Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Monday, 15 September 2025

Virtual Hearing

Name of Registrant:	**Nadine Wilson**
NMC PIN:	97Y0127O
Part(s) of the register:	Midwives Part of the Register: RM: Midwife (19 March 2001) Nurses Part of the Register Sub Part 1: RN1: Adult nurse, level 1 (14 August 1997)
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Allison Brindley (Chair, registrant member) Amanda Anderson (Registrant member) Victoria James (Lay member)
Legal Assessor:	Elisa Hopley
Hearings Coordinator:	Eric Dulle
Nursing and Midwifery Council:	Represented by Bethany Brown, Case Presenter
Ms Wilson:	Present and unrepresented
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (6 months) to come into effect on 18 October 2025 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to extend the current suspension order for a period of six months.

This order will come into effect at the end of 17 October 2025 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 18 October 2025.

The current order is due to expire at the end of 17 October 2025.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved by way of admission which resulted in the imposition of the substantive order were as follows:

First set of charges (2019)

1) *On 5 March 2019 in relation to the preparation of an intra venous (I/V) Syntocinon, infusion for Patient A:*
   a) *Failed to read the prescription chart;*
   b) *Failed to prepare 10 international unts (iu) per 500 ml of sodium chloride;*
   c) *Prepared 40 iu per 500 ml of sodium chloride;*
   d) *Prepared a label with 40 iu per 500 ml of sodium chloride.*

2) *On 5 March 2019 in relation to Patient A failed to demonstrate knowledge of the correct dosage of Syntocinon to be administered to a patient who was in labour.*

3) *On 5 March 2019 in relation to Patient A failed to carry out the required:*
   a) *Observations every hour;*
   b) *Blood sugar/glucose tests;*

c) *Vital signs;*

d) *Amniotic fluid checks;*

e) *Foetal Heart monitoring.*

…

5) *Having been subject to undertakings as varied on 13 October 2022 failed to complete the undertakings within 6 months*

That you, a registered nurse and/or registered midwife, between 18 December 2022 and 19 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in the following:

1) *On or around 19 December 2022, in relation to patient 2:*

   a) *Administered intravenous medication.*

   b) *In relation to charge 1(a) was acting outside her level of competency.*

2) *On 3 January 2023 failed to escalate Patient 3's condition, namely that they were hypothermic.*

3) *On 9 January 2023 in relation to Patient 4:*

   a) *Failed to support the patient's perineum effectively;*

   b) *Failed to ensure the CTG was correctly; recording during the third stage of labour;*

   c) *Did not recognise the correct order of the labour procedure, namely:*

      i. *The administration of Syntocinon:*

      ii. *Delivery of the placenta;*

      iii. *Suturing.*

4) *On 18 January 2023 in relation to Patient 5:*

   a) *Did not make a record in a timely manner; namely within 30 minutes;*

   b) *Did not recognise a Post-Partum Haemorrhage ("PPH").*

5) *On 19 January 2023, in relation to Patient 6:*

a) The management and administration of medication, namely:

i. Oramorph;

ii. Syntocinon.

b) Incorrect labelling of a blood sample;

c) Delayed Patient 6 receiving an epidural.

6) On 25 January 2023 in relation to Patient X:

a) In regard to the timings of listening to the foetal heart rate in the first stage of labour, namely every 15 minutes;

b) In regard to Cardiotocography (CTG) physiology.

7) On 3 February 2023 in relation to patient 7:

a) Administered intravenous antibiotics on the incorrect occasion;

b) Did not make a proper record in regard to the administration of the intravenous antibiotics.

8) On 4 February 2023 in relation to patient 8:

a) Did not provide the correct information during labour, namely the direction in which to push;

b) In regard to the battery on the Cardiotocography equipment:

i. Allowed the battery to cease to function;

ii. Failed to have a backup battery.

c) Did not stimulate Patient 8's baby without prompting;

d) Did not provide third stage labour medication without prompting.

9) On 5 February 2023 in relation to an unknown patient:

a) Did not complete records in a timely manner;

b) Failed to stimulate the baby of the patient.

10) On 10 February 2023 in relation to an unknown patient required prompting to:

a) Check the patient's blood pressure;

b) Escalate the patient's condition;

c) Administer fluids.

11) On 11 February 2023 in relation to Patient 9:

a) Did not escalate Patient 9's condition to:

i. A midwife in charge

ii. An anaesthetist

b) Provided incorrect information to:

i. Colleague Y regarding Patient 9's heart rate;

ii. To Patient 9, namely the reasons for the administration of Terbutaline.

