Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

21 - 25 November 2022

2 Stratford Place, Montfichet Road, London, E20 1EJ

29 – 30 November 2022

19-21 December 2022

06 – 09 March 2023

Virtual hearing

Name of registrant:	**Ann Marie Peareth**
NMC PIN:	83D1232E
Part(s) of the register:	Nursing Sub part 2 Nursing Sub Part 1 RN6: Learning Disabilities nurse, level 2 (28 May 1985) RN5: Learning Disabilities nurse, level 1 (21 September 1999)
Relevant Location:	Durham
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Jayanti Durai (Lay member) John McGrath (Registrant member)
Legal Assessor:	John Bromley Davenport
Hearings Coordinator:	Roshani Wanigasinghe (21 November 2022) Amira Ahmed (22-30 November 2022, 19-21 December 2022 and 06-09 March 2023)
Nursing and Midwifery Council:	Represented by Rakesh Sharma, Case Presenter
Ms Peareth:	Not present and not represented

Facts proved:	1, 2, 4 a) ii), 4 c), 4 e), 5 a), b), c), 6 b), 7 a), b), d), e), 8 a), b), c) and 9
Facts not proved:	3 a), b), 4 a) i), b), d), 6 a), c), 7 c)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Peareth was not in attendance and that the Notice of Hearing letter had been sent to her registered email address noted on the Wiser System on 21 October 2022.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Ms Peareth's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Peareth

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

Mr Sharma submitted that throughout the case preparation stage Ms Peareth had been engaging with the case officer. He referred the panel to a number of communications from Ms Peareth which included email correspondence and telephone notes.

Mr Sharma submitted that on 23 September 2022 Ms Peareth said to the case officer via telephone call that she 'just wants the hearing to be over with.' He submitted that in the same communication Ms Peareth said that she would be prepared not to be present for the first five physical days of the hearing. Mr Sharma submitted that the proposed hearing dates were sent to Ms Peareth on 28 September 2022, however, she had not responded to the case officer.

Mr Sharma then submitted that on 21 October 2022, Ms Peareth had informed the case officer that she would be attending the hearing despite not taking up the offer of financial support to attend after informing the NMC of her financial hardship.

On 25 October 2022, Ms Peareth had failed to keep a telephone appointment arranged for her benefit to discuss the hearing process. He submitted that on 29 October 2022, Ms Peareth had emailed her case officer where she said: '*I have decided to resign from nursing and would appreciate if my name could be removed from the register'.*

On 4 November the case officer had emailed Ms Peareth following the above and asked if she wanted to engage in the proceedings or if she would be happy for the panel to proceed in her absence. Importantly, the case officer asked the following: '*I don't want to assume from your below email that you are don't wish to attend the hearing, although it does appear that way, it is up to you. I'd be really grateful if you could confirm either way, as requested above.'* No communication has been received from Ms Peareth since her last email on 29 October 2022 indicating that she wished to be removed from the NMC register.

Mr Sharma submitted that although the NMC accept there are no express terms used by Ms Peareth to say she will not attend, he submitted that an inference can be taken from Ms Peareth's communication, particularly the last message on 29 October 2022 followed by her non-engagement.

Mr Sharma submitted that Ms Peareth has been fully informed of her rights and has

chosen not to respond when asked by the case officer if she would attend. He submitted that the panel can safely conclude Ms Peareth has voluntarily absented herself. In these circumstances, he submitted that Ms Peareth is unlikely to attend any adjourned hearing.

Mr Sharma also submitted that the panel will have to consider any risk of unfairness to Ms Peareth. He submitted that any unfairness could be mitigated by the hearing process itself. During the hearing, the panel will have the opportunity to carefully assess the strength of all evidence and can test that evidence robustly where necessary.

The panel will hear from a number of live witnesses therefore areas of doubt or weakness/inconsistency can be explored by questioning. Mr Sharma submitted that Ms Peareth was given ample opportunity in the preparation stages to make objection to the written evidence and had failed to do so. Notwithstanding that, he submitted that there will be areas of evidence, particularly in relation to hearsay which the panel will be invited to rule upon with fairness in mind before they enter the hearing record for consideration.

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

- No application for an adjournment has been made by Ms Peareth;
- There is no reason to believe that adjourning would secure her attendance at some future date;

- Nine witnesses have been scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017,2018, 2020 and 2022; further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Peareth in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Peareth'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 and appropriate to proceed in the absence of Ms Peareth. The panel will draw no adverse inference from Ms Peareth's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse:

1. On 15 January 2017, failed to conduct hourly observations in respect of Patient A (2017).

2. During the night shift commencing on 08 February 2017, on being informed by Colleague A that Patient B would require social/personal care assistance overnight, stated in response, one or more of the phrases or words to the effect of those set out in Schedule 1.

3. During the night shift commencing on 08 February 2017, said to Patient B one or more of the following words or words to the effect of;

    a. that Patient B had “better not ring the [call] bell” and/or

    b. that Patient B would have to care for herself in the night.

4. On 02 October 2018, in relation to Patient D;

    a. made inadequate notes of the care provided to Patient D namely

      i) whether you physically attended to assess him during the night and/or

      ii) what pain relief you administered to Patient D

    b. did not carry out sufficient assessment of Patient D’s pain during the course of the night;

    c. did not carry out an assessment for Sepsis during the course of the night;

    d. did not carry out a NEWS assessment for Patient D when the pain relief was not sufficiently effective;

    e. Did not escalate Patient D for further review to a doctor

5. On 31 October 2020, during an incident involving Patient A (2020) you

a. stated "…if you kick us, we will kick you back" or words to that effect;

b. stated that you wished that there were no CCTV cameras around or words to that effect and/or

c. used the word or words to that effect set out in Schedule 2.

