Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

12-16 May2025 and 6-10 October 2025

10 George Street, Edinburgh, EH2 2PF

And

19 May 2025

1 – 2 April 2026

Virtual Hearing

Name of Registrant:	**Janette Donnelly**
NMC PIN:	83B0581S
Part(s) of the register:	Registered Nurse – Adult Nursing
Relevant Location:	North Ayrshire
Type of case:	Misconduct
Panel members:	Clara Cheetham (Chair – Lay member) Margaret Marshall (Registrant member) Bill Matthews (Lay member)
Legal Assessor:	Trevor Jones (12-16 May 2025) Michael Bell (6 - 10 October 2025, 1 – 2 April 2026)
Hearings Coordinator:	Vicky Green (12 May – 10 October 2025) John Kennedy (1- 2 April 2026)
Nursing and Midwifery Council:	Represented by Alban Brahimi (12 May – 9 October 2025) Iwona Boesche (10 October 2025) Debbie Churaman (1 – 2 April 2026), Case Presenter
Mrs Donnelly:	Present and represented by Jennifer McPhee, Senior Solicitor at Anderson Strathern
Facts proved:	Charges 1.b.i, 1.b.ii, 1.c.i, 1.c.ii, 2.a, 2.b and 3

Facts not proved:	Charges 1.a and 2.c
Fitness to practise:	Impaired
Sanction:	Striking Off Order
Interim order:	Interim Suspension Order (18 months)

Details of charge

That you, a registered nurse, while employed by the Millport Care Centre as the Home Manager:

1. On 19 February 2021:
    a. Did not use or consider using Diazepam when Service User A became agitated and/or to assist in the administration of the Covid vaccination; **[Not proved]**
    b. Were responsible for and/or contributed to the restraint of Service User A in that you:
        i. Restrained Service User A's head; **[Proved]**
        ii. Supervised and/or directed further restraint of Service User A by Colleague B and Colleague C. **[Proved]**
    c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
        i. Informed Colleague A that you would not report the way in which the Covid vaccination was injected; **[Proved]**
        ii. Did not report that the Covid vaccination was injected into Service User A's thigh through clothing. **[Proved]**

2. Your actions as set out in charge 1b were not clinically justified in that:
    a. The restraint of Service User A was unnecessary; **[Proved]**
    b. The restraint of Service User A was not in line with their care plan; **[Proved]**
    c. You did not have appropriate training in restraint at the time. **[Not proved]**

3. Your actions as set out at charge 1c were dishonest in that you knew that you had a duty to report the administration of the Covid vaccination by Colleague A through Service User A's clothing. **[Proved]**

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

Decision and reasons on application to make further redactions to Colleague D's witness statement

The panel heard an application made by Ms McPhee, on your behalf, to redact additional parts of Colleague D's witness statement. She submitted that the information contained within paragraphs 27, 36 and 37 is prejudicial and should be excluded from evidence.

In respect of paragraph 27, Ms McPhee submitted that in her witness statement, Colleague D stated that Colleague B and Colleague C appeared to be *'shaken'*. She submitted that neither Colleague B nor Colleague C have been called to give evidence. Ms McPhee drew the panel's attention to Colleague C's local statement and submitted that there is no reference to the conversation with Colleague D or being in any distress. She also drew the panel's attention to Colleague B's local statement which did not mention what had been referred to in paragraph 27.

Ms McPhee submitted that paragraph 27 contains Colleague D's opinion which is not supported by any other evidence. She submitted that the inclusion of this information extends the scope of wrongdoing and is prejudicial to your case. Ms McPhee submitted that if the Nursing and Midwifery Council (NMC) intended to rely on this information, then it should have called Colleague B and Colleague C to give evidence. Furthermore, she submitted that Colleague D is not an expert witness, and that her opinion on how Colleague B and Colleague C presented is not relevant as it has not been charged.

In respect of paragraphs 36 and 37, Ms McPhee submitted that these contain information that has not been charged and is therefore prejudicial to you. She submitted that the entirety of paragraphs 36 and 37 should be redacted in fairness to you.

