Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 2 October 2023 – Thursday, 12 October 2023
Monday, 18 December 2023 – Wednesday, 20 December 2023
Monday, 15 January 2024 – Monday, 22 January 2024

Virtual Hearing

Name of Registrant:	Declan Carroll
NMC PIN	89A2007E
Part(s) of the register:	Registered Nurse – Sub Part 1 RN3: Mental Health Nurse, 28 July 1992
Relevant Location:	Northampton
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Shorai Dzirambe (Registrant member) Stacey Patel (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Monsur Ali (2-12 October 2023) (18-20 December 2023) Stanley Udealor (15 – 22 January 2024)
Nursing and Midwifery Council:	Represented by Grace Khaile, Case Presenter
Mr Carroll:	Present and represented by Dennis Hamill, instructed by Royal College of Nursing (RCN)
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 3a, 3b, 5, 7a, 7b, 11, 12, 13a, 13b and 13c
No evidence offered:	Charge 8
Facts not proved:	Charges 4, 6, 9, 10a and 10b
Fitness to practise:	Impaired

Sanction:	**Suspension order (6 months) with no review**
Interim order:	**Interim suspension order (18 months)**

Details of charges at commencement of the hearing

That you, a registered nurse, whilst working as a charge nurse on Cove Ward at Berrywood Hospital:

1. Imposed unlawful restrictions on Patient A, an informal patient, in that you restricted their informal leave if they did not clean themselves;

2. Failed to work in a professional manner, in that you;
   a. Bullied colleagues;
   b. Intimidated colleagues;
   c. Embarrassed colleagues;
   d. Were dismissive of colleagues;

3. In response to Colleague 1 transferring Patient B to Cove Ward;
   a. Threatened Colleague 1 with making a complaint about them if they did not transfer a different patient;
   b. Told Colleague 1 that you would be "*coming over to Harbour Ward*", or words to that effect, where Colleague 1 was working;
   c. Spoke to Colleague 1 in an aggressive and/or threatening way;

4. Failed to adequately support student nurses and junior colleagues, in that you;
   a. Told Colleague 2;
      i. "*under no account should you provide answers to her [Student Nurse 1], I am in charge of her learning*", or words to that effect;
      ii. Spoke the words referred to in charge 4.a.i. in a raised voice;
   b. Failed to allow Student Nurse 1 to work with and/or learn from other nurses;
   c. Undermined Student Nurse 1, having asked them to tell colleagues why a patient had improved, stated that they were wrong, and that the patient's progress was solely because of you;

5. Left Colleague 2 as the only nurse on Cove Ward, contrary to your own instructions that “under no account should you leave one nurse on their own”, or words to that effect;

6. Shook the chair on which Colleague 3 was sitting, trying to tip them off;

7. In respect of Colleague 4:
   a. Shouted at them regarding their transfer to a different ward, even though they had made you aware of said transfer;
   b. Refused to complete a patient’s observations when asked by them;
   c. When told by them that you were making them uncomfortable, responded by saying, “*I have that effect on people*”, or words to that effect;

8. Referred to Colleague 5 as “*short person*” and/or “*short woman*”;

9. In respect of Colleague 6, following a disagreement over the phone regarding the transfer of a patient:
   a. Threatened to make a complaint about them;
   b. Slammed the phone down on them;

10. After Colleague 7 transferred a patient that you were not expecting, and explained to you that the transfer had been agreed with staff on duty, threatened to make a complaint about them;

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

Approach adopted by the panel from this point to ensure clarity and consistency throughout the hearing

The panel recognised that there was a real risk that lack of clarity and confusion would be caused by the multiple and varying identifications attributed to a number of individuals in the documentation that has been provided to it.

Accordingly, save in relation to the original charges set out above, to achieve clarity and consistency, hereafter, individuals are referred to and identified in accordance with the Determination Key that accompanies this determination.

In addition, to achieve clarity and consistency, the submissions of the representatives have been *"corrected*" where necessary to refer to the appropriate charges. This is indicated by the use of square brackets.

For the avoidance of doubt, this approach was agreed in the course of the proceedings by the parties.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Khaile, on behalf of the NMC, to amend the wording of the charges. She submitted that effectively no new charges are being added and they are just being amended so that they are better particularised. It was submitted by Ms Khaile that the proposed amendments would provide clarity and more accurately reflect the evidence before the panel.

Ms Khaile submitted you and your representative, Mr Hamill, are aware of the proposed amendments to the charges and this is because the Royal College of Nursing (RCN) and you have asked for the charges to be better particularised. Previously, during the investigation process, some of the allegations were put to you and it was discussed that some of the charges and allegations needed further clarification.

The proposed amendments to the charges are as follows:

"That you, a registered nurse, whilst working as a charge nurse on Cove Ward at Berrywood Hospital:

~~*1. Imposed unlawful restrictions on Patient A, an informal patient, in that you restricted their informal leave if they did not clean themselves;*~~

1. On one or more occasions between 13 May 2019 and 13 September 2019 restricted Patient A's informal leave if they did not clean themselves when:

a) It was not part of Patient A's care plan

b) It had not been discussed with Patient A and/or recorded

~~*2. Failed to work in a professional manner, in that you;*~~

~~*a. Bullied colleagues;*~~

~~*b. Intimidated colleagues;*~~

~~*c. Embarrassed colleagues;*~~

~~*d. Were dismissive of colleagues;*~~

2. On or about 26 July 2019, In response to Witness 5 transferring Patient B to Cove Ward;

a) Threatened Witness 5 with making a complaint about them if they did not transfer a different patient;

b) Told Witness 5 that you would be "coming over to Harbour Ward", or words to that effect, where Witness 5 was working;

c) Spoke to Witness 5 in an aggressive and/or threatening way;

~~*3. In response to Colleague 1 transferring Patient B to Cove Ward;*~~

~~*a. Threatened Colleague 1 with making a complaint about them if they did not transfer a different patient;*~~

~~*b. Told Colleague 1 that you would be "coming over to Harbour Ward", or words to that effect, where Colleague 1 was working;*~~

c. ~~*Spoke to Colleague 1 in an aggressive and/or threatening way;*~~

3. On an unknown date, when speaking with Witness 4;

> ***a) Said "under no account should you provide answers to her [Student Nurse 1] I am in charge of her learning", or words to that effect;***
>
> ***b) Spoke the words referred to in charge 3.a in a raised voice;***

~~*4. Failed to adequately support student nurses and junior colleagues, in that you;*~~

- ~~*a. Told Colleague 2;*~~
  - ~~*i. "under no account should you provide answers to her [Student Nurse 1], I am in charge of her learning", or words to that effect;*~~
  - ~~*ii. Spoke the words referred to in charge 4.a.i. in a raised voice;*~~
- ~~*b. Failed to allow Student Nurse 1 to work with and/or learn from other nurses;*~~
- ~~*c. Undermined Student Nurse 1, having asked them to tell colleagues why a patient had improved, stated that they were wrong, and that the patient's progress was solely because of you;*~~

4. Failed adequately to allow Student Nurse 1 to work with and/or learn from other nurses;

~~*5. Left Colleague 2 as the only nurse on Cove Ward, contrary to your own instructions that "under no account should you leave one nurse on their own", or words to that effect;*~~

5. On an unknown date, having asked Student Nurse 1 to tell colleagues why a patient had improved, stated that they were wrong, and that the patient's progress was solely because of yourself.

~~*6. Shook the chair on which Colleague 3 was sitting, trying to tip them off;*~~

6. On an unknown date, left Witness 4 as the only nurse on Cove Ward, contrary to your own instructions that "under no account should you leave one nurse on their own", or words to that effect;

7. On an unknown date with respect to Witness 6

- ***a) shook the chair on which they were sitting,***
- ***b) by your action at 7 a) and/or otherwise, tried to tip them off the chair on which they were sitting***

8. In respect of Colleague 3:

- ***a. Shouted at them regarding their transfer to a different ward, even though they had made you aware of said transfer;***
- ***b. Refused to complete a patient's observations when asked by them;***
- ***c. When told by them that you were making them uncomfortable, responded by saying, "I have that effect on people", or words to that effect;***

~~*9. In respect of Colleague 6, following a disagreement over the phone regarding the transfer of a patient:*~~

- ~~*a. Threatened to make a complaint about them;*~~
- ~~*b. Slammed the phone down on them;*~~

9. Referred to Witness 3 as "short person" and/or "short woman";

~~*10. After Colleague 7 transferred a patient that you were not expecting, and explained to you that the transfer had been agreed with staff on duty, threatened to make a complaint about them;*~~

10. In respect of Witness 2, on or about 01 March 2018, following a disagreement over the phone regarding the transfer of a patient:

- ***a) Threatened to make a complaint about them;***
- ***b) Slammed the phone down on them;***

11. On or about 19 July 2019, after Witness 1 transferred a patient that you were not expecting, and explained to you that the transfer had been agreed with staff on duty, threatened to make a complaint about them;

12. Your actions at 3, 4, and 5 above failed to support and/or undermined Student Nurse 1's professional development.

1. ***Your actions at one or more of charges 1-11:***

    a. ***Were bullying and/or otherwise intimidating to Colleagues***
    b. ***Were embarrassing to colleagues***
    c. ***Were dismissive of colleagues.***

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

The panel heard submissions from Mr Hamill. He indicated that he agreed with the proposed amendments and no injustice or unfairness would be caused to you by the amendments. He stated that these amendments are in fact acceptable to you as they provided clarity.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel determined that the amendments, as applied for, would provide more clarity. It noted that both parties are in agreement with the proposed amendments and there is no objection to the application.

The panel, therefore, was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Application to dispense with witnesses

Ms Khaile informed the panel that the NMC no longer sought to rely on the evidence of Colleague 1 and Colleague 2 as they did not take the NMC's case any further or add anything to the evidence to be adduced in support of the charges.

Mr Hamill indicated that he agreed as they were not required by you to give evidence before the panel.

As the statements of these witnesses were not before the panel, it accepted what it had been told by Ms Khaile and Mr Hamill.

Decision and reasons on application to admit hearsay evidence

Ms Khaile made an application under Rule 31 to admit witness statements of Colleague 3, Colleague 4 and the evidence of Student Nurse 1. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and went through the seven principles set out in this case when considering the application to admit hearsay evidence:

> '*(i) Whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) The nature and extent of the challenge to the contents of the statements;*
> *(iii)Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) The seriousness of the charge, taking into account the impact which adverse findings might have on the [Registrant's] career;*
> *(v) Whether there was a good reason for the non-attendance of the witnesses;*
> *(vi) Whether the [NMC] had taken reasonable steps to secure their attendance;*
> *(vii) The fact that the [Registrant] did not have prior notice that the witness statements were to be read*.'

