Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 29 August – Friday 8 September 2023

Virtual Hearing

Name of Registrant:	**Kirsty Weaver**
NMC PIN	16I7057E
Part(s) of the register:	Registered Nurse – Effective Adult Nursing – RNA - March 2017
Relevant Location:	Nottingham
Type of case:	Misconduct/Caution
Panel members:	David Crompton (Chair, lay member) Janine Ellul (Registrant member) Jennifer Portway (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Stephen Earnshaw, Case Presenter
Ms Weaver:	Not present and unrepresented at the hearing
Facts proved:	Charges 1, 2, 3, 5, 6b), 6c), 6d), 7
Facts not proved:	Charge 4, 6a)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on proceeding with Charges 6-7

Mr Earnshaw, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that it had in advance of the hearing been sent Charges 1-7 in an unredacted form, whereas Charges 1-5 should have been redacted in the copies sent to the panel. The reason for this is that Charges 6-7 consist of an allegation of misconduct, while Charges 1-5 involve an allegation relating to a caution. Mr Earnshaw directed the panel's attention to Rule 29(2) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules), which provides:

> *'The Fitness to Practise Committee may consider one or more categories of allegation against a registrant provided always that an allegation relating to a conviction or caution is heard after any allegation of misconduct has been heard and determined.'*

Mr Earnshaw acknowledged that, in a case such as this, it was the NMC's customary practice, in the light of this Rule, to defer informing panels of charges relating to alleged conviction or caution until after the charges relating to misconduct had been dealt with.

Mr Earnshaw submitted, however, that the wording of the above Rule does not in fact lay down a mandatory rule that the existence of charges relating to a caution must be withheld from the panel prior to the hearing of charges relating to misconduct.

Mr Earnshaw further submitted that there was no reason to believe that Ms Weaver would suffer any prejudice if the panel were to proceed with the hearing of the charges relating to alleged misconduct, merely because the panel is aware of the existence of the allegation and the charges relating to a caution. Mr Earnshaw pointed out that, as an experienced panel, it would no doubt be familiar with cases in which rulings relating to the admissibility of evidence had to be made. In such cases, panels are routinely required to read the evidence in question and, where it is decided not to admit the evidence, to put it out of their minds; and, in practice, panels have no difficulty in doing so.

By parity of reasoning, Mr Earnshaw submitted, the panel in this case will have no difficulty putting the existence of the charges relating to a caution out of their minds. Indeed, those charges as seen by the panel were no more than bare charges: the panel had not been provided with or seen any of the evidence relating to those charges.

Accordingly, Mr Earnshaw submitted that it would be in the interests of justice for the panel to proceed with the hearing in respect of Charges 6-7.

The panel accepted the advice of the legal assessor, who supported Mr Earnshaw's submission as to the proper interpretation of Rule 29(2), and referred the panel to *R. v Ashton, Draz & O'Reilly [2006] EWCA Crim 794.*

The panel accepted the submission that there is nothing in the wording of Rule 29(2) which precludes a panel from hearing charges relating to alleged misconduct, merely because it has knowledge of the existence of charges relating to an alleged caution.

The panel was satisfied that it would have no difficulty in disregarding the existence of Charges 1-5 when considering the evidence relating to Charges 6-7. Accordingly, there was no risk that Ms Weaver would suffer prejudice if the hearing were to continue.

The panel concluded that it would be in the interests of justice to continue with the hearing. It was in the interests of all concerned that the case should be dealt with expeditiously. The case had been listed for a 9-day hearing. Witnesses to be called by the NMC were in attendance.

The panel was satisfied that the charges that are presented are different and highlight separate limbs.

In light of the above, the panel has decided to proceed.