6. On 31 October 2020, during an incident involving Patient A (2020) you inappropriately

a. Applied a painful hold to Patient A's hand/wrists;

b. Raised your leg towards Patient A in attempt to kick or otherwise make contact with her and/or

c. Kicked or otherwise made contact with Patient A's leg with your leg or your foot.

Whilst working as a registered nurse at the Lindisfarne Care Home

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

a. Breached condition 1 by working as a sole nurse in charge of a shift;

b. Breached condition 3 by failing to provide evidence of successful completion of MAPA training or medical evidence showing why you could not, by 31 October 2021;

c. Breached condition 4 by not ensuring that you were supervised appropriately by a line manager, mentor or supervisor;

d. Breached condition 6 by not informing the NMC of your employment at Lindisfarne Care Home within 7 days of commencing the same and/or

e. Breached condition 8 in that you did not give a copy of the conditions placed upon your practice to the person you were working for.

8. On or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, you;

a. Did not complete an accident form/incident report;

b. Did not seek immediate medical input and/or send Patient 2 to hospital and/or

c. Did not immediately inform Patient 2's family.

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

9. On 01 February 2019, at Cleveland Magistrates Court, were convicted of the following offence;

'Driving a motor vehicle after consuming so much alcohol that the proportion of it in your breath, namely 73 microgrammes of alcohol in 100 millilitres of breath, exceeded the prescribed limit, contrary to section 5 (1) (a) of the Road Traffic Act 1988 and Schedule 2 of the Road Traffic Offenders Act 1988.'

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

Schedule 1

"Patient B can sit in their own urine for all I care"

"Well Patient B will have to sit in her own fucking piss"

"I won't be going in to Patient B's room"

Schedule 2

'Fuck'

Decision and reasons on application to amend the charge

At the start of the hearing, the panel heard an application made by Mr Sharma, on behalf of the NMC, to amend the wording of charges 1, pre-amble to charge 6, 8b and 8c.

The proposed amendments were to change Patient 1 to Patient A (2017) in relation to charge 1. This request was made as Patient 1 is referred to as Patient A throughout the evidence to charge 1. The addition of the specified year is to identify the correct Patient A as a different Patient A is referred to in charges 5 and 6. Patient A referred to in charges 5 and 6 will be referred to as Patient A (2020). In relation to the pre-amble of charge 6, he submitted that 30 October 2022 should be changed to 31 October 2022. In relation to charge 8b and 8c, Mr Sharma submitted that Patient 1 should be replaced with Patient 2. It was submitted by Mr Sharma that the proposed amendments would provide clarity and more accurately reflect the evidence.

He proposed the following:

1. That you, a registered nurse: 1. On 15 January 2017, failed to conduct hourly observations in respect of ~~Patient 1~~ **Patient A (2017)**.

6. On ~~30~~ **31** October 2020, during an incident involving Patient A **(2020)** you inappropriately

8. On or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, you;
   b. Did not seek immediate medical input and/or send Patient ~~1~~ **2** to hospital and/or;
   c. Did not immediately inform patient ~~1's~~ **2's** family.

Mr Sharma further submitted that charge 9 should be removed and disregarded by the panel and it may be added at a later stage during the course of the hearing.

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 accepted that charge 9 should be disregarded.

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

Prior to the live evidence in relation to charge 4, Mr Sharma made an application to amend the wording of charge 4 a) ii). He submitted that the word ‘prescribed’ in this charge is incorrect and it should actually be administered. The proposed amendment was to change the words ‘prescribed for’ to ‘administered to’ as this will accurately reflect the evidence.

Mr Sharma submitted that Ms Peareth was aware that she was not able to prescribe medication to Patient D as she is not a nurse prescriber. He submitted that it was Ms Peareth’s duty as a registered nurse to engage with her regulator, to participate in this hearing and make comments on the charges but she has chosen not to do so.

Mr Sharma proposed the following amendment to the charge:

4. On 02 October 2018, in relation to Patient D;

    a. made inadequate notes of the care provided to Patient D namely

        ii) what pain relief you ~~prescribed for~~ **administered to** Patient D

The panel accepted the advice of the legal assessor.

The panel determined to allow the amendment to this charge. The panel was satisfied that there would be no prejudice to Ms Peareth and no injustice would be caused to either party by the proposed amendments being allowed.

Decision and reasons on application to admit the written statement of Mr 1

The panel heard an application made by Mr Sharma under Rule 31 (1) to allow the written statement of Mr 1 into evidence. Mr Sharma submitted that there are some additions within Mr 1's first unsigned witness statement and the most recent signed witness statement dated 21 November 2022. He highlighted paragraph 5 and he asked the panel to disregard the second sentence added to the paragraph and in relation to paragraph 6 Mr 1 provides background to his employment with Cygnet Healthcare. He submitted that Mr 1 is scheduled to give evidence to the panel this week and therefore any concerns could be clarified with him at that time. He submitted that it is clear that the first statement provided appear to be the draft version of the final statement dated 21 November 2022.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Mr 1's witness statement serious consideration. The panel noted that Mr 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by him. It noted that the first witness statement was a prepared draft and had some missing information which was included in the more recent statement dated 21 November 2022.

