Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 August 2023 – Wednesday, 30 August 2023

Virtual Hearing

Name of Registrant:	Carol Marion Donaldson
NMC PIN	89Y0025S
Part(s) of the register:	Nurses part of the register, sub part 1 RN1: Adult nurse, level 1 (18 July 1992)
Relevant Location:	Fife, Scotland
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, Lay member) Pamela Campbell (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Breige Gilmore
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Ms Donaldson:	Not present and not represented
Facts proved:	Charges 2, 3a, 3c, 3d, 4, 5, 6, 7
Facts not proved:	Charges 1a, 1b, 1c, 3b, 8, 9a, 9b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Donaldson was not in attendance and that the Notice of Hearing letter had been sent to Ms Donaldson's registered email address by secure email on 17 July 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing/that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Donaldson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Donaldson

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

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Donaldson's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Donaldson

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

Mr Smalley told the panel that there has been some contact from Ms Donaldson. He referred the panel to a note of a telephone call between Ms Donaldson and her NMC case coordinator dated 31 July 2023, which states:

> *'Case Coordinator returned call to registrant and reminded them about the hearing and was advised by the registrant they will not be attending and no one will be attending...She wont attend the hearing [PRIVATE] and it was so long ago that she will not be able to answer the questions.'*

The panel accepted the advice of the legal assessor.

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

the utmost care and caution' as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Ms Donaldson;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses have been warned to attend today to give evidence and others are also due to attend this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Donaldson in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address. She has denied all of the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Donaldson's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Joinder application

An application was made by Mr Smalley, for the panel to consider an application to join Ms Donaldson's case with another registrant's case, namely Registrant 1, and for both cases to be considered at the same substantive hearing. An application of this nature is referred to as a 'joinder' application.

He referred the panel to Rule 29(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004, as follows:

> ***'29.**—(1) Unless of the view that there is a risk of prejudice to the fairness of the proceedings, and upon taking the advice of the legal assessor, the Conduct and Competence Committee may consider an allegation against two or more registrants at the same hearing where—*
>
> *(a) the allegation against each registrant arises out of the same circumstances; or*
>
> *(b)in the view of the Committee, a joint hearing is necessary.'*

Mr Smalley provided a background to the alleged events which gave rise to the charges against Ms Donaldson and Registrant 1. He submitted that: the allegations in both cases arise out of the same set of circumstances and relate to Resident A; it would be in the public interest in the expeditious disposal of the regulatory concerns to join the remaining extra charges of alleged financial irregularities in Ms Donaldson's case. He submitted that a letter was sent on 1 June 2023 to both Ms Donaldson and Registrant 1, informing them of the NMC's intention to join their two cases. He submitted that neither party has raised any objection to this joinder application and invited the panel to allow the application.

The panel accepted the advice of the legal assessor in which he referred to the NMC Guidance and Rule 29(1)(a) and (b) of the Rules.

Decision and reasons on joinder application

In reaching this decision, the panel accepted the advice of the legal assessor, who set out the panel's power in relation to the application, as set out at Rule 29.

It also had regard to the bundles of documents provided which included the following:

- Proof of service - notice of hearing bundles (in respect of Ms Donaldson and Registrant 1);
- Exhibits bundles (in respect of Ms Donaldson and Registrant 1);
- Charges for notice of hearings (in respect of Ms Donaldson and Registrant 1); and
- Registrant response bundles

Having regard to all of the information before it, the panel decided to allow the application to join these two cases. It noted that the charges in relation to Ms Donaldson and Registrant 1's arise out of the same circumstances and involve Resident A, as a consequence the witnesses and much of the documentary evidence are the same. The panel also determined that it is practical to deal with the separate financial allegations as part of the same hearing.

The panel also noted that there was no objection to this application from either party. In the circumstances, the panel decided that it was appropriate and necessary to join the two cases and no unfairness would be caused to Ms Donaldson or Registrant 1 in doing so.

Details of charges (as read)

That you, a registered nurse:

1) On or after 9 May 2020, failed to follow the correct procedure in reporting the unexpected death of Resident A in that you did not report the death to:
a) The Police
b) Local Authority
c) Adult Support and Protection Team

2) On 11 May 2020 provided inaccurate information concerning the circumstances surrounding Resident A's death to the Care Inspectorate in that you documented that Resident A had died peacefully in their sleep;

3) On or after 9 May 2020 failed to respond effectively and/or compassionately with Resident A's family in that you:
a) provided inaccurate information concerning the circumstances surrounding Resident A's death by stating that Resident A had died peacefully in their chair;
b) did not meet with the family when they attended the Home to collect Resident A's belongings
c) failed to respond to one or more emails and/or telephone calls;
d) failed to offer support;

4) Your actions at Charge 2 and/or Charge 3(a) were dishonest in that you knew that Resident A had not died peacefully in their sleep and sought to mislead others into believing that they had;

5) In April 2020 agreed a higher rate of hourly pay to one or more employee(s) without authorisation from your employer;

6) Between April 2020 and August 2020, provided incorrect information to payroll in relation to the working hours of one or more employee(s) in that you inputted hours indicating that the employee(s) had completed additional training and/or induction

and/or used annual leave when they had not;

7) Your actions at Charge 6 above were dishonest in that you:
a) knew that the information you had inputted was incorrect;
b) sought to mislead your employer

8) Between 11 May 2020 and 16 August 2020, as set out in Schedule 1, you submitted mileage claims that were in excess of the miles that you had travelled;

9) Your actions at charge 8 above were dishonest in that you:
a) Knew that the mileage claims were incorrect.
b) Submitted the claims for financial gain