12) On 12 February 2023 in relation to Patient 10 in labour:

a) Delayed the care of Patient 10;

b) Did not or did not adequately, communicate with Patient 9 during delivery of Patient 10's baby;

c) Delayed the stimulating and/or covering of Patient 10's baby.

13) On or around 13 February 2023 failed to store a placenta correctly.

14) On 16 February 2023 in relation to Patient 11, failed to:

b) Carry out one or more tests/checks on sodium levels;

15) On 17 February 2023 in relation to Patient 11, failed to:

a) Recognise or take appropriate action when Patient 11 suffered a post-partum haemorrhage;

b) Record Patient's 11 blood loss in a timely manner.

c) To keep proper and/or accurate records.

16) Did not effectively communicate with colleagues during handovers on:

a) 9 January 2023

b) 18 January 2023

c) 19 January 2023

d) 25 January 2023

e) 4 February 2023

f) *11 February 2023*

g) *12 February 2023*

The original panel determined the following with regard to impairment:

The panel found that patients were put at risk of serious harm by your lack of competence. The panel also determined that actual physical harm was caused to one patient, particularised in Charge 15, as a result of your lack of competence. Of particular importance for the panel was the level of harm posed to patients by the failures regarding Syntocinon, which could have been fatal to mother and baby.

The panel determined that your lack of competence brings the professions into disrepute. It considered that if a member of the public were to learn of the concerns the profession would be brought into disrepute. The panel noted that at least two patients rejected care and colleagues expressed concern in working alongside you as they deemed it unsafe.

Given the above, the panel concluded that your lack of competence had breached the fundamental tenets of the nursing and midwifery professions. As outlined above, it considered your lack of competence to relate to fundamental skills of the professions which are expected of even newly qualified nurses and midwives.

The panel next considered the context in which these concerns occurred. It noted that there were structured inductions at both hospitals. The panel took into account that there was structured support and training in place, including probationary reviews and proactive feedback. The panel had no evidence of external factors, lack of resources, or excessive workloads, being contributing factors to the failures as found proved.

The panel considered whether the failings can be addressed. It noted that the concerns are wide ranging, multifaceted and relate to your practice and clinical competency. Nevertheless, it was of the view that, although there are many significant aspects to be addressed, these concerns are theoretically capable of being remedied.

However, the panel was not satisfied that these concerns have been addressed as yet.

The panel had before it numerous certificates of attendance at training courses (predominately completed online and unassessed) and reflections. The panel was not satisfied that you have demonstrated a sufficient understanding of how you would apply the learning into your practice in the future. The panel was of the view that there was insufficient evidence of how you would address the multifaceted issues that have been identified. The panel was concerned that the courses and training you have completed were not practical and/or assessed. The panel further noted that some of the competence issues with your nursing and midwifery practice are in areas and skills that cross over with work as a Health Care Assistant, such as communication, record keeping, and escalating concerns. It was of the view that your reflections could have incorporated this practical application of improvement. The panel also noted that most of the training that you have evidenced is mandatory training which you would have been required to complete annually throughout your career as a registered nurse and midwife, including before the concerns in these cases occurred.

The panel next considered that your insight into your lack of competence. It had sight of multiple reflections which you had completed and the chronology of these reflections. Having started with very limited insight which minimised the concerns and deflected the issues in your practice, the panel could see that you are starting to develop a greater understanding of the issues. The panel remained concerned that your insight is not sufficiently developed in that your understanding of the concerns and what you would do differently has not been sufficiently demonstrated to the panel, for example although it was noted that you had reflected on the concerns regarding medication administration, it was of concern to the panel that you were reflecting on it being a positive experience as no drug error was made in Charge 1. However, this was viewed by the panel as "missing the point", due to the fact you should not have administered any IV's as of yet as you were not signed off as competent to do so in your new role. The panel considered that the fact that you did not make an error on this occasion could be viewed as a near miss and not a

good experience as you referred to in your reflection. The panel also had concerns regarding the insight demonstrated in relation to Charge 3 which stated 'when next I am administering medication, I can have a brief discussion with my colleague to ensure that we are following the correct procedure to reduce the risk of medication errors.' However, the panel was of the view that there was a lack of situational awareness and this placed an onus on the second checker. The panel was satisfied that in this context the error was not the amount of drug prepared, rather that it was the inappropriate stage of labour to prepare and administer the drug, namely Syntocinon. It considered that there was a lack of acknowledgement as to the catastrophic impact this could have had on the mother and her unborn baby if the midwife who was checking it had not been so situationally aware and had an oversight of this patients care as the midwife in charge.

