

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Hearing
Wednesday 15 October 2025 – Wednesday 22 October 2025**

Virtual Hearing

Name of Registrant: Laura Jane Jones

NMC PIN: 0010458W

Part(s) of the register: Sub part 1 RNC
Registered Nurse – Children (07 September 2003)

Relevant Location: Bridgend County Borough

Type of case: Misconduct

Panel members: Robert Pragnell (Chair, lay member)
Vanessa Bailey (Registrant member)
Lorraine Chalk (Lay member)

Legal Assessor: Joseph Magee

Hearings Coordinator: Fionnuala Contier-Lawrie

Nursing and Midwifery Council: Represented by Robert Rye, Case Presenter

Ms Laura Jane Jones Not present and unrepresented

Facts proved: Charges 1a, 1bi, 1d, 2a, 2bii, 2f, 2g

Facts not proved: Charges 1aii, 1bii, 2bi, 2c, 2d, 2e

Facts partially proved: Charge 1c

Fitness to practise: Impaired

Sanction: Conditions of practice order (**12 months**)

Interim order: Interim conditions of practice order (**18 months**)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Jones was not in attendance and that the Notice of Hearing letter had been sent to Mrs Jones' registered email address by secure email on 12 September 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Jones

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

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

- No application for an adjournment has been made by Mrs Jones;
- Mrs Jones has not responded to the letters sent to her about this hearing;

- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience the witness, their employer and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2019 and 2022;
- Given the length of time that has already elapsed, a further delay is likely to have an adverse effect on the ability of the witness to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel found it fair to proceed in the absence of Mrs Jones. The panel will draw no adverse inference from Mrs Jones' absence in its findings of fact.

Details of charge

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

- 1) Failed to ensure adequate care to patients in that:
 - a) In March 2020, did not identify that the spirometry equipment:
 - i) Was faulty and needed repair/replacement;
 - ii) Had no service history;
 - b) In relation to Patient K:
 - i) From March 2019 to February 2022, failed to provide adrenaline auto-injector training since they were prescribed an adrenaline auto-injector in March 2019;
 - ii) From September 2021 to February 2022, failed to arrange a follow up appointment to discuss their results from a skin prick test performed in September 2021;
 - c) On or around January to February 2022, failed to provide adrenaline auto-injector training for Patients B/ H/ I/ J;

- d) In relation to Patient G, failed to arrange a follow up allergy clinic appointment following their skin prick test and blood tests done in February 22;
- 2) Failed to keep accurate records concerning the patients in your care in that:
- a) In relation to Patient E, recorded incorrect information in a clinic letter from June 2021;
 - b) In February 2022, in relation to Patient B:
 - i) Recorded that adrenaline auto-injector training had been provided when it had not;
 - ii) Failed to file a copy of their food allergy action plan in their medical notes;
 - c) In February 2022, in relation to Patient C, failed to record any clinic attendances in their medical notes;
 - d) In February 2022, in relation to Patient D, failed to record any clinic attendances in their medical notes;
 - e) In or around February 2022, in relation to Patient F:
 - i) Failed to record consultations that had taken place between you and their mother;
 - ii) Failed to make a referral to a consultant;
 - f) In or around February 2022, in relation to Patient G, failed to record information regarding school contact in their medical notes;
 - g) Between January 2022 - May 2022, in relation to Patient A, failed to record information regarding a previous skin prick test in their medical notes.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Rye under Rule 31 to allow the hearsay evidence contained within the statements and associated exhibits of Witness 1, Witness 2 and Witness 3 into evidence.

While the NMC have produced signed witness statements from Witness 1, dated 21 June 2023, Witness 2 dated 10 January 2024 and Witness 3 dated 21 November 2023, it has not been possible to secure their attendance to give oral evidence.

Mr Rye referred the panel to emails dated 17 and 18 July 2025 from Witness 1 which state that they would not be able to attend due to being on holiday and would be unable to join the hearing. Mr Rye then referred the panel to emails from Witness 2 dated 16 July 2025, 15 September 2025 and 17 September 2025 which state they are unable to attend the hearing as they are on holiday. Mr Rye also referred the panel to the emails dated 16 July 2025, 23 July 2025 and 1 September 2025 sent by Colleague A in relation to Witness 3. The emails state that Witness 3 would not be able to attend [PRIVATE].

