

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

**Substantive Meeting
Wednesday, 8 October – Friday, 10 October 2025**

Virtual Meeting

Name of Registrant:	Jane Prudence Smallwood
NMC PIN:	07H0558E
Part(s) of the register:	Registered Nurse Sub Part 1 Adult Nursing – (Level 1) 8 March 2008
Relevant Location:	East Sussex
Type of case:	Misconduct and Health
Panel members:	Pamela Johal (Chair, lay member) Gillian Tate (Registrant member) Philippa Hardwick (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Abigail Addai
Facts proved:	Charges 1, 2, 3a, 3b, 4
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	Conditions of Practice order (18 months)
Interim order:	Interim Conditions of Practice order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Smallwood's registered email and address by recorded delivery and by first class post on 9 September 2025.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Smallwood's registered address on 13 September 2025. It was signed for against the printed name of 'Smallwood'.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Mrs Smallwood has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Details of charge

That you, a registered nurse,

- 1) [PRIVATE]
- 2) On 19 April 2021, while working at Tonbridge Cottage Hospital, incorrectly administered 8 units of insulin to Patient A instead of the prescribed amount of 11 units.

- 3) On 7 March 2022, while working at Conquest Hospital, incorrectly administered the following medication to Patient B:
 - a) Thiamine
 - b) Vitamin B
- 4) On 11 October 2023, while working at Eastbourne District General Hospital, incorrectly administered Ciprofloxacin instead of Clarithromycin to Patient C.

AND in light of the above, your fitness to practise is impaired by reason of your [PRIVATE] in charge 1 and by reason of your misconduct or [PRIVATE] in respect of Charges 2, 3 and 4 above.

Schedule 1

- 1) [PRIVATE]

Background

On 17 October 2023, the NMC received an employer referral from an agency, TFS Healthcare ('the agency') raising concerns about Mrs Smallwood. The agency informed the NMC that Mrs Smallwood commenced employment as a registered nurse in December 2018. The agency stated that Mrs Smallwood had worked full time hours and worked consistently in several trusts as a committed member of staff. From 2018 until 2021, the agency stated no concerns were raised about Mrs Smallwood's practice. The agency stated from May 2021, they started to receive regular complaints/concerns about Mrs Smallwood's practice. The initial complaints raised were in relation to Mrs Smallwood's medication practice.

- April 2021 – Medication error involving insulin. Mrs Smallwood did not administer a patient's full prescribed amount.
- March 2022 – Medication error. Mrs Smallwood administered medication to the wrong patient.

No direct harm was caused by either of the incidents, which were dealt with by the agency through further training and reflections provided by Mrs Smallwood. [PRIVATE]. She was warned that any further incidents would lead to her dismissal.

On 12 October 2023 the agency received a further notification from a client that Mrs Smallwood had made a medication error where she administered the wrong intravenous antibiotic to a patient. No harm came to the patient. A dismissal meeting was held on 13 October 2023, [PRIVATE].

[PRIVATE].

[PRIVATE]. A further meeting took place on Teams on 17 October 2023 where she confirmed these matters. She accepted that she had made the alleged errors and a referral to the NMC was the next necessary step.

The agency acknowledged that she was showing insight into the fact that all the factors that [PRIVATE] had led to her making mistakes in her practice and that she needed to address this.

The agency stated they believe that the medication errors would not have been made if Mrs Smallwood had been fully focused on her job.

[PRIVATE].

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Clinical Lead at TFS Healthcare at the time of the concerns;
- Witness 2: Children's Community Nurse at the Conquest Hospital at the time of the concerns.
- Witness 3: Staff Nurse at the Conquest Hospital at the time of the concerns.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC and Mrs Smallwood's regulatory concern response form dated 17 July 2024.

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

Charge 1)

1) [PRIVATE]

This charge is found proved.

[PRIVATE].

Charge 2)

2) *"That you, a registered nurse, On 19 April 2021, while working at Tonbridge Cottage Hospital, incorrectly administered 8 units of insulin to Patient A instead of the prescribed amount of 11 units."*

This charge is found proved.

In reaching this decision, the panel first took into account that Mrs Smallwood had made admissions to this charge in the response form she sent to the NMC. Additionally, the panel accepted her reflective piece which provided a clear account of the facts alleged in charge 2. Within the reflective piece, Mrs Smallwood outlined her failings and stated that she used the insulin pen available to her, despite it only having 8 units of insulin remaining, whilst the patient's prescription required 11 units of insulin.

