Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 21 July 2025 – Friday, 25 July 2025
Monday, 28 July 2025 – Friday, 1 August 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Angela Vanessa Brown**
NMC PIN:	96Y0224E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (February 1999)
Relevant Location:	Westminster and Southwark
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Anne Considine (Registrant member) David Anderson (Lay member)
Legal Assessor:	Charlene Bernard
Hearings Coordinator:	Monsur Ali (21 July 2025) Emily Mae Christie (22 – 25 July 2025) Charis Benefo (28 July – 1 August 2025)
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Miss Brown:	Present and represented by Conell Loggenberg
Facts proved by admission:	Charges 1, 2 and 3
Facts proved:	Charges 4, 5 and 6
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, employed by HCA Healthcare Ltd:

1. On or around 20 August 2021, while working at the Lister Hospital, failed to administer Amoxicillin to Patient 1;

2. On 21 August 2021, while working at the Lister Hospital:

    a. failed to take blood from Patient 1 to monitor gentamicin levels;

    b. failed to administer paracetamol and/or ibuprofen to Patient 2;

    c. documented that paracetamol and/or ibuprofen had been administered, to Patient 2, when it had not.

3. On 28 August 2021, while working at London Bridge Hospital, failed to adequately prepare an intravenous saline drip for Patient 3 in that you added an unknown substance to it.

4. On one or more occasion outlined in **Schedule A**, you removed medication in excess of the amount to be administered to each patient, which you documented on the Omnicell system was removed to be administered to that patient.

5. Your actions in charge 4, above, were dishonest in that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not.

6. You stole any or all of the medication referred to in charge 4, above.

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

Schedule A:

No	Date	Drug	Excess medication quantity	Pt
1	1 December 2018	Dihydrocodeine 30mg	6 or more tablets	A
2	1 December 2018	Paracetamol 500mg	2 tablets	A
3	1 December 2018	Ibuprofen 400mg	1 or more tablets	B
4	18 December 2018	Paracetamol 500mg	2 tablets	C
5	19 December 2018	Paracetamol 500mg	2 tablets	C
6	8 February 2019	Paracetamol 500mg	1 tablet	D
7	8 February 2019	Paracetamol 500mg	2 tablets	E
8	27 November 2018	Paracetamol 500mg	2 tablets	F
9	12 December 2018	Dihydrocodeine 30mg	1 tablet	G
10	10 January 2019	Paracetamol 500mg	2 tablets	H
11	18 January 2019	Paracetamol 500mg	2 tablets	H
12	19 January 2019	Enoxaparin 40mg/0.4ml	1 pre-filled syringe	H
13	01 February 2019	Enoxaparin 20mg/0.2ml	1 or more pre-filled syringes	I
14	01 February 2019	Ibuprofen 200mg and/or Ibuprofen 20mg/1ml	2 tablets and/or 20ml solution	J
15	01 February 2019	Paracetamol 500mg	2 tablets	J
16	12 February 2019	Paracetamol 500mg	2 tablets	K
17	16 February 2019	Omeprazole 40mg	1 vial and/or 2 capsules	L
18	19 February 2019	Dihydrocodeine 30mg	2 tablets	M
19	19 February 2019	Paracetamol 500mg	2 tablets	N
20	19 February 2019	Codeine Phosphate 30mg	2 tablets	O
21	11 April 2019	Dihydrocodeine 30mg	1 tablet	P
22	11 April 2019	Sodium Chloride 0.9%	10 ml	P
23	29 September 2019	Dihydrocodeine 30mg	1 tablet	Q
24	18 April 2020	Paracetamol 500mg	2 tablets	R
25	18 April 2020	Dihydrocodeine 30mg	1 tablet	R
26	19 April 2020	Ciprofloxacin 250mg	2 tablets	S
27	17 February 2019	Paracetamol 500mg	2 tablets	U
28	13 July 2021	Paracetamol 500mg	2 oral tablets and/or 2 suppositories	V
29	1 October 2019	Dalteparin 5000u/0.2ml	3 pre-filled syringes	W
30	30 July 2021	Cyclizine	50mg/1 ml	X
31	20 August 2021	Dihydrocodeine 30mg	5 tablets	AA

Background

On 3 September 2021, the Nursing and Midwifery Council (NMC) received a referral from HCA Healthcare Ltd (HCA) about you. You had been working for HCA since 2013 as a Band 5 Bank Nurse.

The referral raised numerous concerns between 20 August 2021 and 28 August 2021 regarding incidents relating to poor medication practice and patient care at two HCA sites: Lister Hospital (Hospital A) and London Bridge Hospital (Hospital B). These alleged incidents included: a failure to administer prescribed medication; failure to take blood from a patient when it was required; failure to administer pain relief to a patient; adding a substance that was not prescribed into a patient's IV fluid; and removing medication in excess amounts when administering patient medication.

As a result of the allegations regarding improper medication administration practices, an investigation was initiated at Hospital B. Hospital B uses the Omnicell system to monitor and track the usage and administration of medications. During the course of the investigation into medication discrepancies, it was identified that you may have been removing medications without proper authorisation. Following its investigation, it was allegedly confirmed that you had been removing medication in excess of the amount to be administered and falsely recording this.

As a result of this, you were dismissed from HCA on 19 November 2021.

Decision and reasons on application to admit hearsay evidence of Mr 1

The panel heard an application made by Ms Da Costa, on behalf of the NMC, under Rule 31 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), to allow the hearsay testimony of Mr 1 into evidence.

Ms Da Costa referred the panel to the documented emails and phone calls to Mr 1 by the NMC. She told the panel that a final email and two phone calls were made to the witness the day before in an attempt to secure him as a witness; however, these have gone unanswered.

Ms Da Costa submitted that paragraphs 13 and 14 of Mr 1's witness statement and exhibit [Mr 1]/3 is highly relevant to charge 4. She submitted that as Mr 1 has chosen not to attend to give evidence, you would be unable to cross-examine him. However, Mr 1's evidence is not the sole or decisive evidence of charge 4, as the panel will hear from two other witnesses regarding this. Those two witnesses can be questioned to clarify any issues, and they also have knowledge of the procedures regarding medication. She submitted that Mr 1 is not the key witness to this charge and he only provides corroborative evidence, and this is not highly contentious.

Ms Da Costa referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). She submitted that the NMC took all reasonable steps to obtain Mr 1's attendance at this hearing, having issued a witness summons and paid for the tracking and tracing of him. Mr 1 has been reminded of his duty under the NMC Code, however, he has told the NMC that he is no longer in the country and does not wish to remain on the register. Ms Da Costa submitted that Mr 1 has chosen not to engage or assist with these proceedings.

In light of her submissions, Ms Da Costa invited the panel to grant her application and allow Mr 1's statement and exhibits into evidence as hearsay.

Mr Loggenberg opposed the application to adduce Mr 1's witness statement and exhibits into evidence as hearsay. He submitted that charge 4 is very serious and it is crucial that you have a reasonable and fair opportunity to test witness evidence. He submitted that whilst he appreciates the attempts made by the NMC to contact Mr 1, the fact that it has been unable to secure him as a witness should not be the sole grounds for admitting the evidence.

Mr Loggenberg submitted that there is a risk of prejudice to you should this evidence be admitted as the nature of charge 4 is very serious and is the type of charge that would see many registrants struck off the register. Mr Loggenberg accepted that Mr 1's evidence is not the sole evidence of charge 4, but Mr 1 is the only witness who would be able to give evidence in relation to the practical use of the system, having worked as a manager on the floor of the ward. He submitted that this evidence is critical to your

case, and admitting this evidence without the opportunity to cross examine Mr 1 would deprive you of clarifying this information. Furthermore, he submitted that without Mr 1 being cross-examined, the evidence of charge 4 would lead to a perception that the systems report is ultimate.