In the preparation of this hearing, the NMC had indicated to Mrs Jones in the Case Management Form (CMF), dated 26 March 2025, that it was the NMC's intention for Witness 1,2,3 and 4 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 1,2,3 and 4, Mrs Jones made the decision not to attend this hearing. On this basis Mr Rye advanced the argument that there was no lack of fairness to Mrs Jones in allowing Witness 1,2 and 3's hearsay testimony into evidence.

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

The panel considered the case of *Thorneycroft v NMC* [2024] EWHC 1565 (Admin) and the test set out therein for accepting hearsay evidence:

- “(i) whether the statements were the sole or decisive evidence in support of the charges;*
- (ii) the nature and extent of the challenge to the contents of the statements;*

(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;

(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;

(v) whether there was a good reason for the non-attendance of the witnesses;

(vi) whether the Respondent had taken reasonable steps to secure their attendance; and

(vii)... [Issues of whether you had received prior notice of this application.]”

The panel gave the application in regard to Witness 1 and Witness 2 serious consideration. The panel noted that the NMC had attempted to secure their attendance several times and it was satisfied that the witnesses were given the standard amount of notice of hearing.

The panel considered that Witness 1 and Witness 2's statements were not sole or decisive evidence in support of the charges, however they would assist the panel in understanding the background of the case and help it understand the organisation's structure.

The panel accepted the reasons for Witness 3 being unable to attend and noted that this statement was not sole or decisive on as if it was to be considered on its own, it would be insufficient.

The panel considered whether Mrs Jones would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 1, 2 and 3 to that of allowing hearsay testimony into evidence.

The panel considered that as Mrs Jones had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 1, 2 and 3 and the opportunity of questioning and probing that testimony.

The panel found that all 3 witness statements were demonstrative and reliable and that it would not be pragmatic to adjourn in these circumstances. The panel found that the evidence of the 3 witnesses was relevant and it was also fair to admit the hearsay evidence into evidence. The panel noted that it would give what it deemed appropriate weight once the panel had heard and evaluated all evidence before it.

Background

The NMC received a complaint on 9 September 2022 about Mrs Jones from Colleague B and Witness 2 at Cym Taf Morgannwg University Health Board where she worked as a Band 6 Paediatric Respiratory Nurse Specialist within Princess of Wales Hospital.

It was identified that a spirometer was defective and had no service history.

Concerns were raised in relation to Mrs Jones' failure to ensure adequate care to patients including to arrange follow-up appointments.

Coverage of Mrs Jones' service at Princess of Wales Hospital when off-sick revealed issues regarding the care of patients including:

- failures to arrange follow-up appointments/reviews including according to Witness 3, Witness 4, Witness 2:
 - Patient B, Patient H, Patient I and Patient J, no auto injector training was given
 - Patient K, no follow-up appointment made or action plan included in the medical notes. No record of training given for auto injector training , nor documentation.
 - Patient G, failed to arrange follow up allergy clinic appointment

Concerns were raised about poor record keeping concerning patients in her care.

Poor documentation including for:

- Patient C
- Patient E
- Patient D
- Patient A
- Patient G
- Patient K
- Patient F

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Jones.

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 witness called on behalf of the NMC:

- Witness 4: Band 7 Paediatric Respiratory and Atopic Clinical Nurse Specialist at Cwm Taf university Health Board.

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

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

Charge 1a)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

a) In March 2020, did not identify that the spirometry equipment:

- i) Was faulty and needed repair/replacement;
- ii) Had no service history;

Charge 1(a)(i) is found proved

The panel reviewed the evidence before it, namely Witness 4's oral evidence and their witness statement.

The panel considered Witness 4's witness statement and had regard to the following section:

'in March, 2020, there was an issue with other respiratory equipment (spirometers), where I found on a visit to Princess of Wales Hospital that this equipment was not fit for purpose as there was no service history and it was broken – there was a broken part on the casing which I considered an infection control risk'

The panel also considered the oral evidence from Witness 4 which stated that they had spoken to Mrs Jones regarding the faulty respiratory equipment and it was satisfied that it had been identified as faulty and in need of replacement and that Mrs Jones accepted this. Notwithstanding this, Mrs Jones did not raise any concerns regarding the equipment, despite it having an expired service tag and still proceeded to use it. The panel therefore found this part of the charge proved.