The panel determined that although these concerns are capable of being remediated, insufficient evidence was before the panel to satisfy it that you demonstrate a level of insight or that you have sufficiently strengthened your practice to lower the risk of repetition. Therefore, the panel was of the view that a finding of impairment was necessary for the protection of the public.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required due to the serious nature of the facts found proved and the failings and lack of competence that was far below the standards expected of a registered nurse and midwife. The panel was of the view that a member of the public would be concerned if they were to learn a nurse/midwife with such findings of lack of competence as these was not found to have their fitness to practice be impaired. Furthermore, it determined that confidence in the profession, and the NMC as their regulator, would be diminished and standards of nursing and midwifery undermined, if a finding of impairment were not found.

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

The original panel determined the following with regard to sanction:

The panel next considered 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:

- *There is a broad range of concerns regarding your practice.*
- *The concerns relate to fundamental and basic nursing and midwifery skills which are expected of even newly qualified nurses and midwives.*
- *A pattern of repetition of the issues despite intensive and structured support, supervision, and feedback.*
- *The risk of harm to patients in all charges that was presented by your lack of competence.*
- *Actual harm caused to at least one patient.*
- *Insufficient insight and awareness into the failings and the severity of the issues.*
- *The impact your actions had on colleagues.*

The panel also took into account the following mitigating features:

- *Full admissions to the facts.*
- *A willingness to undertake courses to strengthen your practice.*
- *Personal mitigation of [PRIVATE].*

The panel bore in mind the submissions made by Dr Akinoshun regarding [PRIVATE] and a lack of support from Kingston Hospital. However, the panel did

not have any evidence before it that corroborated these submissions. Instead, the panel had substantial evidence of the intensive and extensive support that you had been given at Kingston Hospital from a range of colleagues in the form of direct supervision, structured feedback forms, meetings, mentoring and retraining. The panel acknowledged that working in a hospital maternity unit was likely to be pressured but could see no evidence that you were under undue pressure. Therefore, the panel could not find these to be mitigating features.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, 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 was determined that conditions of practice would not be the appropriate and proportionate sanction and would not adequately address the seriousness of this case and would not protect the public.

Although areas of practice in which failings occurred have been identified, the panel was of the view that conditions would not be workable. It noted that the concerns in your case are wide ranging, covering fundamental and core nursing and midwifery skills. The panel considered that this amounted to general incompetence in your practice. It considered that if conditions were to be imposed, the requirement of supervision to mitigate the risk to patients at this time given your current insight, would be so onerous that it would be tantamount to suspension and unworkable.

The panel noted that there were issues with you acting outside of your competence. For example, the Charge 1 of the first set of charges (2019), was that you administered medicine when this was outside of your competency and should not have done so without supervision. These actions put patients at risk of harm and had an impact upon your colleagues.

Furthermore, the panel was mindful that you were unable to comply with Undertakings in relation to the first of charges (2019) due to the termination of your employment during the probationary period because of the failings in your practice. It noted that there were issues of a disregard of direct instruction, responding to feedback, and retraining, which did not result in improvements in your practice. Examples include charges 8(c), 9, and 12 of the second set of charges (2023), which all concerned the stimulation of a newborn baby and which occurred within a short period of time of each other, approximately eight days. The panel considered this to be a simple and fundamental midwifery skill which is central to the role of midwife, which a failure to complete could result in significant harm to the newborn

baby. A further example is in relation to charges 2, 10, 11, and 14 of the second set of charges (2023), all concerned a failure to escalate risks, and occurred over a short period of time, approximately seven days. An example of not following direct instruction was outlined in the witness statement from the Band 7 Midwife and Delivery Suite Co-ordinator at Kingston Hospital:

> *'[you were] not listening to their advice in regards to management of syntocinon. You/your had asked a colleague about turning the syntocinon off in response to changes in fetal heart rate pattern which a colleague did not feel was necessary just yet, however You/your did not follow the recommendation of the senior midwife they were paired to work with and learn from, and stopped the syntocinon regardless.'*

The panel noted that there were serious concerns raised about your communication skills including the seven instances that have been particularised at Charge 16 of the second of charges (2023). The supervising midwives were concerned about inappropriate timing and disjointed communication which made it difficult for colleagues to understand, inadequate identification of risks, and failure to hand over key information. In the witness statement of the Lead for Practice and Development for Maternity at Kingston Hospital, they stated :

