Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 December- Wednesday, 17 December 2025

Virtual Hearing

Name of Registrant:	Emilia Davies
NMC PIN:	21A3812E
Part(s) of the register:	Registered Nurse Adult Nursing – 19 March 2021
Relevant Location:	Stoke-on-Trent and Wrexham
Type of case:	Misconduct/Lack of competence
Panel members:	John Millar (Chair, lay member) Julia Briscoe (Registrant member) Chanelle Gibson-McGowan (Lay member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Hanifah Choudhury
Nursing and Midwifery Council:	Represented by Neair Maqboul, Case Presenter
Mrs Davies:	Present and represented by Jake Herman of Regulatory Defence
Facts proved by way of admission:	Charges 1b, 2ei, 2eii, 2gi, 2gii, 2j and 5
Facts proved:	Charges 1a, 2ai, 2bi, 2bii, 2biii, 2c, 2di, 2dii, 2diii, 2eiii, 2ev, 2evi, 2fi, 2fii, 2h, 2Ii, 2Iii, 2Iiii, 2k, 3a and 3b
Facts not proved:	Charges 2aii, 2eiv and 4

Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Application to admit the hearsay evidence of Colleague A and Colleague B

The panel heard an application made by Ms Maqboul, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to admit the statements of Colleague A and Colleague B and their supporting exhibits into evidence.

Ms Maqboul relied upon the principles set out in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) in relation to whether the hearsay evidence should be admitted.

In relation to Colleague A, Ms Maqboul submitted that the NMC relies on her evidence in respect of charges 1a, 1b, 3a and 5. She told the panel that Colleague A notified the NMC in September that she was unable to attend this hearing, including virtually, due to [PRIVATE]. She submitted that, whilst there is no formal [PRIVATE] in the bundle, the panel is not precluded from admitting her evidence on that basis and may still properly apply the *Thorneycroft* criteria.

Ms Maqboul submitted that Colleague A's evidence is admissible. She submitted that her evidence is not sole or decisive in respect of any of the charges and provides an overview and chronology of events already evidenced elsewhere and explains the circumstances in which the referral to the NMC was made. She submitted that whilst you challenge aspects of the evidence, the admission of Colleague A's evidence does not deprive you of the opportunity to advance your case or provide your own account to the panel. She also submitted that there is no suggestion that Colleague A had any reason to fabricate her evidence.

In relation to Colleague B, Ms Maqboul submitted that her evidence is not sole or decisive in relation to any of the charges. She also submitted that there is no suggestion that Colleague B had any motive to fabricate her account and that her relationship with you was purely professional.

In respect of her non-attendance, Ms Maqboul submitted that the panel had been provided with detailed information of the reasons Colleague B was unable to attend the hearing. She submitted that, while there is no formal [PRIVATE], the information provided explains why she is unable to attend and invited the panel to take this information at face value.

Mr Herman, on your behalf, opposed the application to admit the hearsay evidence of Colleague A and Colleague B.

Mr Herman reminded the panel of your Article 6 right to a fair hearing, which includes an effective opportunity to challenge adverse evidence, particularly where that evidence is central, disputed, or potentially sole or decisive.

Mr Herman submitted that both witnesses' evidence is central to the NMC's case and forms a significant part of the narrative underpinning key allegations. He submitted that admitting such evidence as untested hearsay would be highly prejudicial to you.

In respect of Colleague A, Mr Herman submitted that her evidence underpins the framing of multiple allegations, including those relating to visits to Patient G and notification of your interim conditions of practice order. He submitted that there is no [PRIVATE] explaining her absence nor any explanation as to why she could not give evidence remotely with reasonable adjustments. He further submitted that the NMC had not taken reasonable steps to secure her attendance.

In relation to Colleague B, Mr Herman submitted that her statement is relied upon in support of key competence allegations and goes directly to the NMC's case that you lack basic clinical competence. He submitted that, while the panel has been provided with information regarding [PRIVATE], there is no [PRIVATE] stating that she could not give evidence remotely with appropriate adjustments and that it appears that alternative formats for live evidence were not explored.

Mr Herman submitted that the evidence of both Colleague A and Colleague B is disputed, credibility-dependent, and central to the contested issues. He submitted that the fair course is to refuse the hearsay applications or alternatively require the NMC to explore reasonable adjustments or modified attendance. He also submitted that if the evidence is admitted at all, it should be afforded very limited weight.

The panel accepted the advice of the legal assessor on the provisions of Rule 31 and the principles which would inform its approach to the admission of hearsay evidence.

Decisions and reasons on admitting the hearsay evidence of Colleague A and Colleague B

The panel gave the application in regard to Colleague A and Colleague B serious consideration. The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence.

Colleague A

The panel noted that Colleague A's statement was formal, signed, and included an attestation as to its truth. The panel also noted that Colleague A made clear within her statement, including at paragraph 3, that her role was limited to collating information and making a referral to the NMC, and that her account was based on what others had told her rather than on direct observation. The panel accepted that her evidence was not sole or decisive in respect of the charges, and that other witnesses had provided evidence which spoke directly to the allegations, including contemporaneous accounts describing the relevant incidents, some of which characterised the matters as not serious. The panel further noted that the contents of Colleague A's statement had not been directly challenged in evidence and that, given her professional role, there was no apparent reason for her to fabricate her account.

The panel recognised that the allegations faced by you are serious, noting that while individual allegations may not appear serious in isolation, they are cumulatively serious in nature.

The panel carefully considered the reasons advanced for Colleague A's non-attendance. While it was stated that she was absent from work, the panel found that this, in itself, was not a strong or compelling reason for non-attendance. No [PRIVATE] was provided, and there was no attested explanation as to why she could not give evidence remotely or with reasonable adjustments. The panel also concluded that the NMC's attempts to secure her attendance were limited and did not amount to reasonable steps in the circumstances.

In considering whether to admit the evidence, the panel took into account that Colleague A's primary involvement was as the referrer to the NMC. The panel noted that many of the documents exhibited to her statement were also exhibited through other witnesses and were therefore already before the panel.

The panel concluded that, given the limited relevance of her evidence, the absence of a properly substantiated reason for her non-attendance, and the failure by the NMC to make reasonable efforts to secure her attendance, it would not be fair to admit her hearsay evidence.

Accordingly, the panel determined that the witness statement of Colleague A, together with her associated exhibits, should not be admitted into evidence.

Colleague B

The panel noted that Colleague B's evidence was not sole or decisive in respect of the majority of the charges, as other witnesses provided evidence in support of those allegations. However, the panel observed that in relation to charge 2h, the only other material relied upon by the NMC consisted of a statement and exhibits from Witness 3, which themselves repeated an account originally provided by Colleague B, including an

email authored by her. The panel therefore concluded that Colleague B's evidence amounted to the sole evidence in support of Charge 2h.

The panel considered the nature and extent of the challenge to Colleague B's evidence. The panel noted that you deny the allegations, although you do not provide a detailed explanation as to why Colleague B's account was inaccurate. The panel noted that you had indicated that there were tensions in the workplace but had not identified any specific issue involving Colleague B, nor any reason why Colleague B would fabricate her account. The panel recognised that your account was in direct conflict with that of Colleague B. The panel further noted that Colleague B's statement contained a number of opinion-based assessments of your practice rather than purely factual observations.

The panel acknowledged that the charges are serious in nature. While certain allegations were accepted by you, charge 2h was denied.

The panel carefully considered the reasons for Colleague B's non-attendance. The panel accepted that Colleague B had [PRIVATE]. The panel had sight of a letter from [PRIVATE]. The panel concluded that, in those circumstances, it would not be proportionate and appropriate to expect Colleague B to give evidence at this time.

The panel considered whether reasonable steps had been taken by the NMC to secure Colleague B's attendance. It noted the email correspondence evidencing the NMC's attempts to arrange attendance and was satisfied that reasonable steps had been taken. The panel further noted that you had prior notice of the NMC's intention to rely on Colleague B's hearsay evidence. While the exact length of notice was unclear, this was not raised as an issue on your behalf.

In determining whether it was fair to admit the evidence, the panel recognised that you would not have the opportunity to test Colleague B's evidence through cross-examination. However, the panel found no reason to suspect that her statement had been fabricated. The panel noted that Colleague B had made a formal statement to her regulator, signed

and endorsed with the declaration, *"This statement is true to the best of my knowledge and belief."*

Accordingly, the panel determined that Colleague B's hearsay evidence should be admitted, with the panel making clear that it would attach such weight as it considered appropriate when assessing the evidence as a whole.

Decision and reasons for the hearing to be held partly in private

Whilst Ms Maqboul was making her submissions on the hearsay application, the panel noted that some parts of her submissions made reference to Colleague A and Colleague B's [PRIVATE]. The panel of its own volition invited submissions on whether it should hear parts of the hearing in private.

Ms Maqboul made an application for parts of the hearing to be held in private on the basis that references to witnesses' [PRIVATE] may be raised.

Mr Herman supported this application.

The legal adviser 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 accepted the advice of the legal assessor.

Having heard that there may be reference to [PRIVATE] of witnesses, the panel determined to hold the hearing partly in private in order to protect their privacy. The panel will go into private session as and when such issues are raised throughout the hearing.

Application to allow special measures for Patient G

Ms Maqboul made an application under Rule 23 of the Rules to allow special measures for Patient G when giving evidence.

Ms Maqboul informed the panel that Patient G is homebound due to [PRIVATE] and has no family or friends to assist her. She also informed the panel that Patient G has no internet access and no device capable of connecting to the hearing via Teams.

Ms Maqboul submitted that attempts were made to explore whether Patient G could attend a hearing centre in London with NMC support but due to [PRIVATE], she is unable to travel via public transport and does not have the necessary assistance to do so.

Ms Maqboul submitted that the NMC has fully explored the possibility of Patient G giving evidence by phone, which she has consented to. She submitted that this would allow her to participate in the hearing despite her technological constraints. She also submitted that there is no suggestion of disengagement; Patient G is willing to provide her evidence and that this is a matter of overcoming technological barriers.

Ms Maqboul submitted that, in light of these circumstances, the panel should allow Patient G to give her evidence by telephone. She submitted that this would ensure fairness to both Patient G and to you as it allows Patient G to participate while still preserving your right to cross-examine.

Mr Herman opposed the application and invited the panel to defer any decision until the NMC provides objective medical evidence demonstrating that giving evidence by video link is genuinely impossible.

[PRIVATE].

Mr Herman submitted that Patient G's credibility is materially an issue. He submitted that a central allegation in her statement is that you confronted her on 6 July 2023 and that this allegation is demonstrably false as you were attending your interim order hearing on that date and The Betsi Cadwaladr University Health Board (the Health Board) has confirmed that you were not on shift. He submitted that this is not a minor inconsistency but a fundamental factual error which directly undermines the reliability of Patient G's account and increases the importance of the panel being able to assess her demeanour.

