Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
29 March 2022 – 31 March 2022
4 April 2022 – 7 April 2022
11 April 2022 – 12 April 2022

Virtual Hearing

Name of registrant:	Fionnuala Mary O'Neill
NMC PIN:	80A0248N
Part(s) of the register:	Registered Nurse – Sub Part 1 Children Nursing – January 1988 Adult Nursing – February 1983
Area of registered address:	Northern Ireland
Type of case:	Misconduct
Panel members:	Anthony Griffin (Chair, Lay member) Claire Rashid (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Fiona Moore
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Gemma Noble, Case Presenter
Miss O'Neill:	Not present and unrepresented
Facts proved:	1a), 1b) 1c) 1d) 1f) 2a) 2b) 2c) 2d) 3) 4) 5) 6a) 6b) 7) 8) 9) 10) 11) 12a) 12b) 13) 14a) 15a) 15b) 15c) 16a) i) ii) iii), 16b) i) ii), 17a), 17b) 17c) 18a), 18b), 19) and 20)
Facts not proved:	1e), 14b) and 18c)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a Registered Nurse:

1. In the presence of HCA 1, on a date unknown, when carrying out a catheterisation procedure on Person 1 in A Bay, Bed 1:

    a) On entering the cubicle, abruptly said “right, this is what we’re doing” or words to that effect.
    b) Pushed Person 1’s legs wide open.
    c) Was not mindful of Person 1’s comments that you were “rough” and/or “sore” in that you responded “that’s just me – you know me” and/or “well that’s how it is” or words to that effect.
    d) Pushed the sheet maintaining Person 1’s dignity up to their chest.
    e) Did not ask Person 1 if you could reposition the sheet so as to assist you in carrying out the procedure.
    f) Did not take steps, either by your words or actions, to make Person 1 feel comfortable and/or respected during the procedure.

2. On or around 27 May 2019, in reference to Nurse A:

    a) Said: “Look at that bastard going to pray and break his fast while I’m getting hammered” or words to that effect;
    b) Called him a “Lazy bastard”;
    c) Complained that Nurse A had left you to look after “his Drunks”;
    d) Said “I bet his GMAWS isn’t done”.

3. On an unknown date referred to Nurse A as ‘Kunta Kinte’.

4. On a shift commencing 28 July 2019 said to HCA 3, with reference to Nurse A: “that cunt does not speak to me, everyone thinks he is nice but he is not, he is a cunt” or words to that effect.

5. On unknown dates(s) said in reference to Nurse A “him coming over to your country earning this and that and does nothing only take himself off and pray, cunt” or words to that effect.

6. Your conduct at any or all of Charges 2, 3, 4 and 5 amounts to bullying and/or harassment of Nurse A in that:

    a) Your conduct related to one or more protected characteristics, namely religion and/or race.
    b) Your conduct had the purpose or effect of violating Nurse A’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for Nurse A.

7. Informally complained to colleagues when rostered to work with Nurse A.

8. Spoke negatively with colleagues about patients on the unit who misused drugs and/or abused alcohol.

9. In the presence of HCA 2, made a racist statement about the patient he was with in Bay C in that you said: “if he was in the jungle now they would be throwing bananas at him” or words to that effect.

10. On one or more occasions, spoke in a derogatory way about patients from Eastern Europe.

11. On one or more occasions used the word ‘commanche’ when referring to people.

12. In or around October/November 2018, on responding to a patient buzzer:

    a) Muted the patient buzzer; and/or
    b) Left the patient without providing any assistance to the patient.

13. On one or more occasions did not provide the necessary assistance to patients who had ‘Care of 1’ status.

14. When approached by HCA 2 for pain relief for a patient who had fractured his leg:

    a) Said: “that’s just cramp, not much I can do about cramp” or words to that effect.
    b) Did not take steps to review the patient.

15. On one or more occasion:

    a) Did not prioritise administering pain relief for patients.
    b) Did not administer pain relief when requested by patients.
    c) Did not administer Librium as a PRN to patients when they were prescribed it.

16. While working a night shift at Daisy Hill Hospital between 10 October 2019 and 18 October 2019:

    a) When asked by Person 2 to administer their prescribed medication (Cyclizine) at approximately 17:30:

        i. Replied: “I do not give Cyclizine via vein” or words to that effect.
        ii. Failed to administer Person 2 their prescribed dose of Cyclizine.
        iii. Did not take steps to ensure Person 2 was administered the prescribed medication until Person 2 raised the matter again approximately 1 hour later.

    b) When called by a patient on one or more occasions for assistance to use the toilet responded by:

        i. Throwing your arms in the air; and

ii. Saying “I have not got time to take you to the toilet, I am too bloody busy’ or words to that effect.

17. You did not work collaboratively with colleagues in that you:

a) Would not help others with their tasks.
b) Delegated personal care for patients when you should have done it yourself.
c) Left the task of removing a needle and line from a patient who wished to leave the hospital to the next shift.

18. Administered Librium to Person 3, who was allocated to Nurse A:

a) Without checking with Nurse A before the administration.
b) Without reviewing and/or considering the assessment Nurse A had documented for Person 3.
c) As a PRN dose when it could or should have been the patient’s regular dose.

19. Accused Nurse A of missing Person 3’s dose of Librium.

20. When Nurse A told you that there was no medication error in relation to Person 3 you dismissed his explanation and walked away from him.

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss O'Neill was not in attendance and that the Notice of Hearing letter had been sent to Miss O'Neill and her representative's registered email address on 23 February 2022.

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

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

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Miss O'Neill

The panel next considered whether it should proceed in the absence of Miss O'Neill. The panel had regard to Rule 21(2), which states:

> *'**21.—** (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*
>
> *(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;*

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.'

Ms Noble invited the panel to continue in the absence of Miss O'Neill on the basis that she had voluntarily absented herself. She told the panel that Miss O'Neill has indicated that she does not wish to engage in the proceedings. In November 2021 Miss O'Neill indicated by telephone to the case coordinator that she did not wish to attend the hearing. Ms Noble submitted that there is nothing to suggest that an adjournment would secure Miss O'Neill's attendance. She told the panel that there are a number of witnesses who are due to attend this week and therefore it would be fair and appropriate to proceed in Miss O'Neill's absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R.* v *Jones (Anthony William)* (No.2) [2002] UKHL 5. The panel further noted the case of *R (on the application of Raheem) v Nursing and Midwifery Council* [2010] EWHC 2549 (Admin) and the ruling of Mr Justice Holman that:

'...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" *is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion* "with the utmost care and caution"*, it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need*

not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution.'

The panel has decided to proceed in the absence of Miss O'Neill. In reaching this decision, the panel has considered the submissions of Ms Noble and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Miss O'Neill had not requested an adjournment of this hearing and the panel did not consider that there was information to suggest that an adjournment would result in Miss O'Neill's attendance at a hearing on a future date;
- The panel was satisfied that Miss O'Neill was aware of the date of this hearing. It considered that Miss O'Neill has therefore voluntarily absented herself from this hearing;
- A number of witnesses are due to give oral evidence at this hearing, and not proceeding with the hearing may inconvenience the witnesses, their employers, and for those involved in clinical practice, patients requiring their professional services;
- The charges relate in part to events which occurred in 2018 and 2019, and any further delay may have an adverse effect on the ability of witnesses to accurately recall matters;
- There is a strong public interest in the expeditious disposal of this case.

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

consequence of Miss O'Neill'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.

The panel has decided to proceed in the absence of Miss O'Neill. The panel will draw no adverse inference from Miss O'Neill's absence in its findings of the facts.

Decision and reasons on application under Rule 19

At the outset of the hearing Ms Noble, on behalf of the NMC, made an application for parts of this hearing to be heard in private, on the basis that there would be reference to Person 2's health. This application was made pursuant to Rule 19 of the Rules.

The panel accepted the advice of the legal assessor. While Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to Person 2's health, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with Person 2's health as and when such issues are raised.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Noble under Rule 31 to allow the witness statement and exhibits of HCA 3 into evidence. Ms Noble informed the panel that HCA 3 was not present at this hearing and explained she was unable to attend due to her health.

In the preparation of this hearing, the NMC had indicated to Miss O'Neill that HCA 3 would provide live evidence. However, unfortunately HCA 3 is not in a position to attend

this hearing to provide evidence. The panel was provided with documentation in respect of HCA 3's health condition.

Ms Noble provided the background to this application. She submitted that HCA 3's evidence was relevant as it speaks to several charges. Ms Noble told the panel that in respect of charges 4), 5), 17c) HCA 3's statement and exhibits are the sole evidence and in respect of charges 6), 7), 17a) and 17b) HCA 3's provides supporting evidence. She submitted that it would be fair in all the circumstances to allow the evidence to be read into record as it is not the sole and decisive evidence on all charges and the matters raised are supported by other witnesses who the panel will hear from in due course. Ms Noble submitted that HCA 3's reasons for non-attendance are genuine. She therefore invited the panel to allow HCA 3's written statement and exhibits into 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. She referred the panel to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *NMC v Ogbona* [2010] EWCH 1216.

The panel gave the application in regard to HCA 3 serious consideration. The panel noted that HCA 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered that the evidence provided by HCA 3 is relevant and is the sole evidence in respect of charges 4), 5), 17c). The panel considered that as Miss O'Neill had been provided with a copy of HCA 3's statement and, as the panel had already determined that Miss O'Neill 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 there would be

no prejudice to Miss O'Neill in admitting HCA 3's evidence. She has been sent HCA 3's witness statement and has had the opportunity to comment on this.

The panel also accepted that there was a good and cogent reason for HCA 3's non-attendance which was supported by medical evidence.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the hearsay evidence of HCA 3, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Witnesses

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

- HCA 1: Band 3 Senior Health Care Assistant (HCA) at Belfast NHS Trust (Belfast Trust)
- HCA 2: Senior Nursing Assistant at Belfast Trust
- Nurse A: Band 5 Agency Nurse at Belfast Trust
- Person 2: Patient at Southern Health and Social Care Trust (Southern Trust)
- Witness A: Senior Nursing Assistant at Belfast Trust
- Witness B: Band 7 Registered Nurse at Belfast Trust

- Witness C: Band 7 Registered Nurse at Belfast Trust
- Witness D: Clinical Lead Nurse at Belfast Trust
- Witness E: Nurse Manager for Just Nurses (the Agency)
- Witness F: Ward sister at Daisy Hill Hospital Southern Trust

Background

Miss O'Neill was referred to the NMC on 5 March 2020 by The Placement Group Belfast in relation to regulatory concerns which include:

- Rough handling of a patient when providing catheter care
- Failing to have proper regard for the dignity of that patient
- Using derogatory and racially discriminatory language when referring to patients and colleagues
- Failing to provide pain relief to patients when asked for
- Avoiding undertaking personal care to patients and not assisting them adequately when doing so
- Bullying colleagues and failing to assist and work cooperatively with them

Miss O'Neill had worked as an agency registered nurse between the years of 2016 and 2019 at Belfast NHS Trust (Belfast Trust) and then at Southern Health and Social Care Trust (Southern Trust). Miss O'Neill's agency had moved her following the initial concerns raised by colleagues to work at the Southern Trust and that further complaints were received by patients who were under her care.

