Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
18 – 24 August 2021

Virtual Hearing

Name of registrant:	Miss Margaret McGhee Dunbar
NMC PIN:	78Y0185S
Part of the register:	Registered Nurse General Nursing – 24 March 1980
Area of registered address:	Glasgow
Type of case:	Conviction/Misconduct
Panel members:	Nicholas Cook (Chair, lay member) Susan Tokley (Registrant member) Sophie Kane (Registrant member)
Legal Assessor:	Fiona Moore
Panel Secretary:	Leigham Malcolm
Nursing and Midwifery Council:	Represented by Mr Adam Slack, NMC Case Presenter
Miss Dunbar:	Not present and not represented in absence
Facts proved:	Charges 1, 2, 3, 4 & 5
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 Dunbar was not in attendance and that the Notice of Hearing had been sent to her registered email address on 12 July 2021.

The panel took into account that the Notice of Hearing provided details of the allegations as well as the dates, times and the details for joining the virtual hearing. Amongst other things the Notice of Hearing included information about Miss Dunbar's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Slack, 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.

In the light of all of the information available, the panel was satisfied that Miss Dunbar 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 Dunbar

The panel next considered whether it should proceed in Miss Dunbar's absence. It had regard to Rule 21 and heard the submissions of Mr Slack who invited the panel to continue in Miss Dunbar's absence in view of her permission. He referred the panel to an email from Miss Dunbar to the NMC, dated 4 August 2021, in which she stated:

"…will not be attending… have decided against it…"

A further email from Miss Dunbar to the NMC on 4 August 2021 stated:

"…I will never be seeking employment in any capacity due to my age and drastic change to my domestic circumstances, I, therefore give permission for you to proceed in my absence"

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Miss Dunbar. In reaching this decision, the panel has considered the submissions of Mr Slack and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Dunbar;
- Miss Dunbar has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have been scheduled to give evidence;
- There is a strong public interest in the expeditious disposal of the case.

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

Details of charge

That you, as a registered nurse:

1. *Were convicted on 17 July 2019 at Glasgow Sheriff Court of 'On 7th August at Lilyburn Care Home, Birdston Road Glasgow you MARGARET DUNBAR did assault ******** ********, then aged 96 years, c/o Police Service of Scotland and did forcibly remove her from her bed, drag her by the body to a bathroom and roughly place her onto a toilet'.*

2. *In the course of acting as alleged at charge 1 you shouted "this is a disgrace, the way you are treating these two young girls. You are taking the piss out of them", or words to that effect, at Resident A.*

3. *Following your actions at Charges 1 and 2 you told the two HCA's present, that "you did not see any of this", or words to that effect;*

4. *Your conduct at Charge 3 was dishonest in that your intention was to conceal your conduct;*

5. *Your conduct at Charge 3 was carried out to pressure and/or persuade the two HCA's to conceal your conduct.*

And, in light of the above, your fitness to practise is impaired by reason of your conviction at charge 1 and/or your misconduct at charges 2-5.

Decision and reasons on application to admit local statement of Ms 3 into evidence

The panel heard an application made by Mr Slack under Rule 31 to allow the local statement of Ms 3 into evidence.

The panel accepted the advice of the legal assessor and it bore in mind that Miss Dunbar had been provided with the full evidence bundle, including a copy of Ms 3's local statement, in advance of these proceedings.

The panel considered there to be a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. In the circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the local statement of Ms 3 and it would give the statement what it deemed to be appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

Charge 1 concerns Miss Dunbar' conviction and, having been provided with a copy of the Extract Conviction, the panel finds that the facts are found proved in accordance with Rule 31 (2) and (3).

The panel has drawn no adverse inference from the non-attendance of Miss Dunbar.

Background

The NMC received a referral on 16 August 2018 from the Home Manager of Lilyburn Care Home where Miss Dunbar was employed as a care assistant.

The referral alleged that on 7 August 2018, Miss Dunbar was working a night shift on Skye Unit at Lilyburn Care Home. Two Health Care Assistant's (HCA's) were assisting Resident A, who was quite distressed and had refused assistance to take her wet night dress off. Miss Dunbar then entered the room.

It is alleged that Miss Dunbar grabbed Resident A and dragged her by her body to the bathroom. It is alleged that after Miss Dunbar dragged Resident A to the bathroom she said 'this is a disgrace, the way you are treating these two young girls. You are taking the

piss out of them'. Miss Dunbar dragged Resident A to the bathroom and then said to the HCAs 'Thank you girls you did not see any of this'.