Mr Herman submitted that no enquiries appear to have been made by the NMC as to whether family support could assist Patient G in accessing a community venue with internet access, or in joining a video hearing via a smartphone or tablet. He submitted that while you do not oppose special measures in principle, the NMC has not provided the evidential foundation required to justify the most restrictive form of live evidence, particularly where credibility is central and the allegations are serious.

Mr Herman reminded the panel that fairness under *Thorneycroft* must be assessed witness by witness. He submitted that Patient G is the only witness to these allegations and has already been shown to be factually wrong in at least one respect. He also submitted that your Article 6 rights would be significantly prejudiced if you were denied the opportunity to challenge her evidence in a manner that allows proper assessment of credibility.

Mr Herman invited the panel to defer the application and direct the NMC to obtain medical evidence and explore alternative arrangements.

The panel accepted the advice of the legal assessor.

Decision and reasons on the special measures for Patient G

The panel first considered whether Patient G should be treated as a vulnerable witness. [PRIVATE]. The panel also took into account the information provided regarding her lack

of internet access and technological limitations. In these circumstances, the panel determined that Patient G should be treated as a vulnerable witness.

The panel carefully considered the submissions made, including the dispute of the allegations and the concern regarding the risk of mistaken identity, particularly in light of the assertion that you were at work at the time of the alleged incident. The panel recognised that Patient G would be unable to visually identify you if giving evidence by telephone. The panel also noted that Patient G provides direct evidence in respect of charges 3 and 4 and accepted that her credibility could not properly be assessed until her evidence has been heard.

The panel considered whether it would be appropriate to adjourn the hearing to explore alternative arrangements. The panel concluded that an adjournment would not be appropriate, having regard to the public interest and your interest in the proceedings being concluded without further delay. The panel also determined that it would not be appropriate to seek to assess Patient G's circumstances further or to arrange for representatives to attend her home.

The panel acknowledged the inherent limitations of telephone evidence and recognised that these limitations would be relevant when assessing the weight to be attached to Patient G's evidence. The panel was satisfied that it could properly assess fairness when considering the evidence as a whole and confirmed that, if Patient G's evidence was found to be unreliable or not credible, it would attach little or no weight to it. The panel also reminded itself of its duty to assess all of the evidence in the public interest.

The panel noted that Patient G is scheduled to give evidence on day 13 of the hearing. In light of this, the panel determined that it would be appropriate for the NMC, in the time available, to continue to explore whether there are any alternative means by which Patient G could give evidence, including by video link, which the panel recognised would be preferable if it were possible.

Decisions and reasons on admitting further documents into evidence

During Witness 3's evidence, she made reference to a number of documents, including workbooks and extra training completed by you. The panel made directions for the NMC to obtain these documents from Witness 3 for the panel to have sight of.

The NMC obtained from Witness 3 documents, which included your induction, your workbook completion dates and your rota.

Ms Maqboul invited the panel to admit these documents into evidence. She submitted that the documents contain relevant information regarding your personal learning, development and potential milestones within that learning journey. She also submitted that it is a matter for the panel to determine the relevance and weight to be attached to them.

Mr Herman objected to the application.

Mr Herman submitted that the original request by the panel was specific to evidence relating to specialty training, and that the documents now presented appear to cover additional areas, including rostering and the Step One competency framework. He submitted that, whilst it is acknowledged that the panel has a discretion to determine which documents are relevant and admissible, this raises a concern that expanding the scope in this way could set a precedent for further document requests and could lead to unnecessary and unhelpful exploration of unrelated materials, such as patient records, which would not assist the proceedings.

The panel accepted the advice of the legal assessor.

The panel considered the application to admit the additional documents into evidence. In doing so, the panel had regard to the need to ensure fairness to all parties and to allow the hearing to consider relevant information.

The panel noted that the documents provide useful context and verify evidence already provided by other witnesses. The panel did not identify anything in the documents that required redaction, nor did it consider any content to be contentious or inappropriate. The panel also recognised that some of the information contained may be of assistance to you.

The panel determined that there were no grounds to exclude the documents. It was satisfied that the information was largely self-explanatory and that it was not necessary to recall Witness 3 to provide evidence regarding their content. The panel further noted that, while the documents were admissible, it would attach the appropriate weight to them when considering the evidence as a whole.

Decision and reasons on application to amend the charges

The panel heard an application from Ms Maqboul, in response to the panel's identified concern about the wording of charge 2d, to amend the stem of charge 2d and to amend charges 2dii) and 2diii).

The proposed amendments are as follows:

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
d. On **or around** 25/26 April 2023:
ii. Did not ensure appropriate monitoring of ~~Patient I~~ **an unknown patient.**
iii. Did not provide an adequate handover in respect of ~~Patient I~~ **an unknown patient.**

Ms Maqboul submitted that the facts underlying the charge remain unchanged, and there is no prejudice to you as the same questions would have been posed to witnesses irrespective of this minor clarification.

In relation to charges 2dii) and 2diii), Ms Maqboul submitted that these amendments do not alter the substance of the case or the evidence which remains clear through witness statements and exhibits. She also submitted that there is no prejudice to you as the essential details and nature of the allegations are unchanged.

Ms Maqboul submitted that any amendments would serve to provide clarity without affecting the fairness of the proceedings.

Mr Herman opposed the NMC's application to amend the charges.

Mr Herman submitted that the proposed amendments risk patching over evidential vagueness with broadened charges, which could undermine fairness. He referred the panel to the case of *R (on the application of Wheeler) v Assistant Commissioner House of the Metropolitan Police* [2008] EWHC 439 (Admin) where vague charges were criticised for preventing a respondent from understanding precisely what was alleged and thus fully addressing it in the hearing.

Mr Herman submitted that that the proposed amendments were not neutral. He submitted that witnesses have been cross-examined on the basis of specific dates and broadening this timeframe could materially alter the scope of allegations, particularly given the complexity of your supernumerary period and inconsistent or incomplete witness evidence. He also submitted that the proposed removal of patient identifiers in charges 2dii) and 2diii) would further dilute the factual precision of the charges as anonymisation is intended to protect privacy, not to allow charges to be framed without clear factual anchors.

Mr Herman submitted that these proposed amendments, made at a late stage in the hearing after witnesses have been challenged on the original charges, are reactive rather than proactive clarifications. He submitted that any substantive amendments, especially those removing identifying particulars, should not be permitted as they would undermine fairness and the proper conduct of the proceedings.

The panel accepted the advice of the legal assessor.

The panel considered the NMC's application to amend the stem of charge 2d and charges 2dii) and 2diii.

The panel was of the view that the proposed amendments would broaden the scope of the charges. In particular, the amendments to the stem would remove specificity and would no longer relate to a particular incident. The panel considered that, while individually the proposed changes may appear minor, collectively they would broaden the scope of the evidence and the allegations in a way that the panel considers inappropriate at this stage.

The panel considered that amending 2dii to refer to an "unknown patient" would be unfair on you, particularly as you have stated that you are unable to identify Patient I. Similarly, removing patient identification from 2diii would over-broaden the charge and be unfair as it would remove the factual clarity necessary for you to respond adequately.

In light of this, the panel did not consider it appropriate to make amendments to the charges and refused the NMC's application.

Details of charge

That you, a registered nurse:

1. Between 22 May 2022 and 5 June 2022, on one or more occasions administered insulin to a patient/patients:
    a. Without having the preparation of the insulin checked by a second member of staff.
    b. Without a second member of staff witnessing the administration.

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke

University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:

a. Did not correctly set up and/or monitor and/or adjust a BBraun pump to safely deliver medication to a patient/patients on:
   i. 1 February 2023
   ii. 31 May 2023
b. Did not respond appropriately to patient alarms on:
   i. 1 February 2023
   ii. 12 May 2023
   iii. 16 May 2023
c. On 17 April 2023 did not correctly suction Patient D.
d. On 25/26 April 2023:
   i. Did not correctly change Patient B's arterial flush line.
   ii. Did not ensure appropriate monitoring of Patient I.
   iii. Did not provide an adequate handover in respect of Patient I.
e. On or around 30 April 2023:
   i. Did not carry out recordings for a patient on a PCA pump as necessary/at all
   ii. Did not appropriately label medication without prompting.
   iii. Was not able to independently carry out a blood gas.
   iv. Placed a swab up Patient J's rectum without warning them.
   v. Required prompting to review evening medication charts.
   vi. Was not able to independently calculate and/or mix a controlled drug for administration.
f. On 12 May 2023:
   i. Did not appropriately monitor and/or respond to Patient C while they were on a Draeger Ventilator.
   ii. Was not able to independently carry out an arterial blood gas.
g. On 17 May 2023:
   i. Attempted to draw up IV medication for a patient without a second check.
   ii. Recorded inaccurate notes in respect of Patient H.
h. On 5 June 2023, clamped an EVD without appropriate training or supervision.

i. Displayed poor knowledge in respect of:
    i. Respiratory function.
    ii. Blood gases.
    iii. Medication.

j. Did not complete your Step One Competency Book during the course of your employment.

k. Displayed poor communication skills in respect of staff and/or patients and/or patients' relatives.

3. On or around 11 June 2023 attended Patient G's home without permission and/or clinical justification where you:
    a. Asked Patient G to give you her medication in a forceful manner.
    b. Took Patient G's medication without her permission and/or clinical justification.

4. On or around 6 July 2023 confronted Patient G about a complaint she had raised.

5. On 16 July 2023 acted in breach of provision 11(a) of the interim conditions of practice order imposed on 6 July 2023 in that you did not provide a copy of your interim conditions of practice to Betsi Cadwaladr University Health Board in a timely manner or at all.

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence as set out in charges 1 and 2 and by reason of your misconduct as set out in charges 3,4 and 5.

Background

You joined the NMC register on 19 March 2021 as a registered adult nurse.

The matters you face which arise out of two referrals. Referral 1 relates to incidents relating to work at the Health Board as an agency nurse. Referral 2 relates to your

employment at the Royal Stoke University Hospital (the Hospital) as a Band 5 Staff Nurse on [PRIVATE].

You had been employed by the Hospital as a Band 5 Staff Nurse from 7 November 2022. You had been placed on an informal and then formal capability process, following competency concerns with your nursing practice. It is alleged that you were unable to demonstrate safe practice without supervision. On 8 June 2023, you were advised that you would be moved to the final review stage of the formal capability process. You resigned from the Hospital on 12 June 2023. A referral was made to the NMC on 15 June 2023.

On 6 July 2023, an interim conditions of practice order was imposed on your registration. A referral was subsequently made by the Health Board, where you had been working via an agency, following a complaint from a patient, Patient G. The Health Board then became aware of the interim order imposed on your registration and were concerned that you had not informed them.