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

Schedule 1

1) 11/05/20 to 17/05/20 - claimed 417 miles and the actual miles as calculated by AA route finder were 243;
2) 01.06.2020 – 07.06.2020 claimed 536 miles and the actual miles as calculated by AA route finder were 251;
3) 08/06/20 to 14/06/20 – claimed 532 miles and the actual miles as calculated by AA route finder were 251
4) 15/06/20 to 21/06/20 – claimed 531 miles and the actual miles as calculated by AA route finder were 251
5) 22/06/20 to 28/06/20 – claimed 550 miles and the actual miles as calculated by AA route finder were 309 6) 29/06/20 to 05/07/20 – claimed 503 miles and the actual miles as calculated by AA route finder were 251
7) 06/07/20 to 12/07/20 – claimed 594 miles and the actual miles as calculated by AA route finder were 251
8) 13/07/20 t0 19/07/20 – claimed 556 miles and the actual miles calculated by AA route finder were 251

9) 27/07/20 to 02/08/20 – claimed 564 and the actual miles calculated by AA route finder were 300
10) 03/08/20 to 09/08/20 – claimed 493 miles and the actual miles calculated by AA route finder were 251
11) 10/08/20 to 16/08/20 – claimed 399 miles and the actual miles calculated by AA route finder were 201 miles

Decision and reasons on application for hearing to be held partly in private

At the outset of the hearing, Mr Smalley made a request that elements of this case be held partly in private on the basis that proper exploration of Ms Donaldson's and Registrant 1's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

He referred the panel to the respective registrant's bundles for Ms Donaldson and Registrant 1 in relation to [PRIVATE].

The legal assessor reminded the panel that 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.

The panel determined to go into private session in connection with Ms Donaldson's and Registrant 1's [PRIVATE] as and when such issues are raised, in order to preserve their right to confidentiality and privacy.

Decision and reasons on application to adduce evidence under Rule 31 (Day four)

The panel heard an application made by Mr Smalley under Rule 31 to adduce the pay slips of Ms 3 into evidence.

He referred the panel to paragraph seven of Witness 10's written witness statement in which she refers to reviewing Ms 3 and Witness 9's respective pay slips. He submitted that Witness 9 has exhibited her own pay slips in evidence, however, the pay slips of Ms 3 has not been placed before the panel as evidence. He submitted that it was proposed to exhibit the pay slips, however, unfortunately Ms 3 did not sign her witness statement to the NMC and the NMC made a decision not to rely on her as a witness.

Mr Smalley submitted that the outstanding pay slip will still have some relevance to the panel's considerations. He submitted that the pay slips that were provided to the NMC as part of Ms Donaldson's initial referral, as such, they would have been sent out to Ms Donaldson at that stage, albeit she will not have been provided with copies of the pay slips in the bundles,

Mr Smalley submitted that Rule 31 sets out that evidence is admissible based on a two-fold test. Firstly, is it relevant to the charges under consideration, and secondly, is it fair to the parties, either the NMC and / or Ms Donaldson. Mr Smalley submitted that Ms 3's pay slips are relevant to the charges that the panel are to consider in relation to Ms Donaldson. In relation to whether it is fair to admit Ms 3's pay slips into evidence when it has not been sent to either Ms Donaldson or Registrant 1 as part of the bundle. He submitted that there can be no unfairness to Registrant 1 as the pay slips are not relevant to her and there can be no unfairness to Ms Donaldson as there does not appear to be any dispute as to what was done. He submitted the dispute in respect of the charges appear to be whether or not Ms Donaldson's actions amount to dishonesty in terms of the documents themselves. He submitted that the pay slips are business documents and simply a record of what was recorded at the time.

Mr Smalley concluded by submitting that the pay slips for Ms 3 are firstly relevant to charges that the panel are to consider, and secondly they can be fairly admitted.

The panel accepted the advice of the legal assessor.

The panel had regard to the content of Ms 3's pay slips received the morning of 17 August 2023.

The panel considered whether the pay slips are relevant to the charges. The panel determined that they are mentioned in the witness statement of Witness 10 and also to the detail in the charges that it relates to *'...one or more employee(s)'.*

The panel considered whether it is fair to adduce the pay slips into evidence. The panel was of the view that the documents are not in dispute and are official, verifiable business documents. The panel determined that no unfairness arises from this, as the documents have been seen by Ms Donaldson at the beginning of the case.

In these circumstances, the panel determined to allow the application to adduce Ms 3's pay slips into evidence.

Background

The charges arose whilst Ms Donaldson was employed by Belsize Healthcare (the Employer), working as an interim Home manager at Earlsferry House Care Home (the Home).

On 3 November 2020, the NMC received a referral from the Home about Ms Donaldson.

Ms Donaldson was suspended on 25 August 2020 from Earlsferry Care Home following concerns relating to inaccurate pay for Witness 9 and Ms 3.

Resident A was a resident at the Home from April 2017 until her death on 9 May 2020. The daughter of Resident A, Witness 1, made a complaint to the Home following the death which allegedly was not addressed by Ms Donaldson.

Due to the suspension of Ms Donaldson, her emails were forwarded to Witness 8 who instigated a response to the complaint by the family of Resident A. On investigating further Witness 8 found the circumstances around the recording of the death of Resident A were inaccurate.

Ms Donaldson is alleged to have reported to the Care Inspectorate that resident A '*died*

peacefully in her sleep'. Witnesses at the Home confirmed that Resident A was found unresponsive on her bedroom floor, as this was an alleged unexpected death and as a consequence it should have been reported to the Police, Local Authority and the Adult Support & Protection Team.

It was the responsibility of Ms Donaldson, as Home Manager, to ensure the correct procedures had been followed.

Throughout the course of the enquiries made by Ms Donaldson's employer, it is also alleged that she submitted fraudulent expenses, which recorded excessive and inaccurate mileage.

Ms Donaldson was suspended from the Home on 25 August 2020 and resigned on the same day.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Donaldson.