The panel considered whether Ms Peareth would be disadvantaged by the new witness statement of Mr 1. The panel determined that Ms Peareth would not be disadvantaged given the statement was a draft version of the signed statement and because he is due to attend and provide evidence to the panel and therefore the panel could clarify any questions if they arise. The panel also bore in mind that there was also a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Mr 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on the hearsay applications

Mr Sharma submitted that this application is in relation to charge 6a. He submitted that the main evidence in relation to this charge appears from the CCTV footage. He submitted that it is of good quality however the panel will always be limited by the position of the camera. He therefore submitted that it would be helpful to admit into evidence the witness evidence of Mr 2. He submitted that Mr 2 would not be providing oral evidence to the panel. Mr Sharma submitted that the NMC had taken multiple steps to get in contact with this witness to no avail. He further submitted that Ms 1, Ms 2 and Mr 1 would all be providing evidence in relation to these charges and therefore the hearsay evidence of Mr 2 is not the sole and decisive evidence. He submitted that it would be fair to admit this evidence as the panel will be able to corroborate his statement with other witnesses and the CCTV evidence.

Mr Sharma then referred the panel to charge 8. He submitted that evidence from Ms 3 in relation to Patient 2 is highly relevant as she was the manager at the time and investigated the incident and provides background to the head injury of the patient. He submitted that Ms 4 is scheduled to provide evidence to the panel and that it is fair to admit Ms 3's evidence as the panel would be able to ask Ms 4 questions directly in relation to the documents she has exhibited. Mr Sharma submitted that the panel will be able to cross-reference the documents with the oral evidence and therefore would not be required to rely on Ms 3's evidence as sole and decisive evidence.

The panel accepted the advice of the leal assessor. He referred the panel to the case of *Thorneycroft* & *NMC* 2014 EWHC 1565 (Admin).

The panel accepted Mr Sharma's submissions in relation to admitting the evidence of Mr 2. The panel noted that it was not the sole and decisive evidence as it had CCTV evidence and three other witnesses which speaks to the events in relation to charge 5 and 6. The panel was of the view that it was also fair and relevant and no injustice would be caused by the admission of Mr 2's statement into evidence and therefore accepted the NMC's application.

In relation to the evidence of Ms 3, the panel did not accept the NMC's submissions. The panel determined that Ms 3's evidence is not relevant as there is already documentary evidence in relation to the charge. The panel bore in mind Mr Sharma's submissions about her evidence providing a background to the head injury. The panel noted the fact that the head injury took place is not disputed. Further, the panel was of the view that Ms 3's evidence does not advance the case any further as there is supplementary evidence from other witnesses, who are due to attend the hearing and from whom the panel can ask questions. The panel therefore rejected this application.

During the proceedings Mr Sharma made an additional application under 31 (1) to admit hearsay evidence. He referred the panel to a number of documents from the G4S investigation report which were directly in relation to charge 3 including the statement of Patient B, the signed and dated investigation meetings with Witness 1 and Witness 2. He referred the panel to the handwritten signed and dated report from Witness 2. He also drew the panel's attention to the inference from similar fact evidence in charge 2.

Mr Sharma submitted that the only eye witness in relation to charge 3 would be Patient B. He explained that the NMC have made all efforts to contact Patient B to give evidence at this hearing. He referred the panel to a note of detailed telephone call made to Patient B on 5 April 2022 by the NMC. He submitted that on 8 September 2022 Patient B was contacted again by telephone and she explained to a member Public Support Service team at the NMC that she was unwell and in hospital. She said *'if I'm better then I'll call you then'.* Mr Sharma submitted that Patient B is not going to be present at this hearing and that her hearsay evidence is fair and relevant and should be admitted.

Mr Sharma submitted that the evidence for this charge does not come from a single source as Patient B relayed the information to Witness 1 and Witness 2 and therefore their investigation meeting notes should also be admitted as hearsay evidence. He submitted that the evidence in charge 2 has a striking similarity to the hearsay evidence of charge 3. He told the panel that in charge 2 the words were directed to Colleague A and in this charge it was to Patient B. He submitted that Colleague A will be attending this hearing as a witness to give evidence and the panel can therefore draw inference from the similar fact evidence in charge 2.

The panel accepted the advice of the legal assessor.

The panel noted that all the documents have been dated and signed. It also noted that Ms Peareth had responded to the allegation during the investigation. Her response is also included in the documentary evidence.

The panel agreed that the hearsay evidence produced for charge 3 is similar fact evidence to the evidence supporting charge 2 and noted that Colleague A will be attending to give evidence on charge 2 and can be questioned by the panel.

The panel considered charge 3 to be a serious charge and determined that at this stage it had no reason to believe that parties would fabricate their statements. It decided that all the documentation referred to by Mr Sharma in relation to the charge is fair and relevant.

The panel therefore determined to allow all the hearsay evidence and will give it the weight it considers appropriate in due course.

Background

The charges against Ms Peareth can be broken down into three main areas, each occurring in different settings and over the space of approximately four and a half years. The background is set out below for each setting:

HMP Low Newton

During 2017 to 2018, Ms Peareth was working in HMP Low Newton (the Prison) as a registered nurse. On 15 January 2017, whilst Ms Peareth was working night shift, one of the patients under her care was Patient A (2017). Patient A had inflicted injuries to herself, hitting herself to the head with a metal flask. It is alleged that Ms Peareth failed to conduct hourly observations in respect of Patient A.