In response, Mr Brahimi, on behalf of the NMC, submitted that paragraph 27 contains Colleague D's observation of Colleague B and Colleague C's demeanour and behaviour

when she spoke to them following the alleged incident. He submitted that Colleague D is entitled to give evidence on this, it is an account of what she directly witnessed and the impact on your Colleagues is relevant to the charges. Mr Brahimi submitted that Colleague D is attending the hearing to give evidence, and she will be subject to cross examination.

In respect of paragraph 36, Mr Brahimi submitted that Colleague D provides an account of interactions and communications with you in respect of the matters that have been charged. He submitted that Colleague D's evidence is relevant and goes to her observations of your demeanour following the alleged incident. Mr Brahimi submitted that paragraph 37 also contains information about Colleague D's contact with you after the alleged incident.

Mr Brahimi submitted that none of the evidence contained in the specified paragraphs is hearsay, it is directly connected and provides contextual information about your conduct. He therefore submitted that paragraphs 27, 36 and 37 should remain in evidence and not be redacted.

The panel accepted the advice of the legal assessor.

Paragraph 27

The panel had sight of paragraph 27 and noted that it contained Colleague D's opinion of how she found Colleague B and Colleague C to be after the alleged incident. Having regard to the charges, the panel was of the view that Colleague D's interpretation of her colleagues' demeanour was not directly relevant. Whilst Colleague D is attending the hearing to give live evidence and could be cross examined on this point, the panel noted that neither Colleague B nor Colleague C had been called to give evidence. In view of the above, the panel decided that it would be unfair to allow Colleague D's opinion of their demeanour into evidence. The panel therefore agreed to the requested redaction and only the following information contained within paragraph 27 will remain:

'27.I also spoke to [Colleague C] and [Colleague B] following the incident.'

Paragraphs 36 and 37

The panel noted that paragraphs 36 and 37 contained information about Colleague D's interactions with you following the alleged incident. The panel was of the view that this evidence is relevant, as it provides contextual information about what Colleague D is said to have directly experienced and observed. As Colleague D is attending the hearing to give evidence, the panel determined that it would not be unfair or prejudicial to you to allow these paragraphs to remain and your representative, on your behalf, will have the opportunity to cross examine her.

Decision and reasons on application to admit the evidence of Ms 1 (Registered Nurse and Regional Director of Sanctuary Care, who conducted the local investigation into the alleged incident) as hearsay evidence

Before the NMC closed its case, Mr Brahimi made an application for the witness statement of Ms 1 to be admitted into evidence as hearsay pursuant to Rule 31(1) of the Rules.

Mr Brahimi referred the panel to the NMC Guidance on *'Evidence'* (Reference: DMA-6 Last Updated 02/12/2024) and to the factors set out in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 at paragraph 56:

> *1. 'Whether the statements were the sole and decisive evidence in support of the charges;*
> *2. The nature and extent of the challenge to the contents of the statements;*
> *3. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *4. The seriousness of the charge, taking into account the impact which adverse findings might have on N's career;*
> *5. Whether there was a good reason for the non-attendance of the witnesses;*
> *6. Whether the Respondent had taken reasonable steps to secure the attendance of the witness;*

7. The fact that N did not have prior notice that the witness statements were to be read.'

Mr Brahimi went on to address the panel on the factors set out in the case of *Thorneycroft*. He submitted that the evidence of Ms 1 is not the sole or decisive evidence and that Colleague D who is a direct witness, has provided live evidence at this hearing. Mr Brahimi submitted that the policy and procedure documents exhibited by Ms 1 are not contentious. In respect of the nature and extent of the challenge to Ms 1's evidence, Mr Brahimi submitted that she is not a witness of fact, and her evidence would be of assistance in determining what policies and procedures should have been followed in respect of Service User A.

Mr Brahimi submitted that there is no suggestion that Ms 1 had any reason to fabricate her evidence. He submitted that your denial of the charges does not amount to a suggestion that Ms 1's evidence was fabricated. Mr Brahimi submitted that the charges are serious, and if found proved, are likely to impact your practice. However, he submitted that charge 1 will predominantly be decided on the evidence of Colleague D.