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

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

- Witness 1: Daughter of Resident A

- Witness 5: Clinical lead and senior staff nurse / Investigating officer, at the Home at the relevant time

- Witness 6: Care inspectorate within the Adult services, at the relevant time

- Witness 7: Peripatetic manager at the Home, at the relevant time

- Witness 8: Ms Donaldson's line manager, at the relevant time

- Witness 9: Advanced care practitioner at the Home, at the relevant time

The panel also heard evidence from the following witnesses called on behalf of the NMC in the joined case of Registrant 1, in relation to Charge 1:

- Witness 2: Staff nurse on night duty on 9 May 2020, at the Home.

- Witness 4: Care assistant at the Home, at the relevant time.

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.

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

Charge 1

That you, a registered nurse:

1) On or after 9 May 2020, failed to follow the correct procedure in reporting the unexpected death of Resident A in that you did not report the death to:
a) The Police
b) Local Authority
c) Adult Support and Protection Team

This charge is found not proved in its entirety.

In reaching this decision, the panel took into account the respective written statements and oral evidence of Witness 2 and Witness 8 in this case. It also took into account the version of events in the respective written statement of Witness 5 in the joined case of Registrant 1. The panel also had regard to Registrant 1's reflective piece.

The panel considered Witness 8's written statement, in which she states:

'I do not believe there are any contextual factors that would have impacted the registrant's decision in failing to report the unexpected death of Resident A.'

The panel noted Ms Donaldson's response to the allegation in the Registrant's Response Form:

'When I initially began my role at Belsize Healthcare I had a good relationship with my immediate line manager [Witness 8]. However by the time the pandemic took hold in March 2020, the demands placed on me by [Witness 8] and by [Mr 1] were such that [PRIVATE]. I was offered no support from either, [PRIVATE] I was working 70-80 hours a week.

[PRIVATE]

The panel also noted Ms Donaldson stated in the same form:

'I phoned [Registrant 1] back. I had asked [Registrant 1] during our first telephone call to contact NHS 24 to confirm the patient's Covid status. [Registrant 1] confirmed that she had done that and that the patient was definitely

Covid positive. [Registrant 1] told me that NHS 24 had said that because there was an Expected Death Form they didn't have to send out a GP to confirm the death and the death was confirmed initially by [Registrant 1] with a second nurse providing certification. Nobody mentioned to me at any time that the resident had been found on the floor or in a chair. I was simply told that she had passed away very quickly to the extent that it wasn't obvious that she was at the end of her life, but we had had a number of other residents with Covid positive tests who had passed away very quickly without any obvious signs that they were in the end stage of their life'

...

'Had [Registrant 1] or anyone else told me that the resident was found on the floor I would have immediately have travelled to the Care Home, I would have insisted that a GP attend with a view to reporting the matter to the Police if any suspcicious [sic] circumstances were identified. I would have followed the protocol for reporting an unexpected death to the local authority and to the Care Inspectorate.'

The panel noted Ms Donaldson's response, however it was of the view that it is akin to hearsay evidence as it could not be challenged. As such, the panel attached little weight to Ms Donaldson's response to this charge.

Witness 4 in the joined case of Registrant 1 stated:

'On 15 October 2020, I was interviewed by [Witness 5] and [Witness 7] was taking
notes. A copy of the interview notes can be found at Exhibit ES/03. During this interview, I asked why the police were not called. [Witness 7] said because the death had been recorded as a COVID death.'

Witness 5 in the joined case of Registrant 1 stated*:*

'When I interviewed [Registrant 1] on 15 October 2020, she informed me that she called NHS24 and explained that the death of Resident A was COVID related. This was understandable because at the time, no one really understood COVID related deaths. I provide a copy of these interview notes as Exhibit JR/5. [Registrant 1] also explained that NHS24 gave them permission to move Resident A's body back to the bed'.

The panel considered that NHS24 would not have given Registrant 1 permission to move Resident A's body if there was an indication that this was an unexpected death in unusual circumstances requiring intervention of the police. If there was any suspicion of an unexpected death, NHS24 would have directed that the body be left in place and the Police informed. The panel was of the view that NHS24 were aware that Resident A was found on the floor and Covid-19 positive, and to treat the incident as an expected Covid-19 death.

The panel considered that there was confusion about the Covid-19 test results of Resident A where in her notes she first appeared to be Covid-19 negative and the next day she would appear to have been reported as Covid-19 positive. The panel also considered that Witness 5 in the case of Registrant 1, stated in oral evidence that NHS24 may receive the Covid-19 test results before the Home did and that the previous Home manager, before her sudden dismissal on 8 May 2020, was coordinating the results. The panel believe this may have led to a breakdown in communication in the Home. The panel noted that the NMC have chosen not to challenge this evidence or produced any alternative evidence to the contrary.

The panel determined that on the balance of probabilities that it is more likely than not, that Resident A was Covid-19 positive at the time of her death, on the basis of what NHS24 said to Registrant 1 when she reported the death to them on the telephone. In view of this, and the outbreak of Covid-19 in the Home at the time, the panel considered that it was more likely than not that, although this was a sudden death NHS24 did not consider it as an unexpected death and therefore advised on action accordingly. The panel therefore finds this charge not proved it its entirety.

Charge 2

2) On 11 May 2020 provided inaccurate information concerning the circumstances surrounding Resident A's death to the Care Inspectorate in that you documented that Resident A had died peacefully in their sleep;

This charge is found proved.

In reaching this decision, the panel took into account respective witness statements and oral evidence of Witness 2, Witness 3 and Witness 7. The panel also had sight of the following documents as exhibited: Resident A's notification of death e-form; the update to allegation of misconduct e-form; the minutes from the Adult Case Conference held on 20 October 2020. It also had regard to Resident A's care notes, as exhibited in the joined case of Registrant 1.