It is alleged that during the night shift of 08 February 2017, on being informed by Colleague A that Patient B would require social/personal care assistance overnight, Ms Peareth stated in response, one or more of the phrases or words to the effect of those set out in Schedule 1 of the charges. It is also alleged that on that same night shift Ms Peareth said to Patient B one or more of the following words or words to the effect of; 'that Patient B had "better not ring the [call] bell" and/or that Patient B would have to care for herself in the night'.

HMP Holme house

On 02 October 2018, in relation to Patient D it is alleged that Ms Peareth made inadequate notes of the care provided to Patient D namely; whether she physically attended to assess him during the night and/or what pain relief she administered to Patient D.

It is also alleged that Ms Peareth did not carry out a sufficient assessment of Patient D's pain during the course of the night; did not carry out an assessment for Sepsis

during the course of the night; did not carry out a NEWS assessment for Patient D when the pain relief was not sufficiently effective; and she allegedly did not escalate Patient D for further review to a doctor

Pippin ward at the Cygnet Appletree hospital

In October 2020, Ms Peareth was working as a registered nurse in Pippin ward at the Cygnet Appletree hospital (the Hospital). This was a psychiatric intensive care unit (PICU) and as such cared for some very unwell patients.

It was alleged that whilst working at the Hospital on 31 October 2020, during an incident involving Patient A (2020), Ms Peareth stated "…if you kick us, we will kick you back" or words to that effect. It is also alleged that Ms Peareth stated that she wished that there were no CCTV cameras around or words to that effect and/or allegedly used the word or words to that effect set out in Schedule 2 of the charges.

During the 31 October 2020 incident involving Patient A (2020) Ms Peareth is alleged to have also inappropriately applied a painful hold to Patient A's hand/wrists and raised her leg towards Patient A in attempt to kick or otherwise make contact with her. It is also alleged that Ms Peareth kicked or otherwise made contact with Patient A's leg with her leg or her foot.

Lindisfarne Care Home

In relation to Lindisfarne Care home (the Home) the allegations were that on or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, Ms Peareth allegedly did not complete an accident form/incident report. It is also alleged that Ms Peareth did not seek immediate medical input and/or send Patient 2 to hospital and/or did not immediately inform Patient 2's family.

It is alleged that whilst working at the Home and being investigated for the matters involving Patient 2, Ms Peareth was found to have breached an interim conditions of

practice order imposed by a panel of the investigating committee of the NMC. It is alleged that Ms Peareth breached condition 1 by working as a sole nurse in charge of a shift and also breached condition 3 by failing to provide evidence of successful completion of MAPA training or medical evidence showing why she could not, by 31 October 2021;

Ms Peareth also is alleged to have breached condition 4 by not ensuring that she was supervised appropriately by a line manager, mentor or supervisor; Ms Peareth breached condition 6 by not informing the NMC of her employment at Lindisfarne Care Home within 7 days of commencing the same and/or also breached condition 8 in that she did not give a copy of the conditions placed upon her practice to the person she was working for.

Decision and reasons on facts for misconduct case

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

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

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

- Ms 1: Clinical Manager at the Hospital at the time of event
- Ms 2: Bank Nurse at the Hospital at the time of event

- Mr 1: Support worker at the hospital at the time of events
- Ms 4: Regional Manager at Gainsford Care Homes at the time of events and carried out the investigation of the allegations at the Home
- Ms 5: Senior Investigator in the Professional Regulation Directorate at the NMC during the allegations at the Home
- Ms 6: Registered nurse who worked for G4S at the Prison during the allegations
- Colleague A: Acting Substance Misuse Care Coordinator at the Prison during the allegations
- Ms 7: Clinical Reviewer for Death in Custody in Prisons for NHS England during the allegations relating to the Prison

The panel also took note of the documentary evidence relating to:

- Mr 2: Support worker at the Hospital
- Ms 3: Manager of the Home

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

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

Charge 1

1. On 15 January 2017, failed to conduct hourly observations in respect of Patient A (2017).

This charge is found proved.

In reaching this decision, the panel took into account Ms Peareth's statement in which she explained that she was told to keep an eye on Patient A but was not told to conduct hourly neurological observations. She explained that she did do what she was asked and did keep an eye on the patient.

The panel noted that Ms 6 in her oral evidence was consistent with her first account in 2017. She was clear in her evidence that hourly neurological checks were required. Ms 6 explained that neurological checks entailed waking the patient up to check blood pressure, pupil reaction and dizziness. This would require Ms Peareth entering the cell.

The panel noted that the transcript of the CCTV footage demonstrated that Ms Peareth had failed to conduct the hourly neurological observations as she never entered the cell. The panel further noted that the transcript showed that Ms Peareth conducted cursory glances at the cell but without the use of a torch.

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

Charge 2)

2. During the night shift commencing on 08 February 2017, on being informed by Colleague A that Patient B would require social/personal care assistance overnight, stated in response, one or more of the phrases or words to the effect of those set out in Schedule 1.

This charge is found proved.

The panel took into account the oral evidence Colleague A which was consistent with her original statement. Colleague A had reported the incident straight away and was appalled by what she said she heard Ms Peareth say about Patient B. The panel found Colleague A to be credible.

The panel noted that Ms Peareth denied this charge in her statement.

The panel was satisfied by the evidence of Colleague A on the balance of probabilities in relation to this incident and therefore found this charge proved.

Charge 3)

3. During the night shift commencing on 08 February 2017, said to Patient B one or more of the following words or words to the effect of;

a. that Patient B had “better not ring the [call] bell” and/or

b. that Patient B would have to care for herself in the night.