In respect of Colleague 3, Ms Khaile directed the panel to the correspondence between the NMC and Colleague 3 regarding this matter. [PRIVATE]. [PRIVATE].

Ms Khaile stated that Colleague 3's statement is relevant to charge 8. She submitted that there is a good reason for Colleague 3's non-attendance and that all efforts had been made by the NMC to secure her attendance. [PRIVATE], Ms Khaile submitted that, Colleague 3's evidence is ought to be admitted into evidence.

In respect of Colleague 4, Ms Khaile directed the panel to the correspondence between the NMC and Colleague 4 regarding this matter. [PRIVATE]. [PRIVATE]. Ms Khaile therefore submitted that there is a good reason for Colleague 4's non-attendance at this hearing. She said Colleague 4's witness statement is relevant to charge 12 as he outlined his own encounter with you. Ms Khaile submitted that Colleague 4's evidence is not the sole or decisive evidence in this matter, but it remains a reliable piece of evidence.

In respect of Student Nurse 1, Ms Khaile submitted that her evidence relates to charge 4 [and 5]. She said that it is alleged that during Student Nurse 1's time on the Ward, you failed to allow her to work with and/or learn from other nurses. Student Nurse 1's evidence is the preliminary meeting notes which outlines her concerns and experience under your supervision.

Ms Khaile submitted that the reason for Student Nurse 1's non-attendance is that the NMC has not been able to identify her on the NMC register. She said, either the Student Nurse 1 has left the country or entered the NMC register with a different name, such as a married name or she has not yet joined the NMC register. The NMC contacted the Trust and was told that they do not have her details. Ms Khaile said that the NMC Case Officer conducted WISER checks and there were no results found on the NMC WISER system. She submitted that all reasonable efforts and steps have been taken to locate Student Nurse 1, but the NMC was not able to do so.

Ms Khaile submitted that Student Nurse 1's evidence is not the sole or decisive evidence in relation to charge[s] 4 [and 5] as there are other pieces of evidence from

other witnesses that make reference to this charge and the panel will hear live evidence from those other witnesses.

Upon questions from the panel, Ms Khaile stated that the NMC has not attempted to contact the university in relation to Student Nurse 1.

Mr Hamill submitted that the admission of evidence of an absent witness should not be a routine matter and the panel needs to consider the issue of fairness before admitting the evidence. He said that, according to the principles set out in *Thorneycroft,* the panel must be satisfied that either the evidence is demonstrably reliable or that there are means to test its reliability. Mr Hamill stated that under the principles of *Thorneycroft*, there are several factors that a panel ought to consider when determining whether to admit hearsay evidence and reiterated the factors outlined previously by Ms Khaile.

In respect of Colleague 3, Mr Hamill submitted that this case was originally listed in June 2023 and [PRIVATE]. [PRIVATE].

Mr Hamill submitted that there is a question mark in relation to whether there is a good reason for her non-attendance. He said that Colleague 3 is the sole and decisive witness in relation to the evidence she gives. She is the only person who provides evidence in relation to charge 8. He said Colleague 3's evidence is sole and decisive and there is no way for you to challenge this evidence and therefore this evidence should be excluded.

In respect of Colleague 4, Mr Hamill submitted that [PRIVATE]. [PRIVATE]. [PRIVATE].

Mr Hamill said that there is a question mark as to whether there is a good reason for Colleague 4's non-attendance. Furthermore, Mr Hamill said that he cannot say if this is sole or decisive evidence in relation to any particular charge as it seems to provide context around the issue of patient transfers and does not seem to bear significantly on the matters the panel needs to consider. He therefore left this matter to the panel's judgment.

In respect of Student Nurse 1, Mr Hamill said that it is clear that the NMC had not even been able to contact this witness. He said that the charges around Student Nurse 1 are wide and there is no way you can challenge that evidence. Mr Hamill submitted that this evidence cannot fairly be admitted as you will not be able to respond to the allegations raised in this evidence. He therefore invited the panel not to admit the hearsay evidence of Student Nurse 1.

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.

Having carefully considered the application to admit hearsay evidence, the panel noted that Colleague 3's evidence is sole and decisive evidence in relation to charge 8. The panel noted that you do not accept this charge and will not be able to challenge the evidence. [PRIVATE]. Furthermore, the panel determined that the NMC has not made sufficient efforts to explore alternative method of attending the hearing such as via the telephone.

Having considered the principle of fairness set out in in the case of *Thorneycroft*, the panel determined that it is not fair to you to admit this hearsay evidence.

In respect of Colleague 4, the panel noted that [PRIVATE]. The panel has not been provided with any such evidence.

However, the panel noted that Colleague 4's evidence is not the sole or decisive evidence. It also noted that this evidence provides context to what was going on in the Ward at the time and does not go directly to the charges. Furthermore, the panel noted that Mr Hamill did not raise an absolute objection to this evidence being admitted. The panel therefore decided to admit this hearsay evidence.

The panel noted that the evidence provided in the hearsay bundle relating to Colleague 4 and subject to the hearsay application contained proposed redactions that were still

visible to the panel. On enquiry by the panel, Ms Khaile confirmed that the proposed redactions should be applied. It was agreed with the consent of all parties that the redactions should be applied and that the panel would put the redactions that were previously visible out of its mind.

In respect of the evidence of Student Nurse 1, the panel noted that this is not the sole or decisive evidence because it will hear from other witnesses who will talk about these concerns, and they can be questioned and challenged. However, the panel will carefully consider the weight to be attached to this evidence as this is not something that was taken directly from the witness, and it was not something that she knew would be used as evidence. Having taken all of this into account, the panel decided to admit Student Nurse 1's hearsay evidence.

Application to offer no evidence

Ms Khaile submitted that as a result of Colleague 3's hearsay evidence not being admitted, there is no evidence to support charge 8. She said that there is no realistic prospect of proving the facts of that particular charge and it is not in the interest of public to pursue factual charges against a nurse if there is not enough evidence to prove them. She said that this charge relies solely on the evidence of Colleague 3 who is not in attendance and the application to admit their hearsay evidence has been rejected. She therefore submitted that this is an application to offer no evidence in respect of that charge.

Mr Hamill stated that the objection to the application of hearsay was on the basis that Colleague 3's evidence is the sole and decisive evidence in relation to this particular charge and that evidence has been excluded. He said that it seems inevitable that there are simply no steps by which the NMC can prove that charge.

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

Having heard the application to offer no evidence, the panel determined that Colleague 3's evidence is the sole and decisive evidence in relation to charge 8. It determined that

there is no evidence to support this particular charge and therefore dismissed the charge.

Background

The charges arose whilst you were working at Berrywood Hospital (the Hospital), Northamptonshire Healthcare NHS Foundation Trust (the Trust), as a Charge Nurse at the Cove Ward (the Ward).

In July 2019, anonymous concerns were raised against you. Furthermore, when Witness 9 was looking into a matter you had raised in relation to Witness 5, more concerns were raised. Reports of a negative culture on the Ward which prompted a local investigation by the Trust and during the course of this investigation, a number of concerns were identified with your practice. These included but were not limited to bullying behaviour towards student nurses and staff, and inappropriately restricting voluntary patients to leave if they did not complete tasks instructed of them, such as showering and engaging in occupational therapy.

Furthermore, the Trust found evidence of negative culture which they considered as a contributing factor as to why it had become increasingly difficult to fill vacant shifts in the Ward and staff based on other wards were hesitant and resistant to be moved to the Ward.

Following the local investigation, a disciplinary hearing was held on 15 July 2020 and the outcome of which was a dismissal due to gross misconduct. The NMC was informed that following this dismissal you are no longer employed at the Trust.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Hamill, who informed the panel that you deny all the charges as amended.

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

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

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

- Witness 1: Worked at Berrywood Hospital as a Registered Nurse on Harbour Ward at the time.

- Witness 2: Employed by Northamptonshire Healthcare NHS Foundation Trust at Berrywood Hospital as a Ward Matron on Harbour Ward.

- Witness 3: Worked at Berrywood Hospital as a Band 6 Clinical Team Leader at the time.

- Witness 4: Employed by the Trust as a Registered Staff Nurse.

- Witness 5: Employed by the Trust as a Charge Nurse on Harbour Ward at the time.

- Witness 6: Employed by the Trust as a Registered Nurse mainly on Harbour Ward at the time.
- Witness 7: Worked for the Trust as a Mental Health Nurse on Harbour Ward at the time.
- Witness 8: Employed by the Trust as a charge nurse at Berrywood Hospital.
- Witness 9: Employed by the Trust as a Service Manager at the time.

The panel also had regard to the evidence of the following witnesses:

Colleague 4: Employed by the Trust as a Bed Management and Liaison at the time.

Student Nurse 1: Student Nurse on placement at the Ward at the time.

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

Charge 1

1. On one or more occasions between 13 May 2019 and 13 September 2019 restricted Patient A's informal leave if they did not clean themselves when:
   a) It was not part of Patient A's care plan.
   b) It had not been discussed with Patient A and/or recorded.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 3 who stated in her local interview that she heard you say to patients on a number of occasions *‘you cannot go out until… you have done’*. Furthermore, specifically in the case of Patient A, she said: *‘he kept being threatened by [you] “you will lose your leave”.’*

The panel also took into account the evidence of Witness 4. In his oral evidence, Witness 4 stated *“yeah the patient was prevented from leaving the ward if he hadn’t attended to his personal care”*.

The panel further considered the evidence of Witness 4 in their local statement dated 5 September 2019 in which he confirmed that ‘*sometimes patients are not allowed to leave the ward if they have not attended to their personal hygiene. This is informal and detained patients. This is driven by …. Declan.’* Witness 4 confirmed subsequently that this specifically related to Patient A.

The panel also took account of the evidence of Colleague 5. During her local interview, Colleague 5 stated ‘*We don’t want patients going out if they are smelling unpleasant or not washed, we want them to present well. Restrictions are made with Patient A with persistence we do manage to get him to wash’.*

In relation to charge 1a, the panel noted your position that there were no notes in Patient A’s care plan because there were no restrictions on Patient A.