In response to a panel question, both Ms Da Costa and Mr Loggenberg accepted that there is no suggestion that Mr 1 has fabricated his evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave serious consideration to the application regarding Mr 1. It determined that Mr 1's evidence is relevant to charge 4 but not the sole or decisive evidence of it. The panel noted Mr Loggenberg's submission about the day-to-day practicalities of the Omnicell system; however, it considered that Mr 1's evidence is factual and relates only to the use of the system, not the daily practicalities.

In relation to the nature and extent of the challenge to Mr 1's evidence, the panel acknowledged your concerns regarding being unable to cross-examine Mr 1; however, it considered the evidence would not be prejudicial to your case as your challenge does not relate to the production of the report. Furthermore, the panel determined that any questions you do have regarding the practicalities of the system could be put to the two other witnesses. You also have the opportunity to produce evidence of the practical workings of Omnicell if you wish to.

The panel noted that you received prior notice of this application being made by the NMC. Furthermore, the panel was mindful that all of the charges are very serious and, if found proven, could have significant implications for you. It acknowledged that you would be losing the opportunity to cross-examine Mr 1, but the panel was of the view that this does not cause you any significant unfairness given the factual nature of Mr 1's evidence and the opportunity you have to cross-examine the other two witnesses that pertain to this charge.

The panel noted that there is no suggestion that Mr 1 has fabricated his evidence, particularly since he has provided a report and has not commented on or expressed an opinion about its contents. The panel determined that the NMC has taken reasonable steps to secure Mr 1's attendance, having made numerous attempts to contact him and even securing a witness summons to ensure his attendance. It considered that the reason for Mr 1's absence is unknown, aside from the fact that he is no longer in the country and has stated that he does not wish to remain on the NMC's register.

In all the circumstances, the panel determined that it would be fair to admit Mr 1's witness statement and exhibits into evidence as hearsay and would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

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

During witness evidence, Mr Loggenberg made a request that this case be held partly in private on the basis that proper exploration of your case involves [PRIVATE]. The application was made pursuant to Rule 19.

Ms Da Costa did not oppose this application.

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

The panel determined to go into private session in connection to [PRIVATE] as and when such issues are raised in order to protect [PRIVATE].

Decision and reasons on application to admit hearsay evidence of Ms 3

The panel heard an application made by Mr Loggenberg, on your behalf, under Rule 31 to allow the written statement of your witness, Ms 3 into evidence. He informed the

panel that whilst you had intended to call Ms 3 to attend the hearing as a live witness, he had not been able to secure contact with her.

Mr Loggenberg referred the panel to his email and WhatsApp correspondence with Ms 3, dated 15 August 2023 which related to her witness statement and the provision of an electronic signature. He submitted that Ms 3's evidence related to Omnicell and those charges which were disputed by you.

Mr Loggenberg submitted that it was known that [PRIVATE]. He submitted that Ms 3 had not provided a response to his attempts to contact her since the beginning of this hearing. Mr Loggenberg stated that he had sent Ms 3 WhatsApp messages, to which there was only "*one tick*", and had attempted to call her and left a voicemail message. He told the panel that you had also attempted to call Ms 3 to no avail.

Mr Loggenberg submitted that there was a real possibility that [PRIVATE], and he did not intend to keep attempting to contact her. He submitted that he had hoped Ms 3 would have contacted him over the weekend between days five and six of this hearing, but she did not. Mr Loggenberg confirmed that Ms 3's evidence was "*solely what [you] would have relied on*".

Ms Da Costa indicated that the NMC was relatively neutral on the application to admit Ms 3's witness statement into evidence. She referred to the factors set out in the case of *Thorneycroft v Nursing and Midwifery Council*.

Ms Da Costa submitted that previously, there had been good reason submitted for Ms 3's non-attendance, namely [PRIVATE]. She submitted, however, that in circumstances where you were unsure of the reason for Ms 3's non-attendance there was now no good reason for this. Ms Da Costa referred to the email correspondence between Mr Loggenberg and Ms 3 from 15 August 2023, and highlighted that her witness statement remained unsigned. She submitted that the NMC undertook a search of the register and an entry with Ms 3's name was identified. However, it was not clear to the NMC whether the entry and details on the register could be attributed to Ms 3 as her witness statement did not contain her NMC PIN.

Ms Da Costa submitted that it was a matter for the panel to decide whether to admit Ms 3's witness statement and determine what weight to attach to it. She clarified that there was some dispute to paragraph 20 of Ms 3's witness statement, but highlighted that the panel had heard evidence from the NMC witnesses and yourself in respect of that matter so it was not sole or decisive evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Ms 3 serious consideration. It noted that Ms 3's witness statement had been prepared in anticipation of being used in these proceedings, but had an incorrect spelling of Ms 3's surname typed at the end of it.

The panel considered the factors set out in the case of *Thorneycroft v NMC* in respect of the admission of hearsay evidence.

The panel considered that Ms 3's evidence was relevant to the charges relating to Omnicell, as well as your character and work. It was satisfied that Ms 3's evidence was not the sole or decisive evidence in respect of any of the charges. The panel had before it other relevant evidence, including the evidence of the NMC witnesses and your own evidence.

The panel had heard from Ms Da Costa that the NMC's position in respect of Ms 3's witness statement was neutral, with the exception of one paragraph which was in dispute. There was also no evidence before the panel to suggest that Ms 3 had reason to fabricate her evidence.

The panel considered that the charges in this case are serious. It noted that Ms 3's witness statement was unsigned and that her surname was incorrect, albeit this was likely to have been due to a typographical error.

The panel was not satisfied that there was a good and cogent reason for Ms 3's non-attendance at the hearing, given Mr Loggenberg's inability to secure contact with her. It considered that other than a supposition as to why Ms 3 had not been able to attend, the panel had not seen any documentary evidence to support it. The panel noted Mr Loggenberg's submission that since the beginning of the hearing, he had attempted to contact Ms 3 via WhatsApp and telephone, and it was not satisfied that adequate steps had been taken to secure Ms 3's attendance.

The panel considered that as a result of Ms 3's non-attendance, the panel and parties would be deprived of the opportunity of questioning and probing her evidence. However, the panel took into account that the NMC was neutral in respect of the application and that the majority of her evidence was not contentious. There was nothing before the panel to suggest that it would be unfair to either party to admit Ms 3's hearsay evidence. The panel was therefore of the view that there was a public interest in the issues being explored fully which supported the admission of Ms 3's unsigned evidence into the proceedings.

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

Decision and reasons on application to recall Witness 3

The panel heard an application made by Ms Da Costa to recall the NMC's witness, Witness 3, to give live evidence in the hearing, in light of matters which arose from your live evidence. Witness 3 had provided a signed witness statement which was read into the record, following your admission to charges 1, 2 and 3.

Ms Da Costa submitted that Witness 3's witness statement evidence was limited in relation to the charges you had admitted to. She submitted that during your live evidence, you indicated that you had disclosed issues with the Omnicell system to Witness 3 and that you had handed over discrepancy receipts to Witness 3, because she was in a senior position and the procedure was to hand the receipts to those in

senior positions. Ms Da Costa reminded the panel that you were asked a number of questions in live evidence and you were adamant that you had given the discrepancy receipts to Witness 3 at the time of the incidents.

Ms Da Costa informed the panel that in light of your evidence, she drafted questions on the specific matters of discrepancy receipts, whether there had been any discussion between you and Witness 3 about issues with Omnicell and whether you had given Witness 3 any discrepancy receipts. She submitted that these questions were then sent to Witness 3 and an addendum witness statement was written, only in respect of those specific matters.

Ms Da Costa submitted that you and Mr Loggenberg must have been aware of your case and that these matters would have been raised by you in evidence. She submitted that another NMC witness had been questioned on discrepancy receipts, but there was nothing to suggest that you intended to put the matter to Witness 3. Ms Da Costa submitted that in fairness, these matters ought to be put to Witness 3. She submitted that had the NMC been made aware that Witness 3 would be central to the issue of Omnicell and discrepancy receipts, she would have been called as a live witness and those points would have been put to her. However, the matter only arose on the afternoon of day five of the hearing during your live evidence.