Details of charge

That you, a registered nurse:

1) On 16 November 2021, received a police caution for Fraud.
2) In your self referral form submitted to NMC when asked if you had informed your employer you answered ‘yes’.
    a) Your conduct at charge 2 was dishonest as you had not informed your employer at Alexandra House of your caution.”
3) In correspondence with the NMC on 20 December 2021 stated that you had made Alexandra House aware of what had happened previously regarding the caution.
    a) Your conduct at charge 3 was dishonest as you had not informed your employer at Alexandra House of your caution.
4) When you commenced employment at Eastgate Care Ltd, Alexandra House you stated that you were cleared of theft in the previous home when you had received a caution.

    a) Your conduct at charge 4 was dishonest in that you knew that you had a caution which was on your DBS certificate.
5) When you sent your DBS certificate to your employer on 10 February 2022 you removed a page from your certificate.
    a) Your conduct at charge 5 was dishonest in that you removed the page of your DBS certificate dealing with your caution.

6) Between November 2021 and February 2022:

    a) Failed to administer all prescribed medications to Residents during medication rounds.
    b) Failed to order and maintain medication stock.
    c) Failed to ensure Resident's care plans were in place and up to date.
    d) Left Alexandra House when you were the only nurse on duty.

7) On 9 February 2022 failed to respond appropriately to a physical incident between Resident D and Resident E.

AND, in the light of the above, your fitness to practise is impaired by reason of your misconduct as set out in charges 2-7, and your caution as set out in charge 1.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Weaver was not in attendance and that the Notice of Hearing letter had been sent to Ms Weaver's registered email address by secure email on 26 July 2023.

Mr Earnshaw 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Weaver'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 Weaver 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 Weaver

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

Mr Earnshaw submitted that there had been no engagement at all by Ms Weaver with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Ms Weaver;
- Ms Weaver has not engaged with the NMC and has not responded to any of the emails, telephone calls or the case management form sent to her about this hearing;
- Ms Weaver has not provided the NMC with details of how she may be contacted other than her registered address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 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 2021 and 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Weaver in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Weaver's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to admit Witness 4's statement as hearsay evidence

The panel heard an application made by Mr Earnshaw under Rule 31 to allow the written statement of Witness 4 into evidence. Witness 4 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to being abroad.

In the preparation of this hearing, the NMC had contacted Ms Weaver via email on 22 June 2023, 4 July 2023 and 6 July 2023 advising of their intention to read the statement of Witness 4 as opposed to calling her to give live evidence. Ms Weaver had not responded or raised any objections to any of those emails. On this basis Mr Earnshaw advanced the argument that there was no lack of fairness to Ms Weaver in allowing Witness 4's written statement into evidence.

Mr Earnshaw submitted that this did not represent the sole and decisive evidence because it is supported by other witness evidence.

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 next considered whether Ms Weaver would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 4 to that of a written statement.

The panel considered that as Ms Weaver had been provided with a copy of Witness 4's statement and as the panel had already determined that Ms Weaver had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 4 and the opportunity of questioning and probing that testimony. There was also 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 Witness 4 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Ms Weaver was referred to the NMC on 17 February 2022 by Witness 3, HR and Compliance Manager at Eastgate Care Limited (The Company). At the time of the concerns referred to the NMC Ms Weaver was working as a clinical lead/deputy manager at one of the Company's residential care homes, Alexandra House (the Home). Ms Weaver commenced employment at the Home on 18 November 2021.

The alleged facts are as follows:

During Ms Weaver's employment at the Home, there were several concerns which were raised by other staff including Witness 1 and Witness 2. These included Ms Weaver leaving the Home during her shift when she was the only nurse in charge, not administering all the required medication to residents, failing to effectively manage the medications at the Home, failing to ensure up to date care plans were in place for residents and failing to assess and complete the necessary incident and safeguarding documentation following an altercation between two residents.

Some of these issues were raised with Ms Weaver by Witness 4 in a telephone call on 6 February 2022. Ms Weaver resigned from her employment by email to Witness 4 the same day, with her expected last day at the Home being 6 March 2022. However, during a meeting between Ms Weaver and Witness 4, on 11 February 2022 to discuss the concerns with her practice, she resigned with immediate effect. A letter was then provided to Ms Weaver advising that the Company had decided to terminate her employment during the probationary period on the grounds of unsuitability for the role.