This charge is found NOT proved in its entirety.

The panel took account of the fact that there were multiple hearsay statements regarding this charge and that there is no direct evidence from anyone that was present at the time of the alleged events.

The panel acknowledged that Ms Peareth has denied this happening during the investigation process.

It also noted the investigation interview notes form a prison officer (Oscar 2) who stated:

> *"… can't recall Anne speaking to Patient B and certainly never heard her being unprofessional towards her on the above date or any other day he had been on shift with Ann"*

The panel decided to place limited weight on the hearsay evidence in relation to this charge as it was not presented in a statement form but as typed interview documents. It also noted that the hearsay evidence was contradicted by Oscar 1.

The panel therefore determined that both 3 a) and 3 b) are found not proved.

Charge 4)

4. On 02 October 2018, in relation to Patient D;

a. made inadequate notes of the care provided to Patient D namely

i) whether you physically attended to assess him during the night and/or

This charge is found NOT proved.

The panel took account of Ms 7's evidence. It noted that it was not provided with examples of what was expected of a prison nurse at the time of the allegations. It also noted that the inadequate notes were not defined by Ms 7, and she did not explain in her evidence what would have been adequate.

The panel determined that due to the lack of evidence that Ms Peareth's notes were inadequate when she physically attended to assess Patient B, this charge is found not proved.

4. On 02 October 2018, in relation to Patient D;

a. made inadequate notes of the care provided to Patient D namely

ii) what pain relief you administered to Patient D

This charge is found proved.

The panel noted that Ms Peareth had recorded entering the cell and giving pain relief to Patient D on SystmOne. However, she had not explained in the patient notes what pain relief or dosage she gave. The panel were informed by Ms 7 that this information was important for the nurses that would be making subsequent checks.

It therefore determined that this charge was found proved.

4. On 02 October 2018, in relation to Patient D

b. did not carry out sufficient assessment of Patient D's pain during the course of the night;

This charge is found NOT proved.

The panel made note of the fact that Ms 7 in her oral evidence stated that not all the documentary evidence was presented to her by the Prison and there could be extra documentation that the panel are unaware of regarding pain assessments including a pain chart.

The panel noted that the Health Care Assistant's (HCA's) entry differs from Ms Peareth's as she said after giving the pain relief Patient D seemed to sleep well. The

panel also noted that a lot of emphasis was put on Ms Peareth's use of 'small effects' but it did not have detail of what that means.

Ms Peareth was never interviewed regarding this matter to give her account.

The panel found that, on the balance of probabilities there was insufficient evidence to prove that the assessments of Patient D's pain on 2 October 2018 were not carried out. Therefore, this charge is found not proved.

4. On 02 October 2018, in relation to Patient D

c. did not carry out an assessment for Sepsis during the course of the night;

This charge is found proved.

The panel took account of Ms 7's witness statement and oral evidence.

In Ms 7's oral evidence she explained that she would have expected to see a sepsis assessment. The panel have seen the copies of SystmOne which contains no entry for a sepsis assessment.
It found that there was no evidence to prove that Ms Peareth did carry out a sepsis assessment during the night and there is also no mention of it in Patient D's notes.

The panel therefore found this charge proved.

4. On 02 October 2018, in relation to Patient D

d. did not carry out a NEWS assessment for Patient D when the pain relief was not sufficiently effective;

This charge is found NOT proved.

The panel noted that there was no evidence of a NEWS assessment for Patient D in the documentation. The panel queried the evidence that the pain relief that was given by Ms Peareth was not sufficiently effective. It noted that Ms Peareth and the HCA gave contradictory accounts of what happened that night. The panel decided much like in charge 4 b) it was unclear whether Patient D continued to be in pain and therefore required a NEWS assessment. Therefore, the panel found this charge not proved.

4. On 02 October 2018, in relation to Patient D

e. Did not escalate Patient D for further review to a doctor

This charge is found proved.

The panel took account of the documentary evidence in relation to this charge. It noted that there was no evidence of an entry in Patient D's notes to say that Ms Peareth had escalated the Patient for a further review to a doctor. Therefore, the panel found this charge proved.

Charge 5)

5. On 31 October 2020, during an incident involving Patient A (2020) you

a. stated "…if you kick us, we will kick you back" or words to that effect;

This charge is found proved.

The panel took into account the evidence provided by Ms 2. It decided that her evidence was credible as she was clear about what she heard in her contemporaneous account. The panel noted that Ms 2's oral evidence was consistent with the contemporaneous account.

The panel also noted that Mr 2 corroborated Ms 2's evidence in his written notes made during the local investigation. Mr 2 explained that Ms Peareth said:

"She would fucking kick her back."

The panel also considered Ms Peareth's fact finding meeting in relation to this charge which took place on 5 November 2020 in which she admitted to saying 'I can kick as well you know' on the date of the incident in the charge.

Therefore, the panel found this charge proved.

5. On 31 October 2020, during an incident involving Patient A (2020) you

b. stated that you wished that there were no CCTV cameras around or words to that effect and/or

This charge is found proved.

The panel decided that Ms 2 was credible and clear in her evidence. The panel had sight of the CCTV footage and it determined that Ms Peareth did look at the cameras as described by Ms 2.

The panel decided that on the balance of probability, it is more likely than not that Ms Peareth did state that she wished that there were no CCTV cameras around or words to that effect. Therefore this charge is found proved.