The panel found Mrs Smallwood's admissions corroborated with the following sections of Witness 1's witness statement:

'We were advised that a patient was prescribed 11 units of insulin and when Jane went to administer their 10pm insulin, she found that the patient's insulin pen only had 8 units remaining. It was stated that Jane could not find another insulin pen for that patient to enable her to administer the full, prescribed amount.'

'In Jane's response, she stated that she had discussed the situation with the team who advised her they were happy for the patient's blood sugars to be on the high side due to the patient not eating very much that day, and that their blood sugars always dropped overnight.'

The panel accepted Witness 1's account and noted the substantial evidence which points to Patient A needing 11 units of insulin, including the contemporaneous documents outlining the insulin incident. Further, the panel accepted Mrs Smallwood's admissions to the facts alleged in charge 2 was consistent with the contemporaneous documents from the Trust, which highlighted that Patient A required 11 units of insulin.

The panel also noted Mrs Smallwood's contemporaneous statement dated 26 May 2021 where she admitted the facts around the incident, albeit saying that she discussed the shortage of insulin with colleagues on her team who supported her actions.

The panel therefore concluded on the balance of probabilities that the conduct described constituted a medication error.

Charge 3a and 3b)

- 3) *"That you, a registered nurse, On 7 March 2022, while working at Conquest Hospital, incorrectly administered the following medication to Patient B:*
- a) Thiamine*
 - b) Vitamin B"*

This charge is found proved.

The panel took into account that Mrs Smallwood had made admissions to the facts in charge 3a and 3b in her response form. It also accepted the considerable documentary evidence which supported the facts alleged within charge 3a and 3b, including Mrs Smallwood's reflective piece, Witness 1 and 2's witness statements, and the Datix Incident Management Form.

The panel first had regard to Mrs Smallwood reflective piece which reads:

'I had booked a night shift on adult female Gynae Ward s [sic] they are aware of my [PRIVATE] and have been very supportive and understanding

[PRIVATE] but felt I could work on this Ward that I was familiar with

However on turning up on the ward I was told I had to move to a [sic] children's ward- [PRIVATE] I am not paediatric trained so was given 2 young teenage girls to look after, I greeted them and both had fathers with them. I was shown the clinical room with the medicine dispensing machine called omnicrom, I asked the nurse I was with if she could get me the 2 tablets I needed, she knew the patient and retrieve this for me. I walked up the corridor and remembered the patient needed her observations done so I got an obs machine went in did her observations and gave her the tablets

In future, as I have always done (apart from this occasion) is to take the drug chart to the patient and confirm their identity both verbally and checking the wristband.'

The panel found Mrs Smallwood's reflective piece to be consistent with the following sections of Witness 1's witness statement:

'[PRIVATE]. When she attended work that day, she thought she was going to work a ward she knew well and was familiar with. In addition, knew the staff.

If this was how Jane was feeling, it wasn't ideal to send her to a paediatric ward, [PRIVATE]. There is context there.

[PRIVATE] but as she thought she was going to work on a ward she was familiar with, she attended work thinking she could get on with it. However, when she then got moved to a ward she wasn't trained for and didn't know, [PRIVATE].

[PRIVATE]. It was potentially unfair to move her and wasn't in the scope of her practice.

It was good that they gave her teenagers, but this still brings a different set of requirements. For example, if teenagers get sick, their HR can be much higher than in an adult, they have different normal values of heart rate, blood pressure, and respiration rate compared to adults, Jane may not have known this as she wasn't a trained paediatric nurse. In fairness I don't think she ought to have been sent to paediatrics that day.

This complaint was closed by the trust on 22.04.2022., the restrictions were removed and Jane was able to work at the trust again'

The panel noted Witness 2 who stated:

'On 8 March 2022, following a handover I introduced myself in the usual way to all my allocated patients and their carers on the Ward.

During that time, I spoke to Patient B's mother who informed me that Patient B had been given some tablets the night before, at or about 10pm. The mother went on to

state that she was not aware that her child was on a regular medication. Patient B's mother went on to describe what the medication looked like.

Following that conversation, I looked at Patient B's drug chart to see which medication the mother was referring to. Upon looking at the drug chart, I did not see anything on the drug chart to indicate that that medication described by the mother had been administered to the patient.