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 Earnshaw on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms Weaver.
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: Home Manager at Canal Vue Care Home
- Witness 2: Senior Carer at Alexandra House
- Witness 3: HR/Compliance Manager at Eastgate Care Ltd

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

After hearing live evidence from the witnesses, the panel noted that Ms Weaver had been placed in a position of Acting Home Manager with effect from 31 December 2021 despite some reservations held by Senior Management regarding her competency. Furthermore, she was not provided with an Acting Deputy Home Manager during her time in that post.

The panel also noted that the period spanned by the charges in this case runs from November 2021 through to February 2022. However, Ms Weaver was not solely responsible for the running of the Home for the entirety of this period as there was a Manager in place above her between 18 November 2021 when Ms Weaver's employment commenced and 31 December 2021 when the Manager moved to another Home.

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

Charge 6

Between November 2021 and February 2022:

a) “Failed to administer all prescribed medications to Residents during medication rounds.

This charge is found NOT proved.

In reaching this decision, the panel took into account of the written and oral evidence provided by Witness 1, Witness 2 and Witness 3, together with the documentary records produced by the NMC.

This charge requires a failure to act, and the panel therefore firstly considered whether Ms Weaver was under a duty to administer all prescribed medication. The panel interpreted “administer”, to mean giving the medication to a Resident and observing them taking it. There was clear evidence within the written statements and oral evidence that some medication was routinely administered by Witness 2, a Senior Carer. In addition, whilst the panel accepted that a Manager and/or Deputy Manager would be responsible for ensuring the appropriate administration of medication, this was not the wording of the charge. Furthermore, there was no eyewitness evidence before the panel of a specific failure by Ms Weaver on a particular occasion.

Noting the restricted wording of the charge and the panel’s findings above, the panel found on balance this charge was not proved.

Charge 6b)

"Failed to order and maintain medication stock."

This charge is found proved.

In reaching this decision, the panel took account of the written and oral evidence provided by Witness 1 and Witness 3, together with the documentary records produced by the NMC.

The panel considered the wording of the charge, and whether 'order and maintain' should be considered separately. However, the panel concluded that a reasonable interpretation was to take the two matters together as they are both vital in medicines management and are in effect part of the same process.

The panel noted from the exception report from the electronic medication record (a computer-generated report showing where medications had not been provided to Residents) that some of the stock was marked as "out of stock" as well as other orders needing a further review. The panel further noted a second entry of stock that was awaiting delivery from the pharmacy but was not delivered. The panel took into account that there is some evidence of stock being ordered but not delivered. However, the panel concluded that although the stock was not delivered, it was part of Ms Weaver's duty to know what was ordered, to keep up to date with all the stock and/or establish if the order had been delivered by the pharmacy.

Witness 1 in her statement comments:

> *"On EMAR, you can generate a report which shows you what medications are in stock, so I generated the report and then went to the medications cupboard and physically counted the medication. It quickly became apparent that the Home had a huge overstock of medication, discrepancies between the medication in the Home and on the system and a huge amount of medication exceptions on the system."*

The panel heard consistent evidence from the witnesses about the lack of maintenance of the medication stock by Ms Weaver when in post. Witness 1 explained that she had done her audits in January and February 2022 and had identified significant problems with the system for ordering and maintaining the medication stock. She described it in her oral evidence as being 'practicably un-auditable' and as having numerous double entries for a variety of drugs. In addition to this, she gave evidence that the drugs recorded on the system were at odds with the manual count of the drugs in the Home.

The panel took into account the findings of the compliance check completed by Witness 3 which generated a Report of 'Service Improvement Plan by the Home Manager', which indicated the lack of stock updates and the requirement for these to be completed monthly as an absolute minimum. The panel was satisfied that this documentation revealed that Ms Weaver had failed to complete the stock updates in a timely fashion and the panel concluded that it is more likely than not that as result, Ms Weaver failed to maintain adequate stock of medication.

The panel took into account the oral and documentary evidence of the compliance checks. The panel found that the discrepancies in the stock record had not been rectified despite numerous warnings to Ms Weaver by Witness 1 in both January and February 2022.

The panel determined that Ms Weaver did have a responsibility to order and maintain stock and, on the balance of probabilities, it found that she had failed to do so and accordingly, the panel found Charge 6b) proved.

Charge 6c)

"Failed to ensure Resident's care plans were in place and up to date."