The panel considered the local statement of Witness 7:

> *'On the evening of 9th May at approximately 20.30 I received a call from [Ms Donaldson] ([Ms Donaldson] was on call for Earls ferry as we were taking week about to cover the site) She said that she had just received a call from Earlsferry to say that the night staff had went into check on [Resident A] and she was found dead on the floor of her bedroom. Carol said that it appeared from what they had said that the lady had slipped from her chair.'*

The panel heard evidence from Witness 8 about access to the Care Inspectorate's e-form online system. Witness 8 confirmed that Ms Donaldson would have access to the system carried over from her previous role of regional manager and further, the system generated a system report with Ms Donaldson's name on it as the person who submitted the form. The panel also had sight of Resident A's care notes. It noted that on 11 May 2020, Ms Donaldson recorded an entry in Resident A's care notes which said, *'e-form completed-la informed'*. The panel had sight of a copy of the e-form submitted to the Care Inspectorate and was satisfied that Ms Donaldson submitted the notification, which states:

'What are the circumstances around the death of the Service User?

'Service user peacefully in her sleep... The lady was COVID 19 positive'

The panel was of the view that the information given to the Care Inspectorate was inaccurate by omissions as Ms Donaldson ought to have recorded that Resident A was found on the floor and as such, by inference, may not have died peacefully in her sleep. The panel determined that Ms Donaldson was aware at the time of reporting the incident to the Care Inspectorate that Resident A was found on the floor. The panel determined therefore, that the information concerning the circumstances surrounding Resident A's death was inaccurate. The panel therefore finds this charge proved.

Charge 3a

3) On or after 9 May 2020 failed to respond effectively and/or compassionately with Resident A's family in that you:

a) provided inaccurate information concerning the circumstances surrounding Resident A's death by stating that Resident A had died peacefully in their chair;

This charge is found proved.

In reaching this decision, the panel took into account the written witness statement and oral evidence of Witness 1.

'In the evening of the 9 May 2020, sometime between 20:30 and 20:45, I received a call from Ms Donaldson who told me that Mum had died peacefully in her chair.
On the receiving end of this very sudden, unexpected and distressing news, I was so shocked, I simply could not believe what I was being told. My daughter took the telephone from me until I was able to speak to Ms Donaldson, who then

said we needed to sort out the undertaker. This surprised me as I had not given them any details about undertakers.'

...

'Discovering my mum did not die peacefully in her chair as I was initially told broke my heart. My mum died on the care home floor in her room with a sling around her. Trying to come to terms with the loss of my mum, believing she died peacefully, then to find out I had been deliberately lied to by an employee of the care home who also lied to the authorities was extremely hard for me to deal with. One explanation I was given was that the staff at the care home panicked. I was shocked at this comment and do not believe this excuse'.

The panel noted in Ms Donaldson's Registrant's response form, that she offers no explanation regarding her response to Witness 1.

The panel determined that Ms Donaldson failed to respond effectively to Witness 1 as she gave her inaccurate information by stating that Resident A had died in her chair. Whilst the panel was satisfied that there was a compassionate element to this, it determined that Ms Donaldson had a professional duty to accurately inform Witness 1 of the details surrounding her Mother's death and she did not. The panel therefore finds this element of the charge proved.

Charge 3b

3) On or after 9 May 2020 failed to respond effectively and/or compassionately with Resident A's family in that you:

b) did not meet with the family when they attended the Home to collect Resident A's belongings

This charge is found not proved.

In reaching this decision, the panel took into account written statement and oral evidence of Witness 1.

Witness 1 stated:

> *'Ms Donaldson, when I went to the care home to pick up my mums belongings as arranged, did not even have the decency to be available to meet me, to at least pass on her condolences.*
>
> *...*
>
> *'As I was too upset to return to the care home for one last time on my own, my daughter came with me at the time agreed with Ms Donaldson. On arrival at the care home, we were further upset and surprised when the staff advised that they did not know that we were coming, so we had no choice but to wait outside (due to COVID) whilst my Mum's personal belongings were found. We were then directed to the doorstep and told to pick the bags up, which we did.'*

The panel accepts that this was a very difficult and distressing time for Witness 1. It also took into account that this incident occurred in the context of the Covid-19 pandemic and national lockdown when usual expectations were different in terms of permitted proximity of contact.

The panel considered whether Ms Donaldson had a duty in the circumstances to meet with Witness 1 and by extension the family. The panel took into account that Ms Donaldson did not know the family and had only been the manager of the Home for a short time at that point. The panel determined that Ms Donaldson did not have a duty to meet with the family in the given unprecedented circumstances at that time. The panel therefore finds this element of the charge not proved.

Charge 3c

3) On or after 9 May 2020 failed to respond effectively and/or compassionately with

Resident A's family in that you:

c) failed to respond to one or more emails and/or telephone calls;

This charge is found proved.

In reaching this decision, the panel took into account the written statement and oral evidence of Witness 1.

> *'Ms Donaldson then did not follow up on my email advising that my Mum's belongings had been damaged and that I had received items belonging to another resident (which being honest was not too much of a surprise bearing in mind her treatment of me since my mum's death).'*

The panel determined that Ms Donaldson had a duty to respond both effectively and compassionately with Resident A's family in these circumstances. The panel determined that Ms Donaldson failed on at least one occasion to do so.

Charge 3d

3) On or after 9 May 2020 failed to respond effectively and/or compassionately with Resident A's family in that you:

d) failed to offer support;

This charge is found proved.

In reaching this decision, the panel took into account written statement and oral evidence of Witness 1.

The panel was of the view that Ms Donaldson could have done more to support Resident A's family in terms of responding more promptly and accurately to Witness 1's requests for photos, personal belongings and responding to emails and telephone calls.