Once I looked at the patient in the cubicle next doors drug chart, it transpired that the Registrant had administered Patient B the medication for the patient in the cubicle next door. As the medication described was distinctive, one white table and one brown table, I was able to identify that the medication was Thiamine and strong Vitamin B. Those medications were not prescribed to Patient B and the Registrant had signed for the medication in the other patient's medical chart.

As the medication in question was vitamins, there was no risk of harm. I informed the matron in charge of the incident and I recorded the medication error on the child's notes which I do not have access to.

I then completed the Datix Incident Management Form'

Further, the Datix Incident Management Form outlines that Patient B was given two tablets that *'were not prescribed in her medication chart'*.

Having found that Mrs Smallwood made admissions to the error, followed by the amount of contemporaneous documentation before it, the panel found that there is sufficient evidence that Mrs Smallwood incorrectly administered Thiamine and Vitamin B to Patient B.

Therefore, the panel found charge 3a and 3b proved in its entirety.

Charge 4

4) *"That you, a registered nurse, On 11 October 2023, while working at Eastbourne District General Hospital, incorrectly administered Ciprofloxacin instead of*

Clarithromycin to Patient C.”

This charge is found proved.

In reaching this decision, the panel took into account Mrs Smallwood’s reflective piece where she made admissions to the regulatory concerns. Mrs Smallwood reflective piece dated 13 October 2023 stated the following:

‘[Colleague A] brought this error to my attention showing me the drug chart, i acknowledged the error immediately and apologised. I can only think i miss read this medication [PRIVATE]

‘in future i would make sure the i get a 3rd checker to check the drug chart against any IV S/C or Fluids being given to patients taking extra care with medicines with similar names’

Mrs Smallwood also stated that she would in future:

‘double check before given medications take more time not get distracted into helping other[sic]’.

Mrs Smallwood also said:

‘I have learnt just how easy it is to make a mistake, [PRIVATE] i think i should embrace it rather than hide it and use the opportunity to not be rushed’ and;

‘as soon as I found out my mistake I was open an transparent , and took responsibility for my error I will also complete a medication refresher assessment and drug calculations assessment’

Further, the panel had regard to Witness 3’s statement which reads:

‘When I looked at the drug chart, it was very clear that it was the wrong anti-biotics. Anyone else who checked the drug chart, would have clearly seen the mistake.’

The panel found Witness 3's witness statement corroborated with the antimicrobial prescription record which clearly states that Clarithromycin was to be administered to Patient C. The panel also had sight of a copy of the drug chart where the word 'Ciprofloxacin' is clearly written.

The panel also had regard to the Multidisciplinary Documentation note dated 11 October 2023 which states the following:

'Patient was given incorrect IVABX. I noticed when taking it down, checked drug chart, no allergies, doctor informed obs stable. Datix has been done'

In light of the evidence, the panel found sufficient evidence to show that Mrs Smallwood administered the wrong medication intravenously. It noted that while no harm was caused to Patient C, the consequences of the incorrect medication could have been catastrophic if Patient C was allergic to the medication.

Accordingly, the panel found charge 4 proved in its entirety.

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 Smallwood's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 Smallwood's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The NMC 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.

The NMC identified the specific, relevant standards where Mrs Smallwood's actions amounted to misconduct including sections 1, 1.2, 6, 6.2, 13, 13.3, 18, 18.1, 19, 19.1, 19.4, 20, 20.1, 20.9.

The NMC also invited the panel to consider that Mrs Smallwood's conduct detailed in charges 2 to 4 fell far short of what would have been expected of a registered nurse. The NMC consider the misconduct serious because the medication errors made over three separate occasions between April 2022 and October 2023, suggests a pattern of unsafe practice.

The NMC submitted medication errors carry a real and serious risk of harm to vulnerable service users, particularly as Patient B was a minor. They submitted that while no actual harm was caused, the potential for harm is sufficient to be considered serious. The NMC invited the panel to consider that the medication errors suggests that there is a high risk of repetition. In their submission, such conduct would be seen as deplorable by fellow practitioners and damage the trust that the public places in the profession.

With regards to the Code, the NMC submitted the provisions of the Code constitute fundamental tenets of the profession. As such, Ms Smallwood's actions have breached these in so far as they relate to practising effectively and preserving safety.