This charge is found proved.

In reaching this decision, the panel took account of the evidence provided by Witness 1, as well as the evidence presented by the NMC.

Witness 3 carried out a compliance audit on 19 January 2022 and noted that there were clear deficiencies in some of the care plans for Residents. As a result, she requested Witness 1 to undertake a separate audit. Witness 1's evidence was that in one case there was no care plan at all for a resident who had been admitted earlier in January 2022. She further added that despite raising serious concerns about the care plans in successive audits on 24 January, 4 February and 9 February 2022 there had been little change, and significant deficiencies were still evident which exposed Residents to unnecessary risk.

The panel had sight of Witness 1's statement in which she stated:

> *"[Witness 3] had asked me to perform a care plan audit on two residents at the Home. I do not recall the names of the residents, but both of the documentation for the residents were a complete mess and were missing large amounts of important care plans when I performed the audit on 4 February 2022. One of the residents had been admitted to the Home in January 2022 and did not have nay care plans in place. I spoke to Kirsty about it and she had just said that she was aware of it and it was in hand."*
>
> …
>
> *"I returned to the Home on 9 February 2022 and the issue with the residents' care plans had not been rectified. I followed this up with Kirsty who said they were getting it done."*

The panel determined that Ms Weaver had a responsibility to make sure that the care plans were in place and up to date but did not do so. The panel therefore found Charge 6c) proved.

Charge 6d)

> "Left Alexandra House when you were the only nurse on duty."

This charge is found proved.

In reaching this decision, the panel took account of the written and oral evidence provided by Witness 2, together with the documentary evidence presented by the NMC.

The panel took into account Witness 2's statement where she says:

> *"There was one occasion when Kirsty left the Home and a resident's family member wanted to speak to her but nobody could find her. I was on shift at the time and to my knowledge, Kirsty had not told anyone that she was leaving the Home."*

During her oral evidence to the panel, Witness 3 stated that it would be acceptable for the only nurse on duty in the Home to leave the accommodation on a break and remain in garden providing all staff members were aware of their location. The panel also took into account Witness 2's evidence of receiving a telephone call from Ms Weaver during which Ms Weaver stated she would be late for her morning shift, but it was okay to allow the night nurse to go home. The panel considered this evidence to be supportive of Ms Weaver not complying with the requirement to remain at the Home when she was the only nurse on duty.

Taking all these factors into consideration, the panel was satisfied that Ms Weaver left Alexandra House when she was the only nurse on duty. The panel found Charge 6d) proved.

Charge 7

> "On 9 February 2022 failed to respond appropriately to a physical incident between Resident D and Resident E."

This charge is found proved.

In reaching this decision, the panel took account of the written and oral evidence of Witness 1, together with the documentary evidence provided by the NMC.
The panel had sight of Witness 1's statement dated 14 October 2022, in which she stated:

> *"On 9 February 2022, I was at the Home and there was an incident whereby two residents, Resident D and Resident E had a physical altercation. The actual incident was unwitnessed, but both witnessed were found in the foyer and … was on the floor…"*

The panel noted despite the potentially serious nature of the incident, the panel heard evidence from Witness 1 that there was nothing about this documented in the handover notes for either resident, nor was there anything in the care plans for either resident. The panel heard that it would be the Home's policy to monitor the residents for a period of time after such an incident, check for injuries to the residents, and make a safeguarding referral.

The panel noted that Witness 1 had audited Resident E's care plans and in particular there was no safeguarding documentation, which was a particular responsibility of Ms Weaver's. The panel also had sight of the 'Accident/Incident Form' which contained very limited information regarding the incident, and which had not been completed or endorsed by Ms Weaver at all despite this being her responsibility as a Manager of the Home.

The panel was satisfied that there was clear evidence that Ms Weaver had failed to respond appropriately to the incident in accordance with the Home's policy and guidelines.

The panel therefore found Charge 7 proved.

Having reached its decision on facts in respect of the charges relating to misconduct, the panel went on to consider the charges relating to an alleged Police caution.
The panel took into account the live evidence from Witnesses called on behalf of the NMC, together with the documentary evidence.