Ms Da Costa submitted that the NMC Case Co-ordinator had worked to obtain an additional witness statement from Witness 3, and Witness 3 had indicated that she could make herself available to join the hearing.

Ms Da Costa submitted that it would be in the public interest and fair to both parties if Witness 3 were recalled to give evidence in the hearing. She submitted that it had become a central matter in relation to credibility, in particular your credibility. Ms Da Costa reminded the panel that this was a serious case, relating to the alleged theft of medication and dishonesty, with a sanction bid of a striking-off order. She submitted that the panel ought to allow Witness 3 to be recalled to address the matters you had raised.

Mr Loggenberg indicated that the application was opposed. He rejected Ms Da Costa's submission that you must have been aware that these matters would be raised in your evidence. Mr Loggenberg submitted that your evidence was that you could not remember everything that took place, however it appeared that over the course of your evidence, it might have sparked your memory. He accepted that all of the available evidence should be tested, taking into account the interests of justice and fairness.

The panel accepted the advice of the legal assessor.

The panel was satisfied that Witness 3's evidence in respect of discrepancy receipts, whether there had been any discussion between you and Witness 3 about issues with Omnicell and whether you had given Witness 3 any discrepancy receipts was relevant as these matters had been raised by you in evidence. The panel was of the view that this evidence should be tested.

The panel noted that Witness 3 was scheduled to join the hearing as a live witness before her initial witness statement evidence was agreed by the parties. It considered that Witness 3's initial witness statement evidence did not address the specific matters set out above, which had been raised in your live evidence. The panel took into account that Witness 3 would be available to join the hearing, give evidence on those matters and be cross-examined in this regard.

The panel was satisfied that it would be in the interests of justice and fair to both parties for Witness 3 to be recalled. It therefore acceded to the application.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Loggenberg, who informed the panel that you made full admissions to charges 1, 2 and 3.

The panel therefore found charges 1, 2 and 3 proved by way of your admissions.

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

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: Deputy Head of Pharmacy at Hospital B at the time, who conducted a review of the Omnicell reports during Hospital B's investigation.
- Witness 2: Matron at Hospital B at the time, who conducted the investigation at Hospital B.
- Witness 3: Ward Sister at Hospital B at the time of the concerns.

The panel also took account of the witness statement from the following witness on behalf of the NMC, which was admitted as hearsay evidence:

- Mr 1: Surgical Ward Manager at Hospital A.

The panel had regard to the witness statement from the following witness on behalf of the NMC, which was read into the record with the agreement of both parties:

- Ms 2: Senior Staff Nurse at Hospital B at the time of the concerns.

The panel also heard evidence from you under oath, and took into account the witness statement from the following witness on your behalf, which was admitted as hearsay evidence:

- Ms 3: Bank Nurse at HCA.

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

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

Charges 4, 5 and 6

In reaching a decision on each of the disputed charges, the panel was satisfied that the Omnicell system reports before it related to transactions made by you, and this included the entries for the medications set out in Schedule A, which you had accepted. It noted that the entries in Schedule A related to transactions within Omnicell which showed that medications had been removed in excess of the amount which had been prescribed for the named patients. There was nothing within the Omnicell reports to indicate that any of the medications set out in Schedule A had been returned through Omnicell or documented as destroyed.

The panel noted that none of the allegations preceding 2021 had been dealt with at the material time, and these matters only came to light after Witness 1 was asked to interrogate the Omnicell system in respect of your usage from 2018.

In relation to your training in the use of the Omnicell system, the panel considered that whilst you had indicated in evidence that you did not receive the same length of training

as Witness 2, you had accepted that you were competent in the use of Omnicell and you did not request any extra training prior to the investigation in 2021. There was also no suggestion from you that the entries set out in Schedule A were as a result of inadequate training.

[PRIVATE].

The panel determined that the Omnicell automated dispensing system was robust and reliable, and that the transactions in the Omnicell report, as set out in Schedule A, were not as a result of any glitches or computer errors. The panel heard your evidence that the Omnicell system was not the most reliable, that it must have glitched on the occasions where incorrect entries as per Schedule A were recorded, and that discrepancies were frequently generated. However, the panel considered Witness 1's evidence that the Omnicell system was reliable. Witness 1 stated that it was "*robust in terms of declaring what is done to it*" and there had been no evidence that there were significant issues with it. It had also heard from two other witnesses, including Witness 3 who used Omnicell within her role, that there were no issues with the system. The panel had no evidence before it to suggest that you had raised any issues with the Omnicell system throughout the period between December 2018 and August 2021. The panel therefore preferred the evidence of Witness 1, Witness 2 and Witness 3 over your evidence in this regard.

The panel also considered your evidence that whilst you were logged in to the Omnicell system, a drawer opened and another nurse could access medications from the system during your login period. However, you also told the panel in evidence that you were a conscientious and careful nurse, that you had always complied with Omnicell protocols and training, and that no other colleagues used your details to access the Omnicell system. Further, Witness 3, was clear in her evidence that it was very rare that there would be issues with other nurses accessing the Omnicell system whilst someone else was logged in.

The panel next considered the matter of discrepancy receipts, which was raised by you in oral evidence. It had heard from Witness 3 that discrepancy receipts were automatically generated for controlled drugs only. As none of the drugs outlined in

Schedule A were dealt with under the controlled drugs protocol, this did not apply to these entries. Witness 1 told the panel that any discrepancies raised on the Omnicell system would automatically flag to pharmacy who would investigate thereafter accordingly. Witness 1 also told the panel as Omnicell and the patient medication records were not interfaced or linked at this time, Omnicell would merely record a nurse removing the medications they had inputted into the system for removal.

Witness 1 explained that discrepancies were generated when the countback tally conducted by the nurse did not match the records of the medications contained within the Omnicell system. This generated an automatic flag to pharmacy. Witness 3 said that discrepancies would only occur in situations involving a countback or a miscount.

The panel next considered Mr Loggenberg's closing submissions that Witness 1 had made reference in his oral evidence to a report which showed that you had returned the medications set out in Schedule A, but this had not been provided by the NMC. The panel accepted Witness 1's evidence that he carried out a six-month review of the Omnicell reports during Hospital B's investigation, which included a number of other unrelated reports being generated. The panel was satisfied from Witness 1's evidence that those entries as contained within Schedule A, did not include any instances where medications were documented as destroyed or returned. Further, the panel noted that the return of the medications set out in Schedule A had not been raised by you or put forward as part of your defence during the local investigation.

The panel accepted that Witness 1's review of the Omnicell reports showed exactly what medications were taken by you, and there was no evidence to suggest that these medications had been returned or destroyed. Witness 1's evidence was that you had demonstrated competence in the usage of the Omnicell system. The panel found Witness 1's evidence credible and consistent in respect of the workings of the Omnicell system. In addition, his evidence was corroborated by the other NMC witnesses who were either in a managerial or Omnicell-user capacity.

Given the disputes within this case, the panel determined that it was necessary to consider the contemporaneous documentation, which included the local interviews and statements provided by you and the NMC witnesses, and compare it with the oral

evidence provided in this hearing. The panel considered that the NMC witnesses remained consistent in their evidence, as opposed to your account which had changed and was inconsistent.