The NMC submitted that Mrs Smallwood has sporadically engaged with the NMC and shown some insight and reflection into why the incidents occurred. [PRIVATE].

[PRIVATE].

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

[PRIVATE].

[PRIVATE].

[PRIVATE].

In respect of *Grant* the NMC submitted that limbs a, b and c are engaged. With regards to limb a, the NMC said between 2021 and 2023, Mrs Smallwood made a number of medication errors. Such errors cannot be characterised as isolated lapses and evidence a pattern of unsafe practice over a prolonged period of time. The NMC accepted that there was an absence of actual harm on each occasion, but there was a potential for serious harm.

The NMC submitted that the incident on 7 March 2022 in charge 3 was admitted by Mrs Smallwood. [PRIVATE].

With regards to limb b, the NMC submitted that Mrs Smallwood's conduct was repeated in fundamental areas of practice. Such conduct is capable of seriously undermining public confidence in the nursing profession. The NMC acknowledged that while actual harm did

not occur, the potential for harm was significant. Accordingly, Mrs Smallwood's conduct has brought the profession into disrepute and there remains a real risk of repetition.

With regards to limb c, the NMC referred the panel to the Code's guidance into four categories:

- a. Prioritise people;
- b. Practise effectively;
- c. Preserve safety and
- d. Promote professionalism and trust

The NMC submitted that the relevant sections of the Code indicate how Mrs Smallwood has breached the fundamental tenets of the nursing profession.

The NMC referred the panel to *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) and asked the panel to consider the following:

- Whether the conduct that led to the charge(s) is easily remediable?
- Whether it has been remedied?
- Whether it is highly unlikely to be repeated

[PRIVATE].

The NMC submitted that the concerns can be addressed by taking steps such as completing training courses or supervised practice. However, Mrs Smallwood's engagement has been sporadic therefore it cannot be said that she has fully addressed the concerns. Despite Mrs Smallwood's admissions at the local level and some level of insight, the NMC does not have information regarding what she has been doing to address the concerns. Therefore, Mrs Smallwood presents an ongoing risk to the safety the public.

For these reasons, the NMC invited the panel that a finding of impairment on public protection grounds is necessary.

The NMC also submitted that a finding of impairment on public interest grounds is required to promote and maintain profession standards and maintain public confidence and trust.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct and health

When determining whether the facts found proved amount to misconduct or were a result of her health, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Smallwood's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Smallwood's 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.

13 Recognise and work within the limits of your competence:

To achieve this, you must:

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.

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:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have

enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs.

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

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.

20.9 maintain the level of health you need to carry out your professional role.'

[PRIVATE].

[PRIVATE].

[PRIVATE].

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

The panel having taken all the charges together, determined that there was a pattern of errors over a period of time, which occurred in three different clinical settings. It noted that the individual charges alone are not enough to constitute misconduct. However, the charges when taken cumulatively, are serious and included basic fundamental medication errors over a considerable period of time. The panel also acknowledged that Mrs Smallwood undertook relevant self-directed learning but went on to make similar errors. It also accepted that while no harm occurred to the patients, there nevertheless was a risk of harm to vulnerable patients, particularly in the paediatric setting. Further, the harm from

the erroneous administration of the intravenous medication to Patient C could have been substantial.

The panel found that Mrs Smallwood's actions cumulatively fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, 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/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 limbs a, b and c of *Grant* are engaged in Mrs Smallwood's case. It was satisfied that Mrs Smallwood's actions put patients at an unwarranted risk of harm and indeed she had made admissions of those past errors. With regards to limb b, the panel was of the view that Mrs Smallwood's actions did bring the profession into disrepute. It noted that Mrs Smallwood was questioned by Patient B's mother as to why she gave Patient B tablets. Further, Mrs Smallwood gave a vulnerable patient the wrong intravenous medication. While no harm was caused to the patients, the panel determined that Mrs Smallwood's actions at the time did bring the profession into disrepute. In respect of limb c, the panel determined that Mrs Smallwood's errors amounted to breaches of basic fundamental standards of the nursing profession.

Regarding insight, the panel considered that Mrs Smallwood has demonstrated some level of insight, including providing reflective accounts following the incidents, [PRIVATE].