In relation to charge 1b, the panel heard from you that you did discuss with Patient A that he needed to attend to his personal care. This was one of the number of discussions you said you had, where you encouraged Patient A to attend to his personal care.

While the panel has not heard any evidence that Patient A was physically restricted from leaving the ward, it considered that your discussions with Patient A did effectively amount to a restriction on his informal leave, particularly when considered together with

the evidence of Witness 3, Witness 4 and Colleague 5, which it accepts. For the record, the panel wish to state that it considered in restricting Patient A, you believed you were acting in his own personal interest and in the interest of others in preventing cross-contamination that may have been caused, should Patient A not have attended to his personal care.

Having taken all of the above into consideration, the panel determined that charge 1 is found proved in its entirety.

Charge 2

2. On or about 26 July 2019, in response to Witness 5 transferring Patient B to Cove Ward;
   a) Threatened Witness 5 with making a complaint about them if they did not transfer a different patient;
   b) Told Witness 5 that you would be "*coming over to Harbour Ward*", or words to that effect, where Witness 5 was working.
   c) Spoke to Witness 5 in an aggressive and/or threatening way.

These charges are found proved.

There is no dispute that an issue arose between you and Witness 5 regarding the transfer of a patient from Harbour Ward to Cove Ward. Your account was that it had been agreed that a Polish-speaking patient would be transferred but in effect, Witness 5 reneged on this agreement by sending a different patient. You also accepted that at the time of the transfer, you were tense and on edge, having recently had to deal with a very challenging and aggressive patient. As a result of the issue with the transfer and interaction with Witness 5, you did state that you would raise your concerns and did so in an email. However, you denied that you ever threatened to make a complaint about Witness 5.

The panel heard evidence from Witness 5 in which he stated in his local interview you said *'if you do not send me…. I will put in a grievance'*. Witness 5 further stated in his

local interview *'I was intimidated by Declan saying he would come across.'* He also stated that in his local interview *'.. I received a phone call from CN Declan Carol, in an aggressive and threatening manner Declan informed me that "if you don't send … then I will put in an [sic] grievance against you"*.

Furthermore, during his oral evidence, Witness 5 stated *"he did mention that if I didn't do what he said he would put in a grievance, I said to him, there's no ground for a grievance."*

The panel also heard evidence from Witness 7. In his local interview, Witness 7 described how you behaved when he arrived at Cove Ward. He described you as *'angry'*. He heard you arguing with Witness 5 on the phone and he personally *'felt intimidated, belittled, disrespected, threatened, uncomfortable and disparaged by [your] behaviour'*.

The panel recognised that in his oral evidence, Witness 5 did not relate, as he had in his local interview, having gone to Cove Ward himself to arrange the transfer of the patient. It was also apparent that Witness 5 himself was angered at what had happened, as is evidenced by the text messages he exchanged with another colleague and his refusal the following day to engage in mediation. However, the panel regarded this as a reaction by Witness 5 to how you had behaved towards him and Witness 7. The panel could see no reason to doubt their accounts of what happened. In particular, there was no reason why Witness 7 should exaggerate, let alone fabricate, what occurred. It was satisfied that your behaviour was unprofessional and unwarranted even after having had to deal with a very difficult patient. It was satisfied that you behaved in this way because you were transferred a patient that was different to the one that you wanted.

The panel preferred Witnesses 5 and 7's version of events and was satisfied that you did threaten Witness 5 as alleged, did tell him that you would be coming over to Harbour Ward or words to that effect and spoke to him in an aggressive and/or threatening way.

Having considered all of the above, the panel determined that these charges are found proved.

Charge 3a

3. On an unknown date, when speaking with Witness 4;
   a) Said "*under no account should you provide answers to her [Student Nurse 1] I am in charge of her learning*", or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it including your evidence, the evidence of Student Nurse 1 and Witness 4.

In Student Nurse 1's local interview dated 19 August 2019, she stated *'… I asked [Witness 4] a question about the medication competency. DC came into the office 'why are you asking [Witness 4], don't ask [Witness 4], find out yourself'.'*

In his written statement, Witness 4 stated *'…his response to me was "under no account should you provide answers to her, I am in charge of her learning".'* Witness 4 put it differently in his local interview dated 5 September 2019, where he stated that you had said *'… stop helping her with that, it should only be me that shows her what to do'.'* When Witness 4 was questioned by the panel about the difference between these two accounts, he said *"well, they're both saying the same thing, even though the words differ slightly."* He also said, *"I can't be sure of the exact words that were used, I didn't make a note of what was said."* The panel accepted his explanation.

During your oral evidence, you told the panel that you said *"you shouldn't give the answers to her."* During your cross-examination, your account was that you said, "*I'd prefer it if you leave the teaching to me."*

The panel was not provided with any reasonable explanation why Student Nurse 1 should not ask for assistance from Witness 4 or why Witness 4 should not provide it. It did not accept your explanation that Witness 4 should not get involved as he was only in his preceptorship and not trained as a mentor. On your own account, a conversation involving yourself, Student Nurse 1 and Witness 4 did take place. The panel considered

that you were attempting to downplay how you intervened between Student Nurse 1 and Witness 4. It preferred the accounts of Student Nurse 1 and in particular Witness 4.

The panel accepted that on the evidence, it cannot be satisfied that the words *“under no account should you provide answers to her [Student Nurse 1]”* and “ *I am in charge of her learning”* were specifically said. It was satisfied, however, that words to that effect were said.

Having taken all the evidence before it, the panel determined that this charge is found proved.

Charge 3b

3. On an unknown date, when speaking with Witness 4;
   b) Spoke the words referred to in charge 3a in a raised voice;

This charge is found proved.

The panel has already indicated that it accepts Witness 4’s account of this incident. In his local interview notes, Witness 4 stated *‘Declan walked into the office and in a raised voice stated…’* During his oral evidence, Witness 4 stated *“He said the words in a raised tone, it sounded like a telling off and I was embarrassed, I just wanted to help her.”* Student Nurse 1, in her local interview, also described you as speaking *‘angrily’* to Witness 4.

You denied this allegation saying you were generally softly spoken. The panel rejected this evidence. Not only was it contradicted by the evidence of Witness 4 and Student Nurse 1, it was also contrary to the general evidence heard in this case about how you conducted yourself.

Having taken the above into consideration, the panel determined that it was more likely than not that the words were said in a raised tone. It therefore found this charge proved.

Charge 4

4. Failed adequately to allow Student Nurse 1 to work with and/or learn from other nurses.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Student Nurse 1. In her local interview notes, dated 19 August 2019, Student Nurse 1 stated *'DC wouldn't let me work with all the other nurses, I wasn't allowed.'* However, the panel noted that other evidence such as the Pebble Pad notes which were frequent, comprehensive and supports the contention that you did assist Student Nurse 1 adequately through her placement. The evidence suggests that you gave good direction to Student Nurse 1 and confirmed that arrangements were made for her to engage with two other registered nurses to support her learning.

In respect of the evidence offered by the NMC relating to a phone call between Student Nurse 1 and Witness 2, the panel determined that this was hearsay. Witness 2 had not seen or heard anything themselves and simply recounted a phone call between Student Nurse 1 and themselves, after Student Nurse 1 had failed her placement.

The panel was of the view that you accept that you were primarily responsible for Student Nurse 1's supervision during her placement. However, it could not find, on the basis of the evidence before it, that in the words of this charge that you failed to adequately allow Student Nurse 1 to work with and/or learn from other nurses. The panel accepted your evidence that Student Nurse 1 had the option to work with or learn from other nurses and that was supported in the evidence. In the panel's view, what Student Nurse 1 said in relation to failing her placement, was not a reliable basis on which to find this charge proved.

Having taken all of the above into account, the panel determined that this charge is found not proved.

Charge 5

5. On an unknown date, having asked Student Nurse 1 to tell colleagues why a patient had improved, stated that they were wrong, and that the patient's progress was solely because of yourself.

This charge is found proved.

In reaching this decision, the panel recognised that there is limited evidence on both sides regarding this charge.

However, you accepted that there was a discussion about the reasons for the patient's improvement. Your account was that, after Student Nurse 1 said it was due to the medication provided, you asked her whether the care provided by the staff was also a factor. You denied stating that the patient's progress was solely because of you.

In the panel's view, the accounts of Student Nurse 1 and Witness 8 in their local interviews were consistent about the detail of the description they gave with regards to this exchange. The local interview notes were relatively contemporaneous with Student Nurse 1's interview taken place on 19 August 2019 and Witness 8's interview taken place on 6 September 2019. Witness 8's oral evidence was tested and she was adamant that you insisted that it was because of you that patient had improved. The panel preferred the evidence of Witness 8 and Student Nurse 1. In the circumstances, the panel regarded the accounts of Student Nurse 1 and Witness 8 as a reliable record of what did occur and rejected your account.

Having taken all the above into consideration, the panel determined that this charge is found proved.

Charge 6

6. On an unknown date, left Witness 4 as the only nurse on Cove Ward, contrary to your own instructions that *"under no account should you leave one nurse on their own"*, or words to that effect.

This charge is found NOT proved.

This charge arose from two separate incidents involving you and Witness 4.

Witness 4 told the panel of an occasion when he left Cove Ward in response to an emergency call. On his return, he said that you told him *"under no account should you leave one nurse on their own"*, or words to that effect. Subsequently, there was another occasion when, seemingly in contradiction to what you had told him, you left the Ward in response to an emergency call leaving Witness 4 as the only registered nurse on the Ward.

You told the panel that on the first occasion, Witness 4 had left an agency nurse in charge of the Ward while he responded to the call. On the second occasion, when you responded to an emergency call, you left Witness 4 in charge of the Ward. In your oral evidence, you explained the significance of the different situations. You told the panel *"Agency staff from various agencies who would not have been familiar with the policies and procedures, they wouldn't have access to System One, which was the patient recording system used at Berrywood. So, if there was a query regarding a patient care, the agency nurse would not have been able to answer it or access systems to find the information to subsequently".* On the first occasion, the agency nurse would not have had access to System One. On the second occasion, you stated *"it was quite safe to leave [Witness 4]",* because "*he was a regular qualified member of staff".*

The panel considered that it was possible that there was a misunderstanding between two colleagues. It could not rule out the possibility that Witness 4 misunderstood what you had told him on the first occasion, namely, he should not leave an agency nurse on their own in the Ward. Therefore, the panel found this charge not proved.