It is alleged that on 1 August 2019 concerns were raised in writing at the Belfast Trust by Healthcare Assistants HCA 2, HCA 3, Witness A, Witness C and Witness D. On 1 August 2019, Miss O'Neill was asked to leave the Belfast Trust by Witness D following the concerns raised.

It is alleged that on 5 August 2019 Witness E of Just Nurses had a telephone call with Miss O'Neill to inform her that she would be suspended from working shifts at the Belfast Trust. On 9 August 2019, a meeting was held between Witness E, Miss O'Neill and her Union Representative to discuss the concerns raised. Miss O'Neill provided a written response to the concerns raised in the Belfast Trust.

It is alleged that on 16 September 2019, the first patient complaint was recorded in the Southern Trust by Witness F. On 27 October 2019, a second patient complaint was recorded in the Southern Trust by Witness F. On 29 October 2019, Witness E was informed of the complaints raised by patients against Miss O'Neill.

On 1 March 2020 Miss O'Neill competed her last shift at the Southern Trust.

The panel accepted the advice of the legal assessor, who in relation to charge 6, made reference to the definition of harassment as found within the Equality Act 2010. During the course of the panel's deliberations on the facts, it became apparent that the Equality Act 2010 does not apply to Northern Ireland. The legal assessor then corrected her advice by referring the panel to the relevant applicable legislation, namely, s 4A of the Race Relations (Northern Ireland) Order 1997 and s.3A of The Fair Employment and Treatment (Northern Ireland) Order 1998.

> *'The Fair Employment and Treatment (Northern Ireland) Order 1998*
>
> *s. 3A (1) A person (A) subjects another person (B) to harassment in any circumstances… where, on the grounds of religious belief or political opinion, A engages in unwanted conduct which has the purpose or effect of –*
>
> > *(a) violating B's dignity; or*

(b) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) Conduct shall be regarded as having the effect specified in sub-paragraphs (a) and (b) of paragraph (1) only if, having regard to all the circumstances, including, in particular, the perception of B, it should be reasonably considered as having that effect.'

'The Race Relations (Northern Ireland) Order 1997

s.4A (1) A Person (A) subjects another person (B) to harassment in any circumstances… where, on grounds of race or ethnic or national origins, A engages in unwanted conduct which has the purpose or effect of –

(a) violating B's dignity; or

(b) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) Conduct shall be regarded as having the effect specified in sub-paragraphs (a) and (b) of paragraph (1) only if, having regard to all the circumstances, including, in particular, the perception of B, it should be reasonably considered as having that effect.'

The legal assessor advised Ms Noble of the corrected advice, which she accepted. The corrected advice was formally given to the panel in open session when the hearing resumed.

Panel's 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 Ms Noble on behalf of the NMC and the hearsay evidence of HCA 3.

The panel has drawn no adverse inference from the non-attendance of Miss O'Neill.

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.

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.

Charge 1

1. In the presence of HCA 1, on a date unknown, when carrying out a catheterisation procedure on Person 1 in A Bay, Bed 1:

    a) On entering the cubicle, abruptly said “right, this is what we’re doing” or words to that effect.
    b) Pushed Person 1’s legs wide open.
    c) Was not mindful of Person 1’s comments that you were “rough” and/or “sore” in that you responded “that’s just me – you know me” and/or “well that’s how it is” or words to that effect.
    d) Pushed the sheet maintaining Person 1’s dignity up to their chest.
    e) Did not ask Person 1 if you could reposition the sheet so as to assist you in carrying out the procedure.
    f) Did not take steps, either by your words or actions, to make Person 1 feel comfortable and/or respected during the procedure.

This charge is found proved in respect of charges 1a), 1b), 1c), 1d) and 1f).

In reaching this decision, the panel took into account all the evidence before it. It had regard to HCA 1’s written statement and oral evidence and found that the evidence provided by HCA 1 to be consistent and credible.

Charge 1a)

The panel noted that although HCA 1 was not able to catheterise patients herself, she was experienced in the Clinical Assessment Unit (CAU) and was able to comment on how nurses should or should not behave towards patients. The panel also noted that HCA 1 had chaperoned a number of nurses and was able to explain to the panel what good catheterisation practice looks like. It further noted that HCA 1 had worked with Miss O'Neill on average three or four times a month in the CAU.

The panel considered the written statement of HCA 1 which states the following: *'Once the Registrant had prepared the catheter, she pulled the curtain back and said "right, this is what we're doing". She was very abrupt.'* The panel found HCA 1's account of the incident consistent throughout her written and oral evidence and that she provided a clear account of language used, and the impact which witnessing the incident had upon her. The panel therefore found charge 1a) proved.

Charge 1b)

The panel considered the written statement of HCA 1 which states the following: *'…had her feet up at her bottom and her legs close together. The Registrant abruptly pushed the patient's legs wide open.'* The panel was satisfied that HCA 1's account was consistent and the documentary evidence was supported in HCA 1's oral evidence.

HCA 1 told the panel that *"Miss O'Neill used her hands to separate the legs, but probably could have asked the patient to do it herself or explained what she was going to do or done it gently…"*

The panel considered HCA 1's explanation of what best practice would be and that she would have done it differently. The panel found that HCA 1's evidence was credible and her live evidence did not vary from the written statement which was produced during the NMC investigation. The panel therefore found charge 1b) proved.

Charge 1c)

The panel considered HCA 1's account to be reliable and credible. The panel considered that HCA 1 was clear in her evidence and the information she provided in relation to what the patient had endured. The panel considered the following from HCA 1's written statement:

> *'…Person 1 commented that this was "rough" and "sore". The Registrant responded, "That's just me - you know me" and "well that's how it is". I think she meant that was just her way and how she is with everyone when administering a catheter. Everyone who worked with the Registrant knew she was very abrupt…Person 1 said "Oh you are awful rough" when the Registrant pushed her legs apart. This was before the catheter was inserted.'*

The panel further noted that in HCA 1's oral evidence she explained that she had sensed Person 1 was uncomfortable during the procedure. The panel was satisfied that HCA 1's evidence was clear and unambiguous. It therefore found charge 1c) proved.

Charge 1d)

The panel considered the written statement of HCA 1 which states the following: *'The Registrant also pushed the sheet up to the Person 1 chest. I did not think that this was necessary in order for the Registrant to administer the catheter.*'

In HCA 1's oral evidence she told the panel "*the sheet was on the lower half of the chest, upper abdomen. Relying on statement as well to remember, exposing lower half of abdomen rather than chest."* HCA 1 gave her opinion that Miss O'Neill was not kind or caring towards Person 1. She said that patients should be respected and made to feel comfortable and that there were steps Miss O'Neill could have taken, such as keeping the sheet down as much as possible to preserve Person 1's dignity, but Miss O'Neill made no effort to preserve Person 1's dignity. The panel determined that HCA 1's evidence was clear, coherent, and inherently plausible. The panel therefore found charge 1d) proved.

Charge 1e)

In reaching its decision, the panel had regard to the evidence of HCA 1. However, the panel did not hear any evidence on whether anything was said to Person 1 about repositioning the sheet. The panel considered the written statement of HCA 1 which states that she does not remember Miss O'Neill saying anything. The panel determined that there is no specific evidence to find charge 1e) proved.

The panel therefore did not find charge 1e) proved.

Charge 1f)

In reaching its decision, the panel had regard to the evidence of HCA 1. It noted HCA 1's written statement which states the following:

> *"Patients should be respected and made to feel comfortable. In this situation, there are certain steps that the Registrant could have taken such as keeping the sheet down as much as possible, asking the patient if she was okay or asking the patient if she could push the sheet up a bit if she was struggling to see. Which would have assisted to preserve the patient's dignity. The Registrant did not do any of this. The Registrant made no effort to preserve the patient's dignity."*

The panel noted that during HCA 1's oral evidence she said that patients should be respected and made to feel comfortable and that there were steps Miss O'Neill could have taken, such as keeping the sheet down as much as possible to preserve Person 1's dignity, but Miss O'Neill made no effort to preserve Person 1's dignity. The panel further considered the contemporaneous notes provided by HCA 1. It noted that HCA 1 suggests that Person 1 was embarrassed as a result of Miss O'Neill's failure to take the correct steps to make Person 1 feel comfortable and/or respected during the procedure. The panel was satisfied that there was sufficient evidence presented to find 1f) proved.

Charge 2)

2. On or around 27 May 2019, in reference to Nurse A:

a) Said: “Look at that bastard going to pray and break his fast while I’m getting hammered” or words to that effect;
b) Called him a “Lazy bastard”;
c) Complained that Nurse A had left you to look after “his Drunks”;
d) Said “I bet his GMAWS isn’t done”.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the documentary and oral evidence provided by Witness A. It considered that Witness A has provided clear and consistent evidence in relation to charge 2a) – 2d) and presented in a professional manner throughout.

The panel noted that GMAWs stands for Glasgow Modified Alcohol Withdrawal Scale.

Charge 2a)

The panel considered the written statement of Witness A which states the following:

> *‘I believe it was during Ramadan and [Nurse A] and another nurse had taken their break to pray in the staff changing area. Just after midnight, I was at the nursing station with the Registrant and she said "Look at that bastard going to pray and break his fast while I'm getting hammered", referring to [Nurse A].’*

The panel further considered Witness A’s written concerns submitted to Witness D on 1 August 2019 which states:

> *‘I was on Night duty 27/05/2019 I was the SNA covering the bays on 2F. I was assisting [Nurse A] and [Miss O’Neill]. Around 23:00 [Nurse A] went to break his*

fast during the month of Ramadan, [Miss O'Neill] passed a comment "Look at that bastard going to pray and break his fast huh leavening [sic] *me to look after his drunks. I bet his GMAWS isn't done…'*

The panel noted that in Witness A's oral evidence, he made reference to keeping notes of events that take place at the time in a book so he does not forget.

The panel found that Witness A's evidence was credible and his live evidence did not vary from the witness statement which was produced during the NMC investigation. The panel therefore found charge 2a) proved.