Charge 1(a)(ii) is found NOT proved

The panel considered Witness 4's oral evidence whereby they stated that there should be an annual service of the equipment and that in this case, the spirometry machine had an out-of-date sticker on it, as Mrs Jones admitted to being aware of. The panel accepted this, however it noted that there was no evidence to show that, beyond the expired tag, there was no service history for the equipment. The panel considered that the presence of the expired tag indicated that it had previously been serviced and was overdue for a service, however there was no evidence regarding the age of the equipment, when it was installed or other related information.

The panel found that while it was entirely feasible that there had been a failure at the trust to maintain the equipment by ensuring it had been serviced, on the balance of probabilities, the presence of an expired tag is more likely than not to be proof of a prior inspection and of at least a partial service history. Therefore, the panel found that there was no evidence to substantiate that there was no service history and found this part of the charge not proved.

Charge 1b)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

b) In relation to Patient K:

i) From March 2019 to February 2022, failed to provide adrenaline auto-injector training since they were prescribed an adrenaline auto-injector in March 2019;

ii) From September 2021 to February 2022, failed to arrange a follow up appointment to discuss their results from a skin prick test performed in September 2021;

Charge 1(b)(i) is found proved

In reaching this decision, the panel took into account Witness 4's oral and witness statement and Patient K's notes.

The panel first considered Witness 4's witness statement which states the following:

'I found in February 2022 the registrant failed to do parent training for a mother via home visit.'

The panel also considered the Datix entry dated 01 November 2022 from Witness 4's evidence which stated that no training had been provided.

The panel considered the oral evidence of Witness 4 who confirmed that it was the responsibility of a band 6 nurse to administer this training and to ensure that it had been carried out and therefore it would be expected of Mrs Jones.

The panel were mindful of the lack of clarity about Mrs Jones' deployment for the full period covered in the charge. It was satisfied that from at least March 2019 to March 2022, Mrs Jones was in post as a respiratory nurse. On an unspecified date after March 2020, she was redeployed

as a consequence of the COVID pandemic. The panel also noted that after Mrs Jones' return to the trust and resuming her duties as a respiratory nurse, she went on long-term sick leave. Therefore, for a protracted period of the specified timeline, the registrant was not working as a respiratory nurse at the trust.

The panel was satisfied that a prescription had been issued for the autoinjector and that this should have been present in the patient's medical notes. The panel were satisfied that Mrs Jones would have had sight of these notes before she met with Patient K's parent and that it was Mrs Jones' duty to have checked this.

The panel accepted that Mrs Jones was in post as a respiratory nurse in a consultant-led practice before March 2019, but was required to work with a degree of autonomy. As a respiratory nurse, the panel found that it was incumbent upon her, once aware of the presence of the prescription for an auto-injector, to have confirmed patient K's parent's level of awareness of how to deploy the medication, and delivered any training required to ensure that the patient's parent was trained in the use of the autoinjector.

The panel therefore found this part of the charge proved.

Charge 1(b)(ii) is found NOT proved

The panel considered Patient K's notes dated 5 December 2022 and 15 September 2021 and 15 September 2021 which confirmed that skin prick tests were carried out.

The panel also considered the oral evidence of Witness 4 who provided their understanding of what should happen after a skin prick test is carried out and how this can vary from patient to patient.

Having considered the evidence, the panel found that there was insufficient evidence to substantiate the charge as it is indicated in Patient K's notes that the results were given at the time and that there was no evidence to show that a follow-up appointment was required, or that it was Mrs Jones' duty to arrange a follow-up appointment in this instance.

The panel found that there was a lack of clarity in the evidence to show that Mrs Jones had a duty to arrange a follow-up appointment and therefore found this part of the fact is not proved.

Charge 1c)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

c) On or around January to February 2022, failed to provide adrenaline auto-injector training for Patients B/ H/ I/ J;

Charge 1c) Patient B is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement, the patient's medical notes and Witness 4's oral evidence.

The panel considered the witness statement from Witness 3 which stated:

'I was the staff member who reviewed medical notes for a child in June 2022, regarding training and education for adrenaline pen. This datix relates to Laura failing to provide a parent with adrenaline pen training via a home visit'

The panel also considered the Datix entry which stated that Patient B's mother had informed Witness 3 that no training had been provided to her.