Charge 7

7. On an unknown date with respect to Witness 6
   a) shook the chair on which they were sitting,
   b) by your action at 7 a) and/or otherwise, tried to tip them off the chair on which they were sitting.

This charge is found proved.

In reaching this decision, the panel considered your oral evidence where you stated that *"I did not shake the chair, I tipped the chair slightly forward, she got up and moved laughing."* You also told the panel that this was a humorous exchange and a reciprocal banter. You pointed out that, had Witness 6 been upset about what happened, she could have raised the issue with management either that night or the following day. You told the panel that so far as you were aware, Witness 6 had not complained about the incident.

During her oral evidence, Witness 6 stated that she did not consider she had sufficient relationship with you for the exchange to be reciprocal banter and that it was far from a humorous exchange as far as she was concerned. The panel found Witness 6's oral evidence to be consistent with her local interview notes dated 14 August 2019 and her written statement.

The panel noted that your recollection was that you tipped the chair while Witness 6's recollection was that the chair was jerked up and down to the extent that she felt she had to get off the chair, otherwise she would have fallen off. The panel accepted that Witness 6 was sufficiently upset by this that she went to her Clinical Team Leader (CTL) and explained what happened. The CTL subsequently encouraged her to stay at work but there appear to be no follow up and no formal complaint raised against you. Moreover, Witness 6 told the panel that she was embarrassed by this incident.

The panel carefully considered all the evidence before it and was of the view that, by your action at charge 7a, you did try to tip Witness 6 off the chair in which she was

sitting. You did so because you were about to take the handover at the beginning of the shift and Witness 6 had mistakenly sat on the chair that was customarily used by those in Cove Ward, including yourself, taking a handover.

Having considered all of the above, the panel determined that these charges are found proved.

Charge 9

9. Referred to Witness 3 as *"short person"* and/or *"short woman"*.

This charge is found NOT proved.

This charge relates to an isolated incident where it is alleged that you referred to Witness 3 as a *'short person'* or *'short woman'* . In response to the charge, you stated that you recalled a conversation when Witness 3 said *'you are a tall man*' and you replied '*well, you're not exactly tall yourself.'*

The panel has been presented with two versions of the same discussion with no independent supporting evidence to refer to. The panel does not consider that the NMC has discharged the burden of proof with the evidence provided in respect of this charge. It therefore determined that this charge is found not proved.

Charge 10a

10. In respect of Witness 2, on or about 1 March 2018, following a disagreement over the phone regarding the transfer of a patient:
    a) Threatened to make a complaint about them.

This charge is found NOT proved.

In reaching this decision, the panel considered all the evidence before it and noted that there was disagreement between you and Witness 2 regarding the transfer of a patient.

It also noted that Witness 2 had explained that she could not do the transfer face to face and you were insisting that that happened. You told the panel during your oral evidence that *"I didn't make a complaint. I was pretty sure I said I was going to escalate to her matron which I did. I was pretty sure I said I would escalate it, I didn't make a complaint, I escalated it to her matron as per my emails."*

The panel noted that you said you would escalate your concerns which you did via an email. It did not consider that you threatened to make a complaint about Witness 2 and it was not contingent on anything else happening. The panel deemed that it was a simple statement that you were not happy with the way that Witness 2 had approached the transfer.

Having taken the above into account, the panel determined that this charge was found not proved.

Charge 10b

10. In respect of Witness 2, on or about 1 March 2018, following a disagreement over the phone regarding the transfer of a patient:

    b) Slammed the phone down on them.

This charge is found NOT proved.

The panel carefully considered all the evidence before it and noted that so far as Witness 2 is concerned, she considered that you slammed the phone down. However, there was no direct evidence of what you actually did other than it was clear that you abruptly terminated the call.

The panel took into account your evidence. In an email dated 1 March 2018, you stated that *'due to …[Witness 2]… that this was unacceptable and that I expect her to do face to face handover as per policy, and due to ..[Witness 2]…'s attitude at this time which I*

would consider unprofessional I discontinued the conversation advising her that I expect face to face handover before the end of shift.'

The panel was of the view that this was an abrupt disconnection of the telephone call during a conversation. It acknowledged that the phrase '*slam'* is subtly different to saying that someone hung up or that someone disconnected in an inappropriate time. It therefore determined that you disconnected the call midway through a conversation without warning. The panel concluded that, unlike in charge 2, there was no direct evidence of how you abruptly terminated the call.

Having taken the above into account, the panel determined that this charge is found not proved.

Charge 11

11. On or about 19 July 2019, after Witness 1 transferred a patient that you were not expecting and explained to you that the transfer had been agreed with staff on duty, threatened to make a complaint about them.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Witness 1 who the panel found to be a credible witness. His evidence had been consistent since the first local investigation meeting on 21 August 2019 which was approximately one month after the event. The panel deemed that Witness 1's evidence was detailed, and he told the panel that this incident was something he was surprised that he was in front of the panel for. Witness 1 told the panel that this was not a one-off situation but was a common occurrence.

The panel also took into account the evidence of Witness 1 who stated in his local interview notes dated 21 August 2019, that *'There does tend to be a lot of pressure in relation to when we need to transfer a patient from Harbour Ward to Cove Ward.'* During

his oral evidence, Witness 1 stated *“There always seems to have been a problem with transferring.”*

The panel noted the two versions of events and determined that they were very different. Witness 1 explained that you had arrived at the Cove Ward and he was approached by you after the handover of a patient, on his way out of the Ward at about 12:50. This was before you were due to start your work. Witness 1 said that he found this perplexing and explained that his recollection was that you were challenging which patient was being transferred. You on the other hand stated that the transfer was taking place much later in the afternoon, after you were already on shift. You said that you had not had any indication on handover that a patient was going to be transferred by Witness 1.

In his written statement, Witness 1 states *‘I stated that he was intimidating…’* and *‘He also said that he would put in a complaint and I don't think you would complain unless you were annoyed.’* The panel noted that there is no evidence that a complaint was actually made. However, having considered all the evidence before it, the panel preferred the evidence of Witness 1. It therefore determined that you did threaten to make a complaint about Witness 1 and therefore found this charge proved.

Charge 12

12. Your actions at 3, 4, and 5 above failed to support and/or undermined Student Nurse 1’s professional development.

Parts of this charge are found proved.

In relation to your actions in charge 3, the panel took into account the Pebble Pad notes and your detailed account about the issues you had with Student Nurse 1. The panel also took into account the evidence of Witness 4 who stated in his written statement *‘I became reluctant to support [Student Nurse 1] in any significant way, especially when Declan was around.’* However, the panel heard from you that you did not want Student Nurse 1 to have conflicting information and did not consider Witness 4

to be an appropriate mentor as he did not have mentoring training and had not passed the preceptorship.

Nevertheless, the panel noted that Witness 4's evidence is supported by the evidence from Student Nurse 1 within her local interview notes. The panel was of the view that as Witness 4 was one of the registered nurses on the Ward, Student Nurse 1 should have been able to turn to him with questions. Therefore, the panel determined that this had undermined Student Nurse 1's professional development.

Charge 4 has not been found proved and therefore has not been considered in relation to this charge.

In respect of charge 5, the panel noted that Student Nurse 1 was trying to respond to your questions and this was during the handover in front of others. Further, it considered that having said that the patient had improved because of you, you undermined Student Nurse 1 and this would have a detrimental effect on her confidence when speaking in front of people.

This is confirmed by the evidence of Witness 8, who in her written statement stated *'The Registrant was argumentative and did not waiver from what he was saying.'* It is also confirmed by the evidence of Witness 9. In his written statement, Witness 9 stated *'Throughout their placements, [Student Nurse 1] described incidences when Declan Carroll questioned their knowledge in front of others. They described the negative impact this had on their levels of confidence.'*

The panel determined that your action in charge 5 was undermining because you questioned Student Nurse 1 in front of colleagues which the panel heard from Witness 9 was not appropriate and that you were argumentative.

Charge 13

> *13. Your actions at one or more of charges 1-11:*
> > *a. were bullying and/or otherwise intimidating to colleagues*

b. were embarrassing to colleagues

c. were dismissive of colleagues.

The panel had regard to the advice of the legal assessor that it should consider how your proven conduct was perceived by those referred to in the charges which have been proved.

At the outset, the panel noted that charge 1 relates to a patient and not to a colleague. Therefore, charge 1 has not been considered in the context of this charge.

The panel has considered all other proven charges in the context of this charge. However, for convenience, its findings will only refer to the charges it considers do fall within one or more of the three sub-paragraphs.

Parts of this charge are found proved.

Charge 13a

13. Your actions at one or more of charges 1-11:

a. were bullying and/or otherwise intimidating to colleagues

In considering this charge, the panel referred to the NMC Guidance on Bullying FTP 3 which states *'It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone.'* The panel also took into account the Trust's anti bullying policy which states '*examples of bullying can include: humiliating someone in front of others; ridiculing or demeaning someone.'*

In respect of charge 2, the panel accepted the evidence of Witness 5. In his oral evidence, Witness 5 stated *"Mr Carroll definitely came across as trying to be intimidating and aggressive."* Therefore, charge 13a is found proved in relation to charge 2.

In respect to charge 5, the panel considered that the action found proved was humiliating for Student Nurse 1. Therefore, charge 13a is found proved in relation to charge 5.

In respect of charge 7, the panel determined that your conduct was embarrassing and humiliating, considering this was in a professional environment. It certainly, falls with the NMC's definition of bullying. Furthermore, it took into account the evidence of Witness 6, in her written statement she stated *'I was so upset I reported the incident to one of the Clinical Team Leaders, then Declan left as he had finished his shift and I stayed and carried on with my shift.'* Therefore, charge 13a is found proved in relation to charge 7.

In respect of charge 11, the panel took into consideration the evidence of Witness 1. The panel found that the threat was proved, and Witness 1 said he felt threatened and felt intimidated by your behaviour. In his written statement, Witness 1 stated *'He said in an intimidating manner that he would put in a complaint, this confused me, it didn't make sense to me what he could complain about. I stated that he was intimidating as I felt that maybe by him saying that he was hoping that I would back down and reconsider but I didn't'.* This was also confirmed in his oral evidence. Therefore, charge 13a is found proved in relation to charge 11.

Charge 13b

13. Your actions at one or more of charges 1-11:
    b. were embarrassing to colleagues

In respect of charge 3, Witness 4 stated during his oral evidence that '*I felt like I was being told off and that this was in a raised tone and it was embarrassing'.* This was said in front of Student Nurse 1. In his Witness written statement, Witness 4 said that *'he said this to me in a raised voice, I was very embarrassed'.* Therefore, charge 13b is found proved in relation to charge 3.