The panel considered the submissions of Mr Earnshaw. He submitted that there was sufficient evidence for the panel to find all of the remaining charges proved.
The panel accepted the advice of the legal assessor. This included advice that the panel would follow the approach set out in Ivey v Genting Casinos [2017] UKSC 67 when deciding whether the allegations of dishonesty have been proved.

Charge 1

That you, a registered nurse:

> "On 16 November 2021, received a police caution for Fraud."

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 5, together with the documentary records produced by the NMC.
The panel was not provided with any formally produced Police National Computer (PNC) record of the caution. However, it did find, as detailed below, that there were a variety of other references to the caution being administered.

The panel noted the handwritten form from Derbyshire Constabulary which detailed that Ms Weaver received a Police caution for fraud on 16 November 2021. That form is signed by both Ms Weaver and the Police Officer administering the caution. It also took account of parts of the self-referral form to the NMC from Ms Weaver, which stated:

> *"Fraud of an invoice. Clay Cross (chesterfield) no follow up caution accepted and police no longer investigating. Voluntary interview 16th November I acceoted terms and admitted fault. Police are jo longer following up. [sic]*
> *I received a caution for a criminal offence."*

The panel heard from Witness 5 that the Police Officers kept him up-to-date regarding their investigation and that there had been a caution administered to Ms Weaver for fraud. The panel was aware that this constituted hearsay evidence but considered it to be corroborated by the other evidence referred to above and there was no reason to doubt its accuracy.

The panel was satisfied that there was reliable evidence that Ms Weaver received a Police caution for fraud on 16 November 2021, and accordingly, the panel found this charge proved.

Charge 2:

> "In your self referral form submitted to NMC when asked if you had informed your employer you answered 'yes'.
> b) Your conduct at charge 2 was dishonest as you had not informed your employer at Alexandra House of your caution."

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 3 and Witness 6, together with the documentary records produced by the NMC. In relation to the stem of this charge, the NMC had produced a copy of Ms Weaver's self-referral form submitted to the NMC. At section 14 of that form, Ms Weaver discloses that she has received a caution for a criminal offence. At section 15, in response to the question 'Have you informed your employer,' she has replied 'Yes'. The panel considered this to be clear evidence that the stem of Charge 2 was proved.

The panel then considered whether, as alleged in Charge 2a), Ms Weaver's conduct in that regard was dishonest. The panel received no documentary or oral evidence to indicate that Ms Weaver had at any stage, either orally or in writing, informed her employer of her caution. The evidence before the panel was that Ms Weaver commenced her employment at the Home on or around 18 November 2021. On that date, Witness 6 completed an internal DBS Risk Assessment Form in discussion with Ms Weaver, which Ms Weaver signed as being complete and correct. Whilst Ms Weaver had informed Witness 6 of *"…an allegation of theft from previous home where she was cleared",* Ms Weaver did not disclose the police caution for fraud received only two days previously on 16 November 2021. In addition, both Witness 3 and Witness 6 gave oral evidence that Ms Weaver had not informed them of the caution at any stage during her recruitment process or period of employment and Witness 6 had been unaware of the caution until she was giving her oral evidence before the panel.

Taking all these factors into account, the panel was satisfied that the fact of the caution two days previously would have been fresh in Ms Weaver's mind at the time she signed the DBS Risk Assessment Form and that she knew she should have disclosed it. The panel was also satisfied on the balance of probabilities that the reason for not disclosing it was that Ms Weaver was concerned that it would jeopardise the job offer at the Home. The panel was therefore satisfied that Ms Weaver had knowingly sought to deceive her employer and that her actions were dishonest by the standards of ordinary decent people. The panel therefore found Charge 2 proved.

Charge 3

> "In correspondence with the NMC on 20 December 2021 stated that you had made Alexandra House aware of what had happened previously regarding the caution.
> a) Your conduct at charge 3 was dishonest as you had not informed your employer at Alexandra House of your caution."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence produced by the NMC.

