Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 30 October 2023 – Thursday 2 November 2023
Monday 6 November 2023 – Thursday 9 November 2023

Virtual Hearing

Name of Registrant:	**Lynsey Ann Brown**
NMC PIN	97I0086N
Part(s) of the register:	Registered Nurse – Sub Part 1 Learning Disabilities Nursing – (25 September 2000)
Relevant Location:	Belfast
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Richard Curtin (Registrant member) Carol Porteous (Registrant member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Charis Benefo
Nursing and Midwifery Council:	Represented by Callum Morgan, Case Presenter
Miss Brown:	Present and represented by John Mackell BL, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a, 1b, 1c, 2, 3, 4, 5a and 5b
Facts proved:	Charges 6
Facts not proved:	Charges 7 and 8
Fitness to practise:	Impaired

Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge [as amended]

That you, a Registered Nurse:

1. Between 11 February 2020 and May 2020:
   a. On one or more occasion, left medication on Resident A's table which was not medication for Resident A;
   b. Called Resident B by the wrong name when administering medication;
   c. Left a pill pot with medication in it unattended.

2. Between 11 February 2020 and 20 July 2020, dispensed medication for 3 residents (60ml of paracetamol) into one cup when individual cups should have been used for each resident.

3. Between 09 July 2020 and 10 July 2020, left 20mg of Memantine in a resident's room which was labelled for another resident.

4. On an unknown date in March 2020, said to Colleague A *"you are full of shit"* or words to that effect.

5. Between 11 February 2020 and 20 July 2020 said to Colleague B:
   a. "*I just wish I could do my job without you being a dick head to me*", or words to that effect;
   b. "*You are a prick, that's what you are that's why I'm calling you prick*", or words to that effect.

6. Between 20 May 2020 and 20 July 2020, told one or more colleagues that Colleague B had inserted a catheter into Resident D's bottom.

7. Your actions at charge 6 were dishonest in that you knew Colleague B had not made the clinical error you were attributing to him.

8. Your actions at charge 6 were intended to bully Colleague B by spreading lies which undermined his clinical skills.

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

At the outset of the hearing, the panel heard from Mr Mackell, on your behalf, who informed the panel that you made admissions to charges 1a, 1b, 1c, 2, 3, 4, 5a and 5b.

The panel therefore found charges 1a, 1b, 1c, 2, 3, 4, 5a and 5b proved, by way of your admissions.

Background

The Nursing and Midwifery Council (NMC) received a referral in respect of you on 28 July 2020. You first entered onto the NMC's register as a Learning Disabilities Nurse on 25 September 2000.

The allegations in this case arose whilst you were employed as a Staff Nurse at Glenmachan Tower House Nursing Home (the Home), a residential care home for the elderly. You started working at the Home in February 2020.

The charges in this case relate to unsafe medication practices and your behaviour towards colleagues between February and July 2020.

It was alleged that between 11 February 2020 and May 2020, you left medication on Resident A's table which was not medication for Resident A. You also allegedly called Resident B by the wrong name when administering medication to him, and in response, Resident B refused to take his medication. On another occasion, it was alleged that you left a pill pot with medication in it unattended.

Between 11 and 13 July 2020, whilst working a night shift, you allegedly dispensed 60ml of paracetamol for three residents into one cup when individual cups should have been used for each of these residents. It was alleged that Colleague B, the Deputy Manager, witnessed you doing so and told you that this was not how to dispense medication to separate residents.

It was then alleged that between 9 July 2020 and 10 July 2020, whilst working a night shift, you left 20mg of Memantine in a resident's room which was labelled for another resident.

On an unknown date in March 2020, it was alleged that after being asked to put on a face mask by Colleague A (a Care Assistant at the Home), you said to Colleague A "*you are full of shit*" or words to that effect.

Further, it was alleged that between 11 February 2020 and 20 July 2020, Colleague B asked you what was wrong and why you were so quiet, and in response you said to him "*I just wish I could do my job without you being a dick head to me*", or words to that effect. In addition, it was alleged that while conducting pump training with you, Colleague B stated that he did not like the tension between you and him, that he was hurt and upset by what you had called him earlier and asked for an apology. In response, you allegedly told Colleague B "*You are a prick, that's what you are that's why I'm calling you prick*", or words to that effect.

You then allegedly told one or more colleagues, between 20 May 2020 and 20 July 2020, that Colleague B had inserted a catheter into Resident D's bottom. It is alleged that in doing so, you were dishonest in that you knew Colleague B had not made any such clinical error. It is also alleged that your actions were intended to bully Colleague B by spreading lies which undermined his clinical skills.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Morgan, on behalf of the NMC, to amend the wording of charges 7 and 8 under Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The proposed amendment was to correct the pronoun ascribed to Colleague B in charges 7 and 8. It was submitted by Mr Morgan that the proposed amendments would not cause any prejudice or unfairness to you, but would provide clarity and more accurately reflect the evidence.

That you, a registered nurse:

7. Your actions at charge 6 were dishonest in that you knew Colleague B had not made the clinical error you were attributing to ~~her~~ **him**.

8. Your actions at charge 6 were intended to bully Colleague B by spreading lies which undermined ~~her~~ **his** clinical skills.

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

Mr Mackell, on your behalf, submitted that he had no issue with the proposed amendments to charges 7 and 8.

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

The panel noted that the proposed amendments were to correct a typographical error. It was of the view that the amendments, as applied for, were in the interest of justice and did not materially affect the gravamen of the charge. The panel was satisfied that there would be no prejudice to you 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.

Decision and reasons on application to admit Witness 5's written statement into evidence as hearsay

The panel heard an application made by Mr Morgan under Rule 31 to admit Witness 5's written statement and corresponding exhibits into evidence as hearsay. He submitted that Witness 5's evidence was relevant and fair. Mr Morgan submitted that this evidence pointed to charges 6, 7 and 8. He submitted that the NMC sought to rely on Witness 5's evidence in order to pursue the NMC's statutory objective and progress the hearing as expeditiously and fairly as possible.

Mr Morgan asked the panel to consider the relevant principles from paragraph 56 of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) in making its decision.

Mr Morgan submitted that Witness 5's evidence was not the sole or decisive evidence in support of charges 6, 7 and 8. He reminded the panel that it had also heard the evidence of four other NMC witnesses in relation to those charges.

Mr Morgan submitted that the nature and extent of the challenge to the contents of Witness 5's statement was not clear, nor was there any suggestion that she had fabricated the contents of her statement. He submitted that there was also no suggestion in cross-examination that any of the witnesses had fabricated their allegations. Mr Morgan submitted that the charges are serious as they include allegations of dishonesty.