Decision and reasons on facts

The panel heard from Mr Herman, who informed the panel that you admit charges 1b, 2ei, 2eii, 2gi, 2gii, 2j and 5.

The panel therefore finds charges 1b, 2ei, 2eii, 2gi, 2gii, 2j and 5 proved in their entirety, 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 Maqboul and by Mr Herman.

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: Ward Manager at the Health Board.
- Witness 2: Deputy Ward Manager at the Health Board.
- Witness 3: Senior Sister on [PRIVATE] at the Hospital.
- Witness 4: Band 5 Staff Nurse on [PRIVATE] at the Hospital.
- Witness 5: Senior Staff Nurse on [PRIVATE] at the Hospital.
- Witness 6: Band 6 Senior Staff Nurse on [PRIVATE] at the Hospital.
- Witness 7: Band 6 Senior Staff Nurse on [PRIVATE] at the Hospital.
- Witness 8: Band 5 Staff Nurse on [PRIVATE] at the Hospital.
- Witness 9: Band 5 Staff Nurse on [PRIVATE] at the Hospital.
- Witness 10: Band 6 Senior Staff Nurse on [PRIVATE] at the Hospital.

- Patient G: Patient G

The panel also considered the written evidence of the following witnesses:

- Witness 11: Deputy Ward Manager at the Health Board
- Colleague B: Band 5 Staff Nurse on [PRIVATE] at the Hospital.

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a)

1. Between 22 May 2022 and 5 June 2022, on one or more occasions administered insulin to a patient/patients:
    a. Without having the preparation of the insulin checked by a second member of staff.

This charge is found proved.

In reaching this decision, the panel took into account the Health Board's Competency Framework for Independent Second Check & Witnessed Administration. This policy said:

'BCUHB requires an independent second check and witnessed administration for:-

- *controlled drugs*
- *intravenous medicines*
- *epidural medicines*
- *all chemotherapy and cytotoxic medicines*
- *wherever a calculation is required*
- *administration of drugs to a child under 16 years of age*
- *all insulin products'*

The panel was satisfied that the Health Board required the preparation of insulin to be checked by a second member of staff.

The panel had regard to Witness 2's NMC statement which said:

> *'I recall it was around mealtime, and Ms Davies stated that she had given insulin to this patient who was in his early 20's. I informed her that she was not allowed to administer insulin by herself, as this was not in line with our policy. Ms Davies told me that she was not aware of this.'*

The panel had regard to your witness statement which said:

> *'At that time, I did not understand that the local policy required a second registered nurse to be physically present at the bedside during preparation and administration of insulin. In other ward environments, the second check could be carried out verbally and documented.*
>
> *On one occasion, the nurse in charge was serving meals and was not immediately available. Having already confirmed the dose with her beforehand, I administered the insulin myself.'*

The panel found your evidence to be very vague with no timeline as to when the insulin was checked. The panel also had regard to a Datix, which was contemporaneous to the incident on 5 June 2022, which details a description of the incident where the nurse in charge explained that you had been on this ward before and had been told that insulin needs to be second checked.

In light of this, the panel preferred the evidence of Witness 2 and accordingly found this charge proved.

Charge 2ai)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   a. Did not correctly set up and/or monitor and/or adjust a BBraun pump to safely deliver medication to a patient/patients on:
      i. 1 February 2023

This charge is found proved.

In reaching this decision, the panel took into account the NMC statement of Witness 8 which said:

> *'When I arrived at the bed space, Ms Davies was stood next to the patient and had silenced the alarm. The patient's husband and daughter were also at the bed space.*
>
> *I noticed that the patient's blood pressure was very high. I asked Ms Davies what had happened, but she could not explain and seemed unaware of what was going on.*

I went over to the noradrenaline pump that was located next to the patient's bed and turned this off. The patient's blood pressure began to fall.

I then went to the end of the bed by the end of the patient's feet and read that the patient was documented as requiring 7ml of noradrenaline per hour. I then went to check the noradrenaline pump and saw that the rate of infusion had been set to 30ml per hour. It appeared that Ms Davies had increased the rate of infusion by 23ml per hour.'

The panel considered Witness 8's oral evidence to be consistent with her written statement and that she was clear throughout her evidence.

In your written statement you said:

'The Practice Development Nurse (PDN) then called me aside and asked me what had happened. I explained the incident that took place then the issue was escalated to the manager, i explained the incident saying that I had tried to increase the volume for the infusion that was running low, and I had mistakenly added the volume to the rate instead. I apologised and made clear that I had not received full training on that specific pump.'

However, in your oral evidence you said that your induction included training on BBraun pumps which is inconsistent with your statement. The panel also had sight of your induction programme which included training on BBraun pumps.

Having considered all the evidence, the panel is satisfied that you did not correctly set up a BBraun pump to safely deliver medication to a patient on 1 February 2023. The panel therefore found this charge proved.

Charge 2aii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   a. Did not correctly set up and/or monitor and/or adjust a BBraun pump to safely deliver medication to a patient/patients on:
      ii. 31 May 2023

This charge is found NOT proved.

In reaching this decision, the panel took into account your statement which said:

> *'I do not recall any similar incident occurring on 31 May 2023 and I do not accept that I repeated the same error on that date. I have no specific recollection of being involved in a BBraun pump issue on 31 May 2023. If an error did occur on that date, I do not recall being told that I was responsible.'*

The panel noted that Witness 3 received an email on 31 May 2025; however, this related to an incident that occurred on 30 May 2025. There was no evidence before the panel to substantiate that an incident took place on 31 May 2025.

In the absence of any evidence relating to an incident on 31 May 2023, the panel finds the charge not proved.

Charge 2bi)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   b. Did not respond appropriately to patient alarms on:
      i. 1 February 2023

This charge is found proved.

In reaching this decision, the panel took into consideration the witness statement of Witness 8 which said:

> *'I was stood behind a desk in Pod 4 when I heard alarms sounding from Bed 30. I went over to the bed space to check what was happening.*
>
> *When I arrived at the bed space, Ms Davies was stood next to the patient and had silenced the alarm. The patient's husband and daughter were also at the bed space.'*

During her oral evidence Witness 8 said that the patient was put at risk of harm as a result of your actions.

The panel found that Witness 8's oral evidence was clear and consistent with her written statement.

In your live evidence, when asked if the patient was placed at harm, you agreed and said that it was good that Witness 8 had come to help you.

In light of this, the panel found this charge proved.

Charge 2bii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   b. Did not respond appropriately to patient alarms on:
      ii. 12 May 2023

This charge is found proved.

In reaching this decision, the panel took into account the NMC statement of Witness 3 which said:

> *'At approximately 13:30pm, I walked from the Senior Managers Office to fill up my water bottle at the water fountain near to the nurses' station (by the ward clerk desk). When passing by Bed 12 in Pod 6, I heard the Draeger ventilator (breathing machine) and Phillips monitor alarming. The Phillips monitor displays the patient's electrical impulses for their heart rate, blood pressure, oxygen saturations, respiratory rate.*
>
> *I saw Ms Davies silence the alarms on both the ventilator and the monitor…'*

The panel found Witness 3 to be clear and consistent throughout her evidence, both oral and written.

In your statement you said:

> *'I do not recall ignoring or failing to respond to alarms on… 12 May,…'*

In the light of the evidence, the panel determined that, on the balance of probabilities, it was more likely than not that you did not respond appropriately to a patient alarm on 12 May 2023. The panel therefore found this charge proved.

Charge 2biii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   b. Did not respond appropriately to patient alarms on:

iii. 16 May 2023

This charge is found proved.

In reaching this decision, the panel took into account the NMC statement of Witness 5 which said:

> *'During this shift, I also found that Ms Davies was unresponsive to monitor alarms sounding. I can recall that, on numerous occasions, she would not look up from the task that she was doing to respond to an alarm sounding. For example, I can recall one incident where Ms Davies was writing in the intensive care drug chart and did not come away from this task to respond to an alarm that was sounding.'*

The panel found Witness 5's oral evidence to be clear and consistent with her written statement.

The panel noted that you deny this allegation and wrote in your statement:

> *'I do not recall ignoring or failing to respond to alarms on 1 February, 12 May, or 16 May 2023. I do not recall being spoken to on those days about a failure to respond to an alarm.'*

In light of the evidence before it, the panel preferred the evidence of Witness 5 and determined that it was more likely than not that you did not respond appropriately to a patient alarm on 16 May 2023. The panel therefore found this charge proved.

Charge 2c)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:

c. On 17 April 2023 did not correctly suction Patient D.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 3 which said:

> *'On 17 April 2023, Ms Davies was looking after a Level 3 patient (Patient D). Patient D's daughter and sister were present at the bedside. When I started my shift at 25th April at 07:15am, Witness 10, Senior Staff Nurse, approached me and informed me of an incident involving Ms Davies.*
>
> *Ms Davies had attempted to provide closed suction on Patient D. Closed suction is a device connected to the ventilation circuit that allows for clearance of mucous in the patient's airways.*
>
> *Patient D suddenly went breathless and purple colour. Ms Davies then left the suction catheter (clear plastic tube) inside the tracheostomy and stepped away from Patient D to seek assistance from Witness 10.*
>
> *Witness 10 attended the bed space and found that the closed suction had not been connected to the suction unit therefore it would not remove any mucous from the Patient D's airways.'*

The panel also took into account the NMC statement of Witness 6 which said:

> *'During this shift, Witness 10, a staff nurse, had approached me to say that the relatives of a patient wanted to speak to me.*
>
> *I invited the relatives to leave the bed space to talk to me. The relative of the patient in our care told me that she did not want Ms Davies looking after her relative*

anymore because she seemed very incompetent. I asked her why and she said that her daughter is a paediatric nurse and knows about suctioning. The relative explained that this patient had a tracheostomy in, and Ms Davies had apparently put the tube down the tracheotomy when it was not attached to any suction. This meant that the patient's airway was partially occluded, and they struggled to breathe. The relative told me that there were some other concerns, but she did not explain these in detail.

I escalated this concern to the Band 7 staff and Ms Davies was taken off this patient.

This incident was particular concerning due to the distress levels of the patient and the importance of suctioning correctly. If a patient does not receive suctioning when needed and retains secretions, the patient could end up with pneumonia.'

The panel also had regard to the NMC statement of Witness 7 which said:

'It has been reported to me that during a shift on 17 April 2023, Witness 10, Staff Nurse, and Ms Davies were caring for Patient D. Patient D was a patient in Pod 5 and was assigned to Ms Davies. Patient D was a long-stay patient and had a tracheostomy, which is a tube inserted into the windpipe to help the patient breathe. Sometimes, this tube requires suctioning to remove any secretions.

I spoke to the patient's family to gather evidence and was told by them that Ms Davies had inserted a suction tube into the patient's airway but had not turned the suction on. This meant that the patient's airway was practically occluded, and the patient turned purple and became breathless. The relatives were very concerned by this incident and explained that Ms Davies had just seemed to 'laugh' the incident off.'