Mr Brahimi submitted that Ms 1 had previously informed the NMC that she did not want to attend to give evidence. After being informed of her duties to the NMC as a registrant, she then agreed to give evidence and provided dates on which she would be available. Mr Brahimi submitted that the NMC had no prior knowledge of Ms 1's limited availability this week. In respect of you having prior notice of this application, Mr Brahimi submitted that as soon as it became apparent that Ms 1 would not be attending to give evidence, you were informed.

Mr Brahimi noted that this application was not opposed, and you requested for the hearing to proceed in the absence of Ms 1. He submitted that you will have the opportunity to provide evidence and, if the evidence of Ms 1 is admitted as hearsay, the panel will attach what weight it deems to be appropriate once it has heard all of the evidence.

Ms McPhee made no submissions in respect of this application.

The panel accepted the advice of the legal assessor.

The panel had regard to the NMC Guidance on *'Evidence'* and had particular regard to the section entitled *'Hearsay'*. The panel was also guided by the factors set out in the case of *Thorneycroft*.

The panel assessed all of the evidence before it and decided that the evidence of Ms 1 was not the sole or decisive evidence in this case. It had heard live evidence from Colleague D who was a direct witness to the alleged incident, and she was able to provide additional evidence about the policies and procedures in place at the Home at the relevant time.

The panel noted that whilst you have denied all of the charges, you have not challenged Ms 1's evidence, and there is no suggestion that Ms 1 had any reason to fabricate her evidence. The panel acknowledged that the charges are of a serious nature, and that if found proved, your practice is likely to be adversely impacted. Whilst the panel was not satisfied that there was good reason for Ms 1's non-attendance, it was satisfied that the NMC had taken reasonable steps to secure her attendance. The panel was also satisfied that you were provided with notice of this application as soon as it became clear that Ms 1 would not be attending to give evidence.

The panel noted that Ms 1 carried out the investigation into the alleged incident and exhibited a number of documents. The panel therefore found that her evidence is relevant. The panel noted that you did not oppose this application and that you are legally represented. Having regard to all of the above, and to the question of fairness, the panel decided to grant this application and admit the evidence of Ms 1 as hearsay. Once the panel has heard all of the evidence in this case, it will attach what weight it deems to be appropriate to this hearsay evidence.

Background

The charges arose whilst you were employed by Sanctuary Care as a Service Manager at Millport Care Centre (the Home). Your employment with Sanctuary Care commenced on 6 August 2001. You were responsible for overseeing the supported living aspect of the Home which had a total of 18 service users receiving support. Your responsibilities also included overseeing nurses and care staff, ensuring policies and procedures were adhered to and that service users were well cared for. The Home specialises in caring for service users who have learning difficulties and mental health conditions that prevent them from living without care.

On 19 February 2021, Colleague A, a registered NHS nurse, attended the Home to administer COVID-19 vaccinations (the vaccination/ the vaccine) to residents and staff.

Service User A has a Learning Disability and Bipolar Affective Disorder. Her care plan provided that at times it was necessary for Service User A to be restrained for limited periods (no more than 3 minutes at a time) to allow for essential interventions such as feeding and personal care. Service User A was subject to Welfare Guardianship under the Adults with Incapacity (Scotland) Act (2000) and the Guardianship includes the powers for such basic interventions.

On 19 February 2021, Service User A was due to receive her second vaccination. Prior to the alleged incident, there were failed attempts to administer the COVID-19 vaccine to Service User A in the dining room, in that she had walked away on both occasions before the vaccine could be administered. Later that day, in addition to Colleague A, Colleague B and Colleague C, it is alleged that you assisted the administration of the vaccine to Service User A in her bedroom. Colleague D, who was also present in the room, but did not take part in the vaccine administration, is alleged to have witnessed you inappropriately restraining Service User A on the floor of her bedroom with the assistance of Colleague B and Colleague C, who you were also alleged to have been instructing during this event. Service User A is alleged to have been struggling strongly against the restraint, as well as shouting and screaming. It is alleged that despite Colleague A stating that she needed to administer the vaccination on bare skin, you told

her to administer it through Service User A's clothing and into her thigh, rather than into the usual place, being into the skin of the upper arm.