Mr Morgan submitted that there was good reason for Witness 5's non-attendance. Mr Morgan stated that on 5 October 2023, Witness 5 contacted the NMC stating that she had received the Notice of Hearing, but that she would be out of the country from 25 October 2023 until 5 November 2023. Witness 5 also indicated that this was the first time that she

had been contacted about the hearing dates. Mr Morgan told the panel that the NMC had emailed Witness 5 in June 2023 to advise her of a likely hearing being listed between October 2023 and April 2024, but there had been no response. Witness 5 had responded by indicating that some emails from the NMC were not picked up because they went into the Home's '*junk*' email folder automatically. Mr Morgan submitted that the NMC did not have any concerns about Witness 5 engagement with these proceedings.

Mr Morgan informed the panel that there had been some communication between the NMC and your representative at the RCN about this matter. He stated that an email was sent to the RCN on 11 October 2023 notifying them that Witness 5 would not be attending the hearing and that an application to admit her evidence as hearsay would be made in the hearing.

Mr Morgan told the panel that in a response to the NMC on 18 October 2023, the RCN indicated that they were '*happy to agree*' to the application to admit Witness 5's evidence as hearsay in the hearing. He submitted that the NMC had provided prior notice of the position to the RCN.

Mr Morgan invited the panel to read Witness 5's evidence in order to make a decision on whether to admit it as hearsay. He submitted that the panel would not be able to judge its relevance and fairness without doing so. Mr Morgan submitted that if the panel was minded to refuse the application, then as a professional panel, it would be able to put what it had read out of its mind.

In response, Mr Mackell indicated that the application to admit Witness 5's evidence as hearsay was not contested.

Mr Mackell submitted that whilst he was not contesting this particular application, he would ask the panel to be mindful of the weight placed on evidence where the author of such evidence was not present and would not be subject to cross-examination. He submitted that any potential gaps in that evidence would also have to be assessed accordingly, in

the absence of Witness 5. Mr Mackell submitted that reassurance had been provided insofar as the reasons for Witness 5's non-attendance. In addition, he accepted that Witness 5's evidence was not sole and decisive in relation to charges 6, 7 and 8.

The panel accepted the legal assessor's advice. The legal assessor referred the panel to Rule 31, which provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred to a number of cases including *Thorneycroft v NMC* and *El Karout vs NMC* [2019] EWHC 28 (Admin). He referred the panel to the factors set out in those cases that should be taken into account when considering hearsay applications.

The panel considered the NMC guidance on evidence, as well as the principles set out in paragraph 56 in the case of *Thorneycroft.*

The panel had regard to Witness 5's evidence, which comprised of her written statement dated 17 March 2022 and corresponding exhibits. It noted that Witness 5's written statement had been prepared in anticipation of being used in these proceedings and contained a signed statement of truth. The panel considered that Witness 5's evidence was relevant to charges 6, 7 and 8.

The panel was satisfied that Witness 5's evidence was not the sole and decisive evidence in respect of charges 6, 7 and 8.

The panel had heard from Mr Mackell that you did not challenge the contents of Witness 5's written statement, and that you did not oppose the application to admit her written statement into evidence as hearsay.

There was no evidence before the panel to suggest that Witness 5 had reason to fabricate her evidence.

The panel was satisfied that charges 6, 7 and 8 were serious, involving alleged dishonesty and bullying.

The panel noted that there was a good and cogent reason for Witness 5's non-attendance at the hearing. Witness 5 had informed the NMC that she would be abroad during the scheduled hearing dates. The panel took account of the attempts made by the NMC to secure Witness 5's attendance at the hearing. The panel was satisfied that Witness 5 had taken all possible steps to engage with the NMC by submitting her written statement and corresponding exhibits. The panel noted that Witness 5 is a registered nurse with a duty to comply with her regulator and it had no reason to believe that Witness 5 had intentionally absented herself from giving live evidence in these proceedings.

The panel was also satisfied that your representative at the RCN had been put on notice about Witness 5's non-attendance prior to the start of this hearing, and in a response dated 18 October 2023, your representative agreed for Witness 5's evidence to be admitted as hearsay in her absence.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 5 to that of a written statement. The panel considered that as a result of Witness 5's non-attendance, the panel and parties would be deprived of the opportunity of questioning and probing her testimony. However, the panel took into account that you did not oppose the application in respect of Witness 5. There was also nothing before the panel to suggest that it would be unfair to you to admit Witness 5's hearsay evidence. It was the panel's view that there was a public interest in the issues being explored fully which supported the admission of Witness 5's evidence into the proceedings.

Taking all of the above matters into account, the panel concluded that Witness 5's written statement and exhibits were relevant to the charges and that it would be fair to admit it into evidence as hearsay. In reaching this decision, the panel noted that it would be able to

attach such weight as it deemed appropriate to Witness 5's hearsay evidence once it had heard and evaluated all of the evidence before it at the fact-finding stage.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Mackell that there is no case to answer in respect of charges 6, 7 and 8. This application was made under Rule 24(7). This rule states:

> *'24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*
>
> *(i) either upon the application of the registrant, or*
> *(ii) of its own volition,*
>
> *the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'*

In relation to this application, Mr Mackell submitted written and oral submissions.

Mr Mackell asked the panel to consider the evidence presented by the NMC in relation to charges 6, 7 and 8.

Mr Mackell referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 which, in his submission, required the panel to consider the following two questions or limbs:

- Whether there is any evidence of the complaints raised; if not, the facts should be deemed not to have been proven.
- Whether the evidence taken at its highest is such that a panel properly directed

could not properly convict upon it; it is the panel's duty in such circumstances to deem the facts not to have been proved.

Mr Mackell submitted that his application was primarily grounded in the second limb of *R v Galbraith*.

In relation to charge 6, Mr Mackell submitted that the only direct evidence came from Colleague A and Witness 3, who were the witnesses you are alleged to have spoken about the catheter issue with.

Mr Mackell referred to Colleague A's account in her written statement that whilst working a night shift on 21 May 2020, she was sitting with you, Colleague C and Colleague D when you said that Resident D's catheter had been inserted '*into the wrong hole (up the back passage)*' and that '*it was probably [Colleague B], the Deputy Manager that had done this*'. Colleague A had indicated that this was repeated a number of times and that '*we all heard her say it*'.

Mr Mackell then referred to the local statement of Colleague C, who was also present when the issue of the catheter was discussed. He highlighted that Colleague C recalled the matter being discussed yet did not refer to you mentioning Colleague B's name at any stage in her statement. He submitted that the only evidence that Colleague B's name was mentioned in that discussion came from Colleague A.

Mr Mackell submitted that looking at the language used in Colleague A's account, a number of issues arose when considering the wording of charge 6. He submitted that the charge suggested a positive assertion, unequivocally, that something had been inserted by Colleague B. Mr Mackell submitted that at no stage in Colleague A's written evidence, was it asserted that she was told by you that Colleague B had inserted a catheter into Resident D's bottom. Mr Mackell highlighted the account in Colleague A's written statement that *'...she said it was probably [Colleague B] the Deputy Manager that had done this*'. He submitted that Colleague A's account in her local statement was even less

assured: '*she gossip about that mistake that possibly was [Colleague B] the Deputy Manager*'. Mr Mackell submitted that further, in oral evidence, Colleague A indicated that the discussion was of a gossiping nature and accepted that this was different to telling her that Colleague B definitely did this. Mr Mackell submitted that taken at its "*height*", Colleague A's evidence did not support the particulars of charge 6.