> *'You/your's failure to communicate with their colleagues is very serious, because if a member of staff cannot understand what You/your needs from them / is relaying to them, they cannot make emergency clinical decisions and provide the patient with safe and effective care. The risks of You/your's lack of clear communication is that patients may deteriorate, receive repetition of care/treatment and may not receive the risk care/treatment.*
>
> *You/your's failure to communicate clearly with patients is very serious as their lack of communication meant that the patients did not trust them with their care, did not feel supported by You/your, and were not able to have a say in their own treatment and care.'*

The panel was of the view that these communication failures remain serious, as there was no evidence before it to suggest a strengthen of practice, for the reasons given in the 'Decision and Reasons on Impairment'.

Given the above the panel was of the view that conditions would not be appropriate proportionate, or workable, at this time. It considered that if you were to return to practice with conditions that this would not adequately protect the public or meet the public interest in this case.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was of the view that the concerns in your case are significantly serious and have a detrimental impact on the safety of patients and colleagues. The panel noted the NMC's guidance titled 'How we determine seriousness' (FTP-3) last updated on 27 February 2024. It considered that your actions, conduct, and poor practice indicated a dangerous attitude to the safety of people receiving care, for example by failing to sufficiently acknowledge the seriousness of the concerns and the impact of your actions on the patient. The panel was not suggesting that your actions were in any way deliberate. But due to your incompetence, you put multiple patients at unwarranted risk of harm and the panel was not satisfied that your reflections and training since (predominantly unassessed online courses) were sufficient to enable a return to safe practice, even with conditions. The panel was

also of the view that all the charges demonstrate a lack of understanding and awareness of the fundamental skills required of even newly qualified nurses.

As noted above under 'Decisions and Reasons for Impairment', the panel found that there is a risk of repetition and as such, such you be allowed to practice without restriction there is a risk to patient safety if they were allowed to continue to practise even with conditions.

The panel noted that it was bound by Article 29(6) of the Nursing and Midwifery Order 2001, which states:

> *'A striking-off order may not be made in respect of an allegation of the kind mentioned in article 22(1)(a) [(ii lack of competence), (iv) or (iva)] unless the person concerned has been continuously suspended, or subject to a conditions of practice order, for a period of no less than two years immediately preceding the date of the decision of the Committee to make such an order.'*

Therefore, the maximum sanction this panel could impose was one of suspension. Had striking off been available, the panel may have considered this to be an appropriate sanction given the seriousness and wide-ranging nature of the concerns.

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to protect the public and mark the seriousness of the failings. It further considered that 12 months was necessary to give you sufficient time to evidence sustained and consistent improvement in your practice.

The panel take this opportunity to urge you to actively apply your training and learning in to practice through your current employment and to further develop insight and understanding into the concerns.

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

Any future panel reviewing this case would be assisted by:

- *Evidence of sustained and consistent application of what you learnt through courses in your practice. Courses and strengthening of your practice should focus on core and fundamental nursing and midwifery skills, such as intrapartum care of the mother, care of the newborn, CTG, administration of medication, and communication with colleagues. This could be evidenced through:*
    - *Certificates from courses, focussing on courses that are assessed.*
    - *Testimonials from colleagues.*
    - *Testimonials from a mentor, who should be another registered nurse or midwife.*
    - *Reviews by a line manager or mentor of your performance in your current role, in respect of the core skills which can be practised.*
- *Further reflections, demonstrating a development of insight and full understanding into the concerns.*
- *Attendance and engagement with the NMC and a further panel.*

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's ability to practice kindly, safely and professionally. In considering this case, the panel has carried out a comprehensive review of the order in light of the

current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle and your response bundle. It has taken account of the submissions made by Ms Brown on behalf of the NMC. Ms Brown submitted that you have partially accepted your role in the events, and have demonstrated a clear determination to return to practice. She indicated that you have demonstrated remorse, and some reflection into your conduct is shown. However, Ms Brown indicated that fully developed insight is still lacking, as you do not seem to take full responsibility for your actions, and in some cases refer to the conduct of other colleagues during the incident instead of focussing on where your own conduct fell short of the required standards.