The panel determined that failing to answer emails and phone calls was not supportive of the family's needs during this very difficult time. The panel determined that even in the challenging circumstances of this time, Ms Donaldson had a duty to be more supportive to the family. The panel finds this element of the charge proved.

Charge 4

4) Your actions at Charge 2 and/or Charge 3(a) were dishonest in that you knew that Resident A had not died peacefully in their sleep and sought to mislead others into believing that they had;

This charge is found proved.

In reaching this decision, the panel took into account Witness 7's written witness statement and oral evidence. It also took account of the test for dishonesty in *Ivey v Genting Casinos* (UK) Ltd [2017] UKSC 67.

> *'what was the defendant's actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?'*

The panel applied the test in *Ivey* in relation Ms Donaldsons state of knowledge and whether she was dishonest when she provided the inaccurate information by the standards of the ordinary decent person when applied to Charges 2 and 3a.

The panel referred to Witness 7's local statement dated 20 September 2020:

> *'On the evening of 9th May at approximately 20.30 I received a call from Carol Reid (Carol was on call for Earls ferry as we were taking week about to cover the site) She said that she had just received a call from Earlsferry to say that the night staff had went into check on [Resident A] and she was found dead on the floor of her bedroom. Carol said that it appeared from what they had said that the lady had slipped from her chair.'*

The panel acknowledged that there is evidence that Ms Donaldson was concerned about telling Witness 1 of her Mother's death. The panel noted that Ms Donaldson was aware that Resident A may not have died peacefully in her sleep as she told Witness 7 that she was found deceased on her bedroom floor.

The panel considered the e-form information that she submitted to the Care Inspectorate:

> ***'What are the circumstances around the death of the Service User?***
>
> *'Service user peacefully in her sleep... The lady was COVID 19 positive'*

In relation to Charge 3a the panel considered when Ms Donaldson spoke to Witness 1, and said that Resident A had died peacefully in her chair, whether she believed this to be the case.

The panel referred to Witness 7's local statement dated 20 September 2020:

> *'On the evening of 9th May at approximately 20.30 I received a call from Carol Reid (Carol was on call for Earls ferry as we were taking week about to cover the site) She said that she had just received a call from Earlsferry to say that the night staff had went into check on [Resident A] and she was found dead on the floor of her bedroom. Carol said that it appeared from what they had said that the lady had slipped from her chair.'*
>
> ...
>
> *'Carol said she was not looking forward to this call. I did say to Carol that [Witness 9] had said the lady's daughter had called earlier in the evening and [Witness 9] had updated her from what Amanda had said. Carol repeated that she really did not want to call this lady I asked if she wanted me to make the call. Carol said she would do it and then ended the call.'*

The panel determined that Ms Donaldson was aware of the other circumstances surrounding Resident A's death, in that she was found on the floor. The panel

determined that she deliberately omitted to include this detail from her report to the Care Inspectorate in all likelihood to head off further questions or investigation. The panel was of the view that she sought to mislead others. The panel determined by the standards of ordinary decent people this was dishonest.

The panel determined that this charge is found proved.

Charge 5

5) In April 2020 agreed a higher rate of hourly pay to one or more employee(s) without authorisation from your employer;

This charge is found proved.

In reaching this decision, the panel took into account the respective written statements and oral evidence of Witness 8, Witness 9 and Witness 10.

The panel considered that there is substantive evidence to show that a higher rate of hourly pay was agreed without authorisation from Ms Donaldson's employer. The panel also had sight of the respective payslips of the two employees in question, namely Witness 9 and Ms 3.

Witness 8 stated in her written statement:

> *'In relation to the incident that occurred in April 2020, the registrant had agreed to pay one or more of the employee's a higher rate of hourly pay without authorisation. I would not have been in a position to authorise such a request it would have been the director of the home. The issue came to light when a member of staff informed me that their pay slip was incorrect and that their base rate of pay had been topped by indicating that the employee had completed additional training or an induction or used annual leave when they had not.'*

Witness 10 stated in her written statement:

'When I began my investigation, I discovered that two members of staff at the Home, [Witness 9] and [Ms 3] had been taken on as employees and I could see that they had been offered a very inflated hourly rate of pay. [Witness 9] was offered £15.20 per hour and [Ms 3] was offered £12.50 per hour. Additionally, this was not the right rate of pay for the jobs they had been employed for across the Company. I recall that at this time, the roles were offered at £10.00 per hour for senior carer roles. Furthermore, it was also discovered that at one point, Carol was making up the pay by adding additional expenses such as training.'

The panel noted Ms Donaldson's response in her Registrant's bundle

'On reflection I should have simply implemented [Witness 8's] instructions and left my employer to deal with the consequences of any claim by [Witness 9] or [Ms 3] for unlawful deductions from wages. I did not derive any personal benefit or gain, and I made the decision with the best of intentions because of how hard those two employees had been working in very difficult conditions, but on reflection I should made my employer aware that I had given [Ms 3] & [Witness 9] longer notice of their pay scale being reduced.'

The panel was of the view that there is conclusive evidence to establish that the two employees, Witness 9 and Ms 3, were paid much higher pay rates than Ms Donaldson was authorised to permit. The panel therefore finds this charge proved.

Charge 6

6) Between April 2020 and August 2020, provided incorrect information to payroll in relation to the working hours of one or more employee(s) in that you inputted hours indicating that the employee(s) had completed additional training and/or induction and/or used annual leave when they had not;

This charge is found proved.

In reaching this decision, the panel took into account the respective written witness statements and oral evidence of Witness 7, Witness 8, Witness 9 and Witness 10. The panel also had sight of the respective payslips of the two employees in question, namely Witness 9 and Ms 3. It also had regard to the local investigation report dated 4 September 2020.