In relation to Patient B, the panel was not satisfied that there was sufficient evidence to substantiate the charge. It noted that the only evidence was hearsay which was an account of what Witness 3 was told at a later date. In contrast, the medical notes written by Mrs Jones which the panel had accepted were more likely than not completed contemporaneously. It included a notation that auto-injector training had been provided.

The panel found that Mrs Jones' notes were more likely than not to be a more reliable record of what was done than the hearsay evidence of Patient B's parent. The panel therefore found that in relation to Patient B, this was not found proved.

Charge 1c) Patient H is found proved.

In relation to Patient H, the panel considered the doctors letter dated 25 January 2022 which Mrs Jones was cc'd into and noted that Mrs Jones had been asked to arrange for some auto-injector training to be administered. The panel noted however, Patient H's medical notes indicated that the medication had been prescribed but there was no notation that the required training had been provided or that attempts had been made to deliver it. The panel therefore found this part of the charge proved.

Charge 1c) Patient I is found NOT proved.

The evidence showed contact was attempted with the patient's parents. Patient I's medical notes show that two appointments were cancelled, one by the parent and one by the hospital. There was evidence that attempts were made to secure their attendance by Mrs Jones. In the circumstances, the panel were not satisfied that, given the cancelled appointments, Mrs Jones could be held culpable for the failure to provide the training. The panel therefore found this part of the charge not proved.

Charge 1c) Patient J is found proved.

In relation to Patient J, the panel considered the doctor's letter dated 25 January 2022 whereby Mrs Jones had been copied into the email which stated that she should administer training to Patient J's mother. The panel noted that in Patient J's medical notes it shows that the medication had been prescribed but there was no notation that the training had been provided or that attempts had been made to deliver the required training. The panel therefore found this part of the charge proved.

Charge 1d)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

- d) In relation to Patient G, failed to arrange a follow up allergy clinic appointment following their skin prick test and blood tests done in February 22;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 3 and Patient G's medical notes.

The panel considered the witness statement of Witness 3 which included reference to the medical notes of Patient G which stated that no skin prick test was carried out as Patient G's parent had indicated that they would not tolerate it. However, the notes show that bloods were taken as an alternative. The panel found that there was a lack of evidence in the medical notes to show the blood test results were provided on the day of the test and that therefore Mrs Jones should have known that this meant the patient required a follow-up appointment with the allergy clinic. There was no notation that a follow-up was required or should be arranged or to indicate a follow-up was offered or attended and the panel found this charge proved.

Charge 2a)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

Failed to keep accurate records concerning the patients in your care in that:

- a) In relation to Patient E, recorded incorrect information in a clinic letter from June 2021;

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's witness statement which states:

'During the consultation we discussed previous clinic attendance and treatment used. Mum informed me that the clinic letter dated 16/6/21 that we discussed was incorrect information regarding her son's treatment and symptoms. The clinic letter is sent to the GP and discussed increased chest symptoms and advised increasing inhaled steroid treatments Documentation from this nurse clinic in the medical notes also describes increased symptoms and advises changing current treatment. Mum stated that this never happened for this child but seemed to be the correct information for her other child, who was also previously seen in the nurse clinic.'

The panel noted that although this was the only evidence to show the recorded incorrect information, it found no reason to disbelieve Witness 3 or Patient E's mother. The evidence showed that the medical records for two siblings were corrected following new assessments and was satisfied that this would not have been done had the information recorded by Mrs Jones been accurate and recorded against the correct patient.

The panel therefore found this charge proved.

Charge 2b)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

b) In February 2022, in relation to Patient B:

i) Recorded that adrenaline auto-injector training had been provided when it had not;

ii) Failed to file a copy of their food allergy action plan in their medical notes;

Charge 2(b)(i) is found NOT proved

In reaching this decision, the panel took into account Witness 3's witness statement and Patient B's notes.

The panel considered the witness statement from Witness 3 which stated:

'I was the staff member who reviewed medical notes for a child in June 2022, regarding training and education for adrenaline pen. This datix relates to Laura failing to provide a parent with adrenaline pen training via a home visit'

The panel also considered the Datix entry which stated that Patient B's mother had informed Witness 3 that no training had been provided to her.