Ms Brown further submitted that there is limited evidence of strengthened practice. She submitted that while you have provided evidence of reading and courses you have completed, it is not clear whether these courses are practical or directly relevant to the competencies which were found to be lacking. Ms Brown further submitted that you have been employed as a health care assistant, and have provided evidence of very positive feedback received during that role. However, Ms Brown also submitted that this feedback was not relating to your conduct in a nursing or midwifery setting.

As a result, Ms Brown submitted that you have provided insufficient evidence of insight or strengthened practice, and that a finding of impairment should result. She further submitted that the suspension order should be continued, or in the alternative, stringent conditions of practice should be imposed.

You provided oral submissions during this hearing. You have indicated that you are extremely sorry for your conduct and apologised to the patients that were under your care, the patient's families, your colleagues and other members of the profession that you worked with.

You indicated that you have worked hard to obtain insight. You submitted that you looked closely at yourself and accept full responsibility for your misconduct instead of blaming others for your conduct. You also indicated that you have been in discussions with your

mentor and have worked hard to understand where you made mistakes in your practice. Finally, you submitted that you have been reading NMC decisions to strengthen and add to the attitude and mindset that you want to have as you approach your practice in the future.

Further, you evidence both in your documentation and in your oral submissions of the courses you have taken, including courses attended in-person, at work, and virtually. You also discussed your work as a health care assistant, and acknowledged that even though you are not working in a nursing or midwifery setting, you are constantly keeping in mind the NMC Code of Conduct and try to follow the Code during your work.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that the previous panel found that you had insufficient insight. At this hearing, the panel considered that you were genuinely remorseful and that you have demonstrated an improvement into your insight.

However, the panel found that you have not yet demonstrated fully developed insight. Specifically, the panel found that you have not yet demonstrated an understanding of how your conduct was dangerous to patients. The panel found that there were points in your written reflections where you deflect blame onto other members of staff instead of accepting full responsibility for your conduct. Further, the panel found that while you indicate throughout your reflections that you will act more professionally in the future, you do not indicate specifically how your conduct will change, or why your previous conduct was insufficient in the circumstances. Therefore, the panel found that you have obtained some insight into your practice but have not fully developed insight.

The panel also considered whether you have strengthened your practice. The panel considered that you have taken a number of courses and that you have made an effort to strengthen your practice by attending and engaging in learning. The panel also considered the positive remarks made from your line manager. However, the panel had regard to the fact that most of these courses were completed on 9 September 2025, six days prior to this hearing. Further, the panel was not satisfied that you have demonstrated a direct understanding of how to apply what you have learned to your practice. Specifically, the panel found that you have not demonstrated an understanding of the clinical risk and harm that your conduct could and did cause, nor have you demonstrated how you will act differently in the future.

Regarding the risk that you will repeat your past misconduct, the original hearing panel determined that you were liable to repeat matters of the kind found proved. Today's panel considered your written and oral submissions and had particular regard to your written statements. Upon reviewing your evidence, the panel was not satisfied that you have demonstrated an understanding of how and why your conduct raised a clinical risk of harm to your patients, or how you would act differently in the future. In other words, while you have provided evidence of understanding that your prior conduct was wrong, you have not provided any indication of how you will act differently in the future. Therefore, the panel concluded that a risk of repetition exists in this case.

In light of this, this panel determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance.

The panel determined that, given the seriousness of the original charges that were found proved, a finding of continuing impairment on public interest grounds is also required in order to protect the public's confidence in the profession and to uphold the standards of conduct and performance.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct 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 conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. Given the breadth of the charges, the panel was not able to formulate conditions of practice that would be workable or that would adequately address the concerns relating to your lack of competence.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to deeply reflect on your previous lack of competence. The panel concluded that a further six month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice and demonstrate how you will act differently in the future. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 17 October 2025 in accordance with Article 30(1).

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

Any future panel reviewing this case would be assisted by:

- Evidence of deeper insight of the clinical risk around the scenarios which led to the original charges, and how you would apply your increased insight and learning to your practice in the future.
- Evidence of professional development, including evidence of how your transferable skills and knowledge learned as a health care assistant, particularly around communication, record keeping, escalation, and recognising the deteriorating patient are being applied to your practice.
- Evidence of feedback where possible from your course facilitators about your participation in the courses you have attended or are attending in the next 6 months.
- A testimonial from a registered nurse or midwife which you have recently worked closely with which demonstrates how your further learning has been applied to your practice.

This panel has indicated that an emphasis on the future evidence should be focussed on the quality of further reflections and evidence, rather than quantity.

This will be confirmed to you in writing.

That concludes this determination.