5. On 31 October 2020, during an incident involving Patient A (2020) you
c. used the word or words to that effect set out in Schedule 2.

This charge is found proved.

The panel again noted that Ms 2's evidence in relation to this charge was credible and clear. She was consistent about what she heard Ms Peareth say in her contemporaneous account, her witness statement and in her oral evidence. Mr 2 in his statement at the local investigation corroborated this account. He also said in his account to the local investigation that Ms Peareth used that language.

Mr 2 explained that Ms Peareth said:

> *"She would fucking kick her back."*

Ms Peareth denies swearing and that this ever occurred in her own statement.

The panel decided that on the balance of probabilities Ms Peareth had used the words or words to that effect set out in Schedule 2 and therefore found this charge proved.

Charge 6)

6. On 31 October 2020, during an incident involving Patient A (2020) you inappropriately

a. Applied a painful hold to Patient A's hand/wrists;

This charge is found NOT proved.

The panel considered all the documentary evidence in relation to this charge. It noted that none of the live witnesses pointed out when Ms Peareth used this hold on the CCTV footage when shown it. It also noted no witnesses provided evidence that Patient A (2020) was in pain at any time during the incident on 31 October 2020.

Ms Peareth in a fact-finding meeting after the incident occurred stated that she only knows one restraint and demonstrated the technique on herself and does not admit to using that on Patient A (2020).

The panel therefore decided that there is a lack of sufficient evidence to find this charge proved.

6. On 31 October 2020, during an incident involving Patient A (2020) you inappropriately

> b. Raised your leg towards Patient A in attempt to kick or otherwise make contact with her and/or

This charge is found proved.

Ms Peareth said at her fact finding meeting after the incident that she tried to 'block' Patient A (2020) from kicking her. She said her movement was a 'block' movement.

The panel took into account the of the witness statements and oral evidence of both Ms 2 and Mr 1 who stated that Ms Peareth did raise her leg in the incident with Patient A (2020). The panel also noted that the CCTV footage showed some kind of leg movement and a raising of the leg by Ms Peareth in an attempt to kick or otherwise make contact with Patient A (2020). The account in which Mr 2 gave at the local investigation also corroborates that this happened.

The panel considered Ms Peareth's explanation at the local investigation in which she said that she tried to 'block' Patient A (2020) from kicking her. She stated that her movement was a 'block' movement not a 'kick'.

The panel decided that based on what it had viewed on the CCTV footage and the witnesses accounts of the incident, this charge was found proved.

6. On 31 October 2020, during an incident involving Patient A (2020) you inappropriately

c. Kicked or otherwise made contact with Patient A's leg with your leg or your foot**.**

This charge is found NOT proved.

In regards to this charge the panel considered that none of the witnesses were able to say if there was contact made with Patient A (2020) from Ms Peareth during the incident.

The panel noted that it was told that when Patient A (2020) was given a welfare check after the incident there was no evidence of bruising to her. The panel also noted that the CCTV footage did not show contact being made and Ms Peareth had also denied kicking Patient A (2020) during the incident.

The panel in light of the lack of evidence, found this charge not proved.

Charge 7)

Whilst working as a registered nurse at the Lindisfarne Care Home

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

a. Breached condition 1 by working as a sole nurse in charge of a shift;

This charge is found proved.

The panel took into account the oral evidence of Ms 4 and a statement in which she confirmed that Ms Peareth had been the sole nurse in charge on 30 August 2021.

The panel noted that Ms Peareth had been sent two letters on 15 December 2020 and 2 July 2021 informing her that she had interim conditions of practice orders imposed and confirmed on her practice. The panel noted that the interim conditions practice order stated that Ms Peareth could not work as the sole nurse in charge of a shift.

The panel noted the telephone call made by Ms 5 on 6 September 2021 to Ms 3, the Manager of the Home. During this call, Ms 3 stated:

"…it is difficult to assess what happened as she was the only nurse working".

Ms 5 conducted a further telephone call with Ms 3 on 8 September 2021 who informed Ms 5 that she was not aware that Ms Peareth could not be the sole nurse working on any shift. Ms 4 explained in her oral evidence that Ms Peareth was the sole nurse working on Bank Holiday Monday, 30 August 2021. She also confirmed that Ms Peareth had not made her aware that she could not be the sole nurse working any shift. The panel noted that the Home had never been provided with the letters detailing her interim conditions of practice order.

The panel therefore found this charge proved.

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

b. Breached condition 3 by failing to provide evidence of successful completion of MAPA training or medical evidence showing why you could not, by 31 October 2021;

This charge is found proved.

The panel took into account the interim conditions of practice orders dated 15 December 2020 and 2 July 2021 that were provided by Ms 5 as part of her documentary evidence. It noted that the onus was on Ms Peareth to provide

evidence that she had complied with the interim conditions of practice order and she did not do so.

Ms 5 in her witness statement explained that Ms Peareth did not provide the NMC with evidence of successful completion of the Management of Actual or Potential Aggression (MAPA) training by 31 October 2021 or to date.

Ms 5 also stated that Ms Peareth did not provide the NMC with proof of any medical evidence which shows that she is unable to undertake this training due to health reasons.

The panel also noted that it had not received any information from Ms Peareth regarding compliance with this particular condition.

The panel therefore found this charge proved.

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

c. Breached condition 4 by not ensuring that you were supervised appropriately by a line manager, mentor or supervisor;

This charge is found NOT proved.

The panel took account of all the documentary evidence in relation to this charge. It noted that Ms Peareth had provided her own handwritten documentation of supervision meetings and the NMC failed to provide evidence that she did not ensure she was supervised or that these meetings did not occur.