Charge 2b)

In reaching its decision, the panel considered the evidence of Witness A. The panel was satisfied that Witness A's evidence was consistent when questioned by the panel.

The panel took into account the written statement of Witness A which states: *'…The Registrant then called him a "lazy bastard" under her breath.'* In Witness A's oral evidence he told the panel that he was a foot and a half away and that he was able to clearly hear what was said by Miss O'Neill, just under normal talking tone. The panel also took into account the contemporaneous notes submitted to Witness D on 1 August 2019. The panel concluded that the evidential threshold was met and therefore found charge 2b) proved.

Charge 2c)

In reaching its decision, the panel considered the evidence of Witness A. Witness A told the panel that Miss O'Neill complained that Nurse A had left her to look after "*his drunks*" (referring to Nurse A's patients who were suffering from alcohol withdrawal). The panel noted that Witness A was concerned about the incident and wrote a statement on 1 August 2019 which he provided to Witness D. Witness A further attended a meeting with the Deputy Manager Witness E from the Agency Miss O'Neill worked for and has produced the notes of that meeting.

The panel has not heard any evidence that would call into doubt Witness A's written and oral evidence. The panel was therefore satisfied that there was sufficient evidence presented to find Charge 2c) proved.

Charge 2d)

In reaching its decision, the panel considered the documentary and oral evidence of Witness A.

It considered the following from Witness A's written statement:

> *'The Registrant complained that [Nurse A] had left her to look after "his drunks" and said "I bet his GMAWS isn't done "By "his drunks" she was referring to his patients who were suffering from alcohol withdrawal which is common in the Village…'*

The panel also considered the contemporaneous account submitted by Witness A to Witness D on 1 August 2019 which states:

> *'…leaving me to look after his drunks. I bet his GMAWS isn't done." She then asked what was my thoughts on the issue to which was. "It's [Nurse A's] right to pray so leave him alone also if u have a nursing issue then speak with the band 6" When Nurse A returned [Miss O'Neill] confronted him in the drug room about his GMAWS scores and returned to me then called him a lazy bastard under her breath.'*

The panel was satisfied that Witness A's evidence was clear and supported by his exhibits. The panel therefore found charge 2d) proved.

Charge 3)

3. On an unknown date referred to Nurse A as 'Kunta Kinte'.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had regard to HCA 2's documentary and oral evidence who provided clear and consistent evidence. The panel noted that HCA 2 understood 'Kunta Kinte' to be a reference to a television programme called 'Roots' about slavery. He understood Miss O'Neill's comment to be a racist slur.

The panel considered the written statement of HCA 2 which states the following:

> *'I overheard the Registrant refer to [Nurse A], a Nurse who works in the Unit who is of black ethnicity, as "Kunta Kinte". I do not know [Nurse A's] full name.'*

The panel also took into account the written concern submitted to Witness D on 1 August 2019 which states:

> *'I've witnessed racist remarks by [Miss O'Neill] while working with her over the past 2 years...More recently I've witnessed her referring to another member of staff who is also of black ethnicity as kunte kinte. Her attitude towards this member of staff isn't good in general with no reason for it.'*

In HCA 2's oral evidence, he told the panel that he *"knew the comment 'kunta kinte' was in reference to Nurse A approaching a patient sleeping, night shift and I think it was kind of vague but memory was along the lines of imagine being woken by Kunta Kinte, perhaps not exactly but something along those lines."*

The panel was of the view that HCA 2's evidence was clear and concise and that there was nothing to undermine the credibility of his evidence. The panel therefore found charge 3) proved.

Charge 4)

4. On a shift commencing 28 July 2019 said to HCA 3, with reference to Nurse A: “that cunt does not speak to me, everyone thinks he is nice but he is not, he is a cunt” or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence provided by HCA 3. Whilst this is hearsay evidence, the panel considered it gave important contextual background to this charge. The panel determined that this evidence was entirely compelling and not at odds with other evidence before the panel.

The panel considered the following from HCA 3’s written statement:

> *‘During the night shift on 28 July 2019, the atmosphere was particularly bad between them. I do not know if this was due to them being tired. At one point during the night, the Registrant said to me, in reference to [Nurse A], " that cunt does not speak to me, everyone thinks he is nice but he is not, he is a cunt'. I cannot remember where the Registrant said this to me, it may have been in the drug room, the treatment rom or the store room. I am not aware whether [Nurse A] or the patients in the CAU actually heard this but they potentially could have done as the Registrant said it very loudly and I think I remember the door being half open.’*
>
> *‘The Registrant often used the word 'cunt' in reference to [Nurse A]. I do not think I have ever actually heard her call him, [Nurse A]. I have heard the Registrant use the word 'cunt' generally a few times, but it was often in reference to [Nurse A]. The Registrant's language was always very explicit. I do not know what exactly the Registrant meant by using this word to refer to [Nurse A] but I understand it to be a bad word and she used it in a derogatory way.’*

The panel noted that HCA 3 explains in her written statement that at one point during the shift, Miss O'Neill said to her, with reference to Nurse A *'that cunt does not speak to me, everything thinks he is nice but he is not, he is a cunt*'. She further explains that Miss O'Neill often used the word *'cunt*' in reference to Nurse A. The panel further noted the contemporaneous account provided by HCA 3 dated 1 August 2019 which states:

> *'…they didn't communicate through the night and [Miss O'Neill] on several occasions stated that in her words THAT CUNT DOSENT SPEAK TO ME, everyone thinks hes* [sic] *a nice person but hes* [sic] *not hes* [sic] *a CUNT.'*

The panel was of the view that there was a balanced approach to what HCA 3 had reported. It therefore found charge 4) proved.

Charge 5)

5. On unknown dates(s) said in reference to Nurse A "him coming over to your country earning this and that and does nothing only take himself off and pray, cunt" or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence provided by HCA 3. It had particular regard to the written statement of HCA 3 which states:

> *'On one occasion, on a different shift, I do not remember the date of the shift, the Registrant said, referring to [Nurse A], " him coming over to our country earning this and that and does nothing only take himself off and pray, cunt'. While the Registrant would often complain about [Nurse A] going to pray, it was only on one occasion that I have heard her say "him coming over to our country earning this and that" or anything similar.'*

The panel further considered the evidence by HCA 3 of a written concern submitted to Witness D on 1 August 2019 which states '*I find her comments vulgar and rude towards some staff members especially [Nurse A]. Saying to me him coming over to our country earning this and that and does nothing only take himself off and pray. Cunt he is she said.'*

The panel concluded that the evidential threshold was met and therefore found charge 5) proved.

Charge 6)

6. Your conduct at any or all of Charges 2, 3, 4 and 5 amounts to bullying and/or harassment of Nurse A in that:

    a) Your conduct related to one or more protected characteristics, namely religion and/or race.
    b) Your conduct had the purpose or effect of violating Nurse A's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for Nurse A.

This charge is found proved in its entirety.

Having found charges 2,3,4 and 5 proved, the panel considered the definitions of bullying and harassment set out in Belfast Trust's Conflict, Bullying and Harassment in the Workplace Policy and Procedure (the Policy) issued on 16 May 2019 and effective from June 2019:

> *'**Bullying** occurs 'where one person or persons engage(s) in unwanted conduct in relation to another person which has the purpose or effect of violating that person's dignity or creating an intimidating, hostile, degrading, humilitating* [sic] *or offensive environment for that person. The conduct shall be regarded as having this effect only if, having regard to all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that*

effect' (Harassment and Bullying in the Workplace' – A joint publication by the Equality Commission for Northern Ireland and the Labour Relations Agency).

***Harassment** is based on, motivated by or related to one of the equality grounds laid down in antu-discrimination* [sic] *legislation (age, disability status, marital or civil partnership status, political opinion, race, religious belief, sex (including gender reassignment), sexual orientation, with dependants or without dependants). Harassment can be a single serious incident or an ongoing campaign. Conduct shall be regarded as harassment only if, having regard to all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that effect.'*

The panel also considered the contents of the Policy, in particular:

'Causing or contributing to conflict, bulling and harassment is unacceptable behaviour which will not be permitted, accepted or condoned. Notwithstanding the legal implications of engaging in such behaviour, bulling and harassment are contrary to the standards of conduct that we expect of our staff and have the potential to impact on patient and client care. Such behaviours are detrimental to a productive, harmonious working environment, as well as the confidence, morale and performance of those affected by it, including anyone who witnesses or knows about the unwanted behaviour.'

The panel was also referred by the legal assessor to the definitions of harassment contained in s.3A of the Fair Employment and Treatment (Northern Ireland) Order 1998 (with reference to the protected characteristic of religious belief); and s.4A of the Race Relations (Northern Ireland) Order 1997 (with reference to the protected characteristic of race and/or ethnicity.)

'The Fair Employment and Treatment (Northern Ireland) Order 1998

s. 3A (1) A person (A) subjects another person (B) to harassment in any circumstances… where, on the grounds of religious belief or political opinion, A engages in unwanted conduct which has the purpose or effect of –

(a) violating B's dignity; or

(b) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) Conduct shall be regarded as having the effect specified in sub-paragraphs (a) and (b) of paragraph (1) only if, having regard to all the circumstances, including, in particular, the perception of B, it should be reasonably considered as having that effect.'

'The Race Relations (Northern Ireland) Order 1997

s.4A (1) A Person (A) subjects another person (B) to harassment in any circumstances… where, on grounds of race or ethnic or national origins, A engages in unwanted conduct which has the purpose or effect of –

(a) violating B's dignity; or

(b) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) Conduct shall be regarded as having the effect specified in sub-paragraphs (a) and (b) of paragraph (1) only if, having regard to all the circumstances, including, in particular, the perception of B, it should be reasonably considered as having that effect.'

The panel was conscious that the Trust's policy as exhibited only came into effect in June 2019, which postdates the events referred to in charge 2, and may or may not cover the events referred to in charges 3 and 5, where the dates are unknown. However, the panel had regard to the evidence of Witness D, who stated that the June 2019 policy was an update/ amalgamation of earlier policies which had been in place since 2010 and which were in broadly similar terms. The panel also had regard to the definitions of harassment contained in the Orders of 1997 and 1998 and noted that the Trust's policy closely reflects that wording. The panel was therefore satisfied on the balance of probabilities that the Trust policy in force at the relevant times was the same as, or substantially similar to, the policy which came into effect in June 2019.

Charge 6a)

In reaching its decision, the panel considered the documentary and oral evidence of Witness A, HCA 2, Nurse A and hearsay evidence of HCA 3.