Witness 7, in his oral evidence, confirmed that the incident had been raised with him and that he had spoken to the patient's family at the time.

The panel also considered hearsay evidence from Patient D's relative, which was contemporaneously reported at the time of the incident.

The panel found that there was repeated and consistent evidence from a number of witnesses.

The panel considered your oral evidence, in which you stated that you did not insert a tube down Patient D's throat. The panel noted that this conflicted with your written statement which said:

> *'On 17 April 2023, I attempted to suction Patient D under supervision. When I attempted to suction, the system did not appear to be working correctly.*
>
> *I stopped the attempt and immediately sought help from the supervising nurse. I did not persist with suctioning when it was not effective. My behaviour was to escalate promptly, which is consistent with safe practice for a junior nurse.'*

Having considered the evidence before it, including the clear and consistent evidence from a number of witnesses, the panel determined that it was more likely than not you did not correctly suction Patient D on 17 April 2023. The panel accordingly found this charge proved.

Charge 2di)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   d. On 25/26 April 2023:

i. Did not correctly change Patient B's arterial flush line.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

'On 25 April 2023, Ms Davies was working in Pod 5 and was caring for two Level 2 patients, including Patient B. Patient B required a low – level of care and was almost ready to go to the ward. He had an arterial line to be able to monitor his blood pressure readings and to extract arterial blood samples to see how his oxygen levels were progressing whilst he was an in-patient in critical care.

…Witness 9 was taking over on the night shift on the 25 April 2023 from Ms Davies who had been on the long day shift on the 25 April 2023.

Ms Davies was changing Patient B's old arterial line set for a new arterial line set. When this procedure is carried out, it should be through an aseptic technique to minimise the risk of contaminating an invasive line device, protecting the patient from healthcare associated infections and protecting the nurse from contact with patients' bodily fluids.

Before Ms Davies had begun the procedure, Witness 9 asked Ms Davies if she would like assistance. Ms Davies declined the assistance and said she was fine to do it herself.

When completing the procedure, Ms Davies did not use an aseptic technique, failed to follow the correct steps, and had disconnected the arterial line at the wrong point down the line. This caused blood to flow back from Patient B on the old arterial line and saline to leak on to the floor from the new line.

Witness 9 had to step in to assist Ms Davies to ensure the arterial line flush had been changed correctly.'

The panel also took into account the NMC statement of Witness 9 which said:

'On 25 April 2023, I was on duty on the night shift in Pod 5 in the Unit. This shift continued into the morning of 26 April 2023. I was handing over to Ms Davies as she was beginning her long day shift in the morning.

On my return to the Unit for my night shift on the night of 26 April 2023, I had several concerns about Ms Davies' practice…'

During her oral evidence, the panel found Witness 9's account to be consistent with her written statement.

The panel also had regard to Witness 7's statement which said:

'During a shift on 26 April 2023, Staff Nurse Witness 9 had approached me to raise a concern about Ms Davies.

Witness 9 told me that her and Ms Davies had been caring for a patient with an arterial flush bag.

…Witness 9 told me that Ms Davies clearly did not know what she was doing when she changed this patient's flush bag and the patient had bled significantly.'

The panel found that the evidence from Witness 3, Witness 7 and Witness 9 was consistent with their statements, contemporaneous accounts and each other.

The panel had regard to your statement which said:

‘The nurse I asked for help was Witness 9, who was the nurse taking over from me on the next shift. I explained that I could not carry out the task as she requested when she handed over because it was a busy shift. Witness 9 refused to assist me when I asked for her assistance saying I should perform the task myself.’

However, in your oral evidence you said that it was Witness 9 who had asked you for help with the arterial flush line as she did not know how to change it. The panel found there to be inconsistencies within your evidence in relation to this incident.

Having considered the clear and consistent evidence from a number of witnesses and the inconsistencies in your evidence, the panel determined that it was more likely than not that you did not correctly change Patient B’s arterial flush line. The panel therefore found this charge proved.

Charges 2dii and 2diii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   d. On 25/26 April 2023:
      ii. Did not ensure appropriate monitoring of Patient I.
      iii. Did not provide an adequate handover in respect of Patient I.

These charges are found proved.

The panel considered the evidence in relation to the charge concerning Patient I. While there was no direct identification from the witnesses, the panel was satisfied from an email provided by Witness 9 that Patient I could be identified by their bedspace being Bed 39. You also provided a clear description of patient I, which assisted the panel in understanding the context of the incident.

The panel noted that the term “appropriate monitoring” is a generic term. For the purposes of this charge, the panel defined it to mean watching and keeping an eye on Patient I to ensure their safety. The panel found Witness 9’s accounts were consistent throughout and provided a coherent narrative.

The panel noted that in your statement you said:

> *‘In relation to “Patient I”, I do not recognise the description as relating to any specific patient I can recall.’*

However, in your oral evidence, the panel noted that you demonstrated no difficulty in recalling Patient I and were able to provide details of their circumstances in Bed 39. The panel also noted that you referred to the presence of a Healthcare Assistant (HCA) who could assist Patient I if they attempted to get out of bed.

Having considered all the evidence, the panel preferred the consistent and detailed accounts provided by Witness 9. The panel therefore found these charges proved.

Charge 2eiii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   e. On or around 30 April 2023:
      iii. Was not able to independently carry out a blood gas.

This charge is found proved.

In reaching this decision, the panel took into consideration the NMC statement of Witness 6 which said:

'During this same shift, I can recall there being an issue when completing an arterial blood gas ('ABG') test on a patient. I cannot recall the exact date of this shift or the name of the patient.

During this shift, this patient had required an ABG test, which is where a needle is inserted into their artery so that blood pressure can be continuously monitored and so that a sample of blood can be taken to check gas exchange levels, for example, how much oxygen, potassium and sodium are in the blood. This test can be quite painful for patients as the needle is inserted deep into an artery.

…Ms Davies and I were assisting with this patient's ABG test. During this process, Ms Davies realised she had selected the wrong syringe and left the test to walk around the bed space and look through the drawers for the correct one. Ms Davies was completing this search at a very leisurely pace, and I had to remind her that we needed to keep the test going and flush the line quickly, or we would have to redo the test and the line by coagulate and the patient may need a new arterial line inserted. I felt that Ms Davies had not understood the urgency of the task.

After prompting, Ms Davies did return and flushed the line to get rid of the blood.'

The panel took into account your statement which said:

'On 30 April I was involved in blood gas sampling and interpretation under supervision. I did perform arterial blood gases independently and consider myself fully competent to do so unsupervised.'

The panel noted that there was a direct conflict in the evidence.

Having carefully considered the competing accounts, the panel preferred the evidence of Witness 6, which it found to be more credible and reliable in the circumstances. The panel therefore found this charge proved.

Charge 2eiv)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   e. On or around 30 April 2023:
      iv. Placed a swab up Patient J's rectum without warning them.

This charge is found NOT proved.

In reaching this decision, the panel took into account your statement which said:

> *'I did not carry out a rectal swab without warning the patient and seeking consent first. I always inform patients before intimate procedures and explain what I am going to do and why.'*

The panel also took into consideration Witness 6's statement which said:

> *'I was with the patient and Ms Davies when she was admitted and saw Ms Davies approach the patient and put a swab up the patient's rectum without communicating with the patient or first warning her about what was about to happen. The patient jumped when this happened and was clearly quite shocked.'*

However, in her oral evidence, Witness 6 stated that you went through everything with Patient J during their admission, including that a rectal swab may be administered. When questioned further, she indicated that you had informed Patient J about the swab.

The panel determined that, on the balance of probabilities, it was more likely than not that you had informed Patient J that a swab may be taken. The panel accordingly found this charge not proved.

Charge 2ev)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   e. On or around 30 April 2023:
      v. Required prompting to review evening medication charts.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 6 which said:

> *'During the shift, when I came over to check on Ms Davies and the patient, I noticed that the administration and demand figures had not been recorded. I asked Ms Davies why these had not been recorded and she did not respond. She could not explain why she had not done this and just looked at me vacantly. It was as if I had never told her about documenting this information.'*

The panel also took into account Witness 6's contemporaneous statement, dated 30 April 2023, which said:

> *'She needed prompting with checking the patients drug charts for drugs that had been prescribed in the evening…'*

The panel took into consideration your statement which said:

> *'I reviewed medication charts as part of my routine practice and when abnormal results were identified.'*

The panel noted that your statement and oral evidence did not make reference to the evening medication charts.

In light of this, the panel determined that that it was more likely than not that you required prompting to review the evening medication charts. The panel accordingly found this charge proved.

Charge 2evi)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   e. On or around 30 April 2023:
      vi. Was not able to independently calculate and/or mix a controlled drug for administration.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

> *'On 30 April 2023 I also received an email from Colleague C, Senior Staff Nurse, reporting an incident involving Ms Davies.*
>
> *During her shift on 30 April 2023, Ms Davies was checking a controlled drug, Alfentanil (normal prescription is 25mgs in 50mls of 0.9% normal saline). These vials contain 5mgs per vial.*
>
> *According to Colleague C, Ms Davies struggled to count how many vials would be needed to make up this concentration of Alfentanil (5 Ampoules). Ms Davies also*

could not count how many vials remained in the Controlled Drug Cupboard once the 5 Ampoules had been removed to calculate the remaining stock balance. Colleague C also commented that Ms Davies found it difficult to understand how to mix the drug even though she had been shown before and after Colleague C had explained the prescription to her repeatedly.'

The panel also had sight of the email from Colleague C to Witness 3, dated 30 April 2023, which said:

'Also, there was another occasion where I was checking a CD chart with her (alfentanil small amps to be precise), she struggled to count:
-how many amps we needed
-how many amps was left prior and after taking what we needed

Then afterwards Emilia found it difficult and could not grasp how to mix the drug even though I showed her and explained to her the prescription.'

Witness 3 confirmed in her oral evidence that this account from Colleague C was accurate.

The panel noted that you deny this allegation and in your statement said:

'In relation to the allegation that I was not able to independently calculate or mix a controlled drug, my recollection is that I was able to perform the calculation when asked.'

The panel also noted that in your oral evidence you stated you found the task difficult and explained that administering the controlled medication was challenging due to the way the boxes of controlled medication were arranged in the cupboard. You described feeling flustered and lacking sufficient support from the second nurse at the time.

The panel attached appropriate weight to the hearsay evidence and considered it alongside the other evidence before it. On the balance of probabilities, the panel determined that it was more likely than not that you were not able to independently calculate and/or mix a controlled drug for administration. The panel therefore found this charge proved.