In respect of charge 7, the panel determined that your conduct was embarrassing and humiliating, considering this was in a professional environment. It certainly, falls with the

NMC's definition of bullying. Furthermore, it took into account the evidence of Witness 6, in her written statement she stated *'I was so upset I reported the incident to one of the Clinical Team Leaders, then Declan left as he had finished his shift and I stayed and carried on with my shift.'* Therefore, charge 13b is found proved in relation to charge 7.

Charge 13c

13. Your actions at one or more of charges 1-11:
    c) were dismissive of colleagues.

Regarding its findings in charge 3, the panel considered that your conduct was dismissive of Witness 4's ability to assist Student Nurse 1 in her development despite his being a registered nurse and able to help.

Regarding its findings in charge 5, the panel considered your conduct was dismissive of Student Nurse 1's opinion as to why the patient's condition had improved.

Therefore, charge 13c is found proved in relation to charges 3 and 5.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Khalie referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

Ms Khaile submitted that, given that the panel's findings on facts found proved, your actions amounted to misconduct in line with the case of *Roylance v General Medical Council*. She submitted that your actions particularly in respect of charges one and three in their entirety, as well as charges two, seven and eleven, demonstrates a serious departure from the standards expected of a registered nurse and such departure is sufficiently serious as to warrant a finding of misconduct in this case.

Ms Khaile invited the panel to find that the facts found proved amounts to misconduct.

Mr Hamill submitted that it is significant to note that the charges found proved illustrated a number of individual isolated incidents of difficult, inappropriate and/or misguided interactions with colleagues. However, it is accepted that the panel has made findings under charge 13 about the nature of the actions which are significant.

Mr Hamill referred the panel to the definition of misconduct as provided in the case of *Roylance*. He also referred the panel to the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) where Collins J indicated that the test of seriousness must be given its proper weight:

'...in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

Mr Hamill submitted that the question of misconduct is a matter for the judgment of the panel. He referred the panel to the case of *Mallon v General Medical Council* [2007] ScotCS CSIH17 per Lord Justice Clerk. In considering whether a conduct constituted a misconduct, Mr Hamill referred the panel to the test in *R (on the application of Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin). He further referred the panel to the case of *Spencer v General Osteopathic Council* [2013] 1 WLR 1307.

Mr Hamill invited the panel to take into account the NMC Guidance on Misconduct, FTP-2a; the NMC Guidance on Seriousness, FTP-3 and the provisions of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code").

Mr Hamill thereafter went on to address each of the charges found proved and whether they amount to misconduct. He provided the following submissions:

20. *'The registrant submits that the findings in respect of Charge 1 do not amount to serious misconduct given the panel's view that the actions of the registrant were intended for the benefit of Patient A and others. Whilst the registrant's actions were clearly misguided it does not go further than that. This is not a matter which amounts to serious professional misconduct.*

21. *In respect of Charge 2 it is submitted that this was a heated incident, against a backdrop of the registrant being tense following a difficult period with a patient, in which neither the registrant or Witness 5 distinguished themselves. Witness 5 did not consider that the matter needed to go any further but clearly felt aggrieved that the registrant had raised the issue with his line manager. It*

would be open to you as a panel to find that, in those circumstances, it does not meet the high threshold of serious professional misconduct.

22. *It is submitted that the findings made in respect of Charge 3 represent a misguided attempt by the registrant to ensure that the information being provided to the student was correct. It is not in our submission a matter which amounts to misconduct, let alone serious professional misconduct despite the finding that the registrant raised his voice. The registrant should not have raised his voice but this isolated finding in respect of this witness is not, in our respectfully submission, something which amounts to serious misconduct.*

23. *It is further submitted that the findings in respect to Charge 5 can be similarly characterised to those at Charge 3. Whilst the findings are capable of amounting to arrogance on the part of the registrant, it is not the case that they amount to serious misconduct. Once again, this was an isolated incident in the registrant's dealings with Student Nurse 1.*

24. *In respect of Charge 3 and 5 it is noteworthy that there is no finding of a general failure to support Student Nurse 1 (Charge 4 being dismissed). The findings at Charge 3 represent two isolated incidents during which the registrant's behaviour was inappropriate and misguided towards two different colleagues but it does not cross the high threshold of serious misconduct.*

25. *In respect of Charge 7 it is submitted that the findings amount to a very poor attempt at humour on the part of the registrant. It is clear the registrant thought he was engaged in a humorous interaction. The matter might be properly viewed as inappropriate "horseplay". It is respectfully suggested that an isolated incident such as this is not capable of amounting to serious professional misconduct despite the panel's findings under Charge 13 in respect of this issue.*

26. *It is submitted that Charge 11 should not be viewed as serious misconduct. This was a one-off failure of the registrant to communicate properly with Witness 1 who confirmed he had no other difficulties with the registrant at all.'*

In conclusion, Mr Hamill highlighted that it was a matter for the panel's judgment as to whether or not any of the proven charges amounted to serious misconduct.

Submissions on impairment

Ms Khaile submitted that in considering whether your fitness to practise is currently impaired, the panel should take into account the tests laid down in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) as well as in the case of *Cohen v GMC* [2008] EWHC 581 (Admin).

Ms Khaile submitted that your fitness to practise must be gauged by looking at your past conduct and how you are likely to behave in the future. She submitted that in considering whether your misconduct impairs your fitness to practise, it is necessary to determine whether any impairment present at the time of the incident is still present today. She highlighted that the NMC Guidance sets out that it should not be the aim of fitness to practise proceedings to punish a professional for past events.

Ms Khaile submitted that it is the position of the NMC that your fitness to practise is currently impaired, and this is because you created and cultivated a negative environment for colleagues and patients through bullying, belittling, intimidation and by restricting an informal patient's leave. She submitted that a finding of impairment was necessary in order to protect the public, which in this case, includes your colleagues and patients, as well as to satisfy public interest considerations in this case.

Ms Khaile submitted that the panel should take into the account the context of your actions when considering the questions on impairment raised in the case of *Cohen*. She submitted that in considering whether your conduct is easily remediable and had been remedied, it should be noted that your conduct, as illustrated in the charges found

proved, relates to issues of bullying, intimidation and more especially, an attitudinal issue towards your colleagues and subordinates. She highlighted that although you had provided a reflective statement, some testimonials and training certificates in the areas of concern, it was not clear whether you fully appreciated and understood the severity of your conduct as you attempted to explain your actions in your reflection. She submitted that this demonstrated a lack of accountability on your part.

Ms Khaile submitted that the nature of the charges found proved and your lack of accountability for your conduct, demonstrates that your conduct is difficult to remediate and has not been remedied.

In considering whether there is a risk of repetition, Ms Khaile submitted that your actions arose from serious attitudinal concerns towards your colleagues and subordinates. You failed to adhere to the ideal work culture which was envisioned and encouraged at the Trust. Ms Khaile asserted that due to the attitudinal nature of the concerns, there is a risk of repetition as you are likely to repeat such conduct if your nursing practice was not restricted. She highlighted that during the fact-finding stage of these proceedings, you failed to take accountability for your actions, although you now acknowledge some of your actions in your reflective statement, your current reflection was in light of the panel's findings on some of the charges found proved.

In conclusion, Ms Khaile submitted that there remains a risk of repetition and a consequent risk of harm to the public. It is also in the public interest for a finding of current impairment to be made in this case. She therefore invited the panel to find that your fitness to practise is impaired on the grounds of public protection and public interest.

Mr Hamill highlighted that a finding of misconduct does not lead inexorably to a finding that a registrant's fitness to practise is currently impaired as those findings were about the past, whereas impairment is an assessment addressed to the future, though made in the context of the past conduct. He referred the panel to the case of *Cheatle v GMC* [2009] EWHC 645 (Admin) and the case of *Cohen*. Mr Hamill further referred the panel to the NMC Guidance on Insight and Strengthened Practice, FTP-13.

Mr Hamill referred the panel to the *Grant* test and submitted that limb d was clearly not engaged by the facts of this case. He submitted that your actions in charge 1, did not involve any risk of harm to Patient A and therefore, limb a of the *Grant* test was not engaged. Mr Hamill stated that if the panel should decide that the charges found proved do amount to serious misconduct, then limbs b and c of the Grant test were engaged.

Mr Hamill also referred the panel to the text *"Disciplinary and Regulatory Proceedings"* by Foster, Treverton-Jones and Hanif, on the factors to consider on impairment. He submitted that the panel should generally not "*cumulate*" non-serious misconduct into a finding of serious misconduct when considering the question of impairment in this case. He referred the panel to the case of *Schodlok v GMC* [2015] EWCA Civ 769.

Mr Hamill provided the following submissions on impairment:

> *'The panel's attention is to drawn to the following factors in considering whether the registrant's fitness to practise is impaired.*
>
> ***Private Component***
>
> <u>*The registrant's general approach*</u>
>
> 44. *It is submitted that there is absolutely no question as to the passion for and commitment to nursing on the part of the registrant. He clearly enjoys his current role (which whilst not a nursing role is in the healthcare environment and what seems to be a senior level) and is making great strides in his new workplace. He has demonstrated great skill and knowledge of his work. His clinical skills have never been called into question. Quite the opposite in fact in that the evidence (testimonials etc) demonstrate that he is clearly a capable practitioner who has much to offer the profession. Many of the witnesses in these proceedings commented positively on the skills and knowledge of the registrant.*

45. *The registrant is extremely well thought of by his current colleagues. The panel has the references that have been produced for the hearing. More will be said about these below.*

46. *The registrant has also received positive feedback as evidenced in the review papers submitted where he has been praised for his work as a mentor and it seems he has enthusiastically tackled all tasks that are set for him.*

Training

47. *The registrant has undertaken significant amounts of training since these incidents. Some of the training has been focused on addressing the areas in which problems arose as evidenced by the training certificates produced in the impairment bundle. He has undertaking training regarding providing feedback, understanding attitudes and their impact on practice, communication skills and dignity and respect.*

48. *Some of the training was undertaken in 2020 and is illustrative of the insight the registrant has by identifying what training was required at an early stage. He has also sought to update his training even after this case went part heard.*

49. *Whilst the registrant did not admit the allegations against him he was frank in accepting that he needed to think about and address his communication style and manner.*