The panel noted its decision in relation to Patient B in charge 1(c), where it found the medical notes had been written contemporaneously and were more likely than not, an accurate reflection of

the advice and actions taken with regard to Patient B. In light of its earlier finding, the panel therefore found this part of the charge not proved.

Charge 2(b)(ii) is found proved

In relation to charge 2(b)(ii), the panel was satisfied that Patient B's medical notes showed that an allergy action plan had been issued and provided to their parent. The panel also considered the oral evidence of Witness 4 who stated that where an action plan is issued, a copy should always be kept as part of the medical notes.

The panel was satisfied that there was no action plan contained in the notes. The panel therefore found this part of the fact proved.

Charge 2c)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

c) In February 2022, in relation to Patient C, failed to record any clinic attendances in their medical notes;

This charge is found NOT proved.

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

'The datix states, "Appointment listed for nurse respiratory clinic on 7/2/22" but "no documentation [by Laura] of this review [from 7/2/22] recorded in the medical notes".'

The panel found this charge relied solely on double hearsay evidence. Witness 3 made a statement about what she had been told by someone else, namely a parent. There was no statement of evidence from this parent, nor had they attended this hearing to give oral evidence. In the circumstances the panel found that this charge could not be sustained purely on this hearsay evidence and found it not proved.

Charge 2d)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

- d) In February 2022, in relation to Patient D, failed to record any clinic attendances in their medical notes;

This charge is found NOT proved.

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

'Mum confirmed that the child attended the clinic on 7/2/22 but unfortunately no documentation written in the medical notes from this clinic attendance'

The panel found this charge relied solely on double hearsay evidence. Witness 3 made a statement about what she had been told by someone else, namely a parent. There was no statement of evidence from this parent, nor had they attended this hearing to give oral evidence. In the circumstances the panel found that this charge could not be sustained purely on this hearsay evidence and found it not proved.

Charge 2e)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

- e) In or around February 2022, in relation to Patient F:
 - i) Failed to record consultations that had taken place between you and their mother;
 - ii) Failed to make a referral to a consultant

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 3 and Patient F's medical notes.

The panel considered the witness statement of Witness 3 which states:

'I obtained the medical notes to review the documentation by Laura. On reviewing the notes there was no documentation of any conversation between Laura Jones, mother or consultant which correlated with the information given by the mother.'

The panel found this charge relied solely on double hearsay evidence. Witness 3 made a statement about what she had been told by someone else, namely a parent. There was no statement of evidence from this parent, nor had they attended this hearing to give oral evidence. In the circumstances the panel found that both Charge 2 (e) (i) and Charge 2 (e) (ii) could not be sustained purely on this hearsay evidence and found them both not proved.

Charge 2f)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

f) In or around February 2022, in relation to Patient G, failed to record information regarding school contact in their medical notes;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 3 and Patient G's medical notes.

The panel considered Witness 3's statement which states:

'Mum stated that the respiratory nurse told her she would contact the school to discuss the asthma plan but says this has not happened- no documentation of school contact in medical notes'

The panel also considered Patient G's medical notes which confirm no notes were made in relation to contact with the school.

The panel accepted that a mistake had been made in the notes in that Mrs Jones had made an error when recording details of two siblings. She had confused the two and recorded incorrect information in their medical notes.

The panel noted while the evidence provided is hearsay and that there is nothing to substantiate that the school were contacted, it found that in the circumstances it should have been clear to Mrs Jones that she needed to contact the school and record the contact with clear details of who was advised and when, given the high risk posed to Patient G. The panel therefore found on this occasion that this fact was proved.

Charge 2g)

That you, a registered nurse whilst working for Princess of Wales Hospital and/or Royal Glamorgan Hospital:

g) Between January 2022 - May 2022, in relation to Patient A, failed to record information regarding a previous skin prick test in their medical notes.

This charge is found proved.

In reaching this decision the panel referred to the above decision in charge 2(f) and accepted that a mistake had been made in the medical notes and therefore this fact is found proved by default of it being Patient G's sibling in said recording error.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Jones' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the

NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Rye invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Rye identified the specific, relevant standards where Mrs Jones' actions amounted to misconduct. He submitted that the following sections of the code are engaged in this matter:

'1 Treat people as individuals and uphold their dignity

2 Listen to people and respond to their preferences and concerns

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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*

Mr Rye took the panel through the breaches of the Code and how they related to the conduct in the charges found proved.