Mr Mackell submitted that when recalling the detail of conversations, the panel may wish to consider the witnesses' assertions as to when this incident was alleged to have taken place. He submitted that Colleague A in her local statement referred to the discussion taking place on 21 May 2020 and to this being on a Saturday. He submitted that Colleague A further described writing the statement very shortly after the discussion took place. Mr Mackell submitted that if the statement was completed a short time after any such discussion, a basic error such as the day of the week would not have occurred.

Mr Mackell submitted that Colleague C's local statement referred to the discussion being on a Saturday night in June. He submitted, however, that 21 May 2020 was a Thursday. He submitted that in addition, Witness 1 provided evidence that contrary to the assertion of Colleague A, the incident did not take place in May. Witness 1 stated that she was first aware of this catheter issue in July 2020 after a discussion with Witness 3, and that if she was told something like this in May, she would have acted upon it. Mr Mackell submitted that in oral evidence, Witness 1 could not remember if Colleague A told her that you said that Colleague B inserted a catheter into Resident D's bottom as it was a long time ago. He submitted that she was clear, however, that she was not told of this issue in May or June 2020 and that it was definitely July 2020.

Mr Mackell submitted that the inconsistencies in the retelling of this account and the contrary evidence presented ought to carry weight when assessing the evidence at its height. He submitted that it was also telling that Witness 1 did not mention any discussion with Colleague A in her local statement dated 24 July 2020. He submitted that there was no account of this discussion recorded in a local statement by Witness 1 that was made available to the panel.

Mr Mackell submitted that Witness 3 was the second witness who directly reported speaking to you. Witness 3 reported in her written statement that she was working a day shift on 16 July 2020 when you randomly approached her and started talking about Colleague B and stated that he had inserted a catheter into Resident D's bottom. Witness 3 reported that she spoke to Colleague C and that she had '*no idea what I was talking about*'. Mr Mackell submitted that the panel may wish to weigh that version of events with Colleague C's local statement whereby she described an incident where the catheterisation of Resident D was discussed. Mr Mackell submitted that whilst Colleague B's name was not referenced, it was hard to fathom that Colleague C would have no knowledge of an issue with the catheter and Resident D when she has submitted a local statement on 24 July 2020.

Mr Mackell submitted that Witness 3's understanding that the issue of the catheter took place in July 2020 was contrary to the evidence of Colleague A and Colleague C. He submitted that Witness 3 also clearly stated that she told Witness 5, that you made the comments about Colleague B on 16 July 2020. Mr Mackell submitted that this date was relayed to Witness 5 by Witness 3. He submitted that this account was not supported by the admitted hearsay evidence of Witness 5. Witness 5's evidence was that she was approached by Witness 3 on 17 July 2020, however, the note of that conversation, by Witness 5 in her written statement indicated:

> '*[Witness 3], came into my office, saying that one morning Staff Nurse Lynsey Brown told her that Deputy [Colleague B] had inserted a catheter into Resident D's back passage'*.

Mr Mackell submitted that this was consistent with what was put to you in the internal meeting with Witness 5 on 20 July 2020. He submitted that there was no indication from Witness 5 that Witness 3 was told anything on 16 July 2020. Mr Mackell asked the panel to consider whether it was likely that an incident that took place the day before would be referred to as '*yesterday*', but instead, Witness 3 was recorded as saying '*one morning*'.

Mr Mackell submitted that the lack of specificity as to when the discussion took place impacted the credibility of Witness 3 as a narrator.

Mr Mackell acknowledged that the charge as drafted allowed for a broad timeline. He submitted however, that this panel is a tribunal of fact and that it ought to be in a position to determine when such allegations are made, when witnesses present their evidence. He asked the panel to consider the following question: was the catheter event on 21 May 2020, a Saturday in June and/or 16 July 2020?

Mr Mackell submitted that the NMC had relied upon Resident D's care records from May 2020. He questioned that if that was the correct timeframe, was the case of the NMC that you told Colleague A in May 2020 and thereafter sat on this information until the middle of July before you randomly and without prompting shared it with Witness 3. He submitted that if there was nefarious intent, this information would have been shared regularly and with a number of persons as soon as the event was alleged to have occurred. Mr Mackell submitted that it stretched credibility that you sat and waited for an opportunity to tell Witness 3 nearly eight weeks after first raising this issue with Colleague A.

Mr Mackell asked the panel to also assess the credibility of Witness 3, who stated in her written evidence that she was unsure why you would say anything against Colleague B as he was '*a really nice man and a good nurse*'. However, in the course of oral evidence, she indicated that she was not speaking to Colleague B at the time and that she believed you approached her because you knew Witness 3 did not like Colleague B. Mr Mackell submitted that this evidence was directly contrary to the written evidence provided as true and accurate.

Mr Mackell submitted that the credibility of Witness 3 was compounded by the fact that she denied under questioning from the panel that she had said she did not like Colleague B. He submitted that this was a somewhat bizarre position to adopt when a matter of minutes before, the panel had been told by Witness 3 that she did not like Colleague B. Mr Mackell submitted that the panel is professional and experienced and would make its

assessment on the credibility of a particular witness. He submitted however that, in this instance, Witness 3 made a very clear assertion and then denied that very same assertion within minutes. He submitted that the panel could not reasonably have confidence or certainty in the statements of such a witness having witnessed first-hand and up close her deficiency as a narrator.

Mr Mackell submitted that where there were only two direct witnesses, the panel ought to be clear on the credibility of each of those witnesses and the version of events they presented, but that was not the case on this occasion.

Mr Mackell referred the panel to the case of *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) in relation to assessing the credibility of the available witness evidence.

In relation to charges 7 and 8, Mr Mackell submitted that notwithstanding the absence of evidence to support charge 6, he was inviting the panel to consider his above submissions in respect of charge 6.

Mr Mackell submitted that if you had a nefarious intent and wished to willingly spread malicious rumours about Colleague B, there would be more direct evidence available of instances where this rumour was circulated. He submitted that the reference of '*possibly*' and '*probably*' in the statements of Colleague A did not support a contention that there was a deliberate attempt to undermine Colleague B. Mr Mackell submitted that separately, Colleague C described the conversation in June 2020 as taking place, without a single reference to the name of Colleague B. He submitted that this diminished the assertion that you were circulating rumours.