It is alleged that following the vaccination being administered inappropriately into Service User A's thigh, through her clothing, and whilst she was being forcibly restrained on the floor of her bedroom, you told Colleague A that you would not report the way in which it was administered and consequently did not report this.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Brahimi and those made by Ms McPhee on your behalf.

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, who was called on behalf of the NMC:

- Colleague D: Psychiatric Nurse employed at the Home at the time of the alleged incident.

The panel also heard evidence from you under affirmation.

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

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

Charge 1.a.

1. On 19 February 2021:

    a. Did not use or consider using Diazepam when Service User A became agitated and/or to assist in the administration of the Covid vaccination;

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D and to your evidence.

The panel had regard to Colleague D's written statement to the NMC dated 17 January 2025 in which the following is stated:

> *'Ms Donnelly's use of restraint was also incorrect as physical restraint should be used as last resort. Ms Donnelly should have tried to calm Service User A verbally to administer the vaccine. If Service User A was still agitated, then chemical restraint could have been used as the next step. This involves administered Diazepam to Service User A to calm them down. If Service User A was still shouting and refusing the vaccine, then this should have been taken as a lack of consent and all efforts should have stopped. The vaccine should then be administered on a different date.*
>
> *As a psychiatric nurse, I should have been asked if I could assist with Service User A's vaccination, by providing medication such as diazepam in advance of the administration.'*

The panel had sight of Service User A's PRN (when required) Medication protocol in which it shows that Diazepam was prescribed. The panel noted that the reason for this medication was for *'Agitation/Anxiety'* and it could be administered if Service User A

became anxious and/or agitated or to prevent her from hitting out at staff and service users.

In your evidence you told the panel that Service User A was not agitated on that day, and that she was mostly calm and quiet and presenting in her normal way. You said that Service User A had previously received a COVID-19 vaccination and flu vaccinations without issue. You told the panel that when Diazepam had previously been administered to Service User A, this had at times caused her to become more agitated, with associated complications and side effects which had once led to her choking on food.

Whilst you told the panel that Service User A was not agitated prior to receiving the vaccination, the panel noted that there was evidence from Colleague A, Colleague B and Colleague C that she was. The panel heard evidence that Diazepam would have taken some time to take effect and Colleague D concurred in her evidence that it had previously had some negative side effects on Service User A. Although it was not contested that Diazepam was not used on this occasion with Service User A, the panel found no evidence that you had given no consideration of the use of Diazepam to assist in the administration of the vaccine. The panel therefore found this charge not proved.

The stem of Charge 1.b

b. Were responsible for and/or contributed to the restraint of Service User A in that you:

Before considering charges 1.b.i. and 1.b.ii., the panel first considered whether it could be established that Service User A was restrained. The panel had regard to the evidence of Colleague A, Colleague B, Colleague C, Colleague D and your evidence.

The panel noted that it is accepted that four staff members were in the room at the relevant time and that the evidence supports that Service User A was laid on the floor at the time the COVID vaccine was administered. In her statements in March and April 2021, Colleague B stated that she had her hands on Service User A's legs while

Service User A was on the floor to prevent her from kicking her legs. The panel also had regard to the evidence of Colleague C who said that he had his hands on Service User A's legs and that Colleague B had her hands on Service User A's arms. Whilst the panel acknowledged that the accounts of Colleague B and Colleague C about where their hands were was inconsistent, they both accepted that you were at the top of Service User A, at her head and shoulders, had your hands upon her, and that they had both had their hands on Service User A. Colleague D also provided consistent evidence about Service User A being restrained on the floor by you and Colleague B and Colleague C.

The panel had regard to Colleague D's local statement dated 18 April 2021 in which she stated the following:

> *'Service User appeared distressed as she was screaming and trying to get up from the floor but was unable to due to the position of Manager Janette Donnelly, Support Staff [Colleague C] and Support Staff [Colleague B].'*

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

Whilst the panel acknowledged that you and Colleague B do not consider that a restraint was in place, it considered that given that Service User A was on the floor with the hands of three people upon her, it was more likely than not that the reason for physical contact was to restrain her while the vaccination was administered. The panel noted that once the vaccine had been administered, all parties removed their hands and Service User A sat up. The panel therefore concluded that Service User A was restrained for the purpose of receiving the vaccination. As the most senior member of staff, and by having physical contact, the panel determined that you were responsible for and contributed to the restraint of Service User A.