The panel took into account an email dated 20 December 2021 from Ms Weaver to the NMC in response to her self-referral in which she stated: *"I am a deputy manager at alexandta House and have made them aware of what has happened previously also." [sic].* The panel noted that in this email, Ms Weaver asserts that she has made the Home aware of her caution order. The panel took the view that anyone reading this would think that Ms Weaver had told the Home about the caution when in fact she had not. Within the email, which is an answer to a direct question from the NMC about the caution, Ms Weaver has created the impression that she told the Home about the caution when she had not to intentionally mislead the NMC.

The panel further had sight of an email dated 10 February 2022 from Ms 1 (HR Assistant) at the Home within which she stated: *"I think I might be missing a page from your DBS? Can you pop over to your car please and scan over another copy, I think page 2 is missing potentially (we are aware of what is on it though – so that's not a problem)".* The panel noted that the email stated that the Home was already aware what was on the DBS. However, the panel concluded that this was not reference to the caution, but the allegation of theft that had been declared to the employer on the DBS risk assessment form.
The panel, having taken the above factors into account, found that Ms Weaver did not inform her employer at Alexandra House of her caution and had intentionally misled the

NMC on this matter. By the standards of ordinary, decent people, such conduct would be regarded as dishonest. On the balance of probabilities, the panel found this charge proved.

Charge 4

> "When you commenced employment at Eastgate Care Ltd, Alexandra House you stated that you were cleared of theft in the previous home when you had received a caution.
> a) Your conduct at charge 4 was dishonest in that you knew that you had a caution which was on your DBS certificate."

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary records produced by the NMC.

The panel considered that the natural way of reading this charge was that Ms Weaver had stated she had been cleared of theft when, in fact, she had received a caution for theft. This was incorrect because the caution was for fraud and on that basis the charge fails. Even if this were not the case, the panel concluded that Charge 4a) would fail in any event, based upon an email dated 9 December 2021 correspondence from the providers of the formal DBS record. It stated: *"The application for Kirsty Weaver has been at the DBS longer than expected (when compared with timescales for the average application.) We will continue to monitor this application on a daily basis so there's nothing you need to do. We'll be in touch as soon as we have an update."* This email was written sometime after Ms Weaver commenced her employment. Therefore, the panel concluded that although Ms Weaver would have been aware of the caution on the DBS Certificate sometime after 9 December 2021, the certificate was not in existence at the time of commencing employment. Therefore, at the relevant time as detailed in the charge, she could not have been aware of the content of a document that was not yet in existence.

Taking all factors into account, the panel found this charge not proved.

Charge 5

"When you sent your DBS certificate to your employer on 10 February 2022 you removed a page from your certificate.

b) Your conduct at charge 5 was dishonest in that you removed the page of your DBS certificate dealing with your caution."

In reaching this decision, the panel took into account oral evidence and documentary evidence of Witness 3, and the documentary records produced by the NMC.
The panel took into account an apparent contradiction on the DBS certificate. The certificate indicated in one section that no caution was recorded. However, in another section entitled 'Other relevant information disclosed at the Chief Police Officer's discretion', it referred to information that relates to Ms Weaver's "caution for make false…" which would apparently indicate that there had, in fact, been a caution administered to her. For all the reasons outlined in Charge 1, the panel is confident that there was a caution administered to Ms Weaver and that it would therefore appear on her full DBS Certificate. The panel had no evidence before it of any legitimate reason for Ms Weaver not to submit page 2 from the DBS Certificate. She was asked by Witness 3 via email to submit the missing page but never did so. The panel noted that there were other reminders to submit the same document which spanned a number of weeks. The panel concluded that the only credible reason for not handing over the second page of the DBS Certificate was that she knew it contained information about her caution for fraud.

The panel concluded that this act was intended to deceive the Home into thinking that she had not had a caution for fraud. This would be viewed as dishonest by the standards of ordinary decent people.

Therefore, on the balance of probabilities, the panel found this charge is proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved in relation to Charges 2, 3, 5, 6 and 7 amount to misconduct and, if so, whether Ms Weaver's fitness to practise is currently impaired and by reason of her misconduct and/or by reason of her caution for fraud. 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 Weaver's fitness to practise is currently impaired as a result of that misconduct. In any event, the panel must decide whether Ms Weaver's fitness to practise is currently impaired by reason of her caution for fraud.