Witness 7's witness statement includes:

> *'I did ask Carol why she offered both employees so much, but she did not give an explanation. I was not in a position to question Carol at the time because she was my manager.'*

Witness 8's witness statement includes:

> *'The issue came to light when a member of staff informed me that their pay slip was incorrect and that their base rate of pay had been topped by indicating that the employee had completed additional training or an induction or used annual leave when they had not.'*

Witness 9's local statement includes:

> *'I asked carol on numerous occasions when our ([Ms 3] and me) wages would be dropped as we were aware we should have 28 days notice and an amended contract but we never got this. When I received my payslip 2 months ago it was all disjointed and really hard to relate to as what I had worked. I did text carol about this and was told that the outcome of my pay should be the same outcome and that's all that mattered.'*

Witness 10's witness statement includes:

> *'As the Registered Manager of the Home, it was Carol's responsibility to submit every employee's pay into Carebox and Carol had direct access to this system. This was the system used by the Company in relation to any employee matters including pay, hours and annual leave. Once the information regarding hours and*

pay have been inputted, there is also check and balance system which allows the manager to check if accurate information has been inputted. The final information would be signed off by Carol. Carol was responsible for ensuring the accurate information was put into Carebox.'

...

'...it was also discovered that at one point, Carol was making up the pay by adding additional expenses such as training.'

The panel also had sight of text messages between Witness 9 and Ms Donaldson dated July and August 2020, wherein Witness 9 was querying the difference in the rates of pay on her pay slips.

The panel determined that there is substantial evidence before it to show that Ms Donaldson provided incorrect information to payroll as detailed in this charge. In her own account Ms Donaldson appears to accept that she did this in order to reduce the impact of an immediate reduction in the two employee's rates of pay. The panel finds this charge proved.

Charge 7

7) Your actions at Charge 6 above were dishonest in that you:
a) knew that the information you had inputted was incorrect;
b) sought to mislead your employer

This charge is found proved in its entirety.

In reaching this decision, the panel took into account In reaching this decision, the panel took into account Witness 8's written witness statement and oral evidence. It also took account of the test for dishonesty in *Ivey v Genting Casinos* (UK) Ltd [2017] UKSC 67.

The panel applied the test in *Ivey* in relation Ms Donaldson's state of knowledge at the time, and whether she was dishonest in that she knew the information she was inputting was incorrect and sought to mislead her employer.

The panel determined that Ms Donaldson did know that the information was incorrect. The information on the pay slips is clearly marked *'holiday'* and *'training'* and Ms Donaldson knew this was not the basis for the payments. The panel determined that Ms Donaldson sought to mislead her employer and by the standards of ordinary decent people this was dishonest. The panel finds this charge proved in its entirety.

Charge 8

8) Between 11 May 2020 and 16 August 2020, as set out in Schedule 1, you submitted mileage claims that were in excess of the miles that you had travelled;

This charge is found not proved.

In reaching this decision, the panel took into account the respective witness statements and oral evidence of Witness 8 and Witness 10. It also had sight of: Ms Donaldson's weekly expense claim; an overview of claimed miles actual miles travelled and employment contract.

The panel considered witness statement of Witness 8's, which included:

> *'Between 11 May 2020 and 16 August 2020 the registrant submitted mileage claims that were in excess of the miles that she had travelled. There are no maximum amount of miles that an employee can claim. I noticed that the registrant was claiming mileage similar to what I was claiming for travelling from Aberdeen to Fife which made me check her milage claims and the journey lengths that she was claiming for. I questioned this and offered her a chance to resubmit the correct milage however she confirmed her claim was accurate.'*

The panel considered witness statement of Witness 10's, which included:

'Additionally, in some of the expenses, Carol was claiming from her home to the Home, then from her mother's home to the Home. When we asked for her mother's address, she would not provide it so we could not confirm where she was getting the mileages from.'

The panel did not lend any weight to this as the relationship between them had already broken down at that point. Further, in oral evidence when asked by Mr Smalley if those addresses were known to the company would it have been acceptable for her to claim the mileage from there, Witness 10 responded *'possibly'.*

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When Witness 10 was questioned by the panel as to whether she was able to say with any certainty, as a consequence of her investigation, that Ms Donaldson did not actually travel the mileage she was actually claiming, Witness 10 responded *'No'*.

The panel was of the view that it saw no evidence before it by way of a comparison to previous claims Ms Donaldson had made, and as such could have been making similar journeys. Further, the panel determined that it was unclear whether at the time of these journeys, Ms Donaldson was employed as the manager of the Home or if she remained under the terms and conditions of her substantive contract for her role as a regional manager. The panel noted that the employer's knowledge in relation to which contract of employment applied to Ms Donaldson was unclear and conflicting in a number of areas. The panel considered that depending on the specific terms and conditions which applied to Ms Donaldson this may have entitled her to claim mileage from her home to her place of employment. There appeared to be uncertainty over whether the contract allowed for mileage claims from wherever Ms Donaldson commenced her journey.

The panel considered that Witness 10 as the local investigator had the opportunity to look further into these claims however failed to do so. The panel was of the view that whilst it may appear that Ms Donaldson is claiming more miles than expected, the overall expense claim is incomplete and lacks any other corroborating evidence. The panel was not satisfied that the NMC's has proved its case to establish that it is more likely than not Ms Donaldson did over-claim her mileage. The panel therefore finds this charge not proved.

Charge 9

9) Your actions at charge 8 above were dishonest in that you:
a) Knew that the mileage claims were incorrect.
b) Submitted the claims for financial gain

On the basis that Charge 8 is found not proved, it follows that this charge falls away. The panel therefore finds this charge is found not proved in its entirety.