Charge 1.b.i.

b. Were responsible for and/or contributed to the restraint of Service User A in that you:
    i. Restrained Service User A's head;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D.

The panel heard oral evidence from Colleague D, and had sight of her NMC witness statement in which the following was stated:

> *'Once I had finished talking to the GP, I went to Service User A's room to check up on her. When I opened the door, I saw the support workers [Colleague C] and [Colleague B] restraining the Service User on the floor under the direction of Ms Donnelly.*
>
> *Ms Donnelly was on her knees by Service User A's head and was using her bodyweight and hands to hold Service User A's head in place. [Colleague C] was kneeling down and holding down the torso of Service User A. [Colleague B] was kneeling down on the floor, holding down Service User A's legs in place.'*

The panel also had regard to Colleague D's local witness statement dated 18 April 2021 in which she stated the following:

> *'On opening the bedroom door I was confronted with Service User on floor on her right side, Manager Janette Donnelly was knelt on floor with her hands on Service User 's head Support Staff [Colleague C] knelt on floor with her hands on Service User upper torso and Support Staff [Colleague B] knelt on floor with his hands on Service User legs.'*

In her oral evidence, Colleague D told the panel that she would never forget the sight that she was confronted with, that it was *'horrific'*, and that you had restrained Service User A's head with your hands.

The panel had sight of local meeting notes with Colleague B dated 20 April 2021 in which the following is stated:

> *"[Ms 2] asked if how she was being held. [Colleague B] replied that he had his hands placed on her legs and [Colleague C] on her arms and JD was at her head and shoulders*."

> *'[Colleague B] was asked where everyone was at this point, he replied that [Colleague D] was on the phone to the GP, [Colleague C] was across from him, he thought [you were] at head and shoulders and the NHS nurse to the side of Service User A.'*

The panel also had sight of Colleague C's response during a local meeting:

> *'JD was at [Service User A's] head, kneeling on the floor, JD was talking but I don't know what she was saying I was talking to [Service User A].'*

In your evidence you told the panel that you were holding Service User A's hand in order to comfort her, that you were facing towards Service User A's head, but that you did not restrain her head.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable. Having regard to all of the evidence, and having found that it was more likely than not that Service User A was being restrained, the panel found that it was also more likely

than not that you assisted in the restraint by holding and restraining Service User A's head. The panel therefore found this charge proved.

Charge 1.b.ii.

a. Were responsible for and/or contributed to the restraint of Service User A in that you:
    ii. Supervised and/or directed further restraint of Service User A by Colleague B and Colleague C.

This charge is found proved.

In reaching its decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D, and it had regard to your evidence.

The panel had sight of Colleague D's NMC witness statement in which the following was stated:

> *'Upon seeing the situation, I told Ms Donnelly that this level of restraint was deeply inappropriate and that she could not do this. Ms Donnelly ignored my protests, telling me to "fucking shut up" and continued to shout at the support staff to keep holding Service User A down.'*

The panel also had sight of Colleague D's local statement in which she stated the following:

> *'I voiced that this behaviour towards Service User A was unacceptable and classed as restraint, however this was ignored. Manager Janette Donnelly remained shouting and screaming which was now directed at Support Staff [Colleague C] and [Colleague B].'*

The panel had sight of the local interview with Colleague B and noted the following:

'[Ms 2] asked [Colleague B] if he felt at any point, he could have said no he replied that there were 3 nurses there so that's why he didn't say anything but he did feel uncomfortable and felt it wasn't right.'

[Colleague B] stated that the NHS nurse had stated at this point that I don't think we will be able to do this, but JD replied 'just do it'! [Colleague B] was asked how did JD say this, how was her tone. [Colleague B] replied it was like an order."

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable. Having regard to all of the evidence before it, the panel was of the view that as the senior nurse present you supervised and/or directed further restraint of Service User A by Colleague B and Colleague C. Accordingly, the panel found this charge proved.

The stem of Charge 1.c

c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:

Before considering the particulars of charge 1.c, the panel considered whether the stem of the charge has been made out.