Charge 4

That you, a registered nurse, employed by HCA Healthcare Ltd:

4. *On one or more occasion outlined in Schedule A, you removed medication in excess of the amount to be administered to each patient, which you documented on the Omnicell system was removed to be administered to that patient.*

Schedule A:

No	*Date*	*Drug*	*Excess medication quantity*	*Pt*
1	*1 December 2018*	*Dihydrocodeine 30mg*	*6 or more tablets*	*A*
2	*1 December 2018*	*Paracetamol 500mg*	*2 tablets*	*A*
3	*1 December 2018*	*Ibuprofen 400mg*	*1 or more tablets*	*B*
4	*18 December 2018*	*Paracetamol 500mg*	*2 tablets*	*C*
5	*19 December 2018*	*Paracetamol 500mg*	*2 tablets*	*C*
6	*8 February 2019*	*Paracetamol 500mg*	*1 tablet*	*D*
7	*8 February 2019*	*Paracetamol 500mg*	*2 tablets*	*E*
8	*27 November 2018*	*Paracetamol 500mg*	*2 tablets*	*F*
9	*12 December 2018*	*Dihydrocodeine 30mg*	*1 tablet*	*G*
10	*10 January 2019*	*Paracetamol 500mg*	*2 tablets*	*H*
11	*18 January 2019*	*Paracetamol 500mg*	*2 tablets*	*H*
12	*19 January 2019*	*Enoxaparin 40mg/0.4ml*	*1 pre-filled syringe*	*H*
13	*01 February 2019*	*Enoxaparin 20mg/0.2ml*	*1 or more pre-filled syringes*	*I*
14	*01 February 2019*	*Ibuprofen 200mg and/or Ibuprofen 20mg/1ml*	*2 tablets and/or 20ml solution*	*J*
15	*01 February 2019*	*Paracetamol 500mg*	*2 tablets*	*J*
16	*12 February 2019*	*Paracetamol 500mg*	*2 tablets*	*K*
17	*16 February 2019*	*Omeprazole 40mg*	*1 vial and/or 2 capsules*	*L*
18	*19 February 2019*	*Dihydrocodeine 30mg*	*2 tablets*	*M*
19	*19 February 2019*	*Paracetamol 500mg*	*2 tablets*	*N*
20	*19 February 2019*	*Codeine Phosphate 30mg*	*2 tablets*	*O*
21	*11 April 2019*	*Dihydrocodeine 30mg*	*1 tablet*	*P*
22	*11 April 2019*	*Sodium Chloride 0.9%*	*10 ml*	*P*
23	*29 September 2019*	*Dihydrocodeine 30mg*	*1 tablet*	*Q*
24	*18 April 2020*	*Paracetamol 500mg*	*2 tablets*	*R*
25	*18 April 2020*	*Dihydrocodeine 30mg*	*1 tablet*	*R*
26	*19 April 2020*	*Ciprofloxacin 250mg*	*2 tablets*	*S*

27	*17 February 2019*	*Paracetamol 500mg*	*2 tablets*	*U*
28	*13 July 2021*	*Paracetamol 500mg*	*2 oral tablets and/or 2 suppositories*	*V*
29	*1 October 2019*	*Dalteparin 5000u/0.2ml*	*3 pre-filled syringes*	*W*
30	*30 July 2021*	*Cyclizine*	*50mg/1 ml*	*X*
31	*20 August 2021*	*Dihydrocodeine 30mg*	*5 tablets*	*AA*

This charge is found proved.

In reaching this decision, the panel noted that Schedule A showed specific entries of unaccounted for medication, which had been removed at variance with or in excess of patient prescriptions, and which patient records did not indicate were administered to the patients. There was also no evidence that these medications had been destroyed or returned.

The panel took into account Witness 1's written statement dated 18 May 2023, where he set out a description of his findings from his review of the Omnicell system reports during Hospital B's investigation.

The panel also considered the Omnicell system reports and patient records in respect of each individual entry on Schedule A and was satisfied that there were key themes underlining the removal of medication:

- Medication that had been removed for patients who did not have a prescription for that medication;
- Medication that had been removed in excess of what was prescribed for patients, where the correct dosages were documented as administered and the outstanding doses were unaccounted for; and
- Medication that had been removed in two different formats, and only one of the two formats were documented as administered.

For example, the panel took into account the Omnicell system report which indicated that one dihydrocodeine 30mg tablet had been removed from the Omnicell system under your username for Patient G on 12 December 2018. This patient was not prescribed dihydrocodeine.

In addition, the Omnicell system report indicated that a total of eight dihydrocodeine 30mg tablets had been removed from the Omnicell system under your username for Patient A on 1 December 2018. However, Patient A's medication records indicated that Patient A's prescription was for either one or two tablets. The records indicated that one dosage was administered to Patient A and there was no documented account of where the outstanding six or seven tablets had gone.

The panel also considered that there appeared to be a theme that the majority of the medications that were removed in excess from the Omnicell system were pain relief medications.

The panel noted that during the local investigation, you did not offer any explanation for the errors that had been identified during three meetings with Witness 2 in September and November 2021, and you merely indicated that you could not recall what happened. However, in these proceedings, you stated in evidence that you had not removed any of the medications in excess amounts and that the medications you removed from the Omnicell were either subsequently administered, returned or destroyed. You indicated to the panel that errors may have been as a result in the Omnicell system. The panel found that the evidence you gave during the relatively contemporaneous local investigation was not consistent with the evidence presented to the panel in both written and oral evidence during this hearing. In addition, it had not been provided with any documentary evidence to support your suggestion that the excess medication was subsequently administered, returned or destroyed. The panel therefore preferred the evidence that had been placed before it by the NMC in support of this charge.

Having examined the entries in Schedule A in detail and found as above, the panel was satisfied that on one or more occasion outlined in Schedule A, you removed medication in excess of the amount to be administered to each patient, which you documented on the Omnicell system was removed to be administered to that patient. It therefore found charge 4 proved in its entirety.

Charge 5

That you, a registered nurse, employed by HCA Healthcare Ltd:

5. *Your actions in charge 4, above, were dishonest in that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not.*

This charge is found proved.

In reaching this decision, the panel took into account its findings at charge 4.

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

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

The panel first considered your state of mind as to the facts, i.e. whether in your actions at charge 4, you knew that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not. The panel considered that at the time, you were working as a registered nurse with around 16 years of experience, having worked at the same hospital and used the same Omnicell system on a regular basis. You had also told the panel in evidence that you were a careful, conscientious and "*pernickety*" nurse, who was capable in your role. In addition, the panel noted that that you had been trained and considered yourself competent in the

usage of Omnicell. It was of the view that you would have been very well aware of what you were doing by removing medication which was purported to be for the administration of named patients, but not subsequently administering it.

The panel considered that there were multiple instances of prescribed medications being removed in excess; medication that had not been prescribed to patients being removed in their names; and medication that had been removed in different formats, which had not been administered to patients. The panel considered whether there were any alternative explanations for what occurred. It took into account the other potential explanations raised by Mr Loggenberg in closing submissions, for example, that the medications might have been removed by others while the Omnicell system drawers were open under your login. However this was discounted by the panel due to lack of supporting evidence. The panel noted that these suggestions were not put forward by you in your oral or written evidence or in the local investigation. The panel also did not accept a possible explanation of poor record keeping, given the number and varied nature of instances at Schedule A.

In these circumstances, the panel determined that in respect of your actions at charge 4, you knew that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not.

The panel next considered whether, in the context of what you knew, your conduct was dishonest by the standards of ordinary decent people. In considering your evidence that you were a competent and capable nurse, and the fact that there was no other reason for the excess medication to be removed from the Omnicell system, the panel was of the view that an ordinary decent person would find that the excess removal of medication which was unaccounted for and the removal of medications that were not prescribed suggested premeditation and would be deemed dishonest.

The panel was satisfied that by the objective standards of ordinary decent people, your actions at charge 4 were dishonest in that you knew that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not. It determined that an ordinary decent person would expect a registered nurse to remove medications for patients only in the correct dosages, formats, and in line with

their prescriptions, and in the event of any excess medication being removed, that this would be accounted for.

The panel therefore determined that your actions at charge 4 were dishonest in that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not.

Charge 6

That you, a registered nurse, employed by HCA Healthcare Ltd:

6. You stole any or all of the medication referred to in charge 4, above.

This charge is found proved.