Mr Mackell submitted that the matron, Witness 5, had indicated in her written statement that she was aware that Colleague B had difficulties with the catheterisation of Resident D, and that this was recorded in Resident D's care notes. Mr Mackell submitted that in addition, Colleague C and Colleague A both mention that they were advised of problems

with the catheterisation of Resident D. He submitted that discussion about Resident D's catheter was therefore not unexpected. Mr Mackell submitted that neither Colleague A or Colleague C categorically said that you had asserted that Colleague B inserted a catheter into the bottom of Resident D.

Mr Mackell submitted that there was no evidence of dishonesty exhibited by the testimony of either of these witnesses. He submitted that at worst, according to Colleague A, you discussed the issue in a '*gossipy*' way.

Mr Mackell submitted that when assessing whether there was any attempt to bully Colleague B, the initial response of Colleague B was telling. Mr Mackell submitted that Colleague B described his response as '*amazed and slightly amused*' in his written statement dated 17 March 2022. Mr Mackell invited the panel to consider the impact on Colleague B. He referred the panel to Colleague B's local statement dated 22 July 2020 which set out two pages of concerns, but in Mr Mackell's submission did not make one mention of the issue with the catheter. Mr Mackell submitted that it was '*simply incredible*' that this incident set out by Colleague B in his written statement to the NMC did not garner a single phrase or line in the local statement. Mr Mackell submitted that Colleague B did not take the story shared by Witness 3 very seriously at all. He submitted that there was no record of Colleague B raising this issue in writing until March 2022. Mr Mackell submitted that if there was an attempt to undermine Colleague B and his clinical skills, this view was never expressed by Colleague B in writing in his local statement or in his written statement to the NMC. He submitted that there was no written evidence presented to support the contention that you ever attempted to undermine Colleague B's clinical skills.

In these circumstances, it was submitted by Mr Mackell that there is insufficient evidence to support any of the charges 6, 7 and 8.

In response to this application, Mr Morgan also addressed the panel with written and oral submissions.

In respect of charge 6, Mr Morgan took the panel to the evidence of Colleague A, Witness 3, Colleague B and Colleague C, as well as the minutes from your meeting with Witness 5 on 20 July 2020. He submitted that whilst it was accepted that there were discrepancies with the dates of the alleged comments made by you to other staff members, this did not dilute the contention that these comments were made. Mr Morgan submitted that this was supported by the minutes of your meeting with Witness 5 where you did not deny that you had made comments about a catheter, Resident D, and Colleague B. Mr Morgan therefore submitted that the evidence presented established a case which, taken at its highest, a tribunal of fact, properly directed, could find charge 6 proved.

In relation to charge 7, Mr Morgan submitted that the evidence presented by the NMC on this charge was the same evidence provided in respect of charge 6, namely that you informed others that Colleague B had made a clinical error. Mr Morgan highlighted that when cross-examined, it was not put to Colleague B that he had made the clinical error. Mr Morgan submitted that as such, it must be accepted by you that Colleague B had not made that clinical error. He submitted that you knew this, and that in telling others that Colleague B had made this clinical error, your actions were dishonest. Mr Morgan submitted that the evidence presented established a case which, taken at its highest, a tribunal of fact, properly directed, could find charge 7 proved.

Regarding charge 8, Mr Morgan submitted that the evidence presented by the NMC on this charge was the same evidence provided in respect of charge 6, namely that you informed others that Colleague B had made a clinical error. Mr Morgan submitted that the only reason that you would make these comments to others would be to bully Colleague B by spreading lies about his practice which undermined his clinical skills. He submitted that if you had genuine concerns about Colleague B acting in such a manner then you would have raised this with senior staff members.

Mr Morgan submitted that it was of note that the meeting between you and Witness 5 recorded you expressing a dislike for Colleague B. He submitted that this dislike provided motivation for your intentions. Mr Morgan submitted that the focus of the panel should be

drawn to the intent of the alleged comments rather than the outcome. He submitted that in any event, Colleague B was clear in his evidence that he took the allegation seriously, it undermined him as a nurse and a human, that he felt attacked, like someone was out to get him, and to get him in trouble. Mr Morgan submitted that the evidence presented established a case which, taken at its highest, a tribunal of fact, properly directed, could find charge 8 proved.

The panel took account of the written and oral submissions made by Mr Mackell and Mr Morgan. It also heard and accepted the advice of the legal assessor.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel considered whether there was sufficient evidence to support any of the charges 6, 7 and 8.

Charge 6

In relation to charge 6, the panel had regard to all of the written and oral evidence presented by the NMC in support of this charge.

The panel took into account Witness 3's local statement dated 20 July 2020 which stated:

> '*On Thursday 16th July I was standing in dining room and Lyndsey the nurse came over to me and to... that [Colleague B] had put a catheter up Resident D's bottom and that [Colleague C] night duty had noticed poo coming through the tube and repeated it to her... as this was such a serious allegation I told matron about it the next morning.*'

The panel also noted Witness 3's written statement dated 10 March 2022 which supported this account and stated:

'*On the 16 July 2020 I was working a day shift... Lynsey randomly approached me and started talking about [Colleague B], she said that he had inserted a catheter into Resident D's bottom. That care assistant [Colleague C] had seen it and she had told Lynsey about it.*'

The panel had heard Witness 3's oral evidence which, in the panel's view was material and taken together with her written evidence, capable of supporting her account.

The panel took into account Colleague B's written statement dated 17 March 2022 which stated:

'*Around about the same time I was approached by a Health Care Assistant she told me to be careful as [Lynsey] was saying things about me. She went on to tell me that [Lynsey] had said that I had put a catheter intpo [sic] [Resident D's] rectum. When I was first told this I was amazed and slightly amused. Then I found out that she had said this to a number of members of staff and then I started to believe that she was being malicious...*'

Colleague B confirmed in oral evidence that Witness 3 was the only one who came to talk to him about the catheter incident. The panel was satisfied that Colleague B's evidence was capable of being supporting evidence to charge 6.

The panel then noted Colleague A's undated local statement which stated:

'*On the 21/5/2020 Saturday Night... Later on that night duty staff nurse Lynsey Brown said to us that [Resident D's] catheter had been inserted into the wrong hole (she gossip about that mistake that possibly was [Colleague B] the deputy menager).*' [sic]

In her written statement dated 26 February 2022, Colleague A stated that:

'*Later on in the evening we all sat together, [Colleague C], [Colleague D], Lindsey and me. We were talking and this is when Linsey said to us that catheter had been inserted into the wrong hole (up her back passage). She said that it was probably [Colleague B] the deputy manager that had done this.*'

The panel noted Colleague A's oral evidence that you had said it was "*probably*" Colleague B that inserted the catheter into Resident D's bottom. The panel was satisfied that Colleague A's evidence was capable of being supporting evidence to charge 6.