Charge 2fi)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   f. On 12 May 2023:
      i. Did not appropriately monitor and/or respond to Patient C while they were on a Draeger Ventilator.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

> *'At approximately 13:30pm, I walked from the Senior Managers Office to fill up my water bottle at the water fountain near to the nurses' station (by the ward clerk desk). When passing by Bed 12 in Pod 6, I heard the Draeger ventilator (breathing machine) and Phillips monitor alarming. The Phillips monitor displays the patient's electrical impulses for their heart rate, blood pressure, oxygen saturations, respiratory rate.*
>
> *I saw Ms Davies silence the alarms on both the ventilator and the monitor.*
>
> *…After filling my water bottle at the nurses' station, I walked back towards the Senior Managers' Office. Upon passing Bed 12 for a second time, I noticed that*

Patient C had oxygen saturation levels of 34% on the Phillips monitor. Both the monitor and ventilator were flashing red alarms but had been silenced.
I immediately rushed to Bed 12 and asked Ms Davies: "What is going on? Why have Patient C's oxygen saturations dropped to 34%?" Ms Davies remained silent and did not reply to my question. I placed Patient C on pre-oxygenation via the Draeger ventilator and grabbed the water's circuit.'

The panel found that Witness 3's evidence in relation to this incident was consistent in her NMC statement, local statement taken at the time of the incident and in her oral evidence.

The panel had regard to your witness statement which said:

'I placed the saturation probe on the patient and the monitor then showed that the oxygen saturations were low. I followed the protocol I had been taught, I increased the oxygen on the ventilator support and watched the saturations improve, and then dropped down again. I attempted to increase the oxygen saturations, but it dropped, so I increased it again, in line with my teaching, while I was in the process of seeking further help.

At that point my manager, Witness 3, arrived at the bedside and asked if I wanted help, to which I responded 'yes'. There was a wider response from the team.'

The panel preferred the account of Witness 3, which was consistent throughout her evidence, and accordingly found this charge proved.

Charge 2fii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   f. On 12 May 2023:

ii. Was not able to independently carry out an arterial blood gas

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

> *'I asked if Ms Davies would do an arterial blood gas. This is a sample of blood taken from the arterial line to process through the arterial gas machine. This information provides details of Patient C's oxygen, carbon dioxide and overall gases exchange. When Ms Davies performed this task, I had to tell her to turn off the three-way tap. This is a device to access blood from the arterial line and Ms Davies had not closed it properly. As a result, Patient C's blood was leaking on to the bed sheets.*
>
> *It appeared that there was no bionnector (one way valve) added to the threeway tap which would have stopped the blood from leaking via the port when taking a blood gas. I asked Ms Davies to add this to prevent this from happening again. Ms Davies added the bionnector to the port.'*

The panel also took into account Witness 3's contemporaneous statement which said:

> *'…I placed Patient C back on the ventilator and asked that we do an arterial blood gas to check his oxygen and CO2 levels, SN Emilia Davies decided to assist and carry out this procedure. Whilst, I talked to the patient I noticed that when SN Emilia Davies had obtaining the sample from the arterial line, she left the line open and blood had dripped on to the bed. I told her to stop and immediately took over the control…'*

In your oral evidence you said that this incident did not happen as you were taken to Witness 3's office.

Having considered all of the evidence before it, the panel determined that it was more likely than not that you were not able to independently carry out an arterial blood gas. The panel therefore found this charge proved.

Charge 2h)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   h. On 5 June 2023, clamped an EVD without appropriate training or supervision.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

> *'On 5 June 2023, Ms Davies was working with Colleague B, an experienced Band 5 Staff Nurse. Colleague B reported to me that an incident involving Ms Davies had occurred during this shift.*
>
> *During this shift, Ms Davies and Colleague B were caring for Patient E, a Level 3 neurosurgical patient. Patient E had an ICP bolt (a device in the brain tissue to record pressures) and an EVD (External Ventricular Drain). This small catheter lies within the ventricle in the brain to allow for cerebral spinal fluid to be released each hour helping control ICP pressures in the head.*
>
> *…During this shift, Colleague B had gone to reception to get some forms for Patient E's family. Colleague B was absent for no longer than five minutes. During this time, Ms Davies had attempted to carry out the 16:00pm observations on Patient E. In the process of completing these observations, Ms had clamped the EVD drain.*

On her return to Patient E's bed, Colleague B found that the EVD drain was clamped and asked Ms Davies why she had done this. Ms Davies had replied asking 'did I not do it right?'. Colleague B re-enforced the importance of not touching equipment she is not trained on nor has the experience to use.

Clamping an EVD can cause serious problems for a neurosurgical patient, as this increases ICP pressures within the brain tissue leading to serious damage.'

The panel also had regard to the hearsay evidence of Colleague B which said:

'I said to Ms Davies that I would go to reception and asked her not to touch anything.

Approximately five minutes later, I returned to the bed space. I found that the EVD had been clamped. I asked Ms Davies if she had touched the drain and she said "have I done it right?" I told Ms Davies that the EVD should not have been touched.'

The panel took into account your statement which said:

'On the occasion I recall, I was with a senior nurse, Colleague B, who was teaching me about the EVD as I was still supernumerary in relation to that type of device. She showed me how the taps should be positioned and how the drainage should be monitored.

At one point she had to leave the bedside and told me she would be back shortly. I did not adjust the taps because I could not remember for certain whether she had said to turn them to the left or the right. I waited for her to return and, when she did, I explained that I had not moved anything because I was not sure. I also documented the observations in the notes. I did not clamp or unclamp the EVD independently.'

However, in your oral evidence you stated that this was your first time working with an EVD and you denied the instruction not to touch the equipment. You also said in your oral evidence that you had touched the EVD and that this related to opening the taps. The panel noted that this conflicted with your written evidence.

In assessing this charge, the panel bore in mind the inconsistencies in your evidence. The panel attached weight to the evidence of Colleague B and, in the circumstances, preferred her hearsay evidence over your account.

The panel accordingly found this charge proved.

Charge 2Ii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   i. Displayed poor knowledge in respect of:
      i. Respiratory function.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 10 which said:

> *'During the shifts that I worked with Ms Davies, I can recall becoming aware of her lack of basic anatomical knowledge which I would expect all nurses to have.*
>
> *For example, I can recall becoming aware that she did not understand how to recognise patient deterioration and did not understand the basic knowledge*

required when dealing with respiratory procedures such as general airways reassessments.

I cannot recall the exact dates of the occasions where this lack of understanding had become apparent but can recall seeing this lack of knowledge through watching her day-to-day practice and when asking her follow up questions about patients.

It is vital that all nurses working on the Unit can recognise patient deterioration to prevent unnecessary events. This would have been covered during Ms Davies' training and supernumerary period. It is also vital that nurses working on the Unit have a good understanding of the respiratory system. This also would have been covered during Ms Davies' training and supernumerary period.'

The panel took into account the statement of Witness 5 which said:

'Before beginning this process, I asked Ms Davies if there was anything else she thought we should do. Ms Davies replied saying that we should do the nasogastric aspiration but only when the task list on the computer told us to. When I said that we should complete the procedure now, Ms Davies said we should only do this when the computer says it is due. This was incorrect as the patient had a high volume of fluid in their stomach and needed more regular aspiration. As explained in the paragraph above, I would always expect a nurse to tailor care and treatment to the needs of the patient.

If a patient has a high volume of fluid in their stomach, they could vomit. Although this particular patient had a protected airway with a breathing tube, it is still possible for vomit to go into their windpipe and lungs which could increase the severity of the patient's condition. This could severely impact the patient and lead them to require more oxygen and a longer stay in hospital.'

The panel took into consideration the statement of Witness 3 which said:

> *'On 30 April 2023 I also received an email from Witness 7, Senior Staff Nurse, reporting concerns about Ms Davies…*
>
> *During their shift on 30 April 2023, Witness 7 conducted a teaching session with Ms Davies in Pod 5. This session was aimed at addressing Ms Davies' learning needs for her Step One Competencies Book.*
>
> *Witness 7 discussed the basic respiratory and arterial blood gas interpretation (lungs, breathing, oxygen, and carbon dioxide exchange) with Ms Davies. Witness 7 found that Ms Davies had very poor knowledge of these areas, despite the fact that Witness 7 had just explained the anatomy and physiology of respiratory function and arterial blood gases to Ms Davies. Witness 7 repeated this session four times in succession.*
>
> *Witness 7 reported to me that Ms Davies was unable to retain any information nor was she able to discuss any basic anatomy or physiology relating to respiratory function.'*

The panel also took into consideration the statement of Witness 7 which said:

> *'I can recall teaching Ms Davies during one of these sessions and became concerned about Ms Davies' lack of understanding and knowledge. I cannot recall the date of this session.*
>
> *During this session, I was asking Ms Davies about very basic areas of knowledge required when working in the Unit, including basic knowledge about respiratory systems. For example, I can recall that when asking Ms Davies about gas exchange, I asked her what gases humans breath in and what gases they breathe out. She was not able to tell me and said she did not know. I would expect all nurse*

to know that humans breathe in oxygen and breathe out carbon dioxide at a minimum.'

The panel noted that Witness 7 gave detailed oral evidence to support his written statement. He described concerns about a lack of understanding of basic principles of oxygenation and breathing and explained that he undertook four teaching sessions in one day in an effort to support your understanding.

The panel also noted that Witness 10 provided detailed evidence, which was consistent with and supported Witness 7's account.

The panel noted your statement which said:

'During my placement my knowledge of advanced respiratory physiology, blood gas interpretation, and complex ICU medication regimes was still developing. This was expected for a new ICU nurse but was compounded by the inconsistent supervision I received.'

You stated that you did not have knowledge of advanced respiratory care. The panel noted, however, that the evidence demonstrated a lack of understanding of basic respiratory function.

In light of the consistent evidence from a number of witnesses, the panel accordingly found this charge proved.

Charge 2lii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   i. Displayed poor knowledge in respect of:

ii. Blood gases.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

'On 30 April 2023 I also received an email from Witness 7, Senior Staff Nurse, reporting concerns about Ms Davies…

During their shift on 30 April 2023, Witness 7 conducted a teaching session with Ms Davies in Pod 5. This session was aimed at addressing Ms Davies' learning needs for her Step One Competencies Book.

Witness 7 discussed the basic respiratory and arterial blood gas interpretation (lungs, breathing, oxygen, and carbon dioxide exchange) with Ms Davies. Witness 7 found that Ms Davies had very poor knowledge of these areas, despite the fact that Witness 7 had just explained the anatomy and physiology of respiratory function and arterial blood gases to Ms Davies. Witness 7 repeated this session four times in succession.

Witness 7 reported to me that Ms Davies was unable to retain any information nor was she able to discuss any basic anatomy or physiology relating to respiratory function.'