In reaching this decision, the panel took into account its findings at charges 4 and 5.

The panel noted the NMC's case that the excess medication you took had not been accounted for as administered, returned or destroyed.

The panel also noted your case that you did not remove any excess medication, and any medication you did remove was either administered, returned or destroyed. It considered its findings that this account was inconsistent with the account you had provided at the local investigation and in any event, it did not occur because there was no documentary evidence of the excess medication set out in Schedule A having been administered, returned or destroyed. Further, there was nothing before the panel to indicate that the missing medication had been located since. On this basis, the panel had found you to be an unreliable and inconsistent witness.

The panel had regard to its finding at charge 5 that you had taken the excess medication dishonestly. It determined that by removing the medication, not administering it to the named patients, and then omitting to document the administration, return or destruction of that medication, it was more likely than not that you assumed ownership of it.

The panel was satisfied that by selecting on the Omnicell system that you were removing a particular quantity of medication, and then proceeding to remove that exact amount, no discrepancies would have appeared on that system. The panel noted that the Omnicell system worked independently from patient prescriptions and records, and the two systems did not interact. It took into account that it was only during the local audit of the records, that the Omnicell reports were reconciled with patient records, and the numerous instances of excess medication having been removed by you was identified. The panel noted that had this audit not taken place, the medication count in the Omnicell would have otherwise tallied, so no discrepancies or issues would been raised or DATIX created. It was of the view that had you identified an issue with the Omnicell system, it would have been your responsibility to escalate it, but there was no evidence of any such issues.

In all the circumstances, the panel determined that you had obtained medications through dishonest acts. You did not either return, destroy or administer such medications when it was your responsibility to do so. In light of these acts, you had ownership of the medication which have never been found and therefore had permanently deprived the hospital of their legitimate usage. Hence, the panel concluded that it was more likely than not that you stole any or all of the medication referred to in Schedule A. It therefore found charge 6 proved.

Decision and reasons on application to adjourn the hearing

Before making submissions on misconduct and impairment, Mr Loggenberg made an application for the hearing to be adjourned and for the facts stage to be reopened. He submitted that you were very unhappy with the panel not having taken notice of what he had asked of it in closing submissions regarding obtaining the transcript of Witness 1's oral evidence and any further supporting evidence. Mr Loggenberg submitted that the panel had been advised to follow the NMC guidance on evidence (reference: DMA-6) to ensure it had the relevant evidence before it to make a decision on the facts. He submitted that he had asked the panel to check the transcripts and obtain the necessary information because it would make a significant difference to its findings.

Mr Loggenberg submitted that given the panel's findings on the facts, it would be grossly unfair to continue with the hearing. He submitted that the hearing ought to adjourn at this stage, in order for the relevant information to be obtained and the decision on facts revisited. Mr Loggenberg submitted that Witness 1 and the other NMC witnesses had stated in evidence that there were audit reports and DATIXES, and that this evidence was critical, necessary and relevant information for the panel to consider.

Mr Loggenberg submitted that the relevant documentary evidence to obtain was:

- The transcript of Witness 1's oral evidence;
- The report referred to by Witness 1 in oral evidence which, in Mr Loggenberg's submission, indicated that you had returned the excess medication;
- The DATIXES relating to you for the period between 2018 and 2021; and
- The audit reports carried out by staff at Hospital B.

Ms Da Costa indicated that the application to adjourn the hearing was opposed. In relation to the transcript and recording of the hearing, she reminded the panel of the information she had previously placed on the record that work had been undertaken to assist you and Mr Loggenberg in obtaining the recording of Witness 1's evidence. Ms Da Costa stated that she and the NMC senior lawyer, who having spoken to the hearings co-ordinator and two hearings managers, had informed Mr Loggenberg that the recording of the hearing would not be available within the last two days of the scheduled hearing, due to the recording system process. She submitted that it was not a case of the NMC simply refusing to assist the panel, Mr Loggenberg and you. Ms Da Costa explained to the panel that at the end of each hearing day, the recording system is closed, the recording from that day is uploaded to a cloud, and an external company produces the transcript over which the NMC has no control. Since the recording has already been uploaded to the cloud, there is a process for the request and production of the transcript from the external company, which takes some time.

Ms Da Costa submitted that the participants of this hearing had been taking notes of the evidence and this was what was being relied on. She submitted that her own notes

of the evidence were in line with the panel's with regard to Witness 1's evidence. Ms Da Costa reminded the panel that she had previously stated on the record that her note of Witness 1's evidence was not as Mr Loggenberg had put it in his closing submissions.

Ms Da Costa submitted that it was her understanding that Mr Loggenberg had been in communications with other individuals at the NMC in relation to this matter. She submitted that these issues, which had been addressed in Mr Loggenberg's closing submissions, were matters to be dealt with at an appeal. Ms Da Costa submitted that if Mr Loggenberg was unhappy with the panel's decisions, the proper course would be to appeal at the conclusion of the case. She submitted that the panel had heard and considered all of the evidence the NMC had relied on and produced a determination. She submitted that these were not matters that could be dealt with by this panel and so the hearing should proceed as listed.

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

In response to the legal assessor's advice, Mr Loggenberg referred the panel to the case of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin), where, in his submission, the NMC was told to obtain relevant information when it becomes known to them. He submitted that this panel had a duty to ensure that it obtained the evidence requested. Mr Loggenberg submitted that the information was now known; within your oral evidence you said that you had returned the medications, and the NMC witnesses stated in oral evidence that there were reports. He submitted that it would be grossly unfair to leave these matters to be dealt with by way of an appeal, as it would leave the door wide open for you to have a harsh decision made against you.

Mr Loggenberg referred the panel to the case of *Towaughantse v GMC* [2021] EWHC 681 (Admin) and submitted that it would not be procedurally fair for registrants to receive a harsh sanction for defending allegations made against them.

Ms Da Costa indicated that she agreed with the legal assessor's advice. She submitted that it was at the point when Mr Loggenberg said he heard Witness 1's evidence, that he should have raised the matter procedurally and made the application for the hearing

to be adjourned. Ms Da Costa highlighted that this was not raised or brought to the panel's attention until closing submissions at the facts stage. She submitted that in making closing submissions, Mr Loggenberg had indicated that the panel could make a decision on facts and that there was no further evidence to be given to the panel at that stage. Ms Da Costa submitted that any unhappiness or displeasure with the panel's determination would be a matter for the appeal court and not this panel.

Mr Loggenberg then referred the panel to the case of *S v Birmingham City Council & Others* [2024] EWFC 244 (B), in particular paragraphs 70 to 72. He submitted that there were significant matters that would materially impact on the panel's earlier finding. Mr Loggenberg submitted that in the case law, the court was willing to entertain the reopening of a case if there was genuine new information where a reopening was likely to make a significant difference.

The panel gave the application to adjourn the hearing and reopen the facts stage serious consideration. It considered whether such a course would be appropriate at this material time, given that a decision on the facts had already been made and handed down.

The panel considered Mr Loggenberg's submission that Witness 1 had stated in oral evidence that there existed a report showing that you had returned the excess medication. It noted that any such evidence would be contrary to the evidence that had been placed before the panel. Whilst the transcript of Witness 1's oral evidence was not before the panel at this stage, the panel had referred to its notes of his evidence and did not find any evidence of the report referred to by Mr Loggenberg. The panel also took into account that this challenge had not been raised at the time of Witness 1's evidence. The panel therefore did not accept Mr Loggenberg's challenge about Witness 1's evidence and his submission that a report in support of your case was in existence.

The panel next considered Mr Loggenberg's submission that the NMC witnesses had mentioned in oral evidence that they had completed audits and DATIXES. It took into account its previous decision that the concerns relating to the removal of excess medications were only discovered in 2021 as a result of Witness 1's audit investigation,

not at the time of the removal, hence no DATIXES would have been in existence. This evidence was already before the panel.