The panel had regard to the terms of charge 2, and to the written statement of Witness A:

> *'There were no other members of staff around when the Registrant made these comments but patients could potentially have heard the comments.'*
>
> *'In response to her comments I said "It's [Nurse A's] right to pray so leave him alone. Also if you have a nursing issue then speak with the Band 6". The Registrant did not react badly to this and went to speak with […], the Band 6 in charge.'*
>
> *'The incident was playing on my mind for a while and it just was not right. It was clear that the Registrant was bullying and harassing [Nurse A] and I felt it had to stop. This is why I wrote a statement on 1 August 2019 which I produce as Exhibit…'*

The panel also had regard to the written statement of HCA 2 (in relation to charge 3) in which he states:

> *'I believe Kunta Kinte is a reference to a television programme called Roots, about slavery. I understood the Registrant's comment to be a racist slur. I did not challenge the Registrant about this comment as I only overheard it.'*

HCA 2 told the panel that Nurse A is a black man and to refer to Nurse A as a character from a programme about slavery *"seems very racist."*

The panel noted that there is significant evidence from a number of sources to establish on the balance of probabilities that Miss O'Neill used racially discriminatory and

derogatory language towards colleagues and patients. In particular it is found proved that she made racist and religiously offensive comments towards Nurse A. The panel considered the written statement of HCA 3 in which she explains that Miss O'Neill had never got on with Nurse A and the atmosphere between the two of them was not good when they were working on the same shift. HCA 3 also explains that there was no communication between them which made the atmosphere uncomfortable on the ward.

The panel also considered the evidence of Nurse A. When questioned by the panel, Nurse A said that he was not aware of the derogatory or racially discriminatory language used by Miss O'Neill towards him, until he was asked about this by Witness D. When giving evidence, he indicated that he remains unaware of the specific comments made, and the panel formed a view that he was clearly upset by this. Furthermore, Witness A and Witness D, as well as HCA 2 and HCA 3 all spoke of their concerns at the comments made which they believed were offensive and inappropriate and created a hostile and unpleasant working environment.

Nurse A sensed that Miss O'Neill's behaviour was generally not positive towards him and that her behaviour was dismissive and she was not a team player. Nurse A told the panel that Miss O'Neill would not check medication with him when it required a second signature where medication administration is required to be signed off by two nurses. He told the panel that he would have to *"chase Miss O'Neill for a second signature or get another team member to sign."*

In all the circumstances, the panel determined that Miss O'Neill's conduct related to the protected characteristics of both religion and race and accordingly finds charge 6a) proved.

Charge 6b)

The panel considered the written statement of HCA 3 in which she states:

> *'The Registrant often used the word 'cunt' in reference to [Nurse A]. I do not think I have ever actually heard her call him, [Nurse A]. I have heard the Registrant use the word 'cunt' generally a few times, but it was often in reference to [Nurse*

A]. The Registrant's language was always very explicit. I do not know what exactly the Registrant meant by using this word to refer to [Nurse A] but I understand it to be a bad word and she used it in a derogatory way.

The Registrant then kept repeating to me "don't you think, [HCA 3}". I felt the Registrant was trying to get me agree to her calling [Nurse A] a cunt. This made me feel uncomfortable. I responded "no, I think he is a nice guy and just quiet'. [Nurse A] is quiet, and does tend to just get on with his work and not bother anyone, but I do chat to him sometimes and he always seems to get on with all of the other staff aside from the Registrant. I do not think the Registrant responded to me and I think I just walked away. I did not want the hassle of any confrontation with the Registrant at work.'

The panel was satisfied that Miss O'Neill had encouraged HCA 3 to agree with her offensive comments, which she refused to do.

The panel considered the issue of Nurse A's perception and noted that whilst Nurse A was unaware of the specific nature of Miss O'Neill's derogatory and racist comments, he was aware that she did not wish to work with him and failed to communicate or cooperate with him on the ward, thereby creating a hostile atmosphere. In addition, Miss O'Neill's behaviour created a hostile atmosphere for other staff. The panel took into account all the circumstances and concluded that there was mutually corroborative and credible evidence of Miss O'Neill's conduct having the purpose of violating Nurse A's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for Nurse A whether or not it had that effect. The panel was satisfied that it was reasonable to consider such conduct would have this purpose or effect.

The panel therefore find charge 6b) proved.

Charge 7)

7. Informally complained to colleagues when rostered to work with Nurse A.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness B and Witness C.

The panel considered the evidence of Witness B. She provided clear and detailed evidence. The panel was of the view that her evidence both oral and documentary was of great assistance and deemed her a credible and reliable witness. The panel had regard to Witness B's written statement in which it states:

> *'Whenever the Registrant realised that she had a shift on the rota with [Nurse A] she would be unhappy and would say "oh dear, I'm on with [Nurse A]"…'*

Witness B told the panel that Miss O'Neill would appear "*disappointed and unhappy"* when rostered to work with Nurse A. Witness B told the panel that as nurse in charge she had asked Miss O'Neill why she had problems working with Nurse A, but Miss O'Neill *"never gave reason, huffing and then just leave."* Witness B further told the panel that on a number of occasions she has heard Miss O'Neill negative comments when Nurse A was rostered to work with Miss O'Neill.

The panel also had regard to Witness C witness statement from the internal investigation signed on 18 April 2020 which states:

> *'I was approached at the end of my day shift by Staff Nurse Fionnuala O'Neill who was coming onto night duty. Who stated multiple comment about [Nurse A] (staff nurse) how she couldn't believe she was working with him tonight again and that she always is cleaning up his mess and that then he goes away to pray when things kit off* [sic]*.'*

The panel concluded that there was mutually corroborative and credible evidence to find charge 7) proved.

The panel determined that the evidential threshold was met to find charge 7) proved.

Charge 8)

8. Spoke negatively with colleagues about patients on the unit who misused drugs and/or abused alcohol.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness A, Witness B, Witness C and HCA 2.

The panel considered the written statement of Witness A which states '*The Registrant complained that [Nurse A] had left her to look after "his drunks"…'*

The panel also considered the written statement of Witness B which states:

> *'I have witnessed the Registrant making comments about patients suffering from drug overdose or alcohol withdrawal. The Registrant would say things like "why are they in that state, they should go and fix their life" and "they are only 30, what is wrong with these people.'*

Witness B further told the panel that Miss O'Neill behaved unpleasantly to patients with drug and alcohol issues. She further told the panel that on several occasions that she is aware of, Miss O'Neill would withhold pain relief from patients who came in with alcohol issues, drug overdose and that Miss O'Neill would have a different attitude towards them.

The panel noted Witness B's witness statement from the internal investigation signed on 19 April 2020 which states:

> *'Patients with drug and alcohol issues were treated differently. She was constantly derogatory about them. She would say "why can't they just sort themselves out?" She says negative comments, about them but I didn't hear racial comments.'*

The panel took into account Witness C's written statement which states:

> *'I can't remember any specific examples of the statements the Registrant made, but she would just talk negatively about the patients' drug misuse and alcohol abuse. The Registrant would make these comments almost every shift… I don't know if there's any reason for the Registrant's negative opinions about drug misusers or alcoholics.'*

Witness C told the panel that Miss O'Neill would say "*well they shouldn't be getting treatment because they did this to themselves*." The panel further considered Witness C's written concerns submitted to Witness D on 2 August 2019 which states:

> *'Often referring to them as 'Comanche(s)'. She also uses this term and often makes comments about patient in particular patients that are in alcohol withdrawal, on drugs or taken overdoses. Using inappropriate language and statements.'*

The panel also had sight of Witness C's witness statement from the internal investigation signed on 18 April 2020 which states:

> *'Her comments were offensive in general. The kind of patients we treat can have alcohol and drug abuse issues and we treat them with the utmost respect regardless, we always ensure they are treated with dignity. She would have negative opinions on drug misuse or alcoholics.'*

The panel also had regard to HCA 2's oral evidence in which he told the panel that at times he would come across Miss O'Neill having a negative attitude towards people who had overdosed and had alcohol problems.

The panel concluded that there was mutually corroborative and credible evidence to find charge 8) proved. The panel concluded that the evidential threshold was met to find this charge proved.

Charge 9)

9. In the presence of HCA 2, made a racist statement about the patient he was with in Bay C in that you said: “if he was in the jungle now they would be throwing bananas at him” or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of HCA 2.

The panel considered the written statement provided by HCA 2 which states the following:

> *‘I cannot remember the date, but I recall an incident where I was in C Bay caring for a young man who was awaiting a mental health assessment. The young man had recently split up with his girlfriend and was clearly very distressed.’*
>
> *‘The Registrant was not working in C Bay that day but was walking through C Bay towards the exit. She called me over and said, referring to the young man, "if he was in the jungle now they would be throwing bananas at him."’*
>
> *‘I understood the comment to be a racist statement. I do not know whether the Registrant thought she was making a joke. This shocked me because I do not expect to be working with people who are racist. It goes against the values of nursing and the NMC. It bothered me for weeks afterwards.’*

The panel also considered the written concerns submitted by HCA 2 to Witness D on 1 August 2019 which states: *‘…She was talking about a patient of black ethnicity and said “if he was in the jungle now they’d be throwing bananas at him’.*

The panel considered that the evidential threshold was met and therefore found charge 9) proved.

Charge 10)

10. On one or more occasions, spoke in a derogatory way about patients from Eastern Europe.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness B, Witness C and HCA 2.

Witness B told the panel that Miss O'Neill had a different attitude with patients and staff from Eastern Europe.

The panel also had regard to Witness C's written statement which states:

> *'I know the Registrant also had an issue with giving treatment to patients with an EU background but she never said anything in front of me, it was other staff who told me about that. We had a lot of patients from the refugee community that the Registrant would look after. She perhaps felt that they weren't entitled but at the end of the day we are an emergency department and so we provide care regardless.'*

Witness C told the panel that she was made aware of Miss O'Neill's issue with giving treatment to patients with a European background when Miss O'Neill would say on handing over to other staff *"oh they will have to pay, get someone down, get the finance team down to cost the treatment."* Witness C further told the panel that "*in our A&E we do not charge people with any treatment that attend the department, regardless if they are from EU or America or anywhere and we do look after a lot of our refugee communities, they don't pay or be charged for any treatment.*"

The panel also considered the evidence of HCA 2 who told the panel that he heard Miss O'Neill discussing patients from Eastern Europe in a derogatory way on a couple of occasions. He is unable to recall the dates of any of these occasions. However, he recalls one instance where he heard Miss O'Neill discussing with another member of

staff at the nursing station that Eastern European people were coming to the UK and "*stealing jobs*".

The panel concluded that there was mutually corroborative and credible evidence to find charge 10) proved. The panel concluded that the evidential threshold was met to find this charge proved.