The panel took into account the statement of Witness 6 which said:

'As explained above, ABG blood test used to determine the blood gas levels in patients. During this shift, one the patients assigned to Ms Davies had an ABG test done, and results were produced. I had approached Ms Davies to offer supervision and guidance.

When the results were produced, it was clear that the patient's potassium was too low so I asked Ms Davies, "what do you think you need to do?", Ms Davies said we should give the patient potassium. I said, "ok, and what do we need to do before that?". I then mentioned that a prescription would be needed, and reminded Ms Davies that this patient had some other medication on their drug chart that also needed prescribing. I reminded Ms Davies that her next step should be to go and flag these test results to the doctor and ask for the prescriptions.

At this point, I had to leave to support another staff nurse with a patient who was getting a CT scan, so I left Ms Davies with these jobs to do for her patient.

When I got back, I asked Ms Davies if we had sorted the potassium, but Ms Davies said, "no you're doing that". I reminded Ms Davies that she was accountable for her own patients and that it was her responsibility to escalate to the doctor. In any event, I had talked her through this process and asked her to complete the escalation.

When speaking to Ms Davies, it felt as if we had never had a conversation about what needed to be done and why. She did not recognise that we had already discussed this patient.'

The panel also took into account the statement of Witness 7 which said:

'I can also recall that, during this session, Ms Davies was unable to answer any questions on arterial blood gases, specifically how to determine whether the patient is getting too much oxygen or too much carbon dioxide. I can recall telling Ms Davies the answers to the questions numerous times, and then repeating the question back to her. She then continued to give incorrect responses or say she did not know the answer.'

During his oral evidence, Witness 7 stated that you asked him to sign you off as competent; however, he was unable to do so because you did not demonstrate sufficient understanding. He advised you to undertake further reading and return for further discussion. During cross-examination, he accepted that repeating the same lesson can be a helpful way to support learning.

The panel noted that you deny this allegation and said in your statement:

> *'During my placement my knowledge of advanced respiratory physiology, blood gas interpretation, and complex ICU medication regimes was still developing. This was expected for a new ICU nurse but was compounded by the inconsistent supervision I received.*
>
> *I repeatedly asked for teaching, attended available training, and sought clarification when I was unsure. My reflective submissions record these efforts.'*

In light of the consistent evidence from a number of witnesses, the panel accordingly found this charge proved.

Charge 2Iiii)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   i. Displayed poor knowledge in respect of:
      iii. Medication.

This charge is found proved.

In reaching this decision, the panel took into consideration the statement of Witness 3 which said:

‘*‘On 30 April 2023 I also received an email from Colleague C, Senior Staff Nurse, reporting an incident involving Ms Davies.*

During her shift on 30 April 2023, Ms Davies was checking a controlled drug, Alfentanil (normal prescription is 25mgs in 50mls of 0.9% normal saline). These vials contain 5mgs per vial.

According to Colleague C, Ms Davies struggled to count how many vials would be needed to make up this concentration of Alfentanil (5 Ampoules). Ms Davies also could not count how many vials remained in the Controlled Drug Cupboard once the 5 Ampoules had been removed to calculate the remaining stock balance. Colleague C also commented that Ms Davies found it difficult to understand how to mix the drug even though she had been shown before and after Colleague C had explained the prescription to her repeatedly.

…. Colleague B also reported that Ms Davies had asked her whether Propranolol (an anti-hypertensive drug) was the same as Paracetamol (anti-pyretic/ pain relief). Colleague B said that this was concerning as these drugs have completely different effects on the body. Colleague B told Ms Davies to always check the BNF (British National Formulary) if she was unsure of any prescribed medication.’

The panel took into account the statement of Colleague B which said:

‘During this same shift on 5 June 2023 at around 18:00, I was talking to Ms Davies about a patient who was hypertensive and asked her about the drugs this patient was on (propranolol) Ms Davies thought it was the same as paracetamol.

Ms Davies said she did not know and did not know how to find out.’

The panel also took into account the statement of Witness 9 which said:

'I can also recall an incident when Ms Davies was preparing IV paracetamol for a patient. I cannot recall the exact date of the incident. Before she began the infusion process, I asked Ms Davies she was sure she had done everything right before she commenced. Ms Davies said she had but had not connected the IV medication to the patient before starting the infusion. I then pointed this out to her and asked her to connect the line to the patient. I would have expected her to know that an IV line must be connected to a patient from her basic training and experience in the Unit.

Further, the panel took into account the statement of Witness 5 which said:

'During this shift, Ms Davies forgot to complete all the information on medication labels on numerous occasions. For example, she forgot to write the batch number and expiry date on the labels. Writing the batch number and expiry date on these labels is really important because if the patient has a reaction to the medication, we will need to check this information in order to investigate.

…We then needed to administer Noradrenaline to the patient, and I asked Ms Davies to draw up the dose. Noradrenaline comes in small glass vials which often contain more medication than required for the patient's dosage. Ms Davies proceeded to draw up around 9mls of Noradrenaline. I was aware that the patient required a dose of 8mls, so prompted Ms Davies and asked her whether she had drawn up the correct dosage. Ms Davies told me that she had been told she should never waste medication so was going to administer the entire 9mls in the vial.

This was incorrect. Noradrenaline is an extremely potent medication and must be used with caution, too much can cause a patient to have cardiac arrythmias, leading to death.

It is important that patients are given the correct dosage regardless of any wasted medication. There are no circumstances in which this would be correct practice. I would have expected Ms Davies to know this.'

In reaching its decision, the panel preferred the evidence of the witnesses over your account. The panel therefore found this charge proved.

Charge 2k)

2. Between 7 November 2022 and 12 June 2023, while working at the Royal Stoke University Hospital, did not demonstrate the competence expected of a Band 5 Staff Nurse in that you:
   k. Displayed poor communication skills in respect of staff and/or patients and/or patients' relatives.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 3 which said:

'Patient D's relatives told Witness 10 that Ms Davies appeared to lack awareness, compassion and an ability to prioritise care. Patient D informed Witness 10 that she did not want Ms Davies to look after her again after this event.'

The panel took into account the hearsay statement of Colleague B which said:

'Ms Davies was confused and clearly did not understand the seriousness of the situation.

Later that day, the relatives of this patient expressed concerns about Ms Davies to me and asked me not to leave her alone with the patient.'

The panel also took into account the statement of Witness 10 which said:

'For example, I can recall seeing Ms Davies sat on the computer in a patient's bedspace and ignoring the patient next to her. I can also recall seeing Ms Davies ignore the relatives sat with the patient she was attending. I would expect nurses to talk to the patient they were attending, to explain what they were doing, why and to check that the patient is okay. I would also expect nurses to talk to the relatives accompanying the patient to explain what was happening with the patient and provide updates. I cannot recall the exact dates of these incidents or the patient names. I cannot recall whether I spoke to Ms Davies about these concerns.

I can also recall an occasion where a doctor was attending to a patient allocated to Ms Davies and had asked Ms Davies to reduce the patient's sedation. Ms Davies did not respond to the doctor and just stared at them with a blank, vacant expression. Ms Davies did not reduce the patient's sedation.'

The panel further took into account the statement of Witness 6 which said:

'I can recall that the patient on this shift had a Glasgow Coma Scale ('GCS') of 15 which means she was completely aware and alert and was not sedated. This patient had just come from surgery and was in a lot of pain.

I was with the patient and Ms Davies when she was admitted and saw Ms Davies approach the patient and put a swab up the patient's rectum without communicating with the patient or first warning her about what was about to happen. The patient jumped when this happened and was clearly quite shocked.

I then spoke to Ms Davies and reminded her of the importance of communicating with patients, especially when they are alert and not sedated.

I would expect all nurses to be aware of the importance of this type of communication.'

The panel took into account your statement which said:

'I did not receive any formal complaint about my communication with staff, patients, or relatives.

There were occasions when I felt anxious because of the way some colleagues spoke to me, particularly when I was still learning. Despite this, I continued to escalate concerns and communicate with medical staff about abnormal results or changes in patients' conditions.'

The panel noted that there was consistent and repeated evidence from a number of witnesses. The hearsay evidence provided by Colleague B as well as contemporaneous evidence from patient's relatives was also consistent with these accounts, and the panel preferred this evidence. The panel accordingly found this charge proved.

Charges 3a and 3b

3. On or around 11 June 2023 attended Patient G's home without permission and/or clinical justification where you:
   a. Asked Patient G to give you her medication in a forceful manner.
   b. Took Patient G's medication without her permission and/or clinical justification.

These charges are found proved.

In reaching this decision, the panel took into account the statement of Patient G which said:

'…I was very concerned that Ms Davies had come to my house, with no prior notice, and demanded that I give her the medication she had given to me at the Hospital. When I told her that it was my medication, she said it was another patient's medication and she had given me the wrong medication and just snatched it off me.'

The panel noted that you deny these allegations.

The panel noted that Patient G gave consistent evidence orally, which supported her written statement, and remained credible under cross-examination. The documents provided in relation to the incident were limited in nature, but the statements appeared to support Patient G's account that you had gone to her to recall medication that had been incorrectly administered.

The panel considered your inability to provide a full account concerning, noting that in your reflective document you highlighted learning points regarding ensuring you signed for the correct medication. You also stated that you went to your car at the end of your shift, which prevented you from completing tasks. The panel found no reason to doubt Patient G's evidence or to suggest she fabricated her account. The panel considered that it was more likely that you provided an incomplete account to avoid disclosing that you had dispensed medication incorrectly.

The panel was satisfied that cross-examination did not undermine Patient G's credibility. There was no evidence to suggest any clinical justification for you to attend Patient G's home, nor that you did so with permission. The panel concluded that, on the balance of probabilities, it was more likely than not that you attended Patient G's home, spoke to her in a forceful manner, and took Patient G's medication without clinical justification or consent. The panel therefore found these charges proved.

Charge 4)

4. On or around 6 July 2023 confronted Patient G about a complaint she had raised.

This charge is found NOT proved.

The panel heard evidence that you had a virtual interim order hearing and that you were not on shift on 6 July 2023, with your evidence confirming that you did not work night shifts due to childcare commitments. There was no evidence to suggest that you were present at the Health Board on that date, nor was there any evidence to indicate that Patient G was at the Health Board at that time.

Having considered the evidence in its totality, the panel was not satisfied, on the balance of probabilities, that the charge had been made out. The NMC therefore failed to discharge the burden of proof, and the panel finds the charge not proved.

Fitness to practise

The panel bore in mind that some of the charges brought by the NMC are charges in relation to your lack of competence (charges 1 and 2), and some are in relation to your misconduct (charges 3 and 5).

The panel noted that its decision of impairment must be considered in stages, namely it must consider whether the facts found proved in relation to charges 1 and 2 on competence amounted to a lack of competence, and whether the facts found proved in relation to charges 3 and 5 amount to misconduct. If so, the panel must then consider whether your fitness to practise is currently impaired on either grounds of misconduct or lack of competence.