The panel took into account Witness 1's local statement dated 24 July 2020 which stated:

'*On Friday morning 17th July 2020 domestic [Witness 3] came to me and asked me was it true that deputy [Colleague B] had inserted a catheter into Resident D's bottom... I told [Witness 3] this was not true she told me that Lynsey Brown had told her the previous morning that [Colleague B] had recathetered [sic] Resident D this way.*'

The panel noted that Witness 1's oral evidence and written statement dated 22 December 2021 was also consistent with this account. In the written statement she added that '*I was also told the same story from [Colleague A], who had also heard this from Lynsey*'. The panel was of the view that this evidence was capable of being supporting evidence to charge 6.

In Colleague C's local statement dated 28 July 2020, she stated that:

'*One Saturday night in June... staff nurse Lynsey Brown said to us that Resident D's catheter had been inserted into the wrong hole.*'

The panel was of the view that this evidence was capable of being supporting evidence to charge 6.

The panel had regard to the minutes of your meeting with Colleague B and Witness 5 on 13 July 2020 which stated:

> '*Domestic, [Witness 3], came to Matron [Witness 5], saying that one morning, Staff Nurse Lynsey Brown, told her that Deputy [Colleague B] had inserted a Catheter into a residents back passage.*'

The panel also had regard to the minutes of your meeting on 20 July 2020 with Witness 5 and the Admin Assistant at the Home as the minute taker. It noted that the alleged incident was raised and addressed with you in this meeting.

The panel decided that the minutes of these meetings were also capable being supportive evidence to charge 6.

The panel was therefore satisfied that at this stage, there was sufficient evidence to support charge 6. The panel acknowledged that there were some inconsistencies in the evidence of these witnesses, particularly in relation to the date on which the alleged incident took place. However, the panel did not consider that these inconsistencies, taken as a whole, were such so as to render the evidence supporting this charge as tenuous. The panel concluded that these inconsistencies should be taken into account at the fact-finding stage. As such, the panel considered that there was sufficient evidence to support a case to answer in respect of this charge.

<u>Charges 7 and 8</u>

Having found a case to answer in respect of charge 6, the panel considered that at this stage, there was a possible inference that could be drawn from the evidence that you acted dishonestly (as alleged in charge 7) and/or intended to bully Colleague B (as alleged in charge 8).

The panel therefore determined that these matters could also be determined at a fact-finding stage and, as such, it did not accept the submission that there was no case to answer in respect of charges 7 and 8.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Morgan and by Mr Mackell.

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:

- Witness 1: Night Senior Care Assistant at the Home at the relevant time;
- Colleague A: Care Assistant at the Home at the relevant time;
- Witness 3: Domestic Cleaner and Kitchen Assistant at the Home at the relevant time; and
- Colleague B: Deputy Manager at the Home at the relevant time.

The panel also heard evidence from you under affirmation.

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

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

Charge 6

That you, a Registered Nurse:

6. Between 20 May 2020 and 20 July 2020, told one or more colleagues that Colleague B had inserted a catheter into Resident D's bottom.

This charge is found proved.

In reaching this decision, the panel noted Witness 3's account in her local statement dated 20 July 2020, which set out that she was standing in the dining room of the Home on '*Thursday 16th July*' when you went over to her and stated that '*[Colleague B] had put a catheter up Resident D's bottom and that [Colleague C] night duty had noticed poo coming through the tube and repeated it to [you]*'.

Witness 3's written statement dated 10 March 2022 was consistent with this account, stating that you had randomly approached her and started talking about the incident. In oral evidence, Witness 3 maintained this version of events. Witness 3's evidence was that she spoke to the Home Manager, Witness 5, about what you had told her. The panel accepted Witness 3's evidence.

Witness 5's written statement dated 17 March 2022 stated that Witness 3 came to her office on 17 July 2020 saying that you told her that '*[Colleague B] had inserted a Catheter into resident, Resident D's back passage*'. Witness 5 subsequently held a meeting with

you on 20 July 2020 to address '*the allegations from the two previous meetings*' and to cover other points, including what Witness 3 had told her.

The minutes of your meeting at the Home with Witness 5 on 20 July 2020 stated:

> '*Matron asked why, a month later, were you discussing this with a Domestic?*
> *Lynsey began to speak about how she does not know much about Catheters and how this was [Colleague E's] remit. Matron asked again what this has to do with a Domestic.*
> *Lynsey believes that she and this Domestic have common ground with their dislike for [Colleague B] and asked if it was fair that she was reprimanded when lots of people know about this incident.*'

In oral evidence, you denied the allegation that you told Witness 3 and Colleague A that Colleague B had inserted a catheter into Resident D's bottom. You stated that you only discussed Resident D's catheter with Colleague C when she had alerted you to an issue with the catheter, and with Colleague E (a nurse at the Home) during the course of a handover when she reported that Resident D's catheter had been dislodged. However, you said that you did not mention Colleague B's name.

You told the panel that in that meeting on 20 July 2020, you admitted saying to Witness 5 that what Witness 3 had alleged, namely, that you told her about Colleague B inserting the catheter into Resident D's bottom, was true. You told the panel that this admission was made without you thinking at the time as you felt overwhelmed with the situation and bombarded with questions in the meeting. You said that you "*said yes to everything*" and "*surrendered to anything coming my way*" as by that stage, you felt you were done and "*had nothing more to give*".

The panel did not accept your evidence that you "*said yes to everything*" or that you "*surrendered*" at the meeting with Witness 5 on 20 July 2020. Your response at the meeting suggested that you spoke to Witness 3 about something which other colleagues

were already talking about at the Home. The panel also noted that according to the minutes of that meeting, in relation to other matters, you provided explanations and in some instances, even challenged matters that were put to you. In considering the meeting minutes, the panel was not satisfied that your responses were tantamount to those of someone who was saying "*yes to everything*".

Witness 5 was not present at the hearing and had not given live evidence before the panel. Witness 5's written statement, signed and containing a declaration of truth, was admitted as hearsay. As it was admitted as hearsay, the panel could determine what weight to ascribe to the statement. The panel considered that Witness 5 was a senior member of staff at the Home who had reported on what she had been told by Witness 3, and had recorded her meetings with you in respect of various matters including the catheter incident. Whilst the panel had no opportunity to test Witness 5's evidence, it found that if the allegation relating to the catheter were not true, you would have denied it in the meeting. The panel therefore rejected your explanation that the reason you admitted what Witness 3 had said was because you were "*overwhelmed*" and said "*yes to everything*". The panel found that Witness 5's hearsay written statement supported the allegation.

Witness 1 provided a consistent account in her local statement dated 24 July 2020, her written statement dated 22 December 2021 and in her oral evidence before the panel that on the morning of 17 July 2020, Witness 3 approached her stating that she had heard from you on the previous morning that Colleague B had inserted a catheter into Resident D's bottom. Witness 1 stated that she told Witness 3 that this was not true. The panel accepted Witness 1's evidence.