Charge 11)

11. On one or more occasions used the word 'commanche' when referring to people.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness C and HCA 2. The panel had regard to the written statement of Witness C which states:

> *'I also often heard the Registrant using the word "commanche" in her everyday language. She would just say something like "he's behaving like a complete commanche" The Registrant used the word "commanche" in a negative way. I do know if she meant it in a racial way or it was just a word that she usually used as an everyday way of describing things. I have heard other staff also saying she used this. The Registrant made these comments many times I had an interaction with her.'*

Witness C told the panel that her understanding of the word '*commanche'* meant when people were behaving inappropriately, but she was not sure what the word really meant. She told the panel that she heard Miss O'Neill use the word "*commanche"* towards patients and staff often and in everyday language.

The panel also took into account Witness 2's witness statement from the internal investigation signed on 18 April 2020 which states *'I had heard others say they had and it wouldn't have surprised me but I never heard her say anything directly. I did hear her use the word "commanche" frequently. This would be an everyday language for her.'*

The panel further considered the evidence of HCA 2. When questioned by the panel about whether he had heard Miss O'Neill call people '*commanche'*, HCA 2 responded *"Yes actually that rings a bell yep."*

The panel concluded that there was mutually corroborative and credible evidence to find charge 11) proved. The panel therefore found charge 11) proved.

Charge 12)

12. In or around October/November 2018, on responding to a patient buzzer:

    a) Muted the patient buzzer; and/or
    b) Left the patient without providing any assistance to the patient.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness B.

Charge 12a)

In respect of charge 12a), the panel had particular regard to the written statement of Witness B which states:

> *'The Registrant would mute patients' buzzers. A buzzer is a call button that the patient can use when they need anything, such as assistance to use the bathroom or pain relief. If it is pressed then it will send an alert to the nursing station. To mute the buzzer, or to stop it buzzing, the Nurse has to go to the patient's bed.'*
>
> *'I remember an incident where a patient pressed a buzzer for assistance to use the toilet and the Registrant muted it and left without providing any assistance to the patient. I think this incident occurred around October or November 2018.'*

‘I did not hear the buzzer the first time the patient buzzed as I was in a different area but I heard it the second time and answered it. When I got to the patient, the patient identified that they had already asked the Registrant, who was the Nurse allocated to them, for assistance to go to the toilet 20 minutes prior but the Registrant had gone away without assisting them. I took the patient to the toilet myself, even though I was working in a different Bay. The patient only required minimal help.’

The panel considered the evidence of Witness B to be credible and reliable. The panel noted that she was consistent in her account of events through her NMC written statement and oral evidence. The panel therefore found charge 12a) proved.

Charge 12b)

In respect of charge 12b) the panel had regard to Witness B’s written statement which states:

‘I remember an incident where a patient pressed a buzzer for assistance to use the toilet and the Registrant muted it and left without providing any assistance to the patient. I think this incident occurred around October or November 2018.’

‘I did not hear the buzzer the first time the patient buzzed as I was in a different area but I heard it the second time and answered it. When I got to the patient, the patient identified that they had already asked the Registrant, who was the Nurse allocated to them, for assistance to go to the toilet 20 minutes prior but the Registrant had gone away without assisting them. I took the patient to the toilet myself, even though I was working in a different Bay. The patient only required minimal help.’

‘20 minutes is too long a delay for assistance to be provided to a patient. A buzzer should usually be responded to within a couple of minutes. Unless the Nurse is in the middle of dealing with a sick patient urgently then they should stop what they are doing and provide the assistance straight away. I am not

aware of a policy which covers this, but I think it is just what is expected. I do not remember there being any sick patients who would have required urgent attention on the shift of the incident in question.'

'Assisting patients to the toilet is part of the Registrant's role. It is part of everyone's role who is working on the floor. It is not an allocated task'

Witness B was questioned by the panel about whether she could see the buzzer had been muted. In response Witness B said she "*was in area C Bay with ten patients and that Miss O'Neill was looking after A bay with somebody else. I heard buzzer going and then it stopped. I thought ok someone asked it. Second time again, buzzer went after a minute. After a minute I just went to A bay and to see what's happening. Elderly lady sitting. I approached her asked how can I help and I muted the buzzer asked how can I help and she said I needed to go to toilet desperately and she said I pressed a few minutes and staff came in and stopped buzzer and said I will come back but she did say I desperately need Miss O'Neill and she muted the buzzer and said I will come back. I think she waited and pressed again and second time I answered and said I would.*

I went on to check Miss O'Neill to see what doing, she was in clinical room making up IV Antibiotic. That was Miss O'Neill's patient and I said to her your lady waiting to go to toilet. Lady rang daughter and said hadn't been taken to toilet so after I brought her back and daughter was looking to speak to NIC which was me so when I answered phone daughter told me my mum desperately wanted to go for 40 mins and no one wanted to help and nurse didn't help but someone else can you explain. I had apologised to daughter and said I spoke with staff member. Conversation ended there and reported to band 7 the next morning."

The panel noted that Witness B was consistent in her account of events through her NMC written statement and oral evidence. The panel concluded that the evidential threshold was met to find charge 12b) proved.

Charge 13)

13. On one or more occasions did not provide the necessary assistance to patients who had ‘Care of 1’ status.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness B. The panel had particular regard to Witness B’s oral evidence in which she clarified that ‘assistance of 1’ meant that one member of staff would assist the patient and walk them to the toilet, change their pad and help to get them washed and dressed. Witness B also confirmed that ‘assistance of 1’ is the same as ‘care of 1’

Witness B told the panel that a patient who was ‘assistance of 1’ came in with a fall and pressed the buzzer to use the toilet and that O’Neill responded *“you can do it yourself.”* Witness B told the panel that the patient was nervous and afraid and she insisted that she needed someone with her for fear of falling.

Witness B further told the panel that Miss O’Neill would be aware of the need to prioritise taking a patient to the toilet because every member of staff would know that it was a priority. Witness B told the panel “*if they need to go they need to go, cannot wait until finished to work. If cardiac arrest or someone looks unwell of course you cannot leave that, but anyone else, such as making antibiotics, can pause for a few minutes, take the patient to the toilet and bring them back to bed and then continue with making antibiotics, it’s not something urgent. It can be given 30 mins late no harm.”*

The panel concluded that the evidential threshold was met and therefore found charge 13) proved.

Charge 14)

14. When approached by HCA 2 for pain relief for a patient who had fractured his leg:

    a) Said: “that’s just cramp, not much I can do about cramp” or words to that effect.

b) Did not take steps to review the patient.

This charge is found proved in respect of charge 14a)

In reaching this decision, the panel took into account the documentary and oral evidence of HCA 2. The panel was of the view that HCA 2's evidence was convincing and that he expressed himself in a clear and unambiguous manner.

Charge 14a)

The panel had regard to the written statement produced by HCA 2 which states:

> *'I remember an incident where I was dealing with a patient who had fallen off a ladder and fractured his leg. The patient expressed to me that they were in quite a bit of pain. I asked the Registrant for pain relief for the patient but the Registrant just said "that's just cramp, not much I can do about cramp". I did not believe that it was just cramp. There was no reason for the patient to be exaggerating their pain.'*

HCA 2 told the panel that he remembered the incident clearly and that the patient did not appear to exaggerate his pain in any way. He told the panel that the patient had informed him about his discomfort, but as a nursing assistant HCA 2 had to alert a nurse. HCA 2 further told the panel that Miss O'Neill approached the patient in an abrupt way and was dismissive and responded by saying that she cannot do anything about a cramp and walked away. HCA 2 expressed to the panel that he felt that the patient was genuinely in pain and was in need of pain relief. HCA 2 reported this to a doctor who spoke to Witness C who administered the pain relief.

The panel considered the evidence of HCA 2 to be credible and reliable. The panel noted that he was consistent in his account of events through his NMC written statement and oral evidence. The panel therefore found charge 14a) proved.

Charge 14b)

In respect of charge 14b) the panel carefully considered the wording of this charge and determined that there was no evidence to support charge 14b). The panel was not satisfied that sufficient evidence was presented to suggest that Miss O'Neill did not go back to review the patient.

The panel therefore found charge 14b) not proved.

Charge 15)

15. On one or more occasion:

a) Did not prioritise administering pain relief for patients.
b) Did not administer pain relief when requested by patients.
c) Did not administer Librium as a PRN to patients when they were prescribed it.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the documentary and oral evidence of HCA 1 and HCA 2.

Charge 15a)

In respect of charge 15a) the panel had particular regard to HCA 1's written statement which states:

> *'I knew it would be a horrible shift when I was working with the Registrant because she was so difficult to work with. If I needed to ask the Registrant for pain relief for a patient, she would prioritise doing her notes or taking a break over providing the - pain relief. She would always say "oh there is nothing wrong; they can just wait". I would almost get anxious to ask her for pain relief for patient'*

'I cannot recall any specific instances of this happening but the Registrant always provided the same response. I understand that nurses are sometimes too busy to provide things such as pain relief at the time that they are asked, but she would always put the tasks that she was doing at the time first. The patient always had to wait.'

'On one occasion, the patient had been waiting for pain relief for a long time so I had to ask the Band 6 Nurse in charge if they could do it. I do not remember the approximate date that this happened or the name of the Band 6 Nurse in charge. I do not remember roughly how long they were waiting.'

'I am not aware of any written policy regarding the administration of medication that states how long from asking should pain relief be administered if needed. However, usually, if a patient asks for pain relief and requires it, it is given at the earliest time possible.'

HCA 1 told the panel that Miss O'Neill was difficult to work with, and that she would get anxious asking for pain relief for patients as Miss O'Neill would always prioritise doing her notes or taking a break over providing pain relief. HCA 1 told the panel that Miss O'Neill was rude, abrupt and had her priorities wrong.

The panel further considered the notes from a meeting HCA 1 attended with Witness F and indicated that she was almost frightened to raise her concerns as she felt threatened by Miss O'Neill and that none of the other staff ever stood up to her or questioned her. The panel considered the investigation statement signed on 7 April 2020 which states the following: *'She has often also held back treating patients immediately which require pain relief for example, as they are oversea patients.'*

The panel also considered the evidence of HCA 2 who told the panel that Miss O'Neill did not prioritise giving pain relief to a patient who had fractured their leg.

The panel concluded that there was mutually corroborative and credible evidence to find charge 15a) proved. The panel concluded that the evidential threshold was met and therefore found charge 15a) proved.