The panel considered both in turn below.

Submissions on misconduct, lack of competence and impairment

Ms Maqboul submitted that your conduct, when viewed both individually and cumulatively, clearly amounts to misconduct and a lack of competence. She submitted that the proven facts amount to conduct that is a serious departure from the professional standards expected of a nurse and undermines public confidence in the nursing profession.

Ms Maqboul submitted that there are clear and significant concerns regarding your practice. She submitted that it is your responsibility to familiarise yourself with relevant policies and to practise safely, especially in relation to medication administration. She also submitted that the charges relating to medication errors demonstrate repeated and fundamental failures in basic nursing practice and that these errors occurred in a critical care environment involving highly vulnerable patients, and it was only due to the vigilance and professionalism of other staff that serious harm was avoided. She further submitted that these matters, whether considered individually or collectively, demonstrate a concerning lack of competence.

In relation to charge 3, relating to Patient G, Ms Maqboul submitted that this is serious misconduct. She submitted that it is never acceptable for you, as a nurse, to attend a service user's home and remove medication in the manner described. She submitted that Patient G was a vulnerable individual, recently discharged from hospital, and the removal of her medication exposed her to a real risk of harm, caused distress, and significant inconvenience. She also submitted that such conduct represents a profound failure by you to act in a patient's best interests and a serious abuse of professional trust.

In relation to charge 5, Ms Maqboul submitted that this also amounts to misconduct, arising from your failure to provide timely information relating to your conditions of practice order. She submitted that the evidence demonstrates that you worked a shift without the appropriate level of supervision, contrary to the conditions imposed for public protection. She also submitted that this conduct, coupled with inconsistencies in your evidence, further undermines confidence in your integrity and professionalism.

Ms Maqboul submitted that your actions breached multiple provisions of the 2018 NMC Code of Conduct, including duties to act in patients' best interests, practise within your competence, manage medicines safely, reduce the risk of harm, and uphold the reputation of the profession. She submitted that the charges strike at the heart of what is expected of a registered nurse and demonstrate both serious misconduct and a lack of competence, compounded by an apparent lack of insight and willingness to learn from feedback.

Ms Maqboul 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.

Ms Maqboul submitted that there is a complete absence of insight, remorse or meaningful remediation from you. She submitted that you do not accept that your actions amounted to failings and, in many instances, you do not accept that events occurred as described by multiple witnesses. She submitted that the reflections you provided demonstrate no progression in your understanding or thinking, and there is no evidence that you have sought to test or remediate your practice in a similar setting. She further submitted that there is no evidence before the panel of you working as a nurse or otherwise addressing the deficiencies identified.

Ms Maqboul submitted that, in these circumstances, the risk of repetition is high. She submitted that you have placed patients at an unwarranted risk of harm and that, without a finding of impairment on the ground of public protection, there is a real and ongoing risk to patient safety.

Ms Maqboul submitted that the public interest is strongly engaged in this case. She submitted that your actions have brought the profession into disrepute and have the clear potential to do so again. She also submitted that members of the public would be seriously concerned by the facts of this case and by the care provided to vulnerable patients and that a finding of current impairment is therefore necessary to protect the public and to maintain confidence in the nursing profession and its regulatory standards.

Mr Herman submitted that the facts found proved arose within a period during your early years of practice and whilst working in a highly specialist critical care environment. He submitted that the evidence demonstrates situational difficulty and role unsuitability rather than an experienced practitioner continuing to practise unsafely despite prolonged support He referred the panel to the Hospital's educational assessment, which recorded your engagement, effort and learning capacity while concluding that critical care was not a suitable environment for you. He submitted that this points to contextual difficulty rather than enduring incapacity.

Mr Herman submitted that the panel heard evidence from colleagues who worked with you describe you as pleasant, working well with staff and caring appropriately for patients, which is inconsistent with a picture of fundamental incompetence. He submitted that the evidence directly undermines any suggestion that you are unable to learn or unwilling to engage with professional standards.

In relation to competence, Mr Herman submitted that the regulatory threshold for lack of competence is not met. He submitted that lack of competence requires a sustained and generalised inability to practise safely despite appropriate support. He submitted that the findings in this case relate to a single hospital and a highly specialist environment. He submitted that there is no evidence of repetition outside of this setting and no evidence that you are unable to practise safely within an appropriate role. He further submitted that the contemporaneous records show that you recognised your limitations, sought help, accepted further training and engaged with remedial measures at the time.

Turning to misconduct, Mr Herman submitted that the findings relating to Patient G were serious but seriousness alone does not determine impairment. He submitted that the conduct was isolated, there is no evidence of repetition, and as charge 4 was not proved, this was not part of a pattern of behaviour. He submitted that your reflective work demonstrates engagement with professional boundaries and learning from the concerns raised.

Mr Herman submitted that you have undertaken extensive, targeted training and reflective work directly addressing the concerns. You have completed a master's degree and maintained professional development despite being unable to work due to interim restrictions. He submitted that there is no evidence of repetition and no evidence of current risk to patients.
Mr Herman submitted that the NMC's reliance on multiple alleged breaches of the Code risks counting breaches rather than looking carefully at each one. He submitted that an informed member of the public, aware of the historic nature of the concerns, the absence of repetition, and the substantial remediation undertaken, would not consider a finding of current impairment necessary.

Mr Herman submitted that regulation is about protection from future risk, not punishment for past conduct. He 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 the principles in a number of relevant judgements.

Decision and reasons on misconduct

The panel had regard to the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 which defines misconduct as a *'word of general effect involving some act or omission which falls short of what would be proper in the circumstances'*. The case also stated that to qualify as misconduct the act found proved had to be *'serious'*.

When determining whether the facts found proved in charge 3 and 5 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:

'5 Respect people's right to privacy and confidentiality

To achieve this, you must:

***5.1** respect a person's right to privacy in all aspects of their care*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

23 Cooperate with all investigations and audits

To achieve this, you must:

***23.3** tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.'*

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

In relation to charge 3, the panel found that you left your shift without authorisation, thereby leaving patients without appropriate care and placing your colleagues under additional pressure. The panel further found that you attended Patient G's home without permission or any clinical or medical justification, and that you removed medication from

them, leaving them without essential medication for two days. The panel noted that no clear or credible explanation was provided as to the motivation for these actions.

The panel was of the view that, by attending a patient's home and removing medication, you acted outside your scope of practice and outside any recognised clinical process, exposing a vulnerable patient to potential harm.

Taken together, these actions demonstrated a serious breach of professional boundaries and a failure to uphold the standards expected of a registered nurse. The panel therefore determined that the conduct found proved under charge 3 is sufficiently serious to amount to misconduct.

In relation to charge 5, the panel acknowledged that, although it was not at the start of your working shift but shortly after it commenced, you did notify the ward manager that you were subject to interim conditions of practice. However, the panel found that you failed to provide a copy of the conditions at any stage. As a result, the full extent and detail of the restrictions placed upon your practice were not known or properly implemented within the clinical setting.

The panel concluded that your failure to ensure that the interim conditions of practice were fully disclosed and adhered to placed patients at potential risk and undermined the purpose of those conditions, which were imposed to protect the public. This conduct represented a serious failure to comply with regulatory requirements and a significant departure from professional standards. The panel therefore determined that the conduct found proved under charge 5 is sufficiently serious to amount 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 NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel found that patients, in particular Patient G, were put at risk of harm as a result of your misconduct. The panel also found that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel therefore concluded that limbs a, b, and c of the Grant test were engaged in the past and, if repeated, would be engaged in the future.

The panel then went on to consider whether the concerns had been addressed by you. In relation to charge 3, the panel accepted that the incident giving rise to this charge was an isolated incident and arose in an unusual set of circumstances. The panel further

accepted that there is a low risk of repetition and, on that basis, concluded that your fitness to practise is not currently impaired in relation to this charge.

When considering whether your fitness to practise is currently impaired in relation to charge 5, the panel noted that you practised whilst in breach of your interim conditions of practice. Those conditions were imposed to protect patients, and your failure to comply with them had the potential to place patients at risk of harm. The panel considered that compliance with regulatory restrictions is a fundamental requirement of registration and failure to do so is a serious matter.

The panel found that, while you accepted that you did not provide a copy of your interim conditions of practice order to the Health Board, you maintained that you believed sending a copy of the conditions to your agency was sufficient. The panel noted that you were clearly advised in correspondence to read the conditions carefully and ensure full compliance. You failed to do so and the panel was not satisfied that this advice was adequately followed.

The panel also identified a lack of full insight. While you accepted that you had not provided the conditions to the Health Board, you did not fully acknowledge the seriousness of practising without ensuring that the conditions were properly implemented and adhered to in the workplace. This raised concerns to the panel about your understanding of your personal responsibility to comply with regulatory requirements.

In all the circumstances, while the panel concluded that there is no current impairment on public protection grounds, it determined that a finding of impairment is required on public interest grounds. Such a finding is necessary to uphold professional standards, to maintain public confidence in the nursing profession, and to mark the importance of compliance with regulatory conditions imposed for the protection of the public.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired

Lack of competence

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

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

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

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the NMC's guidance on Lack of competence (FTP-2b) which said:

> *'Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.*

Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate.

We recognise that nurses, midwives and nursing associates sometimes make mistakes or errors of judgement. Our starting position is that the nurse, midwife or nursing associate is usually a safe and competent professional but something may have happened that got in the way of them delivering safe care.

If concerns are raised about the general competence of a nurse, midwife or nursing associate we'll seek to understand the circumstances at the time. We'll also look at their practising history and not just at the period of time when the concerns arose. This will help us understand if there is a particular area of practice where there may be concerns or whether they are more general in nature.'

The panel had regard to the terms of the Code. In particular, the following standards:

*'**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*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

***2.1** work in partnership with people to make sure you deliver care effectively*

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 *maintain the knowledge and skills you need for safe and effective practice*

8 Work cooperatively

To achieve this, you must:

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

8.2 *maintain effective communication with colleagues*

8.4 *work with colleagues to evaluate the quality of your work and that of the team*

8.5 *work with colleagues to preserve the safety of those receiving care*

8.6 *share information to identify and reduce risk*

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

13.5 *complete the necessary training before carrying out a new role*

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

To achieve this, you must:

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

14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

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

To achieve this, you must:

16.2 *raise your concerns immediately if you are being asked to practise beyond your role, experience and training*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard. The panel also had sight of the NMC's Standards of proficiencies for registered nurses and paid particular attention to Section 11 concerning *'Procedural competencies required for best practice, evidence-based medicines administration and optimisation.'*

The panel considered whether the facts found proved under charge 1 amount to lack of competence. The panel noted that the evidence before it related to a single incident only. Although the factual elements of the charge were found proved, the panel accepted that during the shift, the ward was significantly short staffed and that you were working as an agency nurse to fill a staffing gap. The panel also accepted your evidence that you had not been made aware of the relevant policies on medication administration and that agency staff were not routinely provided with policy guidance at that time.

