually breached the Code and were sufficiently serious to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide whether, as a result of this misconduct, Miss Cank'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. Nurses 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 *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 considered that limbs a, b, c and d of the above test were engaged by Miss Cank's past actions. The panel considered that Miss Cank's actions in not investigating the safeguarding concern raised by Colleague C, placed the resident at an unwarranted risk of harm. The panel considered that honesty and integrity are fundamental tenets of the nursing profession and that patients, fellow professionals and members of the public expect nurses to act with honesty and integrity at all times. It considered that Miss Cank's actions, in dishonestly informing Colleague A that she had submitted the statutory notifications to the relevant authorities, when she had not, clearly breached these fundamental tenets of the nursing profession and brought the nursing profession into disrepute.

The panel are aware that this is a forward-looking exercise, and accordingly it went on to consider whether Miss Cank's misconduct was remediable and whether it had been remediated. Whilst the panel considered that Miss Cank's misconduct in relation to failing to submit statutory notifications could possibly be addressed through training, it determined there to be dishonesty and bullying behaviour towards colleagues which are attitudinal. As a result, the panel concluded that Miss Cank's misconduct may be difficult to remediate.

The panel went on to consider whether Miss Cank remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Regarding insight, the panel carefully considered the material before it and found that there was nothing within the bundle that indicated any evidence of insight or remediation.

The panel noted that during the local investigation meeting, Miss Cank denied not submitting the statutory notifications in respect of resident deaths. However, she accepted

that she had not investigated the safeguarding concern raised by Colleague C. The panel considered that Miss Cank has not engaged with these proceedings since 2020 or responded to the regulatory concerns, therefore the panel has not been able to ascertain her current level of insight. In the absence of any steps to strengthen her practice or evidence of remediation, the panel concluded that Miss Cank had not remediated her actions, had not demonstrated insight into her misconduct and had not considered the impact of her behaviour on patients, colleagues and the reputation on the nursing profession.

In all the circumstances, the panel considered that there is a risk of repetition and that Miss Cank remained liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined 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 wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession.

The panel noted that Miss Cank has been a registered nurse since 1989, with no known regulatory concerns. The panel considered that as a registered nurse and senior member of staff, she was a role model for junior staff in the Home and she had a responsibility to fulfil regulatory obligations as the Registered Manager of the Home.

Having regard to its earlier findings, the panel considered that members of the public would be shocked to learn of a senior registered nurse and Registered Manager behaving in such a way towards a junior colleague, failing to investigate safeguarding concerns and not fulfilling her statutory duty to ensure safety of care in the Home. The panel concluded, given the seriousness of Miss Cank’s misconduct, that public confidence in the profession

and in the regulator would be undermined if a finding of impairment were not made in this case. The panel therefore determined that a finding of impairment is also necessary on public interest grounds.

In all the circumstances, the panel was satisfied that Miss Cank's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kewley informed the panel that in the Notice of Hearing, dated 12 February 2024, the NMC had advised Miss Cank that it would seek the imposition of a striking-off order, if it found Miss Cank's fitness to practise currently impaired. He submitted that in light of the panel's findings, this remains the appropriate sanction.

Mr Kewley then outlined what the NMC considered to be the aggravating features of this case. Regarding mitigating features, he submitted that in fairness to Miss Cank, she has had an otherwise long and unblemished nursing career, however it is a matter for the panel as to whether this is relevant in this case.

Mr Kewley invited the panel to consider the sanctions in ascending order, and to have regard to the public protection and public interest issues in deciding on the most appropriate and proportionate sanction. He submitted that taking no action, imposing a caution order or an interim conditions of practice order, would not address the public protection and public interest issues identified. He submitted that Miss Cank's dishonesty was directly linked to her practice and her bullying behaviour towards a colleague also contributed to a culture which suppresses openness about the safety of care. Therefore, he submitted Miss Cank's misconduct is at the higher end of the spectrum of impaired fitness to practise.

Mr Kewley referred to the SG and submitted that a suspension order would not be appropriate, as Miss Cank has not engaged with the process and has not provided any evidence of insight, remorse, reflection, or remediation. He submitted that the panel identified a risk of repetition and attitudinal issues in this case, directly linked to Miss Cank's dishonesty and bullying behaviour towards Colleague C. He further submitted that a suspension order is not sufficient to maintain public confidence in the profession.

Mr Kewley submitted that Miss Cank's misconduct is fundamentally incompatible with being a registered professional and invited the panel to impose a striking-off order.

Decision and reasons on sanction

Having found Miss Cank'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 NMC's published guidance on sanctions. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel considered the following to be aggravating features in this case:

- Miss Cank's actions were a breach of trust;
- A series of failings between September 2019 and February 2020 demonstrating a pattern of behaviour, over a period of time;
- Miss Cank's behaviour was intended to bully and intimidate Colleague C;
- The misconduct in this case was conducive of creating a negative culture in the Home;
- Failure to investigate a safeguarding complaint, thus putting patients at potential risk of harm;
- Evidence of deep-seated attitudinal issues arising from bullying behaviour, dishonesty and failure to follow regulatory procedures in the Home;
- Miss Cank has not provided any evidence of remediation and acceptance of her misconduct or steps taken to strengthen her practice; and
- Dishonesty directly related to her clinical practice.