Charge 15b)

In respect of charge 15b) the panel had particular regard to the written statement of Witness B which states:

> *'I am also aware of the Registrant withholding Analgesia from patients generally. This was not directed at ethnic minority patients, it was all patients.'*
>
> *'Analgesia is pain relief. Patients reported to me that they asked the Registrant for pain relief and she had not given it to them. When patients asked for pain relief, the Registrant would tell them "no, you have had it, just try to get some sleep.'*
>
> *'I would ask the Registrant why she had not provided the patient with pain relief and the Registrant would tell me that she did not think that the patient was in pain, that they were just "needy" and being "demanding". She would not say this to the patient. Often it was true that the patients were attention seeking'*
>
> *'When this happened, I would go to the Kardex, which is the prescription and administration record for the patient to see when the patient had their last dose of pain relief and when they can have PRN. Most patients are prescribed a regular dose of medication and PRN is additional doses that the patient can have as required in accordance with the prescription. I do not know what 'PRN' is an acronym for. In my opinion, if a patient is prescribed PRN then they should be given it when they ask for it, rather than making a judgement of whether they are in pain.'*
>
> *'I remember an incident in either November or December 2018 when I received a complaint from the family of a patient because the patient had not received pain relief when they had asked for it.'*

The panel also considered the internal investigation statement signed on 19 April 2019 provided by Witness B in which she indicates that Miss O'Neill withheld analgesia to all

patients. The panel considered the evidence of Witness B to be credible and reliable. The panel noted that she was consistent in her account of events through her NMC written statement, the internal investigation and oral evidence. The panel therefore found charge 15b) proved.

Charge 15c)

In reaching its decision, the panel considered the evidence of Witness B and the internal investigation report signed on 19 April 2019. In particular it had regard to the written statement which states:

> *'The Registrant was more reluctant to give Analgesia to patients with drug and alcohol misuse issue. For example, patients suffering from alcohol withdrawal are usually prescribed Librium, which helps settle their symptoms, four times a day and PRN. If a patient feels shaky and sweaty then they will often ask for Librium. The Registrant would use her own judgement and say that she did not think they needed it.'*
>
> *'If a patient who is suffering from alcohol withdrawal does not get Librium when they need it, then there is a danger that they can go into Detoxification ("the DTs") the next day. If a patient goes into the DTs then this can be difficult to control and can cause serious harm and must be treated with Lorazepam. It is unlikely that the DTs would lead to death.'*
>
> *'I am aware of patients going into the DTs because of the Registrant's failure to provide Librium on two or three occasions. From then on I would always highlight to the Registrant at the beginning of the shift which patients might require Librium and told her to make sure that she gave them it if they asked.'*

The panel considered the evidence of Witness B to be credible and reliable. The panel noted that she was consistent in her account of events through her NMC written statement, the internal investigation report and oral evidence. The panel therefore found charge 15c) proved.

Charge 16)

16. While working a night shift at Daisy Hill Hospital between 10 October 2019 and 18 October 2019:

    a) When asked by Person 2 to administer their prescribed medication (Cyclizine) at approximately 17:30:

        i. Replied: “I do not give Cyclizine via vein” or words to that effect.
        ii. Failed to administer Person 2 their prescribed dose of Cyclizine.
        iii. Did not take steps to ensure Person 2 was administered the prescribed medication until Person 2 raised the matter again approximately 1 hour later.

    b) When called by a patient on one or more occasions for assistance to use the toilet responded by:

        i. Throwing your arms in the air; and
        ii. Saying “I have not got time to take you to the toilet, I am too bloody busy’ or words to that effect.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the documentary and oral evidence of Person 2. The panel was of the view that Person 2 was able to assist the panel to the best of her ability and gave balanced evidence given the difficult circumstances she had experienced. The panel found her to be credible and reliable.

Charge 16a)

i) The panel considered the written statement of Person 2 which states:

‘At around 17:30pm, half an hour after I was due my dose of Cyclizine, I called the Registrant over and asked for my dose to be administered. The Registrant

replied "I do not give Cyclizine via vein" I told the Registrant that I was prescribed for my dose of Cyclizine to be administered into the vein and she just replied "well I do not give it into the vein" in a very cheeky way. The Registrant said that she could administer it into my muscle but I told her that I did not want it in the muscle as that would be too sore. The Registrant just repeated that she did not administer Cyclizine via the vein.'

Person 2 gave a detailed and consistent account and was a direct witness to the incident. The panel found her evidence to be credible and reliable and was precise about what was said to her. The panel determined that Person 2's NMC statement was supported by her oral evidence. The panel was therefore satisfied that Miss O'Neill did not administer Cyclizine via vein, but only muscle. The panel therefore found charge 16a) i) proved.

ii) In respect of charge 16a) ii), the panel considered the written statement of Person 2 which states:

'I heard the Registrant talking to the Nurse in the corridor. The Registrant said to the Nurse "you should go and give that patient their medication because I am not going to do it", referring to my dose of Cyclizine. I did not hear any more of their conversation.'

The panel considered that Person 2's evidence was that half an hour after she was due her medication, which she was receiving intravenously, she called Miss O'Neill over and asked for the medication to be administered. Miss O'Neill replied "*I do not give Cyclizine via vein".* Person 2 explained that the medication had been prescribed for administration in that way but Miss O'Neill refused to administer it and walked away. The panel also noted that around one hour later Person 2 called Miss O'Neill over again and said that if she would not administer the medication, she would have to get someone else to do so. Person 2 told the panel that Miss O'Neill then got a nurse from another ward to administer the medication.

Having considered the above evidence in relation to this charge the panel determined the evidential threshold was met to find this charge proved.

iii) In respect of charge 16a) iii) the panel considered the written statement of Person 2 which states:

> *'Approximately one hour later, at 18:30pm, I managed to get the Registrant's attention and asked again for my dose of Cyclizine. I told the Registrant that if she would not administer it for me then she would have to get another Nurse to administer it. The Registrant eventually got a Nurse from another ward to administer my dose of Cyclizine at around 18:45pm.'*

The panel was satisfied that Miss O'Neill did not take steps to ensure Person 2 was administered the prescribed medication until Person 2 raised the matter again approximately one hour later. The panel therefore found charge 16a) iii) proved.

Charge 16b)

i) The panel considered the written statement of Person 2 which states:

> *'There was either 5 or 6 patients in the Ward that the Registrant was looking after. It did not seem busy on the Ward. However, from when I first saw her arrive to start her shift on the Ward, the Registrant was rushing around. I noticed that whenever any of the patients called her over for assistance, the Registrant would just roll her eyes and throw her arms around. A couple of times patients in the Ward rang their call bell and she would not respond so one of the Nurses from another Ward had to come and respond.'*

> *'On one occasion, the patient called out to the Registrant and the Registrant turned around to the patient, threw her arms up in the air and shouted at the top of her voice "I have not got time to take you to the toilet, I am too bloody busy". I was in complete shock and disbelief when I heard this….'*

The panel also considered Miss O'Neill's written response to the concerns raised at the Belfast Trust in which she states that she uses her arms to express herself.

The panel determined that Person 2 was consistent in her account of events through her NMC written statement and oral evidence. The panel therefore found charge 16b) i) proved.

ii) In respect of charge 16b) ii) Person 2 explained in her written statement and oral evidence that she saw a patient in the opposite bed call Miss O'Neill at least four times, for assistance to go to the toilet. On one occasion when the patient called out to the Miss O'Neill, she is said to have turned around, thrown her arms up in the air and shouted "*I have not got time to take you to the toilet, I am too bloody busy."*

Person 2 told the panel that she believed that the patient had wet the bed and was embarrassed as she required assistance to go to the toilet.

The panel determined that Person 2 was a credible and reliable witness and was consistent in her account of events through her NMC written statement and oral evidence. The panel therefore concluded that the evidential threshold was met to find charge 16b) ii) proved.

Charge 17)

17. You did not work collaboratively with colleagues in that you:

    a) Would not help others with their tasks.
    b) Delegated personal care for patients when you should have done it yourself.
    c) Left the task of removing a needle and line from a patient who wished to leave the hospital to the next shift.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness A, Witness B and Nurse A.

Charge 17a)

In respect of charge 17a) the panel had particular regard to the written statement of Witness B which states:

> *'By the Registrant not responding to the buzzer this put additional pressure on me as I was working in a different Bay and had my own responsibilities as the Nurse in Charge, but I had to attend to her patient. In general, if a patient was sick in the Registrant's Bay, she would expect other Nurses to help her but she would not do the same for other Nurses.'*

The panel also considered the written statement of Witness A which states:

> *'The Registrant seemed to overwork the Band 3 nursing assistants and treat us more assertively. She would look down her nose at us because we were not trained as she was, but that is quite common; a lot of Band 5 nurses would do the same.'*
>
> *'The Registrant expected us to do all of the bloods, observation charts, cannulas and patient care. If we were busy she would not help us the way we helped her. This was too much because we cannot get around everything. The Registrant only looked after one bay which is six patients, I assist in both bays so have twelve patients. I cannot do everything myself. She expected us to do everything so all she would have to do is the paperwork. She is not the only Band 5 nurse like that though.'*

The panel further took into account the written statement of Nurse A which states:

> *'I know the Registrant's behaviour was generally not positive towards myself. The Registrant would often try and avoid me. Her behaviour was dismissive towards me and she was not a team player. For example, there is a system on the Ward where medication administration is signed off by two Nurses. It is usually*

considered best practice to check with the other Nurses at medication times if there is anything that required a second signature. However, when I was in the treatment room, the Registrant would not ever check with me if there was anything that I required a second signature for. I would have to chase the Registrant for a second signature or get another team member to sign. I was not aware of any specific things that the Registrant said about me.'

The panel concluded that there was mutually corroborative and credible evidence to find charge 17a) proved.

The panel concluded that the evidential threshold was met to find charge 17a) proved.

Charge 17b)

In respect of charge 17b) the panel had regard to Witness B's written statement which states:

'A few times HCAs working on the Unit had reported concerns to me about the Registrant. I do not want to provide names of the HCAs. The HCAs reported that the Registrant would always ask the HCAs to take her patients to the toilet. The Registrant would not do this herself. The Registrant did not like carrying out personal care such as taking patients to the toilet, helping them wash and dress, and doing skin care. The Registrant was just not very interested in doing personal care for patients and would try to get the patients to do it themselves. She would say to the patient "sure, you can do that yourself can't you" I am not aware of this putting any pressure on other members of staff as patients in the Unit rarely require personal care.'

'I would expect the Registrant to ask the HCAs for assistance with personal care for her patient if she was in the middle of doing something else and the HCA was free. Personal care is a task that is shared between the Registered Nurses and the HCAs. However, if the HCA is busy then the Registrant should carry out the personal care herself. For example, the Registrant used to just say to the HCA

"when you are finished, can you take this patient to the toilet" rather than doing it herself.'