Insight

50. *The registrant has, it is submitted, demonstrated a high level of insight into his wrongdoing. He has reflected at length on the matter and provided a detailed and appropriate reflective piece. No doubt the reflective piece will be considered in detail and at length by the panel so it is not intended to rehash same here.*

51. *It is clear that he understands the impact that his behaviour had. He has acknowledged his failings in how he communicates with colleagues.*

52. *It is clear that the registrant is very remorseful and upset by what has happened. It is submitted that this is clear and genuine remorse for his behaviour and the impact it had on his colleagues.*

53. *The registrant reflected on his behaviour at an early stage. See his initial reflective piece.*

54. *The registrant has identified in his evidence that he was experiencing some difficult personal circumstances around the time of these incidents but he did not raise those with his colleagues and line management. He accepts on reflection he may have bene struggling more than he realised. It is not suggested that this provides any excuse for for his behaviour. It is simply important context against which his actions should be judged. He is clear that he did not deal with these matters appropriately and would address his own issues differently in the future.*

The risk of repetition

55. *It is respectfully submitted that the risk of repetition of the behaviours giving rise to these proceedings is so remote that the panel can safely discount it. The registrant has undergone extensive training and reflection. He has remediated to the fullest extent possible in our submission. It is submitted that the registrant has demonstrated very fulsome insight which greatly reduces the risk of repetition.*

56. *The registrant is well supported and clearly has a strong relationship with his line manager and the team more generally.*

57. *Whilst the impact of the regulatory process is always secondary to issues of public protection and public confidence, it is clear that this episode and the subsequent fallout from same has been devastating for the registrant and a salutary lesson to him. It is submitted that it is extremely unlikely that he would ever allow himself to behave in such a way again.*

58. *It is therefore submitted that the risk of repetition is so minimal that the panel can safely discount it.*

<u>The registrant's approach to the proceedings</u>

59. *The registrant cooperated with the Council in the course of their investigations.*

60. *The registrant has engaged at all times with the Council. He has attended the hearing and given evidence at some length at the facts stage. He has fully participated at all times demonstrating a high level of respect for the NMC and the panel.*

61. *The registrant gave his evidence in a straightforward way even though the panel found against him on a number of points. The panel will no doubt make some allowances for the inherent stress of giving evidence and consider the registrant's written and oral evidence as a whole.*

<u>The registrant's character</u>

62. *Mr Carroll has never been subject to any other regulatory or disciplinary action. That goes directly to the risk of repetition.*

63. *The registrant has also provided you with a number of testimonials in the impairment bundle. It is not proposed to rehash same here. However, it will be observed that of the references provided all come from professional colleagues who are well placed to comment on the skills and experience of the registrant. Those commenting are in a good position to comment on the*

registrant's current behaviour and character. They are also well aware of the nature of the concerns raised about the registrant.

64. *The referees praise the registrant's skills and experience. They talk of the positive experience they have had with him and note how the registrant has behaved towards colleagues. The registrant clearly inspires confidence in his colleagues.*

65. *His current employer has been working extensively with the registrant in meetings. They have provided a detailed reference which is very positive about their experience of the registrant.*

66. *Even in his former workplace there was a mixed picture of the registrant as many colleagues clearly had no concern about his behaviour.*

Summary

67. *For all the reasons given above it is respectfully suggested that a finding of current impairment on the private component is not necessary in this case.*

Public Component

Public confidence/Need to uphold and declare standards

68. *The panel need to consider whether the public component of impairment is engaged by the admitted facts. You will have to address the question of whether given the nature of the allegation and the facts found proved, would public confidence in the profession be undermined if there were to be no finding of impairment?*

69. *Regard should be had to what has been said earlier about "seriousness" and the need to maintain public confidence.*

70. *It is not accepted that this is a case in which the concerns are serious and therefore a finding of impairment is likely to be necessary on public confidence grounds. Whilst there are some findings of bullying it is submitted that these are one off incidents with particular individuals but there is no course of conduct or suggestion of any individual being targeted. The registrant's behaviours were obviously inappropriate and misguided. It is submitted that, for the reasons set out above, these concerns which can, and indeed have, been remediated to the extent that they can by virtue of the insight, remorse and reflection which has taken place.*

71. *Any finding of misconduct is itself a powerful message to the registrant, the profession and the public.*

The registrant's future

72. *Finally, the registrant's circumstances continue to evolve in a positive way. He is keen to move on with his career and learn from the very difficult and salutary experience which he has been through.*

73. *The registrant contends that a finding of impairment is not necessary.*

74. *If it was considered necessary to make a finding of impairment, it is submitted that the panel could properly conclude that this is only required on public confidence grounds. It is therefore submitted that the events giving rise to the matters found proved are not matters which should ground a finding of current impairment on the personal component.*

75. *A summary of the factors which point away from a finding of impairment on the personal component are as follows:*

- *The registrant's engagement in the proceedings and with his regulator;*
- *The registrant's skills and experience;*
- *His otherwise unblemished career to date;*

- *The time lapse since the incidents (even allowing for the fact that the registrant has worked in any alternative healthcare setting);*
- *The concerns have been remedied to the extent that they can;*
- *The high degree of insight displayed by the registrant;*
- *The high regard in which the registrant is held by his colleagues;*
- *The risk of repetition is so low as to be negligible;*
- *The extensive training undertaken;*
- *The registrant has the clear confidence and support of his employer.*

Conclusion

76. *It is matter for the judgment of the panel as to whether there is misconduct in respect of charges proved. It is contended that whilst some of the failings identified may indeed amount to misconduct, they do not reach the high bar for serious misconduct and therefore the case should be stopped at that stage.*

77. *It is further submitted that, if the panel are to find current impairment, this should be on the public component only. In view of what has been said above there is no need for a finding of current impairment on the personal component.'*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

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

***1.1** treat people with kindness, respect and compassion*

***1.5** respect and uphold people’s human rights*

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*

***9.4** support students’ and colleagues’ learning to help them develop their professional competence and confidence*

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

__20.8__ 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.

With respect to charge 1, the panel took into consideration that you believed that in restricting Patient A, you were acting in his own personal interest and in the interest of others in preventing cross-contamination that may have been caused, should Patient A not have attended to his personal care. Nevertheless, the panel considered your conduct to be unacceptable and that it fell short of the standard of nursing care expected from a registered nurse. It was of the view that your conduct, in restricting Patient A, was not a reasonable response as you ought to have complied with the Trust's Policy for Facilitating Informal Patients Leave as well as the Mental Health Act Code of Practice – Blanket Rules, by utilising appropriate methods to ensure Patient A attended to his personal care.

The panel took into account that at the time of the incidents, Patient A had mental capacity and such restrictions were neither agreed with him nor documented in his care plan. It noted that such restrictions were not isolated incidents as it occurred over a period of time. The panel was of the view that as a result of your actions in charge 1, you failed to respect and uphold the dignity of Patient A by depriving him of his fundamental human right to liberty. This was also in contravention to section 1.5 of the Code. The panel therefore found that your conduct in charge 1, to be sufficiently serious

and amounted to a breach of fundamental aspects of professional conduct and behaviour. Accordingly, it determined that your conduct in charge 1 amounts to misconduct.

With regards to charge 2, the panel took into account that at the time of the transfer, you were tense and on edge, having recently had to deal with a very challenging and aggressive patient. It also considered that although Witness 5 was aggrieved, he did not consider making a complaint, indeed the incident was only investigated because of your complaint against Witness 5.

However, the panel considered your actions in the context of your general behaviour towards your colleagues, particularly with respect to transfer of patients at the Hospital, and in the context of its findings in charge 13a. It was of the view that your behaviour towards Witness 5 was unprofessional and unwarranted, even after having had to deal with a very difficult patient. The panel noted that your conduct in this charge was consistent with a pattern of behaviour towards your colleagues in which you used threats to intimidate your colleagues to achieve your aims. Witness 5, in his local interview dated 16 August 2019, stated:

> *'I did feel intimidated and threatened'….'Declan is intimidating on a regular basis and forces himself upon people. What stood out is he was bullying me to make a decision which was not safe. When he said he was coming over, he made me feel intimidated and staff who did the handover felt the same, so it was not just me who felt like that. I was shocked when I came in the following day to find he had written an email about me. Since then, I have avoided Cove. This is as a result of what happened.'*

The panel therefore found that your conduct in charge 2, to be sufficiently serious and amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, the panel determined that your conduct in charge 2 amounts to misconduct.

The panel then considered charge 3. It took into consideration the surrounding circumstances and the context of the incident. It noted your reason for your conduct that Witness 4 was not trained as a mentor and was yet to pass his preceptorship, therefore, you considered that as an experienced nurse yourself, and Student Nurse 1's mentor, you were in the best position to guide her and answer her questions.

The panel was of the view that it had found that your conduct undermined Student Nurse 1's professional development and was embarrassing to Witness 4. The panel was therefore satisfied that such isolated incident was not sufficiently serious on its own to amount to misconduct. Accordingly, it determined that your actions in charge 3 does not amount to misconduct.

In relation to charge 5, the panel had regard to the NMC Guidance on Bullying FTP 3 which states *'It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone.'* The panel also took into account the Trust's anti bullying policy which states '*examples of bullying can include: humiliating someone in front of others; ridiculing or demeaning someone.'*

The panel was of the view that although this was an isolated incident, your conduct (as found proved in relation to charges 13a and 13c) amounted to bullying as Student Nurse 1 felt humiliated and undermined in the presence of others. It noted that the incident had a negative impact on Student Nurse 1's confidence and therefore undermined her professional development. This was also in contravention to section 9.4 of the Code. The panel considered your conduct to be wholly unacceptable and that it amounted to a breach of fundamental aspects of professional conduct and behaviour.

Accordingly, the panel determined that your conduct in charge 5 amounts to misconduct.

With respect to charge 7, the panel had regard to the NMC Guidance on Bullying FTP 3 which states *'It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone.'* The panel also took into account the

Trust’s anti bullying policy which states ‘*examples of bullying can include: humiliating someone in front of others; ridiculing or demeaning someone.’*

The panel was of the view that your conduct towards Witness 6 was unprofessional and unwarranted in a work setting as there were more appropriate methods to persuade Witness 6 to leave the chair. It noted that your conduct (as found proved in relation to charge 13a) was humiliating to Witness 6 and amounted to bullying, and (as found proved in relation to charge 13b) she felt embarrassed. She stated in her witness statement dated 2 September 2021 that:

> *‘He made out that it was a joke but I got up and sat somewhere else to avoid further embarrassment. This incident took me back to when I was newly qualified and the control and power was still evident in him.’*
>
> *‘I was so upset I reported the incident to one of the Clinical Team Leaders…’*

The panel further noted that the extent of humiliation and embarrassment on Witness 6 was apparent during her oral evidence. The panel determined that your behaviour was sufficiently serious and amounted to bullying. It therefore found that your conduct in charge 7 amounts to misconduct.