Ms 3 explained in an email dated 27 May 2021 to the NMC that she was aware that Ms Peareth needed supervision. She stated:

"I was informed by my manager in regards to the situation and was due to give AMP regular supervisions (6 weekly)…"

The panel therefore on the balance of probabilities found this charge not proved.

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

d. Breached condition 6 by not informing the NMC of your employment at Lindisfarne Care Home within 7 days of commencing the same and/or

This charge is found proved.

Ms 5 in her witness statement stated that Ms Peareth failed to inform the NMC within seven days about her updated employment status. She explained that Ms Peareth informed the NMC on 20 May 2021 via email that she commenced employment at the Home on 4 January 2021.

The panel noted that there was no evidence from Ms Peareth that she had informed the NMC before this and therefore found this charge proved.

7. Breached an interim conditions of practice order imposed by a panel of the investigating committee of the Nursing and Midwifery Council ("NMC") in that you;

e. Breached condition 8 in that you did not give a copy of the conditions placed upon your practice to the person you were working for.

This charge is found proved.

In Ms 5's oral evidence and witness statement she explained that Ms 3 confirmed in a telephone call with her that Ms Peareth made her as the Home manager aware that the supervision documents were to be sent to the NMC but that she was not aware of any other conditions placed on her practice.

The panel noted that Ms 3 stated that Ms Peareth never provided a copy of the Interim conditions of practice order. This was confirmed by Ms 4 who told Ms 5 that she was never provided a copy of the interim conditions of practice order by Ms Peareth. The panel also noted that Ms 4 in her witness statement explained that she was only aware of the conditions in place when she conducted a PIN check on Ms Peareth's registration.

The panel therefore found this charge proved.

Charge 8)

8. On or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, you;

a. Did not complete an accident form/incident report;

This charge is found proved.

The panel took account of all the documentary evidence in relation to this charge. It noted that Ms 4 stated in her witness statement and oral evidence that Ms Peareth did not complete an accident form/incident report. The panel also noted that the care plan for Patient 2 explicitly said that any falls were to be recorded on an accident form/incident report.

No evidence of the accident form/incident report being completed by Ms Peareth was provided to the panel. It therefore determined that this charge is found proved.

8. On or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, you;

b. Did not seek immediate medical input and/or send Patient 2 to hospital and/or

This charge is found proved.

The panel took account of the care plan for Patient 2 which explicitly states that any head injuries need immediate medical input. It noted that Ms Peareth at the time documented that she applied three sterile strips and did observations but did not seek any other medical attention.

The panel also noted that in the handover and daily accountability notes Ms Peareth documents the actions she took but there is no record of a professional visiting in relation to this injury.

The panel therefore found this charge proved.

8. On or around 30 August 2021, after Patient 2 suffered a head injury to his left forehead, you;

c. Did not immediately inform Patient 2’s family.

This charge is found proved.

The panel noted the documentary evidence it had been provided in relation to this charge. It noted that there was no entry on the communication to relatives form by Ms Peareth to say that she did contact the family of Patient 2.

Ms 4 informed the panel in oral evidence that the family should be informed immediately or if that is not possible at least on the same day.

The panel also took account of the admission of Ms Peareth that she did not contact the family of Patient 2 in relation to the head injury he had suffered.

The panel noted that Ms Peareth said in the handover note at the time that she couldn’t find Patient 2’s relatives’ number and would try again on Wednesday (two days later) to contact them.

The panel determined that Ms Peareth clearly did not abide by the care plan in place for Patient 2 by not immediately contacting his family after the head injury he had suffered. Therefore, it found this charge proved.

Decision and reasons on service of Notice of Hearing for Conviction case

Once the panel handed down its decision on facts for charges 1-8, Mr Sharma drew its attention to charge 9. He submitted that the notice of hearing which included this charge has been served accordingly to Ms Peareth on 21 October 2022.

The panel accepted the advice of the legal assessor.

The panel were therefore satisfied that Ms Peareth has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Peareth

Mr Sharma submitted that throughout the hearing he has ensured that the case officer has made attempts at contacting Ms Peareth to ask her whether she would like to attend the hearing.

He submitted that she has made clear that she has voluntarily absented herself and has not made any contact with the NMC since the start of the hearing.

The panel accepted the advice of the legal assessor.

The panel noted the attempts that were made to contact Ms Peareth by the NMC.
It also noted that she has not made an application for an adjournment and there is
a strong public interest in the expeditious disposal of the case.

The panel therefore determined to proceed in the absence of Ms Peareth in
relation to the decision for the conviction case. It noted that the NMC will be

sending her the determination on all the facts and reminding her that she can still make the decision to join the hearing at this stage.

Decision and reasons on facts for conviction case

Charge 9)

9. On 01 February 2019, at Cleveland Magistrates Court, were convicted of the following offence;

> 'Driving a motor vehicle after consuming so much alcohol that the proportion of it in your breath, namely 73 microgrammes of alcohol in 100 millilitres of breath, exceeded the prescribed limit, contrary to section 5 (1) (a) of the Road Traffic Act 1988 and Schedule 2 of the Road Traffic Offenders Act 1988.'

This charge concerns Ms Peareth's conviction and, having been provided with a certified copy of the memorandum of conviction, the panel finds that this charge is found proved in accordance with Rule 31 (2) and (3).