Regarding mitigating features, the panel accepted the Miss Cank had been a registered nurse since 1989, with an otherwise unblemished record.

Prior to considering the sanctions in ascending order, the panel had regard to the NMC's guidance on considering sanctions for serious cases and assessed the dishonesty in this case. It noted that the most serious forms of dishonesty, which are most likely to question whether a nurse should be allowed to remain on the register, often involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *[…]*
- *direct risk to patients*

- *[…] longstanding deception*

The panel noted that dishonesty will be generally considered less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate'*

Having regard to this case, the panel considered that Miss Cank's dishonest behaviour was not an isolated incident. Miss Cank had also deliberately sought to mislead Colleague A in respect of submitting statutory notifications. Balancing these factors as a whole, the panel considered that the dishonesty in this case was at the upper end of the spectrum of seriousness.

The panel then went onto consider what action, if any, to take 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 misconduct. The panel decided that taking no action would not protect the public and it would not satisfy the wider public interest.

The panel next considered whether a caution order would be appropriate in the circumstances. The panel took into account the SG, which states that a caution order may be appropriate where:

> *"…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again."*

The panel considered that Miss Cank's misconduct was not at the lower end of the spectrum of impaired fitness to practise, given that it involved dishonesty and bullying behaviour towards Colleague C, which the panel found to be attitudinal in nature. The panel was of the view that this was a dishonest course of conduct, over a period of time. A caution order would fail to place any restrictions on Miss Cank's practice. The panel therefore considered that a caution order would not protect the public. Furthermore, it would not address the seriousness of this misconduct, and the public interest, in maintaining confidence in the nursing profession and in the NMC as a regulator.

The panel next considered whether placing conditions of practice on Miss Cank's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be appropriate, proportionate, measurable and workable.

The panel had regard to the fact that the misconduct in this case did not involve concerns about Miss Cank's clinical practice. However, it involved dishonest behaviour over a period of time, failure to investigate safeguarding issues and bullying behaviour towards Colleague C. The panel did not consider that it was possible to identify workable, measurable and practicable conditions of practice to address this type of behaviour. In addition, there was no evidence before it to suggest Miss Cank would be willing to comply with conditions. Furthermore, the panel considered that a conditions of practice order would not mark the seriousness of Miss Cank's misconduct, or address the wider public interest in maintaining confidence in the nursing profession and in the NMC as a regulator.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG, which states that a suspension order may be appropriate where 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, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

The panel considered that Miss Cank's behaviour was not a single instance of misconduct. The panel bore in mind its earlier findings in respect of deep-seated attitudinal problems, Miss Cank's lack of insight and the risk of repetition identified.
The panel noted that Miss Cank has not engaged with the NMC since 2020 and therefore it had no material before it to demonstrate Miss Cank had developed any insight into the importance of honesty and integrity to the role of a registered nurse.

Taking all of this into account, given the serious level of dishonesty in this case and the lack of evidence of insight and remorse, the panel did not consider that a period of suspension would be sufficient to protect patients and public confidence in nurses and to maintain professional standards.

The panel went on to consider whether to impose a striking-off order. The panel had regard to the SG which states that:

> *This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
> - *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that Miss Cank's actions were significant departures from the standards expected of a registered nurse and that her behaviour involved dishonesty and bullying. The panel found that this behaviour is fundamentally incompatible with her remaining on the register. The panel was of the view that, in light of its finding of serious misconduct, to allow Miss Cank to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel reminded itself that honesty and integrity are fundamental tenets of the nursing profession, and it considered that Miss Cank's behaviour did raise fundamental questions about Miss Cank's professionalism. Given Miss Cank's level of dishonest behaviour, and the lack of evidence of insight, the panel considered that public confidence in nurses would not be maintained unless Miss Cank was permanently removed from the register. It considered that a striking-off order is the only sanction sufficient to protect patients and members of the public and to maintain public confidence in the profession.

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 nursing profession a clear message about the standard of behaviour required of a professional and a registered nurse.

Interim order

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

Submissions on interim order

Mr Kewley submitted that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. He relied on the panel's earlier findings to support that submission. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period and for any potential appeal to be lodged and considered.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

Having regard to the findings in this case, the panel did consider that an interim order is necessary to protect the public and is otherwise in the public interest. Having regard to the seriousness of the misconduct in this case and the reasoning for its decision to impose a striking-off order, the panel considered that to not impose an interim order would be inconsistent with its previous findings.

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

That concludes this determination.

This will be confirmed to Miss Cank in writing.