With regards to charge 11, the panel considered your conduct towards Witness 1 in the context of your general behaviour towards your colleagues, particularly with respect to transfer of patients at the Hospital, and in the context of its findings in charge 13a. It noted that your conduct was consistent with a pattern of behaviour towards your colleagues in which you used threats to intimidate your colleagues to achieve your aims. The panel noted that your conduct was intimidating towards Witness 1. In his witness statement dated 11 September 2022, he stated:

> *‘He said in an intimidating manner that he would put in a complaint, this confused me, it didn't make sense to me what he could complain about. I stated that he was intimidating as I felt that maybe by him saying that he was hoping that I would back down and reconsider but I didn't’.*

The panel therefore found that your conduct in charge 11, to be sufficiently serious and amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. Accordingly, it determined that your conduct in charge 11 amounts to misconduct.

In relation to charge 12, the panel noted that it was your responsibility as Student Nurse 1's mentor to support her learning to help her to develop her professional competence and confidence. However, the panel had found that your actions in charges 3 and 5 had failed to support and also undermined Student Nurse 1's professional development. These were in contraventions to sections 9.4 and 20.8 of the Code. The panel noted that your lack of support to Student Nurse 1 (as found proved in charges 3 and 5) had a negative impact on her. Student Nurse 1, in her local interview stated that:

> *'It was a lot of pressure and very overwhelming. The stress was too much. Looking back I felt bullied. I wasn't sleeping because of the pressure he was putting me under…'*

The panel therefore found your actions in charge 12 to be sufficiently serious and it amounts to misconduct.

The panel then considered charge 13. It had regard to the NMC Guidance on Bullying FTP 3 and the Trust's anti bullying policy. The panel bore in mind that health professionals are entitled to work in an environment free from bullying and intimidation in order to discharge their obligations effectively to the public. It noted that the presence of bullying and intimidation in a work environment could have a negative impact on the confidence and performance levels of health professionals.

The panel noted that your conduct towards your colleagues was humiliating, embarrassing and caused serious concern to them. It determined that, as a result of your conduct, you failed to respect and uphold the dignity of your colleagues at the Hospital. The panel therefore considered your actions to be extremely serious and unprofessional, and that they would be seen as deplorable by other members of the

profession and members of the public. Accordingly, it found your actions in charge 13 to amount to misconduct.

Consequently, having considered the charges individually and as a whole, the panel determined that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

Registered 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 registered nurses with their lives and the lives of their loved ones. To justify that trust, registered 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) *….'*

The panel found that limbs b and c of the *Grant* test were engaged in the past. The panel determined that your conduct towards your colleagues constituted a serious breach of the fundamental tenets of the nursing profession as you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the profession into disrepute. However, it considered that limb a of the *Grant* test is not engaged in this case as your conduct did not place Patient A at unwarranted risk of harm.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

'*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel is aware that this is a forward-looking exercise and, accordingly, it went on to consider whether your misconduct is remediable and whether you had strengthened your nursing practice.

The panel had regard to the case of *Cohen v GMC,* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

The panel considered whether your conduct found in the charges proved is easily remediable. The NMC Guidance (such as FTP-3a, FTP-3b and FTP-3c) refers to cases where a registrant is found to have deep-seated attitudinal issues and that these are more difficult to remediate. The panel did not consider that your conduct in the charges found proved, indicates this. Rather, the panel considered that you crossed boundaries due to a lack of self-awareness about which the panel has then been given reassurance. You have provided evidence of your insight and strengthening of your practice.

Regarding insight, the panel was of the view that you have shown considerable insight into your actions. It took account of your reflective statement dated 16 January 2024. It noted that you provided context into the personal circumstances that may had led to your conduct towards your colleagues and Patient A. You have also shown remorse and apologised for your conduct. The panel took into account that you have demonstrated insight on the seriousness of your conduct and its impact on Patient A, your colleagues, the nursing profession and the wider public. In particular, the panel noted that in your reflection dated 16 January 2024, you stated:

> *'I acknowledge the factual findings against me. I am saddened by them, in particular the findings of bullying, dismissive and / or intimidating behaviour. I am sorry about my behaviour and the impact this has had on my former colleagues.*

I understand that if a member of the public, or a fellow professional read these findings, then they would have concerns about my behaviour towards my colleagues when these allegations took place. I accept that they would expect that a registrant should not behave like this and should undertake further training and remediation as a result of facing these allegations.'

You have also set out how you would act differently if a similar situation should occur in the future or to prevent such a situation from re-occurring.

In considering whether you have strengthened your nursing practice, the panel took account of the various training courses that you had completed in the relevant areas of concern. It noted that you had been practising in a non-nursing care role since the incident occurred, with no further concerns raised. In this regard, it had sight of the various positive references made on your behalf.

Consequently, the panel was of the view that you had made considerable progress in strengthening your nursing practice and that there is a low risk of repetition in this case. In light of this, this panel determined that you do not pose a risk of harm to the public and that a finding of impairment is not necessary on the ground of public protection.

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

The panel had regard to the NMC Guidance on Impairment, DMA-1, which states:

'In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training.

However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.'

The panel had regard to the serious nature of your misconduct and determined that public confidence in the profession, particularly as it involved bullying and intimidating behaviour towards your colleagues, would be undermined if a finding of impairment were not made in this case. It was of the view that a well-informed member of the public, aware of the misconduct in this case, would be very concerned if you were permitted to practise as a registered nurse without restrictions. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Khaile submitted that, given the panel's findings of serious misconduct and impairment as well as the severity of the charges found proved, it is the NMC's position that the appropriate sanction in this case is a striking-off order.

Ms Khaile referred the panel to the *NMC Guidance on Available sanction orders* (SAN-3) and submitted that the proper approach is to consider the full range of sanctions, starting with the least restrictive.

With respect to taking no action and a caution order, Ms Khaile highlighted that the SG states that taking no action will be rare at the sanction stage. She submitted that given the seriousness of the misconduct in this case, taking no action or a caution order would not be appropriate in this case.

Ms Khaile submitted that a conditions of practice order would not be appropriate or proportionate in this case, given the severity of the charges and the public interest. She submitted that an examination of the charges found proved, particularly charge 13 which involved the bullying of colleagues and charge 1 which involved the restriction of Patient A's leave, raises a fundamental question about your professionalism. There were still considerable attitudinal concerns as despite some insight, it was still unclear at this stage whether you fully acknowledge your misconduct and have taken accountability.

With regards to a suspension order, Ms Khaile highlighted that the concerns are so serious as you created and contributed to a dangerous work environment which negatively affected the careers of colleagues and a student nurse. You also deprived an informal patient from his basic right to leave the Ward. She submitted that your responses indicated that you fundamentally misunderstood the seriousness of your actions and the charges found proved. This demonstrates that there are serious attitudinal concerns in this case which are incompatible with continued registration as a nurse. Ms Khaile therefore submitted that a suspension order is not appropriate or proportionate in this regard.

Ms Khaile submitted that the only proportionate and appropriate sanction in this particular case is a striking-off order. She referred the panel to the key factors to be considered in imposing a striking-off order as provided by the SG in the following:

- *‘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 Khaile submitted that your conduct in cultivating a work environment or workplace rife with bullying, belittling and harassment, which made colleagues wish to avoid you, clearly raises concerns and questions about your professionalism. She submitted that the charges found proved suggests serious, harmful and deep-seated attitudinal concerns, which at present mean it is still unclear whether you fully understand them and whether looking forward, they will not be repeated.

In conclusion, Ms Khaile invited the panel to impose a striking-off order as the only appropriate and proportionate sanction in this case.

Mr Hamill first addressed the panel in response to the submissions made by Ms Khaile. In relation to the NMC’s position that a striking off order is the appropriate sanction, Mr Hamill submitted that such an order would be totally disproportionate and not appropriate in the circumstances of this case. He highlighted that the submissions made by Ms Khaile that there are serious attitudinal concerns in this case and there was a risk of repetition, were not in accordance with the panel’s earlier findings on impairment. Mr Hamill therefore submitted that the position of the NMC’s that a striking off order is the appropriate order was built on flimsy foundations.

Mr Hamill stated that in making its decision on sanction, the panel should consider all the materials before it as well as its earlier findings on impairment. He also referred the panel to the principles laid out in the SG. He submitted that most of the potential aggravating factors that are identified in the SG, are not present in this case. Mr Hamill however accepted that the panel may consider that there was a pattern of misconduct over a period of time and that this could be an aggravating factor in this case.

With respect to mitigating factors, Mr Hamill submitted that all of the mitigating factors listed in the SG are present in this case. He submitted that the panel had found that you had apologised and shown remorse for your conduct and that you had demonstrated considerable insight into the seriousness and impact of your conduct on your colleagues, the nursing profession and the public. You have also set out how you would act differently if a similar situation should occur in the future or to prevent such a situation from re-occurring.

Mr Hamill submitted that there was also evidence that you had followed the principles of good practice as you had completed training courses in the areas of concerns and there were various positive references made on your behalf. He highlighted that the panel had also found that you had made considerable progress in strengthening your nursing practice.

Mr Hamill further highlighted that the panel in its findings on impairment, also took account of your personal circumstances at the time of the incidents, which it found to be relevant context for your conduct at that time. He asserted that your personal circumstances amount to relevant personal mitigation in this regard.

Mr Hamill submitted that the fact that you have been subject to an interim order is a relevant factor to be considered by the panel in terms of the nature of the sanction to be imposed and the length of such sanction. He submitted that you have been subject to an interim conditions of practice order which has been akin to a suspension on your part as you have not been able to secure clinical work under such interim order although you are currently working in a healthcare role.