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Peareth's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Mr Sharma referred the panel 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 Sharma invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Sharma identified the specific, relevant standards where Ms Peareth's actions amounted to misconduct. He submitted the conduct found proved in this case is wide ranging, spanning several diffident workplaces where care was being given. He submitted that Ms Peareth's conduct also spans a considerable time of over three years. He concludes that the conduct found proved both individually and collectively falls far short of the behaviour reasonably expected of a registered nurse.

Submissions on impairment

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

Mr Sharma submitted that some of the fundamental tenets of the profession had been breached by Ms Peareth given the charges found proved. He submitted that these include providing adequate and compassionate care, avoiding conflict or physical abuse of patients and accurate assessment and documentation when dealing with vulnerable residents and patients.

In relation to charge 9, Mr Sharma submitted it would be a matter for the panel to decide if this conduct is likely to have brought the profession into disrepute.

Mr Sharma submitted that the first three limbs of the *Grant* test are engaged in this case. He submitted that Ms Peareth has failed to show insight into these matters and without evidence of insight the NMC cannot say that these concerns are 'highly unlikely' to be repeated. He therefore concluded that a finding of impairment is necessary on public protection and public interest grounds.

The panel accepted the advice of the legal assessor.

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 determined that charges 4 c) and e) did not amount to misconduct. It noted that on SystmOne Ms Peareth explained that Patient D slept through the night and therefore there was no reason to suspect sepsis or escalate to a doctor at that time.

The panel was of the view that Ms Peareth's actions in charges 1, 2, 4 a) ii), 5 a), b), c), 6 b), 7 a), b), d), e), 8 a), b), c) and 9 fell significantly short of the standards expected of a registered nurse. It determined that her actions in these charges also amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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

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

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stage

6 Always practise in line with the best available evidence

6.2 maintain the knowledge and skills you need for safe and effective practice

10 Keep clear and accurate records relevant to your practice

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

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

20 Uphold the reputation of your profession at all times

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the conduct found proved in this case is serious, wide ranging and spanned over three years in different work environments. It also noted that Ms Peareth's conduct includes receiving a conviction as well as her clinical failings during the three-year period. The panel therefore found that Ms Peareth's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Peareth'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. 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) …*

The panel finds that patients were put at risk of physical and psychological harm as a result of Ms Peareth's misconduct. The panel determined that Ms Peareth's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if Ms Peareth's regulator did not find such charges serious.

The panel did take into account Ms Peareth's response bundle and the fact that she has previously engaged with the NMC during her interim order hearings where she was represented. The panel noted Ms Peareth's long career as a nurse and the certificates of commendations she received between 2004 to 2014. However, it noted that it had no evidence from Ms Peareth before it regarding remorse or strengthening of her practice in relation to the clinical and attitudinal deficiencies identified in the charges for this hearing.

The panel determined that Ms Peareth has demonstrated very limited insight into her actions. It did note that there are two supervision notes where she has reflected on her behaviour but since then there has been no relevant information from her in regard to her practice. The panel also noted that whilst Ms Peareth referenced a stressful personal time during 2019, she has not provided it with any mitigating factors for her actions and has recently stated that she no longer wishes to practice as a nurse.

The panel is of the view that there is a high risk of repetition as Ms Peareth has not taken full responsibility for her actions and has displayed deep seated attitudinal issues. 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Peareth's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Peareth'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 Ms Peareth off the register. The effect of this order is that the NMC register will show that Ms Peareth 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 Sharma submitted a striking off order is required in this case. He explained that there are elements shown in this case and the facts found proved which raise fundamental questions about Ms Peareth's suitability to remain on the Register.

Mr Sharma submitted that the cumulative effect of the clinical errors and omissions, the attitudinal concerns, the attempted physical abuse and the breach of regulatory requirements all combine to create a case in which the ultimate sanction is the minimum required to both protect the public and maintain confidence in the profession.

Decision and reasons on sanction

Having found Ms Peareth'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:

- Ms Peareth's lack of insight into her failings;
- Her conduct over a period of time in three different work environments;
- She put patients at risk of physical and psychological harm;
- Lack of remorse for her failings;
- Apportioning blame to others.

In terms of mitigating factors the panel found no professional mitigating factors and had received no representations regarding personal mitigation.

The panel noted that Ms Peareth had been a nurse for 40 years with no previous referrals to the NMC.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Peareth's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the*

spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Ms Peareth's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order nor would a caution order protect the public.

The panel next considered whether placing conditions of practice on Ms Peareth's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the range of Ms Peareth's clinical and attitudinal failings. In addition, her breaching of her interim conditions of practice order would suggest a conditions of practice order as a sanction would not protect the public. Furthermore, the panel concluded that the placing of conditions on Ms Peareth's registration would not adequately address the seriousness of this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel noted Ms Peareth's conduct:

- was deliberate and she misused her power
- involved vulnerable patients
- included multiple incidents in a variety of environments
- showed no real insight
- evidenced deep seated attitudinal issues
- poses a high risk of repetition
- in that she failed to engage with these proceedings.

The panel decided that the misconduct found in this case, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Ms Peareth's actions are fundamentally incompatible with her remaining on the register. The panel therefore

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 each of which in the panel's judgement apply in this case:

- *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?*

The panel was of the view that the findings in this particular case demonstrate that Ms Peareth's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Peareth'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 mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Ms Peareth 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 Ms Peareth's own interests until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Mr Sharma. He submitted that an interim suspension order for a period of 18 months to cover the appeal period would be appropriate.

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.

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

That concludes this determination.