Mr Rye submitted that Mrs Jones had breached the fundamental tenets of the profession as the conduct found proved could be said to be serious. Mr Rye submitted that Mrs Jones had a duty to prioritise those in her care and in not completing vital auto-injector training she failed to do so.

Mr Rye further submitted that Mrs Jones had failed to practise effectively In not maintaining effective communication through the correct recording of information or keeping records up to date for the patients in her care and in turn she failed to preserve the safety of those in her care. Mr Rye submitted that documentation is vital to the nursing profession as this allows others to know what has taken place and what is required. The failure to keep clear records increased the risk of harm to patients and those who subsequently read them cannot be certain as to what has taken place.

Mr Rye submitted that Mrs Jones had failed to act as a role model and that the charges show a pattern of misconduct that took place over a period of time, therefore when considering the overall conduct found proved individually and collectively, it is serious and falls short of the standards that the public expects of a Band 6 registered nurse.

Submissions on impairment

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

Mr Rye submitted that Mrs Jones is impaired under public protection and public interest grounds. He invited the panel to consider the questions set out in *Grant* and determined that limbs a, b and c were engaged. Mr Rye submitted that the conduct found proved demonstrates that Mrs Jones had breached fundamental tenets of the profession and such conduct brings the profession into disrepute.

Mr Rye submitted that the conduct here is mainly clinical and as such it is conduct that can be addressed through matters such as reflection, insight, further training and strengthened practice. However, he noted that Mrs Jones has not engaged with the process by attending this hearing.

Mr Rye submitted that Mrs Jones has not reflected on what went wrong, what should be done in the future and how her conduct damages the profession and how the public would perceive such conduct. There is also no evidence of further training or strengthening of practice. Mr Rye noted however that Mrs Jones has expressed a willingness to undertake further training to address concerns in her practice.

Mr Rye submitted that there remains a risk that the conduct could be repeated and in turn this risks harm to members of the public. In these circumstances, a finding of impairment on public protection grounds would be warranted.

Mr Rye submitted that a finding of impairment on public interest grounds is also required to mark the unacceptability of the behaviour and to emphasise that fundamental tenets have been breached and to reaffirm that proper standards of behaviour are required of a registered nurse in order to maintain confidence within the profession

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*_(No 2) [2000] 1 A.C. 311, and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services

6.2 maintain the knowledge

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

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

To achieve this, you must:

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

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in relation to each charge, the following parts of the Code were breached:

Charge 1(a)(i): 19.1 and 19.4

Charge 1(b)(i): 1.2 and 1.4

Charge 1(c)(i) In relation to patient H&J: 1.2 and 1.4

Charge 1(d): 1.2 and 1.4

Charge (2)(a): 1.2, 1.4, 6.1, 8.2 and 10.3

Charge 2(b)(ii): 1.2 and 10.3

Charge 2(f): 2.1 and 8.6

Charge 2(g): 6.1, 6.2 and 10.3

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, however it found that the charges engaged multiple code breaches and were satisfied that individually they amounted to misconduct.

The panel found that taken in their totality, the behaviour in the charges put patients at risk, including children. Therefore, Mrs Jones' behaviour fell significantly short of the conduct and standards expected of a nurse. The panel also found that Mrs Jones' errors were repeated across several charges and had not shown any evidence to show she had learnt from her errors and therefore she still poses a risk to the public.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to NMC Guidance Document DMA-1 updated on 3 March 2025 which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:

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

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

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

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

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

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

- a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) ...'

The panel were satisfied that limbs a, b and c of the *Grant* test were engaged.

The panel found that there was no evidence provided to them to show that Mrs Jones showed any insight into her actions and the impact they would have on patients and the general public's confidence in the profession. The panel noted that despite the development plan which was put in place for Mrs Jones, her engagement was limited in attempts to remediate her practice.

The panel determined that the breaches were to do with capacity and clinical errors and could be addressed with supervision and strengthening of practice and therefore could be remediated, however there was no evidence to suggest that such undertakings had taken place. The panel therefore found that the risk of repetition still remains.