Miss Dunbar resigned from her role as care assistant on 13 August 2018.

Miss Dunbar was convicted, admonished and dismissed in relation to the incident at Glasgow Sheriff Court on the 17 July 2019, as set out in the charges.

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

The panel heard live evidence from two witnesses called on behalf of the NMC. The panel considered the evidence of the witnesses and made the following conclusions:

Ms 1, Care Assistant at Lilyburn Care Home. The panel considered Ms 1 to be a clear, open and credible witness who did her best to assist in difficult circumstances.

Ms 2, Home Manager at Lilyburn Care Home. The panel considered Ms 2 to be an honest and credible witness who was clear about what she was unable to remember. The panel bore in mind that Ms 2 did not conduct a full investigation as the incident was reported early to the police.

In reaching its decisions on the remaining Charges, the panel took into account all the oral and documentary evidence before it together with the submissions made by Mr Slack. It accepted the advice of the legal assessor and made the following findings.

Charge 1

1. *Were convicted on 17 July 2019 at Glasgow Sheriff Court of 'On 7th August at Lilyburn Care Home, Birdston Road Glasgow you MARGARET DUNBAR did assault ******** ********, then aged 96 years, c/o Police Service of Scotland and did forcibly remove her from her bed, drag her by the body to a bathroom and roughly place her onto a toilet'.*

This charge is found proved.

As set out above, Charge 1 concerns Miss Dunbar' conviction and, having been provided with a copy of the Extract Conviction, the panel finds that the facts are found proved in accordance with Rule 31 (2) and (3).

Charge 2

2. *In the course of acting as alleged at charge 1 you shouted "this is a disgrace, the way you are treating these two young girls. You are taking the piss out of them", or words to that effect, at Resident A.*

This charge is found proved.

In reaching this decision, the panel took into account all of the written evidence before it along with the oral evidence of both Ms 1 and Ms 2.

The written and oral evidence of both Ms 1 and Ms 2 were corroborative. When questioned by the panel, Ms 1 explicitly denied being encouraged to exaggerate and embellish her account of the incident, as alleged by Miss Dunbar. Miss Dunbar was previously unknown to Ms1 and Ms 3. The panel could see no reason or motivation as to why Ms 1, Ms 2 and Ms 3 would all exaggerate or embellish their accounts of events given

that Miss Dunbar had resigned from her role. The panel considered that the witnesses had nothing to gain from making false allegations.

On the evidence before it, including the statements of Ms 1, Ms 2 and Ms 3 which are all corroborative, the panel considered it more likely than not that the incident occurred as alleged. It therefore found Charge 2 proved.

Charge 3

3. *Following your actions at Charges 1 and 2 you told the two HCA's present, that "you did not see any of this", or words to that effect;*

This charge is found proved.

Ms 2's oral and written evidence corroborated the written contemporaneous statements of Ms 1. The panel accepted the oral evidence of Ms 1, a first-hand and credible witness, and could find no reason why she would make a false allegation.

The panel bore in mind that all of the written witness statements were sent to Miss Dunbar prior to these proceedings, and Miss Dunbar has not denied the allegations. Instead Miss Dunbar has stated that they are 'exaggerated'.

In view of the corroborative evidence before it, and on the balance of probabilities, the panel considered it more likely than not that the incident occurred as alleged. It therefore found Charge 3 proved.

Charge 4

4. *Your conduct at Charge 3 was dishonest in that your intention was to conceal your conduct;*

This charge is found proved.

Having found Charge 3 proved the panel reached the view that Miss Dunbar's intention could only have been to conceal her conduct.

The panel took account of the case of *Ivy v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67* and considered why Miss Dunbar would have said this, what her reasons were for saying this, and how her conduct would be viewed by fellow nursing professionals. The panel considered Miss Dunbar to be aware that her conduct was unacceptable and she intended to conceal it so as not to be reported, in so doing she was acting dishonestly. The panel therefore found Charge 4 proved.

Charge 5

5. *Your conduct at Charge 3 was carried out to pressure and/or persuade the two HCA's to conceal your conduct.*

This charge is found proved.

Having found Charge 3 proved, the panel considered Miss Dunbar was aware that her conduct was unacceptable. It reached the view that Miss Dunbar's intention could only have been to pressure/persuade Ms 1 and Ms 3 to conceal her conduct. The panel therefore found Charge 4 proved

Fitness to practise

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

Submissions on misconduct and impairment

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

Mr Slack invited the panel to take the view that the facts found proved amount to misconduct. He submitted that Miss Dunbar's actions involve a conviction for assaulting a resident in her care and clearly breach the standards expected of a registered nurse. He identified a number of specific standards of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) where Miss Dunbar's actions amounted to misconduct.