In summary, therefore, the panel accepted the evidence of Witness 3, the hearsay evidence of Witness 5 and the supporting evidence of Witness 1 in respect of the allegation that you told Witness 3 that Colleague B had inserted a catheter into Resident D's bottom.

Colleague A was the only other direct witness in respect of this charge. The panel noted her undated local statement which set out that you told her that Resident D's catheter had been inserted into the wrong hole and that it was '*possibly*' Colleague B who had done this. In her written statement dated 26 February 2022 and oral evidence before the panel, Colleague A stated that you said it was '*probably*' Colleague B who had inserted the catheter. The panel noted the inconsistency in Colleague A's account in relation to whether you said it was '*possibly*' or '*probably*' Colleague B.

The wording of charge 6 alleges that you made a positive assertion that Colleague B had inserted a catheter into Resident D's bottom. The panel considered that Colleague A's evidence did not support the charge as set out because at its highest, there was no suggestion that you had made a positive assertion to her that it was Colleague B who had inserted the catheter.

The panel took into account the inconsistencies in the dates provided by Colleague A in her evidence. In her undated local statement, Colleague A stated that you told her about the catheter on '*21/5/2020 Saturday Night*'. Colleague A told the panel that the local statement was written close to the time that you allegedly spoke to her. The panel noted that 21 May 2020 was a Thursday and not a Saturday. It considered that a significant error of this nature was more likely to occur if a statement was being made after a passage of time, rather than contemporaneously. The panel was of the view that Colleague A's account did not appear to reflect a contemporaneous and accurate position of what took place. These inconsistencies reduced the panel's confidence in relying on Colleague A's evidence in relation to charge 6.

Whilst it had accepted that Colleague A's evidence was capable of supporting the charge, the panel was not satisfied that her evidence was reliable or convincing.

On this basis, the panel found that Colleague A's evidence was not sufficiently reliable so as to support charge 6 (to the extent that you told her that Colleague B had inserted a catheter into Resident D's bottom) on the balance of probabilities.

The panel, having accepted the evidence of Witness 3, Witness 5 and Witness 1, concluded on the balance of probabilities that on 16 July 2020, you told a colleague, namely Witness 3, that Colleague B had inserted a catheter into Resident D's bottom. It found charge 6 proved.

Charge 7

That you, a Registered Nurse:

7. Your actions at charge 6 were dishonest in that you knew Colleague B had not made the clinical error you were attributing to him.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel took into account that the burden was on the NMC to prove that you knew that Colleague B did not make the clinical error you were attributing to him.

The panel noted the minutes of your meeting at the Home with Witness 5 on 20 July 2020, where the allegation in respect of Colleague B was put to you. It stated:

> '*Lynsey believes that she and this Domestic have common ground with their dislike for [Colleague B] and asked if it was fair that she was reprimanded when lots of people know about this incident.*'

The panel considered that this response suggested that it was likely you were repeating gossip that was in general circulation at the Home. In her written statement dated 26 February 2022, Colleague A said that '*[you] just likes to gossip*' and in her undated local statement she stated that '*[you] gossip [sic] about that mistake*'.

In the minutes of the meeting with Witness 5 on 20 July 2020, it is reported that:

> '*Matron asked if Lynsey had any grounds for this to which Lynsey said yes. Matron asked Lynsey to explain what grounds she felt she had.*
>
> *Lynsey stated that it was mentioned in a report and [Colleague B] said he had inserted the Catheter and [Colleague E] had to reinsert it. Care Assistants as well as Lynsey saw it. All handed over to SN [Colleague E] the next morning.SN [Colleague E] changed it and gave this out at the handover and agreed there had been faeces in the tube. This was back in May.*
> *...*
> *Lynsey said everyone was being quiet about the matter and said she was frightened. Matron asked Lynsey why she was frightened and who she was frightened of. Lynsey did not know. Matron asked if Lynsey was frightened of her to which Lynsey said no.*

Lynsey said she's not making this up to which Matron said that she is not calling Lynsey a liar, the issue is that Lynsey did not go through the right channels re reporting concerns.

...

Lynsey acknowledged that she shouldn't have kept quiet about it. Lynsey stated that she should of [sic] told a superior such as Matron or Pastor but did not think she would get the support from Matron'.

The panel concluded that this was evidence that you believed the allegation to be true.

In her written statement dated 10 March 2022, Witness 3 said that you told her that you believed the allegation to be true. The panel concluded that this was further evidence that you believed the allegation to be true at the time, and it accepted that that was your genuine belief at that time.

In considering all the evidence, the panel determined that at the time you told Witness 3 that Colleague B had inserted a catheter into Resident D's bottom, you believed this to be true. Therefore, it concluded that this was evidence that you were not being dishonest because you believed the allegation to be true.

The panel was not satisfied that the NMC had provided sufficient evidence for the panel to be satisfied, on the balance of probabilities, that you knew the allegation about Colleague B to be false. It therefore found charge 7 not proved.

Charge 8

That you, a Registered Nurse:

8. *Your actions at charge 6 were intended to bully Colleague B by spreading lies which undermined his clinical skills*.

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings at charges 6 and 7.

Having found that, on the balance of probabilities, you did not know the allegation about Colleague B to be false, the panel was satisfied that you were not '*spreading lies*' about him.

The panel therefore concluded that you could not have intended to bully Colleague B by spreading lies which undermined his clinical skills because you were not saying something to Witness 3 which you knew to be untrue.

Fitness to practise

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

The panel, in reaching its decision, recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

The submissions of Mr Morgan and Mr Mackell were made orally and in writing.

Mr Morgan 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.'* He also acknowledged that the misconduct has to be serious.

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

Mr Morgan identified the specific, relevant standards where your actions amounted to misconduct. In respect of charges 1, 2 and 3, Mr Morgan submitted that you did not observe the basic tenets of the nursing profession, but instead followed an unsafe level of practice that was likely to cause a serious risk of harm. In respect of charges 4 and 5, Mr Morgan submitted that there were attitudinal concerns. He submitted that as a registered nurse, your colleagues should be able to trust and respect you and you should be a role model for other student and aspiring nurses.

Mr Morgan submitted that your actions as proven fell far short of what would be expected of a registered nurse. He submitted that colleagues would expect that they could rely upon their other colleagues to work together as a team, be dependable and respectful, communicate effectively and deliver safe and effective care. Mr Morgan submitted that the public would expect that they could depend on the nursing profession to properly care for friends, relatives and members of the public. He submitted that they would expect nurses to uphold the reputation of the profession.

Mr Morgan therefore invited the panel to make a finding of misconduct.

Mr Mackell asked the panel to consider the context within which the complaints arose. He submitted that you were a busy nurse operating within a residential nursing home with 20

years experience of working with adults with learning difficulties. He submitted that you had limited experience of working in a care home setting, and you spent a total of five months working at the Home. Mr Mackell submitted that it was a challenging experience for you. He referred the panel to your reflective piece dated 27 October 2023, which he submitted set out the context in an honest and forthright manner.