The panel finds that patients were put at risk and could have been caused harm as a result of Mrs Jones' misconduct. The panel determined that a finding of impairment is necessary on the grounds of public protection.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. There were significant and repeated failings that compromised the care and safety of the patients that were so serious that they must lead to a finding of impairment in this case. Therefore, the panel also finds Mrs Jones' fitness to practise impaired on the grounds of public interest.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and

midwifery professions and upholding the proper professional standards for members of those professions.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mrs Jones' name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

Mr Rye referred the panel to NMC guidance: *Available sanction orders* (Reference: SAN-3) and went through each sanction in turn. Mr Rye submitted that a conditions of practice order for a period of 6 months with a review, would be the appropriate sanction in this case. He further submitted that an order was required because the panel had found that Mrs Jones' practice was impaired on both public protection and public interest grounds.

Mr Rye submitted that the public must be satisfied that they are kept safe. It is the NMC submission that a conditions of practice order would allow Mrs Jones time to undertake relevant training and provide an update to any future reviewing panel.

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

Decision and reasons on sanction

Having found Mrs Jones' 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 then NMC Sanctions Guidance (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:

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm
- Senior band 6 nurse

The panel also took into account the following mitigating features:

- No evidence of actual harm caused
- The impact of the Covid pandemic
- Impact of the restructuring of the hospitals and services of the combined trust following a merger on staff
- Mrs Jones' supervisors and managers were based in different hospitals at different locations to her and it is accepted that this created challenges in supervision, management in supporting her as a respiratory nurse

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 Mrs Jones' 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 Mrs Jones' misconduct was 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 Mrs Jones' registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Jones' case. The panel found Mrs Jones would benefit from undertaking supervised training in the field which would not be possible if she were to be temporarily removed from the register.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. Your principal employment must be with:
 - a) NHS provider or;
 - b) Agency that limits your working to one designated clinical area or hospital site and;
 - c) You must only work within a general nursing role and not act as a specialist nurse.

2. You must have a designated work place supervisor.

3. You must ensure that you are supervised any time you are working. Your supervision must consist of:
 - a) You working along-side a registered nurse of an equivalent band, under direction of the nurse in charge
 - b) Fortnightly meetings with your supervisor to review case notes and any training undertaken by you or required.

4. You must undertake a Continued Professional Development (CPD) course in respect of:
 - a) Accurate and comprehensive record keeping
 - b) Communicating with patients and their families
 - c) Safe use and management of medical equipment

5. You must create a personal development plan (PDP). Your PDP must address your record keeping and communication with patients and/or when required family members. You must meet with your line manager (at least once every 2 months) to discuss your progress with specific reference to record keeping and any training you are undertaking.
 - a) Following the creation of your PDP, you will send your case officer a copy within 6 weeks of commencement of employment in your role.

- b) Send your case officer a report from your line manager every 2 months. This report must show your progress towards the aims set out in your PDP.
6. You must keep us informed about anywhere you are working by:
- a) Telling your case officer within seven days of accepting or leaving any employment.
 - b) Giving your case officer your employer's contact details.
7. You must keep us informed about anywhere you are studying by:
- a) Telling your case officer within seven days of accepting any course of study.
 - b) Giving your case officer the name and contact details of the organisation offering that course of study.
8. You must immediately give a copy of these conditions to:
- a) Any organisation or person you work for.
 - b) Any agency you apply to or are registered with for work.
 - c) Any employers you apply to for work (at the time of application).
 - d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
 - e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity
9. You must tell your case officer, within seven days of your becoming aware of:
- a) Any clinical incident you are involved in.
 - b) Any investigation started against you.
 - c) Any disciplinary proceedings taken against you.
10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

- a) Any current or future employer.
- b) Any educational establishment.
- c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for **12 months**.

The panel determined that a year would give Mrs Jones the opportunity of finding employment and meeting her conditions of practice.

Before the order expires, a panel will hold a review hearing to see how well Mrs Jones has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion of the above mentioned courses, a reflective piece and testimonials from a line manager or supervisor that detail your current work practices.

This will be confirmed to Mrs Jones in writing.

Interim order

As the conditions of practice 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 Mrs Jones' own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Rye. He invited the panel to impose an interim conditions of practice order for a period of 18 months. He submitted that this will cover the 28 days before the conditions of practice order would take effect, and the appeal period should an appeal be lodged.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings in relation to the nature of the misconduct. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months as this will cover the appeal period should an appeal be lodged.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Jones is sent the decision of this hearing in writing.

That concludes this determination.