Schedule 1

1) 11/05/20 to 17/05/20 - claimed 417 miles and the actual miles as calculated by AA route finder were 243;
2) 01.06.2020 – 07.06.2020 claimed 536 miles and the actual miles as calculated by AA route finder were 251;
3) 08/06/20 to 14/06/20 – claimed 532 miles and the actual miles as calculated by AA route finder were 251
4) 15/06/20 to 21/06/20 – claimed 531 miles and the actual miles as calculated by AA route finder were 251
5) 22/06/20 to 28/06/20 – claimed 550 miles and the actual miles as calculated by AA route finder were 309 6) 29/06/20 to 05/07/20 – claimed 503 miles and the actual miles as calculated by AA route finder were 251
7) 06/07/20 to 12/07/20 – claimed 594 miles and the actual miles as calculated by AA route finder were 251
8) 13/07/20 t0 19/07/20 – claimed 556 miles and the actual miles calculated by AA route finder were 251
9) 27/07/20 to 02/08/20 – claimed 564 and the actual miles calculated by AA route finder were 300
10) 03/08/20 to 09/08/20 – claimed 493 miles and the actual miles calculated by AA route finder were 251
11) 10/08/20 to 16/08/20 – claimed 399 miles and the actual miles calculated by AA route finder were 201 miles

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Smalley invited the panel to take the view that the facts found proved amount to misconduct. He identified the specific, relevant standards of the Code where, in the NMC's view, Ms Donaldson's actions amounted to a breach of those standards:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*

1.1 treat people with kindness, respect and compassion

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

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'

Submissions on impairment

Mr Smalley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*; Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Cohen v GMC* [2008] EWHC 581 (Admin).

Mr Smalley submitted that limbs a), b) c) and d) of Dame Janet Smith's test, set out in the Fifth Shipman Report, were engaged in this case, by way of Ms Donaldson's past actions.

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

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

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

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

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

Mr Smalley told the panel that it has heard that Resident A sadly passed away and the upset it caused to her family in not knowing the true circumstances of their relative's passing. He submitted this engages the first limb in *Grant.*

In assessing whether Ms Donaldson was likely to repeat such actions in the future, Mr Smalley invited the panel to consider whether there was any evidence of remediation and insight in this case.

Mr Smalley submitted that Ms Donaldson was in a position of trust and responsibility in dealing with the financial affairs of the Home and has been found to have been dishonest in that respect. He submitted that Ms Donaldson had a professional duty to colleagues, people in her care and everyone alike to act with honesty and integrity in any financial dealings she would have with them.

Mr Smalley submitted that Ms Donaldson has acted dishonestly and that this is a breach of a fundamental tenet of the nursing profession. He submitted that it follows

from that, the profession has been brought into disrepute. He further submitted that looking at a risk that Ms Donaldson's practise poses in the future, the panel is to ask, is the concern easily remediable, whether in fact it has been remedied and whether it is unlikely to be repeated. He submitted that it is the NMC's position that an allegation of dishonesty is a concern that is more difficult to put right, although not impossible. He submitted that in respect of the dishonesty Ms Donaldson has shown no insight into those concerns and therefore it follows that the panel can conclude that there is a risk of repetition.

Mr Smalley submitted that dishonesty surrounding the clinical care of patients is unacceptable for a registered nurse. He submitted that it is in those circumstances, irrespective of the risk of any repetition, a finding of impairment is necessary to maintain public confidence in the profession and uphold proper professional standards. In these circumstance, he invites the panel to find Ms Donaldson currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *General Medical Council v Dr Iheanyi Chidi Nwachuku* [2017] EWHC 2085 (Admin) and Professional Standards Authority for Health and Social Care v (1) General Medical Council (2) Parvan Kaur Uppal, [2015] EWHC 1304.

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: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

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

> ***'5 Respect people's right to privacy and confidentiality As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are***

receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.
To achieve this, you must:
5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel had regard to each individual charge found proved in order to determine whether Ms Donaldson's actions fell significantly short of the standards expected of a registered nurse, and were therefore so serious as to amount to misconduct.

Charges 2 and 4

The panel was of the view that Ms Donaldson did not give a full explanation to the Care Inspectorate into the circumstances of Resident A's death. The panel accepted that there [PRIVATE], noting that she was working 70 – 80 hours per week. It further noted

that it heard evidence from Witness 8 that a secretary may also have had access to the system. However, the panel also heard that there were access controls in place to ensure the record was completed by the authorised user and the document was name stamped. The panel was of the view that Ms Donaldson was responsible for having provided inaccurate information, by omission, when she reported the death to the Care Inspectorate. The panel therefore concluded that Ms Donaldson's action was dishonest and amounted to misconduct.

Charges 3a and 4

The panel had previously determined that the above charges are found proved. It found that Ms Donaldson did tell Witness 1 that her Mother had passed away '*peacefully in her chair'.* The panel took into account that Ms Donaldson stated repeatedly that she did not want to make the call to Witness 1 (Resident A's daughter) but the effect of her giving inaccurate information to Witness 1 was dishonest and this caused emotional harm to Witness 1 and distress to the family of Resident A. The panel was of the view Ms Donaldson's intention may have been to save the family from distress by minimising the circumstances in which Resident A was found. However, the panel had no evidence before it from Ms Donaldson that this was the case, in fact in her reflection which was before the panel she stated that she provided the information to Witness 1 based on what she knew at the time. In these circumstances, the panel finds that Ms Donaldson's actions were dishonest in this regard. Consequently, the panel finds this amounts to misconduct.

Charge 3c

The panel assessed the context of events in that Resident A's death occurred during an unprecedented and extremely challenging time to be working in a care home environment. Nevertheless, the panel was of the view that Ms Donaldson should have responded in a timely manner and should have been more aware of the family's needs. Given the overall circumstances arising from the Covid-19 pandemic, the panel did not find that Ms Donaldson's actions amounted to misconduct.