Mr Mackell submitted that the context of the new home, unfamiliar work tasks, the demands and pressures of being the nurse in charge and operating through the worst health pandemic in a century were matters of relevance for the panel to consider when determining whether charges 1, 2 and 3 may be considered as serious misconduct. He reminded the panel that no harm was caused to residents as a result of your actions in these charges. He submitted that there was no evidence of a systematic or deliberate approach to engaging in less than the expected standards when administering medication, and that the failings when identified were accepted in local interviews.

In relation to charges 4, 5 and 6, Mr Mackell submitted that the language used was not appropriate for a professional setting, which you have accepted. He submitted that the type of language you used and your approach was out of character and could be seen in the context of poor reactions to [PRIVATE]. Mr Mackell referred the panel to your reflective piece and submitted that you accepted your wrongdoing and took responsibility for the comments made.

Mr Mackell submitted that there was no clear rationale for engaging in the discussions set out in charge 6 with staff members. He submitted that you were embarrassed by this episode. Mr Mackell submitted that whilst not looking to diminish the charge, a "*gossipy*" transfer of a half story had caused unnecessary professional suffering for you.

Mr Mackell submitted that your history does not support the view that you are someone with deep-rooted problems with your attitude or your ability to work with others.

Mr Mackell referred the panel to the case of *Khan v Bar Standards Board* [2018] EWHC 2184 and submitted that your behaviour is forgivable. He submitted that your reflection demonstrated insight, candour and genuine remorse. Mr Mackell highlighted that no harm was caused to a resident and that any harm or annoyance caused to a colleague was temporary.

Submissions on impairment

Mr Morgan moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Morgan referred to the “test” endorsed in the case of *CHRE v NMC and Grant* and submitted that the first three limbs were engaged in this case.

Mr Morgan referred to your documentary evidence in respect of impairment, and submitted that within your reflective piece dated 27 October 2023, you acknowledged the seriousness of the concerns and referred to the Code. However, Mr Morgan submitted that your insight was limited because you denied charge 6 and therefore showed no acceptance or remorse in relation to that charge. He submitted that there was therefore limited evidence upon which the panel could conclude that there has been full insight, acceptance or remorse.

Mr Morgan informed the panel that you are currently subject to an 18-month interim suspension order which was imposed on 19 July 2021 in relation to a separate referral. He submitted that you have therefore not been able to improve your clinical practice in a clinical setting since the imposition of the interim order.

Mr Morgan submitted that there was very limited evidence that could convince the panel that you are not at risk of repeating this behaviour were you to continue to practise.

Mr Morgan therefore invited the panel to make a finding of current impairment.

Mr Mackell submitted that your fitness to practise is not impaired. He submitted that none of the limbs were engaged in the "test" endorsed in the case of *CHRE v NMC and Grant*. Mr Mackell submitted that your errors could be rectified and remedied, and there were no concerns about keeping clinical records or the general provision of care. He asked the panel to consider your reflective piece dated 27 October 2023.

Mr Mackell submitted that the errors are unlikely to be repeated due to your ability to reflect on your mistakes and errors of judgement. He submitted that with a positive record of nearly 20 years, you can be an effective nurse who operates and practises within the regulations and without coming to adverse attention of the NMC.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Johnson and Maggs v Nursing and Midwifery Council* [2013] EWHC 2140 (Admin) and *CHRE v NMC and Grant* and *Cohen v General Medical Council*.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically:

'5 ***Respect people's right to privacy and confidentiality***

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care...

To achieve this, you must:

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

8 Work co-operatively

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel acknowledged that breaches had to be serious to amount to misconduct.

The panel had regard to the NMC guidance on '*Serious concerns which could result in harm to patients if not put right*'.

The panel considered your behaviour at charges 1, 2 and 3 which related to concerns of poor medication administration and management. It noted that as a result of your actions, patients were put at risk of harm, and patients' confidence in you as a registered nurse was undermined. On this basis, the panel found that your actions at charges 1, 2 and 3 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

The panel next considered your language towards colleagues as set out at charges 4 and 5. It noted that you used inappropriate language towards Colleague A, a junior member of staff, after she had asked you to put on a mask in line with the Home's COVID-19 policy. You then used inappropriate language towards a fellow nurse who was supporting you to administer medication safely. The panel was of the view that your actions would be regarded as deplorable by fellow practitioners. It therefore found that your actions at charges 4 and 5 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

In respect of charge 6, the panel considered that you acted unprofessionally when you failed to treat Resident D's condition with confidentiality by discussing it with other colleagues at the Home. The panel determined that this was a serious concern and demonstrated a disregard for patient confidentiality and dignity. It therefore found that your

actions at charge 6 fell seriously short of the conduct and 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, your fitness to practise is currently impaired. The panel had regard to the NMC guidance on impairment.

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 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 found that patients were put at risk of harm as a result of your misconduct. It found that your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute in that you demonstrated unacceptable levels of care and communication with your colleagues.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Cohen v General Medical Council* and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you had provided evidence of insight and remorse.

Regarding insight, the panel had regard to your reflective piece dated 27 October 2023 in relation to charges 1, 2 and 3. The panel was of the view that you had not recognised the

impact your actions had on patients, your colleagues and the reputation of the nursing profession. You stated that you are '*grateful that no patient came to harm*' but you did not demonstrate an understanding of how your actions put patients at a risk of harm and how this impacted negatively on the reputation of the nursing profession.

In your reflection on charges 4 and 5, you stated that you were '*deeply embarrassed*' and '*deeply sorry*' about the language you used towards Colleague A and Colleague B. However, the panel found that you had not demonstrated that you appreciated the impact your language had on your colleagues.

In respect of charge 6, the panel had seen no reflection from you concerning the breach of Resident D's confidentiality and dignity and there was no evidence of how you would act differently in the future.

The panel therefore found that you demonstrated very limited insight into your failings.

The panel was satisfied that the misconduct in relation to medicines administration and management is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel considered that despite undertaking '*Safe Administration of Medicines*' training in May 2020, you went on to act in an unsafe manner with medication at the Home. This was compounded by your attitude at the meeting at the Home on 13 July 2020 where you '*didn't find anything wrong with*' dispensing several doses of paracetamol into the same medicine cup. This suggested that you did not apply the training completed in May 2020 to your nursing practice.

You provided training certificates dated between May 2020 and October 2023 in respect of various areas, including stress management, assessing needs and pain management. The panel noted that you have completed a number of online training courses relating to medication management and administration between May 2020 and October 2023. However, there was no information before the panel about what you have learnt and how

you have applied it to your practice. The panel also took into account that you have been subject to an interim suspension order since July 2021 and therefore did not have the opportunity to demonstrate safe practice since that time. The panel was not satisfied that it had sufficient evidence of strengthened practice with respect to your medication management and administration.