Submissions on misconduct and impairment

Mr Earnshaw provided written submissions in relation to misconduct and impairment. His submission was that misconduct is proved and that Ms Weaver is impaired both on public protection and public interest grounds. He further submitted that the following parts of the Code of Conduct had been breached:

> ***4*** *Act in the best interests of people at all times*
>
> ***6*** *Always practise in line with the best available evidence*

10 *Keep clear and accurate records relevant to your practice*

20 *Uphold the reputation of your profession at all times*

21 *Uphold your position as a registered nurse, midwife or nursing associate*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C.

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

1 Treat people as individuals and uphold their dignity
1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

16 Act without delay if you believe that there is a risk to patient safety or public protection

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

20 Uphold the reputation of your profession at all times

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

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

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

21 Uphold your position as a registered nurse, midwife or nursing associate

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care.

23 Cooperate with all investigations and audits

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

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 failure to maintain accurate care plans and the dishonesty regarding the caution and DBS Certificate fell below the standards expected of a registered nurse in the circumstances.

The panel noted that in relation to Charges 2-5, the dishonesty occurred on multiple occasions, it was premeditated and lasted over a period spanning nearly 3 months. The panel considered this to amount to a serious breach of trust baring in mind Ms Weaver's previous position as a Manager at the Home.

When considering dishonesty, the panel took into account that Ms Weaver concealed the fact of her caution, despite having many opportunities to disclose it. The panel considered this to be a serious matter which indicated a course of conduct by Ms Weaver intended to deceive not only her employer but also caused the regulator to believe the Home had been informed of the caution.

In relation to Charges 6-7, the panel took into account that Ms Weaver was the only nurse on duty, and she left the vulnerable patients alone in the Home with no registered nurse present. Furthermore, the panel took the view that her failure to deal appropriately with Residents D and E was serious and potentially placed them at risk of harm. Similarly, the poor administration of medication stock management was equally serious and could also have had significant adverse consequences for vulnerable residents.

The panel therefore found that Ms Weaver'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, and by reason of her caution, Ms Weaver'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel found that all four limbs of the test are engaged by reason of Ms Weaver's misconduct. It determined that vulnerable patients and residents were potentially put at risk when their care plans were either not in place or not up to date. In addition, by leaving the Home when she was the only nurse on duty and having not informed other staff members of her whereabouts, Ms Weaver breached the Home's policy and her actions had the potential to put residents at risk. In relation to Charge 7, her failure to appropriately respond to a physical incident between two residents, which included not updating their patient records, accordingly, had the clear potential to put residents at future risk in the panel's view. The panel therefore determined that Ms Weaver put patients and residents at risk of harm and that, there being no evidence of remediation, there is a high risk of repetition.

In relation to the instances of dishonesty found proved, the panel noted that the police caution was for an offence of dishonesty committed against her employer. Thereafter, that dishonesty was aggravated by Ms Weaver seeking to cover up the fact of that caution upon commencement of her new employment and seeking to mislead the NMC, her regulator, into believing that she had in fact disclosed the caution to her new employer. It follows that her dishonest conduct was ongoing over a number of months despite opportunities to disclose the true position. The only evidence of insight before the panel is

Ms Weaver's reflective statement provided to the NMC, which focuses on the behaviour that led to the police caution for fraud. The panel had no evidence of Ms Weaver reflecting on her dishonest behaviour thereafter towards the NMC and her new employer or any evidence of strengthening practice. In all the circumstances the panel therefore concluded that her risk of future repetition is high.

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.

Noting the serious and premeditated nature of her dishonesty, together with the risk of serious harm linked to her failures within the Home whilst in a managerial role, the panel concluded that a finding of current impairment is necessary on the grounds of both public interest and public protection. This conclusion was based not only on Ms Weaver's misconduct, but also on her caution for fraud.

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 Weaver off the register. The effect of this order is that the NMC register will show that Ms Weaver 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.

Submissions on sanction

Mr Earnshaw informed the panel that in the Notice of Hearing, dated 26 July 2023, the NMC had advised Ms Weaver that it would seek the imposition of a striking-off order if the panel found Ms Weaver's fitness to practise currently impaired.