Charge 3d

The panel was of the view that it was difficult to quantify what other support could have been offered in the circumstances. The panel considered this incident within the context of the Covid-19 pandemic. The panel took into account that Ms Donaldson did not know the family and had only been in the post of Home manager for one day. The panel was of the view that Ms Donaldson could have delegated the task of bereavement support to a staff member who knew the family. It considered that Ms Donaldson's inaction fell short of what was expected however it determined that under the circumstances, her behaviour does not constitute misconduct.

Charge 5

The panel was of the view that Ms Donaldson would have known that she did not have the authority to agree these enhanced hourly rates in respect of the two employees. She knew what she was doing and that it was wrong. The panel determined that Ms Donaldson's actions amounted to misconduct.

Charge 6

The panel determined that this is clear misconduct in terms of Ms Donaldson inputting or causing to be inputted false information into her employer's IT system. The panel determined that, although there was no financial benefit to Ms Donaldson, she knew what she was doing and would have known it was wrong to do so.

The panel concluded that Ms Donaldson's actions did amount to misconduct.

Charge 7a and 7b

The panel determined that Ms Donaldson knew the information relating to employee's pay inputted was incorrect and that it was her intention to mislead her employer. The panel determined that this was a serious departure from the Code. It determined that Ms Donaldson's actions amounted to misconduct.

The panel concluded that Ms Donaldson's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Donaldson's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel determined that there was no direct risk of patient harm in this case. However, It determined that because of the dishonesty that occurred on one or more occasions, there is a pattern of deliberate intent to mislead and attempt to cover up what she was doing.

Ms Donaldson's dishonesty and misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty to be very serious.

Regarding insight, the panel considered that Ms Donaldson has provided limited insight into her behaviour and wrongdoings. The panel considered that the reflective piece provided shows no insight into the harm caused to Resident A's family or to the reputation of the profession.

The panel was satisfied that the misconduct in this case is capable of being addressed and carefully considered the evidence before it in determining whether or not Ms

Donaldson has taken steps to strengthen her practice but was unable to find evidence of how she has done this.

In the absence of any evidence of remediation and only limited insight, the panel is of the view that there is a high risk of repetition based on the finding of dishonesty, which is not easily remediated, especially as the panel determined that there was more than one incident of dishonesty. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Donaldson off the register. The effect of this order is that the NMC register will show that Ms Donaldson has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published

by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement. The panel accepted the advice of the legal assessor, which included reference to the case of *Lusinga v NMC* [2017] EWHC 1458 (Admin).

Submissions on sanction

Mr Smalley outlined the sanction bid for a striking-off order.

Mr Smalley referred the panel to the NMC SG in particular: 'Factors to consider before deciding on sanctions' Reference: SAN-1; 'Considering sanctions for serious cases' Reference: SAN-2; and 'Striking-off order guidance' Reference: SAN-3e. He also referred to the case of *Sawati v General Medical Council* [2022] in relation to dishonesty. He submitted that the only appropriate sanction in this case was one of a striking-off order on the grounds of public protection and also in the wider public interest.

Mr Smalley submitted that Ms Donaldson had abused her position of trust and her dishonesty involved a breach of her duty of candour towards both her employer in terms of wages being wrongly paid to staff, towards Resident A's family and also in the report to the Care Inspectorate. Mr Smalley submitted that whilst Ms Donaldson's actions in causing distress to Witness 1 may have been an isolated incident, she maintained this dishonesty and the facts were not revealed to Witness 1 until the Police highlighted them. He further submitted that Ms Donaldson displayed this long-standing pattern of behaviour over a period of time. He submitted that she has demonstrated a lack of insight and poses a significant risk of repeating her behaviour.

Mr Smalley acknowledged that in relation to the dishonesty found proved, Ms Donaldson did not benefit from any financial gain, and further, he accepted that the events occurred at the beginning of the first Covid-19 lockdown.

Having found Ms Donaldson'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:

- Abuse of a position of trust
- Lack of insight into her failings
- A pattern of misconduct over a period of time
- Dishonesty in multiple areas over a period of time
- Emotional distress caused to the family of Resident A

The panel also took into account the following mitigating features:

- Lack of financial gain
- Events took place at the early stage of the Covid-19 pandemic when there was lack of clarity and rapidly changing guidance, excessive working hours, staff shortages and challenges in recruiting staff
- Organisational factors given that the Home was in administration including limited support from her line manager
- [PRIVATE]
- Ms Donaldson's intentions in failing to tell Witness 1 the full details of Resident A's passing, may have been motivated by compassion
- No direct risk of harm to patients

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that

does not restrict Ms Donaldson's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Donaldson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to the SG, in particular the list of factors to take into account when deciding whether a suspension would be appropriate. The panel could not identify any factors applicable to be considered in this case. The panel considered that the charges found proved are serious, involving dishonesty which is indicative of attitudinal problems on her part. The panel was of the view that Ms Donaldson had a serious lack of insight into her misconduct. It noted that it had no evidence put before it to show any degree of developing insight in this case. As such, it considered that Ms Donaldson did pose a significant risk of repeating her behaviour. In light of these circumstances, the panel did not consider that a period of suspension would be sufficient to protect the public or maintain public confidence in the nursing profession.

The panel determined that Ms Donaldson's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

The panel noted that these serious breaches of the fundamental tenets of the profession evidenced by Ms Donaldson's actions are fundamentally incompatible with remaining on the register.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Ms Donaldson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that its findings demonstrate that Ms Donaldson's actions were very 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, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Donaldson's actions in bringing the profession into disrepute, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards of behaviour required of a registered nurse.

This will be confirmed to Ms Donaldson in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Donaldson's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Smalley. He submitted that an interim suspension order for a period of 18 months should be made on the ground that it is necessary for the protection of the public and is otherwise in the public interest, in order to cover any appeal period.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months. 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 suspension order will be replaced by the substantive suspension order/striking off order 28 days after Ms Donaldson is sent the decision of this hearing in writing.

That concludes this determination.