'The Registrant's lack of sympathy and empathy for tasks such as taking patients to the toilet and providing pain relief did make the patients unhappy. They would have to ask other Nurses, such as me, for assistance which I do not think should be necessary.'

The panel concluded that the evidential threshold was met to find charge 17b) proved.

Charge 17c)

In respect of charge 17c) the panel had regard to HCA 3's written statement which states:

'On one occasion, I do not remember the approximate date, I was working a day shift with the Registrant. At 19:45, 15 minutes until the day shift was due to finish, a patient who was admitted to the CAU after a heroin overdose was trying to leave the Hospital. Often patients who have suffered overdoses are quite mellow when they are admitted to the CAU but they often suddenly regain full consciousness and want to leave. The patient who was trying to leave still had a needle and line in his arm. It is important to take this out quickly as, if the patient leaves the hospital with it in, they might inject drugs directly into it. A patient cannot be allowed to leave with a needle and line still in. It is necessary to get hold of the patient and take it out.'

'I asked the Registrant for help to take the patient's line out but the Registrant replied that this should be left to the night staff, who had started to arrive in the CAU for their shift. I responded that it was only 19:45, our shift had not yet finished. The Registrant then responded telling me that she was the Nurse in charge of the bay and ordered me to leave the patient, which I did. The Registrant would not go near the patient. I believe that a staff member did manage to get the line out in the end, I cannot remember which staff member.'

The panel also considered the written concern dated 1 August 2019 which was produced by HCA 3 and submitted to Witness D:

> *'There was a patient heroin od who was trying to abscond, I asked her to help me get his line taken out she replied no leave it for the day staff. I replyed* [sic] *its only 19.45 which she replyed* [sic] *im the nurse in charge in this bay just leave him be, so I did.'*

Although there was some discrepancy between the witness statement and the written concern dated 1 August 2019 as to whether Miss O'Neill had said that the line should be left in for the day shift or the night shift, the panel was satisfied that this was not a material issue in the context of the charge.

The panel concluded that the evidential threshold was met to find charge 17c) proved.

Charge 18)

18. Administered Librium to Person 3, who was allocated to Nurse A:

a) Without checking with Nurse A before the administration.
b) Without reviewing and/or considering the assessment Nurse A had documented for Person 3.
c) As a PRN dose when it could or should have been the patient's regular dose.

This charge is found proved in respect of charges 18a) and 18b).

In reaching this decision, the panel took into account the documentary and oral evidence of Nurse A. The panel was of the view that Nurse A was knowledgeable and his evidence was clear and concise. The panel found him to be professional, fair, balanced, credible and reliable.

Charge 18a)

In respect of charge 18a) the panel had regard to Nurse A's written statement which states:

> *'If the Registrant had looked at the assessment that I had documented for the patient, she would have seen that I had not administered the patient's regular Librium dose and the reason why I had not done so. Therefore, the Registrant would not have given the PRN Librium. The Registrant could have also talked to me about this and I would have explained why I had not given the regular Librium dose at that time.'*

> *'As the patient was allocated to me, the Registrant should have checked with me first before administering the Librium as PRN. If she had done so, I would have told her that the patient could have their regular Librium dose and it would not have to be PRN. I did not mind the Registrant assisting with the care of patients that were allocated to me, but she should have communicated with me about it and I would have explained that I had not yet given the regular dose to the patient and why.'*

The panel concluded that the evidential threshold was met to find charge 18a) proved.

Charge 18b)

The panel noted that PRN stands for 'when required'.

In respect of charge 18b) the panel had regard to the written statement of Nurse A which states:

> *'If the Registrant had looked at the assessment that I had documented for the patient, she would have seen that I had not administered the patient's regular Librium dose and the reason why I had not done so. Therefore, the Registrant would not have given the PRN Librium. The Registrant could have also talked to*

me about this and I would have explained why I had not given the regular Librium dose at that time.'

In oral evidence, Nurse A described the occasion whereby he had determined not to give a patient their regular dose of Librium as, having carried out an assessment, he believed the patient was displaying signs of over-sedation. However, Miss O'Neill then provided the patient with a dose of Librium 'PRN' without speaking to Nurse A about why Nurse A had declined to provide the medication earlier. Nurse A further told the panel that Miss O'Neill told him that she *"should make a medication incident report"* and that Nurse A responded *"if [Miss O'Neill] wants to she can do it but it wasn't a medication incident because I have a window but if you want to take that decision would have given regular would have asked, checked assessment chart if not given…."*

The panel concluded that the evidential threshold was met to find charge 18b) proved.

Charge 18c)

The panel carefully considered the wording of this charge and determined that there is insufficient evidence that supports this charge. The panel had no documentary evidence to show if a regular or PRN dose had been given to the patient such as a medication chart which could have assisted the panel. The panel was also aware that Miss O'Neill and Nurse A had restricted communication between them. The panel therefore concluded that there is insufficient evidence to determine on the balance of probabilities that charge 18c) could be found proved.

The panel therefore determined that charge 18c) is not proved.

Charge 19)

19. Accused Nurse A of missing Person 3's dose of Librium.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Nurse A. The panel had particular regard to the written statement of Nurse A which states:

> *'The Registrant approached me and accused me of missing the patient's dose of Librium, which would amount to a medication error on my part. I challenged her that the onus was on her to prove that it was a medication error. I told her that any attempt to then provide the regular dose after she had provided the dose of PRN would amount to double dosing as it would be within 2 hours of the PRN Librium. The Registrant just dismissed this and walked away.'*

When Nurse A was questioned about what happened when he had asked Miss O'Neill if person 3 had been assessed, Nurse A responded "*When we were talking about it I realised its given and she told me that I didn't give the regular and she told me I was, I should make a medication incident report and I said if she wants she can do it but it wasn't a medication incident because I have a window but if you want to take that decision would have given regular would have asked, checked assessment chart if not given…".*

The panel concluded that the evidential threshold was met to find charge 19) proved.

Charge 20)

20. When Nurse A told you that there was no medication error in relation to Person 3 you dismissed his explanation and walked away from him.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Nurse A. In particular it had regard to the written statement which states:

> *'The Registrant approached me and accused me of missing the patient's dose of Librium, which would amount to a medication error on my part. I challenged her*

that the onus was on her to prove that it was a medication error. I told her that any attempt to then provide the regular dose after she had provided the dose of PRN would amount to double dosing as it would be within 2 hours of the PRN Librium. The Registrant just dismissed this and walked away.'

Nurse A told the panel that Miss O'Neill was not willing to learn or be open with him and that Miss O'Neill could have engaged with him, but she was dismissive and walked off. The panel considered the evidence of Nurse A to be credible and reliable. The panel noted that he was consistent in his account of events through his NMC written statement and oral evidence. The panel therefore found charge 20) proved.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

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

Ms Noble 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.

Ms Noble identified the specific, relevant standards where in her submissions Miss O'Neill's actions amounted to misconduct. She submitted that Miss O'Neill's behaviour and comments to patients and colleagues were discriminatory and that Miss O'Neill would treat certain patients differently. She told the panel that these were not one-off behaviours or comments made by Miss O'Neill and that the comments were made in a variety of different situations and to a number of different colleagues. She told the panel that at times it appeared to be "*casual*" use of discriminatory language.

Ms Noble submitted that Miss O'Neill's conduct lacked compassion and there was evidence of unwillingness to do certain work that she was obliged to do. She submitted that there are a number of regulatory concerns and that it therefore amount to misconduct.

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

Ms Noble submitted that Miss O'Neill had acted in a way which put patients at an unwarranted risk of harm and may have caused emotional harm should patients have

heard comments made by Miss O'Neill. She told the panel that Miss O'Neill's conduct has brought the profession into disrepute and that her actions fell far short of what was expected of a nurse.

Ms Noble told the panel that the issues identified reflect both a lack of professionalism and attitudinal issues. She submitted that attitudinal issues are difficult to remedy and fall way below what the public would expect from a nurse.

Ms Noble submitted that these issues have not been remedied as Miss O'Neill has not engaged with the NMC proceedings and has not provided a reflective piece or any evidence of steps taken to strengthen her practice. She submitted that the only evidence of insight was from Witness D who told the panel that she had had conversation with Miss O'Neill about some of the allegations regarding Nurse A and excluding colleagues from sharing food. Witness D said in her evidence that Miss O'Neill later commented that she understood that excluding people could be seen as bullying. However, Ms Noble submitted that there is no further insight or evidence of further training. Ms Noble therefore submitted that there is a risk of repetition.

Ms Noble told the panel that many of the patients who attended the CAU were vulnerable due to alcohol and/or drug misuse, and that there are potential safety issues regarding the unwillingness to prioritise patient care. She also submitted that there was a risk of emotional harm to patients should they have overheard the comments made by Miss O'Neill.

Ms Noble submitted that the public would not expect a nurse to act in such a way and would be rightly concerned about patients in Miss O'Neill's care. She submitted that nurses must make sure that their conduct at all times justifies the public's trust in the profession.

Ms Noble therefore submitted that Miss O'Neill is currently impaired in respect of public interest and on public protection grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included: *Roylance v General Medical Council* and *Meadow v GMC* [2006] EWCA Civ 1390.

Decision and reasons on misconduct

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

The panel was of the view that Miss O'Neill's actions did fall significantly short of the standards expected of a registered nurse, and that Miss O'Neill's actions amounted to numerous breaches of the Code including amongst others:

The 2015 Code:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.3 encourage and empower people to share decisions about their treatment and care*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are addressed and responded to***
> *To achieve this, you must:*

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

8 Work cooperatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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, and

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively. It took account of all the evidence before it and the circumstances of the case as a whole.

The panel determined that Miss O'Neill failed to ensure that patients care needs were met. She failed to ensure that the dignity of patients and colleagues were respected. She failed to ensure that residents were able to participate in decision making with regards to their own care and treatment. A number of concerns had arisen in respect of Miss O'Neill working collaboratively with colleagues. The panel also considered the racist comments made by Miss O'Neill within the workplace, and about patients and in particular Nurse A, which the panel considered constituted bullying and harassment. Although the patients and Nurse A were not aware of the racist and discriminatory comments made by Miss O'Neill, comments like these can reasonably be expected to cause upset to other colleagues as well and can have a detrimental impact which can then impact patient safety. The panel considered that both patients and colleagues were impacted by Miss O'Neill's misconduct.