The panel had regard to the email dated 19 January 2022 from the Nurse Manager of a care home you worked at in 2021. In this email, the Nurse Manager confirmed that you were employed between March and May 2021 and they provided information in response to whether there were any concerns about your fitness to practise. They did not indicate any concerns about your fitness to practise and stated that you were '*always professional and...very kind hearted and empathetic*'. The panel was concerned that the comments provided in this email were very broad and did not make any reference to what your role at the care home was, or to your medication management and administration practice. The panel could not draw conclusions from this that you have strengthened your practice.

The panel was not satisfied that you can currently practise safely, kindly and professionally.

The panel was not satisfied that it was highly unlikely that your conduct would be repeated in the future. It found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 which concerned serious misconduct relating to medication administration and management and your behaviour towards colleagues. It therefore also found your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel considered this case very carefully and decided to make a suspension order for a period of twelve months. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel 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.

Submissions on sanction

Mr Morgan informed the panel that in the Notice of Hearing, dated 27 September 2023, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. Mr Morgan submitted that in light of the panel's findings in relation to charges 7 and 8, the NMC had revised its proposal to a 12-month suspension order with review.

Mr Morgan submitted that the seriousness of this case requires your temporary removal from the register and that a period of suspension would be sufficient to protect patients and promote public confidence in nurses. He referred to the SG and submitted that in this

case, there were multiple incidents of misconduct and that there is evidence of attitudinal and personality problems, although "*perhaps slightly short of deep-seated*". He submitted that there was repetition of behaviour, both in terms of medicine administration and attitude. In addition, he reminded the panel that it had found you demonstrated limited insight into your failings. In light of this, Mr Morgan submitted that while there were factors that may indicate that a suspension order is not sufficient, any greater sanction would be disproportionate in the circumstances of this case.

Mr Mackell submitted written and oral submissions.

Mr Mackell asked the panel to consider your professional history since the misconduct took place, and submitted that you are competent, hard-working and dedicated to your patients. Mr Mackell explained the circumstances around your current interim suspension order which relates to a separate ongoing matter. He reminded the panel that you have had no previous findings of a regulatory nature.

Mr Mackell submitted that you have, from the very outset, accepted the vast number of charges faced both in relation to errors with medication and your poor choice of communication. He submitted that you accepted wrongdoing and took responsibility for your actions at the very earliest of opportunities during the local investigation. Mr Mackell submitted that your transparent approach supported your general duty of candour and was indicative of someone who the public can have confidence in as a nurse going forward.

Mr Mackell referred the panel to your reflective piece dated 27 October 2023 and submitted that you have set out how you have learnt from this episode. He submitted that the additional training undertaken should give confidence that you have appropriately reflected on the misconduct found. Mr Mackell submitted that the errors of professional judgement related to [PRIVATE]. He also described the impact that these regulatory matters have had on your career and reputation.

Mr Mackell invited the panel to consider the testimonial from your most recent employer dated 19 January 2022 which in his submission, portrayed you as a good and competent nurse who has the capacity to reflect on mistakes made and errors of judgement exhibited. Mr Mackell informed the panel that you worked as a Staff Nurse on day duty and there had been no issues with your medication administration.

Mr Mackell submitted that you have already completed a period of suspension, arising from these proceedings and other unrelated proceedings. He submitted that such an outcome would no longer be proportionate, nor necessary to maintain public confidence at this time. He submitted that a further period of suspension would also make it more difficult for you to return to practice shortly and gain the required experience to demonstrate to the public that confidence can be maintained. He submitted that such action is not necessary given the full circumstances of the case.

Mr Mackell submitted that the concerns are capable of being addressed through retraining or assessment, and so a conditions of practice order, with conditions relating to supervision of medication and not being the nurse in charge (for a period), would be appropriate.

Mr Mackell submitted that there is no evidence that your failings in communication are deep-seated, nor is there evidence of general incompetence. He submitted that you have shown a commitment to continuous professional development and undertaken training regularly since May 2020. Mr Mackell therefore submitted that conditions of practice could be put in place that are workable, relevant and measurable to address the concerns identified.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your conduct put patients at risk of suffering harm.
- There was a repetition of concerns after you received direction from your manager at the Home.
- You demonstrated very limited insight into the failings.

The panel also took into account the following mitigating features:

- You expressed that you were committed to taking the steps necessary to restore your professional standing
- You had limited experience of working in a care home setting [PRIVATE].

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was*

unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel was satisfied that conditions of practice could be put in place to robustly manage the concerns relating to medication administration and management. However, it found that there were no workable, practical or measurable conditions of practice that would address the attitudinal concerns it had found in respect of charges 4, 5 and 6. It considered that the attitudinal concerns relating to your behaviour towards colleagues and confidentiality, and your very limited insight into those concerns were not something that could be addressed through conditions of practice.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public nor satisfy the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel considered that whilst this was not a single instance of misconduct, the misconduct took place within a relatively contained period of time and setting. The panel found that although there were attitudinal problems, there was no evidence of it being deep-seated. Further, there was no evidence of repetition of the misconduct since this matter came before the NMC. The panel was satisfied that you have some limited insight and have stated a commitment to improving your practice.

In light of your limited insight, the panel considered that there was a continued risk to patient safety. It determined that this was a serious case that warranted your temporary suspension from nursing practice.

The panel was satisfied that a suspension order would prevent you from working as a registered nurse. It would also give you time to reflect on the ways you failed in the areas relating to the charges found proved, and provide evidence of developed insight into your misconduct, the impact it has had on patients, colleagues and the wider profession and

the attitudinal concerns identified. The panel determined that in the circumstances, a suspension order would suitably protect the public and meet the wider public interest.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel was satisfied that a striking-off order was not the only sanction that would protect patients nor was it required in the public interest and it would be unduly punitive in your case.

Balancing all of these factors the panel concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct. In addition, the panel concluded that such a period would be adequate to provide you with the opportunity to demonstrate developed insight.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- An updated reflective piece which demonstrates insight into your actions and the impact on patients, colleagues and the reputation of the nursing profession.
- References and testimonials from any paid or unpaid work.
- Evidence of continued professional development and your reflection on that learning.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension 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 Morgan. He invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

Mr Mackell submitted that an interim suspension order was not necessary in this case as there was already an ancillary interim order in place in respect of another NMC referral. He submitted however that this was a matter for the panel to determine.

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 took into account Mr Mackell's submissions about the necessity of the interim suspension order. The panel noted that you are currently subject to an interim suspension order for a separate NMC referral. However, the panel considered that it was still necessary to make an interim order because it could not be assured that the interim suspension in relation to the other matter would necessarily extend to cover the appeal period for this case, particularly in the event that the other interim suspension order becomes ineffective.

The panel therefore imposed an interim suspension order for a period of 18 months to ensure that you cannot practise unrestricted before the substantive suspension order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.