Mr Earnshaw submitted that neither no further action nor a caution order would be appropriate as the concerns are not at the lower end of the spectrum and the panel had found a risk of repetition in its decision on impairment. He also submitted that, with regard to a conditions of practice order, conditions would be difficult to formulate because of the dishonesty, and furthermore it would not go far enough to address the concerns which were found by the panel to be extremely serious. He further submitted (by referring to the SG) that a suspension order would also not be appropriate given that there were attitudinal concerns arising from dishonesty and a risk of repetition.

Mr Earnshaw submitted that, in light of the panel's decision on misconduct and impairment, Ms Weaver's misconduct breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

Mr Earnshaw submitted that for the reasons outlined, and in the light of the finding that Ms Weaver's fitness to practise is currently impaired by reason of her misconduct and caution, public confidence would be undermined if a striking off order was not made and that in cases of this kind, the only proportionate sanction is to remove the registrant from the NMC register.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms Weaver'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:

- Concealing the caution involved making a misrepresentation to the regulator
- The dishonesty involved a course of conduct and premeditated actions
- The dishonesty continued after receiving the caution despite opportunities to tell the truth and explain her behaviour
- Residents in the Home were vulnerable and were placed at risk by her actions
- There is a lack of insight into the impact of her actions on patients and her colleagues
- Ms Weaver's dishonesty and failures in her nursing practice occurred when she was in a management position as a Deputy Manager

The panel also took into account the following mitigating features:

- No evidence of any actual harm to residents
- Evidence that she had been a good nurse in the past
- Evidence that these events occurred at a time when Ms Weaver had some personal difficulties in her life
- Ms Weaver was promoted relatively soon after joining the Home despite not having an extensive history of nursing and despite the Home already having problems that had not been fully rectified.

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

The panel next considered whether placing conditions of practice on Ms Weaver's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining alone. Furthermore, the panel concluded that the placing of conditions on Ms Weaver's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel took into account the above criteria and concluded that this was not a single instance of misconduct but was a course of conduct which lasted some time. Bearing in mind the course of dishonest misconduct, the panel also considered that this was consistent with a deep-seated attitudinal issue.

This conduct was repeated throughout Ms Weaver's time at the Home, although the panel noted it had not been made aware of any dishonest conduct since then. Furthermore, the panel also took the view that Ms Weaver has shown little insight and has not engaged with the process, and therefore the behaviour is liable to be repeated.

In reaching this decision, the panel had regard of NMC guidance SAN-2 '*Considering sanctions for serious cases'* which details factors that are likely to indicate a higher level of seriousness, namely:

- *Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *Misuse of power*
- *Vulnerable victims*
- *Personal financial gain from a breach of trust*
- *Direct risk to patients*
- *Premeditated, systematic or longstanding deception*

The panel considered the above points and took the view that the Residents at the Home were clearly vulnerable and that there was an element of potential personal gain in Ms Weaver's dishonesty which was premeditated and systematic. Taking the above factors into account, the panel considered that the dishonesty was not at the lower end of the scale.

For the above reasons, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel concluded that Ms Weaver's conduct is fundamentally incompatible with remaining on the register. The panel decided that the nature of Ms Weaver's misconduct and the circumstances of her caution are fundamentally incompatible with what is required of a nurse.

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, and 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 Weaver 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 Weaver's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Earnshaw. He submitted that, given the panel's reasons for imposing the striking-off order, an interim suspension order of 18 months is in the public interest.

Mr Earnshaw submitted that public confidence in the profession would be seriously damaged if Ms Weaver were allowed to practise without restriction during the appeal period. He submitted than an interim order of 18 months was required to allow sufficient time for any appeal lodged to conclude.

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

Decision and reasons on interim order

The panel is satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. It had regard to the seriousness of the case and the reasons set out in its decision on sanction in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate in this case, due to the reasons set out in its decision on sanction. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and to maintain public confidence in the profession and in the NMC as its regulator.

The panel determined that an 18-month period is required to allow sufficient time for any appeal lodged to conclude.

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

That concludes this determination.