The panel determined that Miss O'Neill's conduct demonstrated repeated and extremely serious departures from the standards expected of a registered nurse. It could fathom no scenario in which the charges found proved could be deemed anything other than serious misconduct.

In all the circumstances of this case, the panel determined that Miss O'Neill's actions represented departures from good professional practice and the facts found proved are sufficiently serious to constitute misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss O'Neill'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, they must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *…'*

The panel determined that limbs a, b and c of the above test were engaged by Miss O'Neill's past actions.

The panel finds that patients and colleagues were put at risk and were caused emotional harm as a result of Miss O'Neill's misconduct. The panel judged that Miss O'Neill's conduct was such as to bring the nursing profession into disrepute, and that members of the public would have been horrified if they had witnessed her behaviour.

In relation to Miss O'Neill's behaviours, the panel considered the evidence given from the witnesses, who had worked alongside Miss O'Neill and all whom spoke about her negative and intimidating behaviour towards them. The panel considered Miss O'Neill's behaviour had a negative effect on colleagues which created an intimidating, hostile, degrading, humiliating and offensive environment which caused staff distress. For example, HCA 1 told the panel that her *"heart would sink"* when she was on shift with Miss O'Neill.

The panel also considered the use of the word '*commanche'* by Miss O'Neill. It noted that some colleagues did not fully understand the meaning of the word, but that Miss O'Neill had on numerous occasions said about patients that *"they are behaving like complete commanches".* The panel noted that the ordinary meaning of the word '*commanche'* is the name of an indigenous American tribe. The panel determined that using the word in such a way was for the purpose of being discriminatory.

The panel noted that Miss O'Neill used racially discriminatory language and derogatory language towards colleagues and patients. In particular it is said that she made racist comments towards a colleague, Nurse A and that she used derogatory language when discussing patients who were suffering from drug overdoses or alcohol withdrawal as well as patients from different races and other European regions. These comments

were said to other members of staff on the ward which created an unpleasant working environment.

The panel also considered that Miss O'Neill excluded some members of staff when sharing food on a number of occasions.

The panel determined that the use of discriminatory and derogatory language towards colleagues and patients is far removed from the high standards of conduct expected of a nurse. Although the patients and Nurse A were not aware of the racist and discriminatory comments made by Miss O'Neill, her comments caused upset to other colleagues and had a detrimental impact on the working environment which could then impact patient safety. The panel also determined that members of the public becoming aware of misconduct of this nature from a nurse could feel reluctant to engage with healthcare services.

In relation to Miss O'Neill's practice, the panel considered that Miss O'Neill failed to work cooperatively with colleagues. The panel noted that Miss O'Neill would not assist colleagues when required. For example, Miss O'Neill failed to read Nurse A's assessment of a patient as to why medication had not been administered. Then failed to speak to Nurse A about this, and simply administered the medication to the patient and then accused Nurse A of making a medication error. The panel also noted that Miss O'Neill was reluctant to carry out personal care for patients and would try to delegate or get the patients to do it themselves.

The panel also considered that Miss O'Neill on occasion failed to provide assistance and pain relief to patients. Miss O'Neill would refuse to provide pain relief to patients, saying that they did not require it or that they were being '*needy'*. Miss O'Neill would also refuse to take patients to the toilet, when this should have been a priority. The panel heard evidence that Miss O'Neill would prioritise non-urgent matters such as completing paperwork when she should have been responding to patients. The panel also considered that Miss O'Neill was capable and competent to administer intravenous Cyclizine to Person 2, however she walked away and left Person 2 waiting for an hour. This medication was later administered by a different nurse.

The panel determined that patients were put at risk and that there was the potential for harm as a result of Miss O'Neill's conduct. The panel noted that patients in Miss O'Neill's care were vulnerable, and that there were potential safety issues regarding the unwillingness to prioritise patient care. The panel considered that making the care of people a first concern, treating them as individuals and respecting their dignity; working with others to protect and promote the health and wellbeing of those patients, providing a high standard of practice and care at all times and acting with integrity and upholding the reputation of the profession, were fundamental tenets of the nursing profession. The panel considered that Miss O'Neill failed to ensure that such fundamental tenets of the profession were upheld.

The panel then went onto consider whether Miss O'Neill has strengthened her practice or has shown any insight. Miss O'Neill's has not engaged with the NMC investigation and has not provided any material for the purpose of this hearing which might demonstrate her insight. The panel noted that Miss O'Neill had accepted some of the allegations in the internal investigation interview with Witness D. However, the panel attached limited value to this acceptance and did not consider that it amounted to insight, as it did not provide any insight into the effects of her actions on the patients in her care, or her colleagues. The panel was satisfied that the misconduct in this case was indicative of an attitudinal issue and therefore more difficult to remediate.

Due to the lack of insight and remorse on Miss O'Neill's part, the panel concluded that there is a real risk of repetition based on the deep seated attitudinal issues which Miss O'Neill displayed whilst at work. The panel considered that Miss O'Neill's behaviour was that of a bully to both patients and colleagues which continues to present a risk to patients and the public.

The panel also considered that Miss O'Neill's failure to provide appropriate care to patients put them at risk of potential harm. The panel noted that patients in Miss O'Neill's care were vulnerable, and that there were potential safety issues regarding the unwillingness to prioritise patient care. The panel therefore determined that Miss O'Neill was liable to put patients and colleagues at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel

therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that a finding of impairment on public interest grounds is required because of Miss O'Neill's continued and repeated misconduct, and her disregard of her duty of professional conduct. It considered that the public would be concerned, on the basis of the facts found proved, if it were to learn that Miss O'Neill's fitness to practise was not found to be currently impaired.

In addition, the panel concluded that public confidence in the profession and the need to uphold proper standards of conduct and behaviour would be undermined if a finding of impairment were not made in this case and therefore also finds Miss O'Neill's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss O'Neill's fitness to practise is currently impaired on the basis of both the public protection and public interest grounds identified.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss O'Neill off the register. The effect of this order is that the NMC register will show that Miss O'Neill 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 has had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Noble invited the panel to impose a striking-off order considering the panel's findings on misconduct and impairment.

Ms Noble submitted that a striking-off order is necessary to maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. She told the panel that such a sanction is necessary because Miss O'Neill has failed to remediate her conduct, has failed to engage with the NMC investigation and has shown no remorse. Accordingly, Ms Noble submitted there is a high likelihood of repetition of the conduct found proved.

Ms Noble submitted that a conditions of practice order and the lesser restrictive sanctions would not be appropriate given the seriousness of this case. She told the panel that it would be difficult for a conditions of practice order to manage the concerns and that a strike-off is the only sufficient sanction.

Ms Noble further submitted that a suspension order would not address the seriousness off the case. She referred the panel to the NMC guidance in particular 'cases relating to discrimination' which states:

> *'We may need to take restrictive regulatory action against nurses, midwives or nursing associates who've been found to display discriminatory views and behaviours and haven't demonstrated comprehensive insight, remorse and strengthened practice, which addresses the concerns from an early stage.*
>
> *If a nurse, midwife or nursing associate denies the problem or fails to engage with the [Fitness to Practise] process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence.'*

Ms Noble submitted that the NMC consider, that based on the findings in this case that it is no longer appropriate for Miss O'Neill to remain on the register.

Decision and reasons on sanction

Having found Miss O'Neill'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:

- A serious departure from the relevant professional standards as set out in the Code and internal Trusts policies
- Extremely discriminatory language in relation to race and religion used towards colleagues and patients
- Deep-seated attitudinal issues
- Incidents of bullying over a long period of time to patients and colleagues which continued after being told to desist by colleagues
- Evidence of actual distress and upset caused to colleagues and patients due to Miss O'Neill's conduct
- Conduct which put vulnerable patients at risk of suffering physical and emotional harm
- Lack of engagement with the NMC
- Lack of insight into failings
- Lack of remorse
- Abuse of a position of trust

The panel was unable to identify any mitigating factors in this case.

The panel then went on to consider what sanction to impose in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, Miss O'Neill's lack of insight and

remorse and given the fact that the panel has identified a risk of repetition. The panel determined that taking no further action would not protect the public and it would not satisfy the wider public interest.

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

> *'The case is at the lower end of the spectrum of impaired fitness to practise and the Fitness to Practise Committee wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel determined that Miss O'Neill's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel determined that Miss O'Neill's misconduct was at the high end of the spectrum of impaired fitness to practise, given the widespread nature of the failings in this case. The panel therefore determined that imposing a caution order would not protect the public and it would not satisfy the wider public interest.

The panel next considered whether placing conditions of practice on Miss O'Neill'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 panel considered that the charges related to matters of serious ingrained attitudinal issues and bullying behaviour which was not something that can be addressed through conditions such as requiring Miss O'Neill to work under close supervision or undergoing retraining. The panel further noted that Miss O'Neill has not provided the panel with any evidence of insight or strengthened practice, nor has she engaged with the NMC regulatory process. Therefore the panel could not be satisfied that, even if workable conditions could be formulated, Miss O'Neill would comply with a conditions of practice order. Furthermore, the panel concluded that the placing of conditions on Miss O'Neill's registration would not adequately address the seriousness of this case and would not protect the public or 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 did not consider any of the aforementioned factors to be relevant to this case. The panel found the misconduct was sustained over a period of months and was repeated on numerous occasions. The panel also noted that Miss O'Neill's behaviour within the workplace continued over a prolonged period of time and contributed to a negative working environment. Further, it considered that Miss O'Neill has not displayed insight into the regulatory concerns which would reduce the risk of repetition of such conduct in the future. The panel also considered that an informed reasonable member of the public would be shocked and concerned to know that a nurse who bullied and intimidated members of colleagues and patients was allowed to continue to practise as a nurse.

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

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction and will not be sufficient to protect the public and satisfy the public interest.

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 determined that Miss O'Neill's misconduct raises fundamental concerns about her professionalism, and considered that colleagues would find it extremely difficult to place their confidence in a colleague who acted in the manner that Miss O'Neill had displayed over a significant period of time. Further, members of the public would find it difficult to place their trust in a nurse who displayed bullying and intimidating behaviour to patients and colleagues. The panel was of the view that the findings in this particular case demonstrate that Miss O'Neill's actions were extremely serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss O'Neill's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel 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**.**

Determination on Interim Order

Under Article 31 of the Nursing and Midwifery Order 2001 ('the Order'), the panel considered whether an interim order should be imposed in this case. A panel may only

make an interim order if it is satisfied that it is necessary for the protection of the public, and/or is otherwise in the public interest, and/or is in the registrant's own interests.

The panel considered the submissions made by Ms Noble, on behalf of the NMC, that an interim suspension order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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 to impose a striking-off order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.