The panel took cognisance of the three cases outlined by Mr Loggenberg. It noted that:

- *PSA v NMC & Jozi* related to the duty on the panel to ask the NMC to obtain relevant evidence if it believes it exists.
- *S v Birmingham City Council & Others* related to the reopening of a case which had concluded in the event of procedural errors or new evidence having come to light.
- *Towaughantse v GMC* related to the right of a registrant to robustly defend their case and that doing so should not be held against them.

The panel determined that it had no concerns of any gaps in the evidence presented in this case that prevented it from properly performing its function. In addition, the panel considered that this hearing had not yet concluded. The panel noted that you had the right to defend the allegations and did not hold this against you. The panel had not yet reached any decisions on misconduct and impairment.

In the circumstances, the panel decided to refuse Mr Loggenberg's application. It determined that it would be inappropriate to grant an adjournment , and that any challenge to the decisions made during the facts stage would be best addressed through the appeals process at the conclusion of this hearing.

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 ability to practise kindly, safely and professionally.

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 Da Costa invited the panel to take the view that the facts found proved amount to misconduct. She submitted that this is a serious case involving the theft of multiple medications from your place of work which were intended for patients. Ms Da Costa submitted that your theft of medication was systematic and sophisticated enough in nature to deceive the Omnicell system, which was robust and intended to ensure that those administering medication were doing what they were supposed to, when they were supposed to be doing it. She submitted that your conduct at the charges found proved were at the very end of the threshold of seriousness.

Ms Da Costa submitted that in all of the charges found proved, your conduct was improper and fell far short of the conduct and standards expected of a registered nurse, in particular given your experience at the time of the incidents. She referred to the

specific parts of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code), which in her submission had been breached.

Ms Da Costa submitted that the public interest is highly engaged in this case. She submitted that your conduct diminished public confidence and trust in the nursing profession as a whole. Ms Da Costa submitted that your conduct in relation to the medication administration errors placed patients at risk of harm. She submitted that your conduct in respect of the theft of medications also placed multiple people at risk of harm, because you removed medications from patients who required it and the use of the stolen medications was not known.

Mr Loggenberg submitted that any regulatory concerns around a nurse's conduct or practice that are found proved are likely to amount to misconduct. He submitted that it was a matter for the panel to decide whether the charges found proved in this case amount to misconduct. Mr Loggenberg asked the panel to consider the unique set of circumstances of the charges in this case, in particular charges 4, 5 and 6.

Mr Loggenberg drew the panel's attention to the case of *Towaughantse v GMC* and submitted that it would not be fair for you to face the risk of enhanced sanctions as a result of a robust defence regarding dishonesty. He submitted that dishonesty could undermine trust and confidence in the profession. Mr Loggenberg submitted, however, that you are mindful about moving forward and that your actions at the charges found proved are unlikely to be repeated.

Submissions on impairment

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

Ms Da Costa referred the panel to the NMC guidance on impairment and invited it to consider the nature of the concerns and the public interest.

Ms Da Costa conceded that medication administration errors at charges 1, 2 and 3 could be remediated. She submitted that you had, in fact, provided a number of training certificates, character references and reflections in respect of those errors. Ms Da Costa submitted that it was a matter for the panel to decide whether you had sufficiently remediated those concerns.

Ms Da Costa submitted that your conduct at charges 4, 5 and 6 clearly indicated a deep-seated attitudinal issue. She highlighted that from 2018 to 2021, there was systematic removal of medications from the workplace, sophisticated enough to go unnoticed until the medication administration errors were identified. Ms Da Costa submitted that this attitudinal issue brought into question your professionalism, trustworthiness and ability to carry out your role kindly, safely and professionally.

Ms Da Costa referred to the case of *CHRE v NMC and Grant*, which endorsed Dame Janet Smith's "*test*", and submitted that all four limbs were engaged.

Ms Da Costa submitted that whilst the medication administration errors in this case were capable of being remediated, the attitudinal concerns would be at the forefront of the panel's consideration. She highlighted that your conduct at charges 4, 5 and 6 were repeated for some four years and only came to a stop when it was discovered by HCA. Ms Da Costa submitted that there had been no insight, and that there could be no remediation. She submitted that your trustworthiness had been called into question and so you presented a risk of harm to patients and the public. Ms Da Costa therefore invited the panel to make a finding of current impairment on public protection grounds.

Ms Da Costa submitted that the public interest was also highly engaged in this case. She submitted that nurses are required to uphold proper standards and maintain public confidence in the profession. Ms Da Costa submitted that nurses hold a position of privilege and trust in respect of medications and vulnerable patients. She submitted that given your behaviour in the charges found proved, public confidence in the profession would be diminished if a finding of current impairment were not made. Ms

Da Costa submitted that a member of the public would be alarmed and distressed to discover that a nurse had been stealing medication from her place of work for some four years.

Mr Loggenberg reminded the panel of your oral evidence that you have since been practising as nurse; managing and administering the same medications to patients under your care, with no issue. He also highlighted your training certificates in the area of medicines management, and submitted that you have reflected extensively on your practice in this area.

Mr Loggenberg submitted that your current employer does not use Omnicell as its electronic medication management system. He submitted, however, that you have gone on to watch videos on Omnicell to better inform yourself of the system, as a point of responsible continuous professional development. Mr Loggenberg submitted that it was not a statutory or regulatory requirement for all employers to have Omnicell in place, or for nurses to only work with Omnicell. Rather, it was a requirement for nurses to adhere to the code of conduct. Mr Loggenberg submitted that you have reflected extensively on this area of practice. He submitted you have also been working without supervision and there have been no concerns about your medication management practice.

Mr Loggenberg addressed the panel on trustworthiness and referred to the character references in respect of your current practice. He submitted that the NMC would like the panel to focus on the history of the incidents involving medication to conclude that there had been repetition. Mr Loggenberg submitted, however, that the panel ought to consider the subsequent position where you were allowed to return to practice under interim condition of practice. He submitted that you have continued to practise safely without repetition. Mr Loggenberg implored the panel to look at the track record of your training and reflection. He submitted that you had reflected on what you would do differently and also provided oral evidence on what you would have done if you were informed of the errors or incidents at the time. Mr Loggenberg submitted that it was highly unlikely that you would repeat the same conduct.

Mr Loggenberg highlighted that the NMC's core function is to protect the public. He submitted that you engaged with your employer as soon as they informed you of the concerns, and you also engaged with the NMC. Mr Loggenberg submitted that you had complied with the interim conditions of practice that were imposed on your practice and satisfied them. He submitted that the NMC had now brought you to a hearing many years since the incidents took place. Mr Loggenberg submitted that you do not undermine the seriousness of the incidents and the implications of dishonesty. He submitted that responding to a concern about your honesty and defending yourself should not be held to your detriment. Mr Loggenberg reiterated that you can be trusted and that you are trusted at your current place of work.

Mr Loggenberg asked the panel to consider your oral evidence that you had no reason to believe that what you were doing was dishonest, the circumstances you described about contributing factors, including the lack of feedback you received from your employer, and whether those circumstances contributed to the continuity of the conduct that has been found to have been dishonest. He submitted that it was your genuinely held belief that you did not act dishonestly. Mr Loggenberg asked the panel to strongly consider your mindset and thinking at the time in relation to the conduct.

Mr Loggenberg reminded the panel that assessing fitness to practise is a forward-looking exercise, and therefore invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *CHRE v NMC and Grant* and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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.'*

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:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

4 Act in the best interests of people at all times

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all time

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...'

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

Charge 1

The panel considered that by failing to administer Amoxicillin to Patient 1, you did not follow the directions of the doctors treating the patient. It noted that you had a responsibility as the nurse undertaking Patient 1's care to ensure that they received the medication that had been prescribed to them. The panel determined that by failing to do so, Patient 1 could have suffered harm. The panel therefore found that your omission at charge 1 fell seriously short of the conduct and standards expected of a registered nurse, and therefore amounted to misconduct.