Mr Slack then 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. He referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that all four limbs of the test arising from this case were engaged. He highlighted to the panel that Miss Dunbar's misconduct had caused Resident A actual harm, brought the nursing profession into disrepute, breached fundamental tenets of nursing, and included dishonesty. He therefore invited the panel to find her fitness to practise currently impaired on the ground of public protection as well as the wider public interest.

The panel accepted the advice of the legal assessor which included reference to *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant and Mallon [2007] Scot CS CSIH17.*

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognising… individual choice

1.5 respect and uphold people's human rights.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.3 encourage and empower people to share decisions about their treatment and care

2.5 respect, support and document a person's right to accept or refuse care and treatment, and

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

4 Act in the best interests of people at all times

To achieve this, you must:

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

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

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

To achieve this, you must:

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

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

20.4 keep to the laws of the country in which you are practising

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel bore in mind that Miss Dunbar's conviction involved assaulting a resident in her care, which it considered to be a gross departure from the standards expected of a registered nurse and amounted to serious misconduct. It considered that Miss Dunbar's comment set out in Charge 2, when looked at in isolation,

was not serious misconduct. However, when considered in the context of her actions at Charge 1, the panel determined that it too amounted to serious misconduct.

The panel noted that Miss Dunbar was aware that her conduct was unacceptable and through her dishonesty she caused further distress to colleagues. Miss Dunbar's dishonesty caused her colleagues to be unaware of Resident A's care needs and a delay in Resident A receiving treatment.

The panel decided that both individually and cumulatively Miss Dunbar's conviction along with the facts found proved fell far below the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Dunbar'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 Resident A was caused physical and emotional harm as a result of Miss Dunbar's misconduct. Miss Dunbar's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, the panel 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 therefore found all four limbs of the Grant test engaged.

The panel bore in mind that dishonesty is difficult to remediate. Nonetheless, it carefully considered the evidence before it in determining whether or not Miss Dunbar has remedied her practice. There was nothing before the panel to suggest that Miss Dunbar has any insight into her misconduct, has taken any steps to remediate, or has displayed any remorse. From the information before it the panel considered that Miss Dunbar had attempted to deflect blame instead of taking responsibility.

In the absence of insight and any remedial action, the panel reached the view that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case and therefore also finds Miss Dunbar's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Dunbar off the register. The effect of this order is that the NMC register will show that Miss Dunbar 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 Slack informed the panel that the NMC sought the imposition of a Striking-Off Order. He submitted that Miss Dunbar's misconduct gave rise to serious attitudinal concerns which were underpinned by questions around her integrity. He submitted that to keep Miss Dunbar on the register would undermine public confidence in the nursing profession. Therefore, a striking-off order was the only order that would both protect the public as well as satisfy the public interest.

Having found Miss Dunbar'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:

- Miss Dunbar's misconduct resulted in actual harm to a vulnerable elderly patient with dementia;
- Miss Dunbar attempted to cover up the incident;
- Miss Dunbar failed to fully engage with the NMC as her regulator;
- There is evidence before the panel of attitudinal concerns which included dishonesty, a breach of duty of candour, misuse of power, and her assault of an elderly vulnerable patient, for which there was no evidence of remorse or regret;
- Miss Dunbar put pressure on her colleagues to conceal her misconduct.

The panel identified no mitigating features in Miss Dunbar's case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of Miss Dunbar's 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 Miss Dunbar's practice would not be appropriate. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Dunbar's misconduct, along with her conviction, were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Dunbar's registration would be a sufficient and appropriate response. The panel is of the view that given the seriousness of Miss Dunbar's conviction, along with the dishonesty found proven, no workable conditions could be formulated which would address the dishonesty and sufficiently mark the seriousness of the case and address the public interest.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

Miss Dunbar's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Dunbar's actions is fundamentally incompatible with her remaining on the register.

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

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

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

Miss Dunbar'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 Miss Dunbar's actions, resulting in a conviction, 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 determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Dunbar'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 this would be sufficient in this case.

The panel considered that this order was necessary to protect the public, 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 Miss Dunbar in writing.

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 Dunbar's own interest until the striking-off sanction takes effect.

The panel took account of the submissions made by Mr Slack 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 seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that 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 allow for any potential appeal period.

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

That concludes this determination.