Mr Hamill asserted that you have complied with the terms of the interim order and there was no suggestion of any breach in this case. This should provide reassurance to the panel about your attitude to the NMC proceedings. He reiterated that the interim order is relevant to the question of sanction because you have been subject to an interim conditions of practice order for approximately four years at this stage. He submitted that while it is not usually appropriate to approach a case on the basis of the length of time served under an interim order, it is nonetheless relevant to the length of any sanction

that the panel would consider imposing. He highlighted that the SG suggests that the panel could have regard to the length spent under an interim order in considering the sanction to be imposed. Mr Hamill therefore invited the panel to impose a much shorter sanction than it might otherwise have done on the basis of the time you had already served under an interim order.

Mr Hamill stated that another factor that the SG suggests to be considered by the panel is the registrant's past fitness to practise history. In this regard, he submitted that you are person of good character with no previous fitness to practise history. He highlighted that there was no finding of deep-seated attitudinal concerns in this case and the panel had specifically found that you crossed boundaries due to a lack of self-awareness about which it had been given reassurance. Mr Hamill emphasised that such finding was particularly significant at this stage in terms of the sanction to be imposed by the panel.

Mr Hamill highlighted that although the NMC Guidance on Considering Sanctions for Serious Cases SAN-2 categorises bullying as a serious case and that the panel could consider insight, remorse and strengthened practice made at an early stage. In this case, the panel had found that you had demonstrated insight, remorse and strengthened practice, albeit not at an early stage. He submitted that the fact that those elements were not present from an early stage, should not be used to punish you nor should you be punished for defending the allegations made against you as you were entitled under the law to do so. This should not be the basis for criticism or for more severe sanctions to be imposed on you.

Mr Hamill then went on to address the panel on the appropriate sanction to be imposed. He submitted that taking no further action is a rare decision and it was accepted that the panel may not consider it as appropriate in this case albeit it was a matter entirely at the panel's judgement.

With respect to a caution order, Mr Hamill submitted that the criteria provided in the SG has been met in this case. He highlighted that the panel had found that there was no risk to patients' safety and there was a low risk of repetition in this case. He submitted

that a caution order would therefore be more appropriate in this case in order to mark the unacceptable nature of your behaviour and that it should not be repeated. Such order could run for a period of one to five years.

Mr Hamill submitted that it was accepted that a conditions of practice order may not be appropriate, given that such order is usually geared towards addressing clinical issues, although not exclusively so. He submitted that it could be gleaned from the panel's findings that the concerns in this case had been addressed through your insight and strengthened practice. Mr Hamill highlighted that the criteria for the imposition of a conditions of practice order as provided by the SG, has been met in this case and the panel could, in its own judgement, devise conditions which could address the public confidence issues which arise from its findings.

Mr Hamill submitted that a suspension order would be entirely disproportionate given the findings that the panel had made in this case. He asserted that while it is accepted that the concerns are serious, the findings of the panel on impairment demonstrates that the misconduct was not so serious that it could require a temporary removal from the register. Mr Hamill submitted that a suspension order would be unduly punitive and it would be going too far in terms of protecting the public.

With regards to a striking-off order, Mr Hamill submitted that this is not a case of fundamental incompatibility, particularly given the very important finding that the panel had made about attitudinal issues. He asserted that public confidence could be maintained with a less severe sanction than a striking-off and such sanction is not appropriate in the particular circumstances of this case. Mr Hamill referred the panel to the case of *Giele v GMC* [2005] EWHC 2143 in which Mr Justice Collins stated in paragraph 29 that:

> *'I do not doubt that the maintenance of public confidence in the profession must outweigh the interests of the individual doctor, but that confidence will surely be maintained by imposing such a sanction as is, in all the circumstances, appropriate. Thus, in considering the maintenance of confidence, the existence* of *a public interest in not ending the career of a competent doctor will play a part.*

Furthermore, the fact that many patients and colleagues have in the knowledge of the misconduct found, clearly indicated their views that erasure was not needed, is a matter which can carry some weight in deciding how confidence can be can properly be maintained.'

Mr Hamill submitted that the case of *Giele* clearly demonstrates that in terms of assessing the public interest, there is a public interest in maintaining a very skilled experienced and capable practitioner on the register. He therefore submitted that a striking-off order would be disproportionate in this case.

In conclusion, Mr Hamill invited the panel to impose a caution order of up to five years, which would mark the seriousness of your misconduct and send out a powerful message to the nursing profession and the general public. He submitted that if the panel should consider that a more severe sanction is required, a suspension order for a short period of three months would be more appropriate given the findings of the panel on impairment.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of serious misconduct over a period of time.

The panel also took into account the following mitigating features:

- Evidence of considerable insight and remorse into your misconduct.

- Evidence of steps taken to remediate the concerns through a reflective statement and various training courses in the areas of concern.
- Various positive references on your behalf.
- Difficult personal circumstances at the time of the incidents.
- No further concerns raised about your nursing practice since the incidents.
- Evidence that you have kept up to date with your practice since the incidents.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel had regard to 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 panel wishes to mark that the behaviour was unacceptable and must not happen again.'* It also carefully considered the submissions of Mr Hamill with respect to the imposition of a caution order in this case.

The panel noted that the nature of your misconduct relates to bullying and intimidation of your colleagues and in its findings, it had considered your conduct to be extremely serious and unprofessional, and that they would be seen as deplorable by other members of the profession and the public. The panel had also found that a well-informed member of the public, aware of the misconduct in this case, would be very concerned if you were permitted to practise as a registered nurse without restriction.

In light of its findings in this case on misconduct and impairment, the panel determined that due to the serious nature of your misconduct, and the public interest considerations identified, an order that does not restrict your nursing practice would not be appropriate in the circumstances of this case. The panel was of the view that your misconduct was not at the lower end of the spectrum of impaired fitness to practise. It therefore concluded that it would be neither proportionate nor in the public interest to impose a caution order.

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

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *no evidence of harmful deep-seated personality or attitudinal problems;*
> - *identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
> - *no evidence of general incompetence;*
> - *potential and willingness to respond positively to retraining;*
> - *……..;*
> - *patients will not be put in danger either directly or indirectly as a result of the conditions;*
> - *the conditions will protect patients during the period they are in force; and*
> - *conditions can be created that can be monitored and assessed.'*

The panel was of the view that the misconduct identified in this case could not be addressed through retraining. It noted that you had been practising in a non-nursing care role since the incident occurred, with no further concerns raised. Whilst there are a number of factors set out in the SG above that applies to your case, the panel determined that no useful purpose would be served by a conditions of practice order and there are no practical or workable conditions that could be formulated, to address the concerns in this case. It concluded that a conditions of practice order would not adequately address the seriousness of this case nor satisfy the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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 found that your actions amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It considers bullying and intimidation in the workplace as serious abhorrent conduct which could have a negative impact on the confidence and performance levels of health professionals. It bore in mind that the work environment in which health professionals operates, should be safe and free from bullying and intimidating behaviours. The panel considered that your misconduct was a serious breach of the fundamental tenets of the nursing profession which brought the nursing profession into disrepute.

The panel recognised that your misconduct was not limited to a single instance, however, the panel noted that you had demonstrated considerable insight into the seriousness and impact of your misconduct. You had also taken sufficient steps to strengthen your nursing practice and there was no evidence of repetition of behaviour since the incident. The panel had found that there was no evidence of harmful deep-seated personality or attitudinal problems and there was a low risk of repetition in this case. Consequently, the panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel carefully considered the submissions of Ms Khaile in relation to the imposition of a striking-off order in this case. However, in taking account of all the evidence before it including your considerable insight and steps taken to strengthen your nursing practice, the panel concluded that such an order would be disproportionate. Whilst the panel acknowledges that a suspension order may have a

punitive effect, it would be unduly punitive in this case to impose a striking-off order. It was of the view that a striking-off order could deprive the public of a registered nurse who had taken sufficient steps to strengthen their nursing practice and have demonstrated evidence of good practice. This would not serve the public interest considerations in this case.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction. It was satisfied that a suspension order for a period of six months would satisfy the public interest in this case. It decided that this order is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the profession, and to send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse.

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

In accordance with Article 29 (8a) of the Order, the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary. It bore in mind that it determined there were no public protection concerns identified in this case and that your fitness to practise is solely impaired on the grounds of public interest. In light of this, the panel therefore decided that a review of this order is not required. Accordingly, the suspension order will expire, without review, at the end of its six-month period.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Khaile. She highlighted that you are currently subject to an interim conditions of practice order and she invited the panel to impose an interim conditions of practice order for a period of 18 months with the same conditions as previously except the previous condition four which would no longer be applicable as it was made pending the conclusion of these proceedings. Ms Khaile submitted that the interim conditions of practice order is otherwise in the public interest, to cover the 28-day appeal period.

Ms Khaile suggested the following conditions:

1. "*You must not work in a managerial capacity.*

2. *You must ensure that you are supervised any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by a registered nurse.*

3. *You must meet with your line manager, mentor or supervisor at least once a month to discuss your performance in relation to:*
    - *Communication skills, verbal and non-verbal*
    - *Person centred approach to care*

4. *You must keep the NMC informed about anywhere you are working by:*

    a. *Telling your case officer within seven days of accepting or leaving any employment.*
    b. *Giving your case officer your employer's contact details.*

5. *You must keep the NMC informed about anywhere you are studying by:*

a. Telling your case officer within seven days of accepting any course of study.
b. Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
a. Any organisation or person you work for.
b. Any agency you apply to or are registered with for work.
c. Any employers you apply to for work (at the time of application).
d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e. Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

7. You must tell your case officer, within seven days of your becoming aware of:
a. Any clinical incident you are involved in.
b. Any investigation started against you.
c. Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
a. Any current or future employer.
b. Any educational establishment."

The panel also took into account the submissions made by Mr Hamill. He submitted that given the panel's findings that your fitness to practise is solely impaired on public interest grounds, an interim order is not necessary during the 28-day appeal period as there are no public protection concerns in this case. He submitted that if the panel should consider that an interim order is necessary, an interim conditions of practice order with the same conditions that you were subject to, should be imposed to cover the 28-day appeal period.

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

Decision and reasons on interim order

The panel was satisfied that an interim order 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 noted that it had considered whether to impose a conditions of practice order at the sanction stage and found that there are no practical or workable conditions that could be formulated to adequately address the seriousness of this case nor satisfy the public interest. Therefore, 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 on public interest grounds, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

The panel considered the advice of the legal assessor and the submissions of the parties with respect to the decision made in the case of *Aga v General Dental Council* [2023] EWHC 3208 (Admin). However, the panel was of the view that it was not necessary to consider the case in reaching its decision.

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

That concludes this determination.