Charges 2a, 2b and 2c

The panel considered your conduct at charges 2a, 2b and 2c, which you had admitted to. In the panel's view, this conduct related to numerous failures and omissions in basic and fundamental areas of nursing practice.

In relation to your failure to take blood from Patient 1 to monitor gentamicin levels (charge 2a), the panel considered that the patient could have suffered harm as a result, as the ability of healthcare professionals to accurately monitor Patient 1's condition and future needs would have been affected.

In respect of your failure to administer paracetamol and/or ibuprofen to Patient 2 (charge 2b), the panel took into account the circumstances around the patient's requirement for this medication. You had a duty to administer the prescribed medication to the patient in line with expected practice, but failed to do so. The panel was of the view that your failure to administer this medication was serious in that it posed a risk of harm to a patient who may have been deprived of relief from pain. The

panel determined that your omission fell below the standard expected of a registered nurse. It therefore found misconduct in respect of charge 2b.

In considering your actions in documenting that paracetamol and/or ibuprofen had been administered to Patient 2 when it had not (charge 2c), the panel determined that your conduct was a serious deviation from the standards expected of you. It considered that your actions could have led to patient harm. It also considered the effect of incorrect records on continuity of care by other colleagues, and the potential for patient harm as a result of this. The panel therefore determined that your actions at charges 2c fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

The panel concluded that your actions at charges 2a, 2b and 2c were a serious departure from the expected standards of a registered nurse, and therefore amounted to misconduct.

Charge 3

In respect of charge 3, the panel considered your failure to adequately prepare an intravenous saline drip for Patient 3 in that you added an unknown substance to it. It noted that this unknown substance was not prescribed to the patient and had the potential to cause them serious harm, despite not actually being administered to the patient. The panel therefore determined that your actions fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

Charge 4

The panel determined that your removal of medication in excess of the amount to be administered to patients, which you had documented on the Omnicell system was removed to be administered to those patients, was serious. In the panel's view, this was aggravated by the fact that it took place on multiple occasions between December 2018 and August 2021, and in respect of numerous patients. The panel considered that this conduct was unacceptable for a nurse and it found that you had circumvented the

correct procedures put in place to ensure that the process of medication dispensing and administration were carried out properly at Hospital A.

The panel determined that your actions at charge 4 fell far below the conduct and standards expected of a registered nurse. It therefore found misconduct in respect of charge 4.

Charge 5

The panel noted its finding that your actions at charge 4 were dishonest in that you recorded the purpose for taking any or all of the medication was to administer it to the patients, when it was not. The panel considered that as a result of your conduct, you carried out a systematic deception in respect of medication that was solely intended for the use of administration to patients at the hospital.

The panel considered that you had a duty as a registered nurse to be open and honest, and act with integrity, but you did not do so. It was of the view that your dishonesty in respect of charge 4 brought your integrity into question and was a significant departure from the conduct and standards expected of a registered nurse. The panel was therefore satisfied that your dishonesty was so serious as to amount to misconduct.

Charge 6

In relation to its finding that you stole any or all of the medication referred to in Schedule A, the panel considered that you had been entrusted with the responsibility to access medications that were owned by the hospital for a particular purpose, that is to dispense the correct medication for the correctly named patient in accordance with their prescription, and not for any other purpose. It considered you were expected to do this professionally and honestly, and by not doing so and stealing the medications, your actions were serious.

The panel considered that your theft of the medication set out in Schedule A deprived patients of the medication required for their care, and there was potential for harm to be caused to patients throughout the period between December 2018 and August 2021, if

medications were not readily available as a result of your actions. It therefore determined that your actions fell seriously short of the conduct and standards expected of a registered nurse, and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel determined that limbs a), b), c) and d) are engaged in this case. The panel found that patients were put at risk of harm as a result of your misconduct because you failed to administer painkillers, failed to take blood to monitor gentamicin levels, put an unknown substance in an intravenous saline drip, removed medications in excess of the amount to be administered to patients, dishonestly recorded that they were for the usage of patients and then subsequently stole them. The panel was satisfied that your misconduct had breached the fundamental tenets of the nursing profession, including promoting professionalism and trust and practising effectively, and therefore brought its reputation into disrepute as these were not the actions of a reputable nurse. Further, it

determined that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel had regard to the case of *Cohen v General Medical Council* and considered the following factors:

- whether the misconduct is capable of being addressed;
- whether it has been addressed; and
- whether the misconduct is highly unlikely to be repeated.

The panel was satisfied that the misconduct relating to medication administration, taking blood from patients, record keeping and adequately preparing an intravenous drip at charges 1, 2 and 3 is capable of being addressed.

The panel considered, however, that the misconduct at charges 4, 5 and 6 was so inextricably linked that it would be difficult to separate the removal of medication in excess of the amount to be administered to patients, which you documented on the Omnicell system was removed to be administered to those patients, from the dishonesty and theft that had been found proved. It determined that your misconduct at these charges raised deep-seated attitudinal concerns which are more difficult to address. The panel was of the view that your misconduct at these charges was on the higher end of the scale of seriousness, as it involved multiple instances of theft and dishonesty in respect of medications over a sustained period of time.

In relation to whether your misconduct has been addressed, the panel first considered the clinical failings at charges 1, 2 and 3. It carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel acknowledged the training, remediation, and strengthened practice that you have undertaken. It had regard to your certificate of continuing professional development in '*Medicines Management for Nurses and AHPs – Level 3*' dated 7 June 2022.

The panel noted that you are currently working as a registered nurse practitioner within the area of ophthalmology. It also took into account the character references from your

employers, which attested to your safe administration of medication and pain relief to patients.

Regarding your insight in respect of charges 1, 2 and 3, the panel took into account your reflective statement dated 14 August 2023, which in the panel's view demonstrated an understanding of where you went wrong and how you would do things differently in the future. It noted that you had made admissions to these charges from the outset, and demonstrated some understanding of how your actions put patients at risk of harm and why what you did was wrong. The panel found, however, that you have not yet developed full insight into your clinical failings as you still appeared to seek to blame others and deflect responsibility for your misconduct. You also did not appear to fully recognise how your misconduct impacted negatively on patients, colleagues and the nursing profession.

The panel therefore found that there remains a residual risk of repetition which could put patients at risk of future harm, due to your limited insight in respect of the clinical charges 1, 2 and 3.

The panel next considered your misconduct at charges 4, 5 and 6. Whilst the panel acknowledging that you are entitled to defend yourself in respect of the charges, the panel determined that your actions at these charges demonstrated a deep-seated attitudinal issue, in relation to your honesty and trustworthiness as a registered nurse.

The panel was also concerned that you were less than credible in your oral evidence, and evasive to questioning at both the local investigation stage and during your oral evidence at this hearing. The panel acknowledged your reflective account, in which you highlighted the need for nurses to be honest and trustworthy. Whilst the panel appreciated that you denied charges 4, 5 and 6, there was no evidence before it of any attempt of reflection or remediation in relation to your misconduct at these charges, in particular, the dishonesty and theft of excess medication identified. It therefore determined that there was a high risk of repetition in respect of charges 4, 5 and 6.

As such, the panel could not be satisfied that it is highly unlikely that your misconduct would be repeated in the future. It therefore found that there is a high risk of repetition

and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is to mark the unacceptability of your misconduct and to uphold proper professional standards. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made in the specific circumstances of a case involving failings in different areas of clinical practice and a very serious level of dishonesty and theft of medications.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was not satisfied that at this stage, you can practise safely and professionally. It therefore determined that your fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

In the Notice of Hearing, dated 12 June 2025, the NMC had advised you that it would seek the imposition of a striking-off order if the panel found your fitness to practise currently impaired.

Ms Da Costa submitted that the appropriate sanction in this case is that of a striking-off order. She submitted that the following aggravating factors were present in this case:

- The potential for harm to patients in relation to the incorrect medication administration in charges 1, 2 and 3; and
- The sophisticated nature of the dishonesty and theft of medications, and the fact that it was repeated over a number of years.