The panel have only limited evidence of remediation or engagement with the NMC. In light of this, the panel formed the view that there is a continued risk of repetition, given Mrs Smallwood's limited engagement with the NMC. For these reasons, the panel determined 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; 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.

Taking into consideration the findings above, the panel determined that a finding of impairment on public interest grounds is also required. It was satisfied that there is a need to uphold professional standards and public confidence would be undermined if a finding of impairment were not made.

Having regard to all of the above, the panel determined that Mrs Smallwood's 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 18 months. The effect of this order is that Mrs Smallwood's 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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 9 September 2025, the NMC had advised Mrs Smallwood that it would seek the imposition of a 12 month Conditions of Practice order if it found Mrs Smallwood's fitness to practise currently impaired.

The NMC identified the following aggravating features in this case:

- A pattern of medication errors over a period of time
- Conduct which could have put patients receiving care a risk of suffering harm
- [PRIVATE].
- Limited engagement with the NMC.

The NMC also identified the following mitigating factors:

- [PRIVATE]
- Mrs Smallwood informed the NMC that they have a supportive manager willing to help with their performance.
- Early admissions
- Insight at local level

The NMC submitted that a Conditions of Practice order would be the most appropriate sanction to impose in this case. They submitted it is proportionate when taking into consideration that the conduct relates to medication administration. There is also no evidence of harmful deep-seated personality or attitudinal problems because Mrs Smallwood has demonstrated insight and reflection at the local level. [PRIVATE].

The NMC submitted that under conditions of practice, the risk to the public can be managed through measurable and workable conditions such as retraining and supervision.

Decision and reasons on sanction

Having found Mrs Smallwood's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind

that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Three incidents of unsafe practice
- A pattern of misconduct over a period of time
- Conduct which put patients under Mrs Smallwood's care at risk of harm
- Limited engagement with the NMC
- Patient B was under the age of 18.
- [PRIVATE].

The panel also took into account the following mitigating features:

- [PRIVATE].
- Early admissions.
- A degree of insight by way of written reflections at a local level.
- In relation to charge 2, Mrs Smallwood was acting on the erroneous instruction of her team.

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 and does not reflect the misconduct identified.

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 Smallwood's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Smallwood's misconduct was not at the lowest end of the spectrum and that a caution order would be inappropriate in view of the issues identified.

The panel next considered whether placing conditions of practice on Mrs Smallwood's 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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 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 her case because the misconduct identified is capable of being addressed through conditions. The panel noted that Mrs Smallwood has not completely disengaged and there was some indication of recent engagement in October 2025.

The panel were mindful that the purpose of any sanction is to protect the public and should not be punitive. In its view, a conditions of practice order could ensure Mrs Smallwood can return to safe practice.

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. You must limit your nursing practice to a single substantive employer.
2. You must not be the nurse in charge of any shift.
3. You must ensure that you are directly supervised by a registered nurse any time you are managing and or administering medication until deemed competent to do so by a registered nurse.
4. You must ensure that you are supervised by a registered nurse any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered nurse.
5. You will send your case officer evidence that you have successfully completed a course on Medicine Administration by end of March 2026.
6. You must keep a personal development log every time you meet with your manager. You must meet with your manager monthly. The log must be signed by your manager each time.
7. You must keep the NMC informed about anywhere you are working by:

- a) Telling your case officer within seven days of accepting or leaving any employment.
 - b) Giving your case officer your employer's contact details.
8. You must keep the NMC informed about anywhere you are studying by:
- a. Telling your case officer within seven days of accepting any course of study.
 - b. Giving your case officer the name and contact details of the organisation offering that course of study.
9. 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.
10. 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.
11. 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 18 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Smallwood 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:

- Mrs Smallwood's engagement with the NMC.
- Sight of Mrs Smallwood's Personal Development Plan (PDP) and an up-to-date reflective piece.
- References from Mrs Smallwood's manager.

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

Representations on interim order

The panel took account of the representations made by the NMC. The NMC submitted that if a finding of public protection is made and a restrictive sanction is imposed, the NMC consider an interim be made in the same terms as the substantive order. The NMC submitted this should be imposed on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

The NMC further submitted that if Mrs Smallwood is impaired on public interest alone and her conduct is fundamentally incompatible, then an interim suspension order should be imposed.

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. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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 Smallwood is sent the decision of this hearing in writing.

This will be confirmed to Mrs Smallwood in writing.

That concludes this determination.