The panel took into account that the patient received the correct dosage of insulin at the correct time and that no harm was caused. The panel accepted that you believed you had checked the insulin dosage and assumed you were authorised to administer it. In the circumstances, the panel was satisfied that this was a mistake rather than evidence of an ongoing inability to practise safely.

The panel also took into account the Health Board's acceptance that policies were not adequately explained to agency staff and its acknowledgment that changes would be implemented going forward, as evidenced in the Datix incident form:

> *'Management Review/Make it safe plus. What were the findings of the management review/Make it safe plus?*
>
> *Staff education around current practice and policy was missing. This is now raised on ward safety brief and on handover for new staff on the ward.'*

This supported the panel's conclusion that the incident arose from systemic factors rather than a fundamental deficiency in your competence.

Accordingly, the panel determined that your conduct in charge 1 does not amount to lack of competence.

In relation to charge 2, the panel noted that the stem of the charge explicitly encompassed lack of competence, and it assessed the incidents collectively.

The panel considered the minutes from performance meetings which indicated that you accepted there had been deficiencies in your practice. The panel also noted the evidence from a number of witnesses who said that you received more support than other staff members, including extended supernumerary periods, and that additional supervision and training had also been provided.

The panel found that the issues were not isolated. The incidents occurred over a series of eight to nine shifts, both while you were supernumerary and after you had begun working as part of [PRIVATE]. This demonstrated repeated concerns over a prolonged period. The panel further acknowledged that, although [PRIVATE] was highly specialised and intensive, you had chosen to work in this setting.

The panel considered the timeline of your work on [PRIVATE] in detail. You commenced work on 7 November 2022 and were supernumerary for nine weeks. You began independent practice on 1 February 2023 but were returned to supernumerary status on 3 February 2023, with an action plan implemented on 9 February 2023. You started again as an independent practitioner in March 2023 but were placed back into supernumerary status on 30 April 2023. The panel noted that, if it had not been for the supervision in place, serious harm could have occurred to patients during this period.

The panel also noted that at no stage did you raise any concerns or request to be moved to a different environment. Although there was limited evidence for the period between November 2022 and February 2023, the panel determined that the combination of supervised and independent shifts provided a sufficient fair sample of practice to assess your competence.

The panel concluded that the repeated concerns over an extended period, despite the support and supervision provided, demonstrate a sustained and generalised inability to practise safely in this setting. The panel therefore determined that the conduct found proved under charge 2 amounts to a lack of competence.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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/their fitness to practise is impaired in the sense that S/He/They:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) …'

The panel found that a number of patients were put at serious risk of unwarranted physical harm as a result of your lack of competence. Your lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel found that your failings related to fundamental and basic areas of nursing practice. There was a period of evidenced instances of lack of competence, including repeated errors despite being placed on supernumerary status and receiving extensive supervision. Whilst the panel acknowledged your submission that you had not had enough time to apply your learning, it noted that you had multiple opportunities to practise under supervision, yet errors persisted.

The panel further noted that it appeared that you did not accept the seriousness of these incidents or the additional pressure placed on your colleagues as a result of your lack of competence. There was a lack of personal responsibility, with the onus appearing to be on colleagues around you rather than yourself. The panel considered that your choice to work in a highly pressurised critical care environment contributed to the issues observed, and attitudinal issues were apparent in how you addressed concerns regarding your competence.

The panel also considered the risk of repetition. While you had submitted to the panel a reflective piece that had been sent to the Case Examiners at an earlier stage, the panel found limited evidence of insight. There was no acknowledgement of the potential harm to service users or the impact of your actions on colleagues and the nursing profession. No updated reflection had been provided and your focus on professional boundaries appeared to overshadow fundamental nursing practice.

Further, the panel considered that your rationale focused heavily on a limited opportunity for practical application of your learning during your initial period of supernumerary status in [PRIVATE]. While you have completed further training, including a master's degree in oncology, the panel had no evidence of you working in any role in a clinical setting. This was a factor that contributed to the panel's determination that there is a high likelihood of future similar errors, given the time that would be required to familiarise yourself with any new role.

In terms of remediation, the panel acknowledged that you had undertaken some training courses. However, the panel concluded that there is no evidence that you have currently strengthened your practice, particularly as you have not been working in a clinical setting. The panel also noted a lack of remorse and understanding of the impact of your actions, leading to a real risk of repetition if unrestricted practice were permitted. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are 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, which 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, in this case, a finding of impairment on public interest grounds was required. The panel considered that you have not upheld the proper standards required and therefore public confidence would be undermined if your practise was not restricted.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Ms Maqboul submitted that, while it remains open to the panel to consider a strike-off arising from its finding of impairment in relation to charge 5, the panel is obligated to act proportionately when determining sanction.

Ms Maqboul submitted that your conduct in charge 5 is indicative of a pattern of behaviour, particularly when considered alongside the findings under Charge 2.

In relation to charge 2, Ms Maqboul submitted that the concerns were not isolated and that there were repeated issues over a prolonged period, creating a risk of serious harm to highly vulnerable patients in a critical care environment.

Ms Maqboul submitted that there has been a distinct lack of accountability and insight from you with no appreciation of the real risk of harm posed. She submitted that many of the issues identified relate to fundamental nursing and clinical skills, including documentation and medication administration, and there has been no evidence of remediation within a clinical environment. She further submitted that there is no evidence of meaningful remediation of these basic aspects of nursing practice.

In relation to mitigating features in this case, Ms Maqboul acknowledges that no actual harm was caused to patients, albeit this was due to the intervention of colleagues. She also submitted that some academic training has been undertaken. However, she submitted that this training does not address the central concerns in this case.

Ms Maqboul submitted that, in light of the seriousness of the concerns and the absence of remediation and insight, a suspension order is the most appropriate and proportionate sanction. She submitted that it is a matter for the panel to determine the length of such an order.

Mr Herman reminded the panel that the purpose of a sanction is to protect the public rather than be punitive.

Mr Herman submitted that, in relation to charge 2, the finding of impairment arises from concerns about your clinical competence in a highly specialised critical care environment. He submitted that a conditions of practice order would allow any risk to be managed with precision, requiring appropriate supervision and enabling your competence to be demonstrated over time with the safeguard of meaningful review.

Mr Herman submitted that a suspension order would be a counter-productive and disproportionate response as it would remove you from practice altogether rather than facilitating remediation.

In relation to charge 5, Mr Herman submitted that the impairment found relates to a failure to notify your employer of your interim conditions of practice order. He submitted that this concern does not automatically require suspension and can be effectively managed through a conditions of practice order requiring ongoing compliance and engagement with the regulator.

Mr Herman informed the panel that you [PRIVATE]. He said that, since being subject to an interim order, you have been [PRIVATE].

Mr Herman invited the panel to impose a conditions of practice order. He submitted that the risks identified by the panel are specific and capable of being managed through supervision, restriction of scope and clear regulatory oversight.

The panel accepted the advice of the legal assessor.

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 have shown a significant lack of insight into your clinical failings and misconduct. The panel noted the evidence of Witness 3 which said:

  'I did not feel that she had any empathy, remorse or understanding of what she had failed to do as a qualified staff nurse or any idea of the gravity of the situation.'

- You abused your position of trust by attending Patient G's home without consent or medical justification.
- There have been repeated incidents of a lack of competence in failing to implement basic fundamentals of nursing care, demonstrating a pattern of incompetence over a period of time.
- You have consistently sought to blame colleagues for your failings and have shown an inability to work effectively with colleagues.
- There has been an absence of remorse from you in relation to colleagues, service users and the wider nursing profession.
- Your lack of competence placed patients at serious risk of harm and had it not been for the interventions of colleagues, serious harm would have been caused.

- By failing to provide a copy of your interim conditions of practice order, you were in breach of your interim order.

The panel also took into account the following mitigating features:

- The [PRIVATE] you have faced, in particular [PRIVATE] as a result of NMC proceedings.
- At the time of the incidents, you were at an early stage of your clinical practice.
- You were working in an intensive environment within a clinical care setting.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict 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 and lack of competence were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG which states that a conditions of practice order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel noted that aspects of your impairment include attitudinal concerns, arising from an inability to fully recognise the limits of your competence at the relevant time, your failure to take accountability or responsibility for your clinical failings or to recognise the severity of your actions. Whilst the panel acknowledged that you have stated a willingness to retrain and accepted that conditions could in principle protect the public, it concluded that such an order would not be workable in the circumstances of this case.

The panel determined that any conditions capable of addressing the identified risks would require a very high level of direct and ongoing supervision. Given your extended period out of practice, and the significant level of supervision required even while you were in practice, the panel was not satisfied that conditions could be implemented without placing an unreasonable burden on colleagues and employers. The panel also noted that effective conditions of practice rely on trust, proactivity and professional ownership, including a willingness to work cooperatively with colleagues and to be open and forthcoming about the existence of conditions.

In reaching its decision, the panel attached weight to the fact that you have previously been subject to an interim conditions of practice order and failed to comply with it. The panel was mindful of the NMC's guidance on sanction (SAN-1), which states:

> *'Equally, any evidence that the nurse, midwife or nursing associate did not fully comply with an interim order may be relevant to questions about insight, their*

attitude towards professionalism, and whether they are likely to comply with any order the Fitness to Practise Committee might make.'

For these reasons, the panel concluded that although a conditions of practice order might be relevant to the nature of the impairment, it would not be proportionate or sufficient when taking into account the need to protect the public and the wider public interest. The panel therefore determined that a conditions of practice order was not an appropriate sanction in this case.

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 repetition of behaviour since the incident;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct and lack of competence was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order. The panel also determined that this was not the only sanction available to meet public interest and public protection considerations.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and lack of competence and to allow you time to address the range of issues covering a broad range of fundamental nursing aspects.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Undertaking employment or voluntary experience in a care setting
- Providing evidence of development of communication skills
- Providing evidence of development of team working
- Providing testimonials or feedback from recent and/or current employers, commenting on your clinical or transferrable learning and improvement
- Providing more significant reflections on your clinical failures and their impact on patients, colleagues and the public
- Engaging with and attending future NMC proceedings

Interim order

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

Submissions on interim order

Ms Maqboul submitted that an interim suspension order for a period of 18 months is required to cover the 28-day period of appeal and the time that can be taken for an appeal to be heard.

Mr Herman made no submissions in respect of this application.

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 allow for any time required for an appeal process. The panel also considered it is necessary for the protection of the public.

In addition to protection of the public, the public interest includes maintaining public confidence in the profession and maintaining proper standards of conduct and performance.

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

This will be confirmed to you in writing.

That concludes this determination.