Ms Da Costa asked the panel to accept that by way of a mitigating factor, you have always admitted to charges 1, 2 and 3 from the outset.

Ms Da Costa highlighted the panel's findings on impairment. She submitted that taking no further action or imposing a caution order would not be appropriate in the circumstances of this case. Ms Da Costa submitted that whilst a conditions of practice order could be formulated to address the clinical practice issues, such an order would not be appropriate in this case as the panel had found dishonesty, attitudinal issues, a clear risk of repetition, and insight that is not fully developed.

Ms Da Costa submitted that a suspension order would not be an appropriate sanction in this case. She referred the panel to the NMC guidance on '*available sanction orders*' (reference: SAN-3) and '*sanctions for particularly serious cases*' (reference: SAN-2), and submitted that the misconduct in this case, particularly at charges 4, 5 and 6 was clearly incompatible with a registered nurse remaining on the register. She submitted that the dishonesty and theft was not a one-off incident, but sophisticated in nature enough to deceive the Omnicell system, go unnoticed for a number of years, and only be discovered due to your actions at charges 1, 2 and 3.

Ms Da Costa referred to the NMC guidance on striking off orders (reference: SAN-3e) and submitted that there is a risk of harm quite clearly attached to your misconduct. She highlighted the fact that you removed medication intended for patients and that the use of the medication after it was stolen from HCA remains unknown. Ms Da Costa submitted that there is a high risk of repetition and that the public interest ground is also highly engaged. She submitted that your professionalism and trustworthiness had been brought into question and that you should not continue practising in a profession that allows your continued access to medication.

The panel also bore in mind Mr Loggenberg's submissions. He submitted that taking no action was entirely a matter for the panel to decide. Mr Loggenberg invited the panel to impose a "*warning*", or caution order for up to five years to send a clear message that the NMC expects nurses to improve their practice where it falls short of the expected standards. He submitted that such an order would be a necessary and proportionate response, taking into account the fact that you have been practising safely and effectively since satisfying the interim conditions of practice order that was previously imposed on your practice. Mr Loggenberg highlighted that there had been no repetition of any errors or conduct amounting to dishonesty at your current place of work, and your employer and colleagues have confidence in your practice. He submitted that a caution order would satisfy the public interest and ensure public safety.

Mr Loggenberg submitted that if the panel was not satisfied that a "*warning*" is appropriate, then a conditions of practice order would be the most appropriate, proportionate and effective sanction. He submitted that a conditions of practice order would allow you to revisit your medications management and conduct, and also refine your own reflection on what happened to ensure standards are upheld. Mr Loggenberg submitted that the integrity of the profession would be upheld and the public would be protected because specific conditions could be formulated to address these concerns. This includes direct or indirect supervision with periodic assessments and practising as a nurse at your current workplace.

Mr Loggenberg submitted that it would be a matter for the panel to determine what a suspension order would achieve in this case. He submitted that suspending your practice for a period of time could protect the public and allow you to deepen your

reflection and learning. Mr Loggenberg submitted that a suspension order would also protect the public from any risk of harm.

Mr Loggenberg reminded the panel that you are currently employed and have been proven to practice safely and effectively. He submitted that a striking-off order would be harsh, disproportionate and would be punishing you for your past mistakes. Mr Loggenberg submitted that the NMC guides panel's not to impose sanctions that punish registrants. He submitted such an order would have a significant adverse impact on you, and that there were other measures available to protect the public and meet the public interest such as a conditions of practice order.

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:

- You abused a position of trust.
- Your conduct put patients at risk of suffering harm.
- There was a systematic pattern of dishonest behaviour and theft of medication over a number of years.
- You demonstrated limited insight into your failings.

The panel also took into account the following mitigating features:

- You admitted to charges 1, 2 and 3 from the outset.
- You have taken steps to strengthen your medication administration practice, by way of training and continuing to practise as a nurse.

- There were positive references from employers attesting to your medications management practice.

In considering the seriousness of your misconduct, the panel had regard to the NMC guidance on '*Sanctions for particularly serious cases*' (reference: SAN-2), which set out the following in respect of cases involving dishonesty:

> '*Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
> - *misuse of power*
> - *vulnerable victims*
> - *personal financial gain from a breach of trust*
> - *direct risk to people receiving care*
> - *premeditated, systematic or longstanding deception*
>
> *Dishonest conduct will generally be less serious in cases of:*
>
> - *one-off incidents*
> - *opportunistic or spontaneous conduct*
> - *no direct personal gain*
> - *incidents outside professional practice*'

The panel was satisfied that your misconduct posed a direct risk to people receiving care, and that it was a systematic and longstanding deception. The panel did not identify any of the factors that could make your dishonest conduct less serious in this case. It therefore determined that your dishonesty was serious and more likely to call into question whether you should be allowed to remain on the register.

In deciding which sanction to impose, 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.

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. It was mindful that any conditions imposed must be proportionate, measurable and workable. The panel noted that the misconduct relating to your clinical practice at charges 1, 2 and 3 could be addressed through retraining. The panel had regard to the fact that the incidents last occurred in 2021, and since then, you have been practising as a registered nurse with no concerns raised about your practice.

However, the panel considered the seriousness of your misconduct in respect of the dishonesty and theft of medications at charges 4, 5 and 6 and the deep-seated attitudinal issues identified. The panel determined there were no practical or workable conditions that could be formulated, given the nature and seriousness of your misconduct at those charges, and such misconduct was not something that could be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel noted that your actions were not a single instance of misconduct. It considered that there was evidence of an deep-seated attitudinal problem in relation to your conduct at charges 4, 5 and 6. The panel took into account that there was no evidence of repetition of your behaviour, however, your insight was not fully developed and it had found that you pose a significant risk of repeating your behaviour.

The panel was not satisfied that temporary removal from the register would reflect the seriousness of the case. It considered that a well-informed member of the public would take the view that you, as an experienced nurse in a position of trust, abused that trust through your dishonesty and theft of medication that was solely intended for the use of patients. The panel considered that, in the circumstances of this case, there was nothing before it to suggest that placed in the same situation again, you would not repeat the behaviour and place patients at risk of harm.

Your conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

The panel determined that in the particular circumstances of this case, a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel considered that the regulatory concerns in this case raise fundamental questions about your professionalism. The panel determined that public confidence in the profession would be undermined if you were not removed from the register. It was of the view that members of the public and other nurses would be most concerned to learn that you acted in the way that you did.

The panel concluded that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards because a lesser sanction would not reflect the seriousness of the misconduct in this case, nor address the ongoing risk of repetition identified by the panel.

Whilst the panel noted the hardship such an order would have on you, it was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to you in writing.

Decision and reasons on proceeding with the hearing in your absence

Following the handing down of the decision on sanction, you and Mr Loggenberg, who had joined the hearing via Microsoft Teams for the day, disconnected from the hearing. The written determination on sanction had been emailed to you and Mr Loggenberg. The hearings co-ordinator received an email from Mr Loggenberg stating:

'*we got disconnected*'.

However, numerous subsequent attempts to contact both Mr Loggenberg and you by email and telephone call were unsuccessful. Ms Da Costa indicated that it would be a matter for the panel to decide whether to proceed with the hearing in your and Mr Loggenberg's absence. She reminded the panel that she had already put the hearing participants on notice that the NMC would be seeking an interim order, so you and Mr Loggenberg were aware that such an application would be made.

After waiting a period of 25 minutes and following the advice of the legal assessor, the panel decided to proceed with the hearing in your and Mr Loggenberg's absence.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Da Costa. She submitted that an interim order was required on public protection and public interest grounds for the

same reasons given for the substantive striking-off order. Ms Da Costa invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive striking-off order takes effect.

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to ensure that you cannot practise without restriction before the substantive striking-off order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.