The panel had regard to the NMC witness statement, local statement and oral evidence of Colleague D. It noted that her evidence was consistent that you were aware of the vaccination having been administered through Service User A's clothing.

The panel also had regard to the evidence of Colleague B who, in his local meeting said that you were aware of the vaccination being administered through Service User A's clothing.

In your evidence you told the panel that as you were facing Service User A's head you were unaware that the vaccination had been administered through her clothing.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

The panel accepted the evidence of Colleague D, that whilst you were knelt at the head of Service User A, you were facing down her body. The panel found that on the balance of probabilities, given that you were positioned in close proximity to Service User A and holding her head, it was not plausible that you would not have been aware of the vaccination having been administered through her clothing, or at least informed of it at the time. The panel therefore found that for this reason, as well as on the basis of all the evidence before it, the stem of the charge has been made out, and went on to consider the particulars of charge 1.c.

Charge 1.c.i.

> c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
>
> i. Informed Colleague A that you would not report the way in which the Covid vaccination was injected;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D.

The panel also had sight of Colleague B's responses during a local meeting on 20 April 2021 in which he stated the following:

‘He described how attempts had been made to lower the leggings to access her thigh but this wasn’t possible, so JD told the NHS nurse just to do it. The nurse administered the injection through the leggings.’

The panel also noted Colleague C’s responses during a local meeting in which she said that she felt that the vaccination was going to *‘happen regardless’*.

In her witness statement to the NMC, Colleague D stated the following:

‘[Colleague A] then said that she needs bare skin to be able to administer the vaccine and asked if Service User A’s leggings are pulled down until there is enough skin to administer the vaccine.

Ms Donnelly then asked the support staff if they had a good grip, then looked at [Colleague A] and told her to “just administer it through the leggings”. After Ms Donnelly continued to shout at [Colleague A], [Colleague A] followed the instructions and administered the vaccine through Service User A’s leggings.

Once the vaccine was administered, [Colleague A] said to Ms Donnelly, “please don’t tell anyone I’ve administered the vaccine in this way”, to which Ms Donnelly said, “of course I won’t”. Ms Donnelly then released the patient who then got up and ran down the corridor waving her hands, screaming.’

The panel also had regard to Colleague D’s local statement dated 18 April 2021:

‘Manager Janette Donnelly continued shouting and screaming towards Support Staff [Colleague C] and [Colleague B] to get a hold of Service User , Manager Janette Donnelly then shouted at NHS Nurse [Colleague A], Hurry up WE (referring to herself and the two support staff [Colleague C] and [Colleague B) have a hold of her, (referring to Service User) to administer COVID19 Vaccine straight through Service User ’s leggings.

NHS nurse [Colleague A] in a scene of chaos, shouting and screaming administered COVID19 Vaccine straight through Service User leggings.

Once NHS Nurse had administered the COVID19 Vaccine to Service User, she looked at Manager Janette Donnelly and said, "please don't tell ……I've administered Vaccine in this way "Manager Janette Donnelly replied of course I won't.'

The panel also heard oral evidence from Colleague D which was consistent with her contemporaneous statement and NMC witness statement.

In your evidence you told the panel that you were not aware of the vaccination being administered through Service User A's clothing at the time of the incident and that this conversation did not take place.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

The panel found that Colleague D's evidence was supported by the evidence of the support workers, one of whom was aware of the administration of the vaccine through clothing. The panel found that it was more likely than not that you were involved in the decision to administer the vaccine through Service User A's clothing. Having found that you were aware of the administration and involved in the decision to administer it in this way, the panel also found that, as a Registered nurse you would have been aware of the inappropriate nature of its administration. The panel determined that it was more likely than not that you informed Colleague A that you would not report the way in which the vaccination was injected. The panel therefore found this charge proved.

Charge 1.c.ii.

c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
    ii. Did not report that the Covid vaccination was injected into Service User A's thigh through clothing.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D and the evidence set out above in charge 1.c.i.

In your evidence you told the panel that you did not report that the vaccination was administered through Service User A's clothing as you were not aware that this had happened.

The panel was satisfied that you were aware that the vaccination had been administered through Service User A's clothing, and you did not report it. The panel therefore found this charge proved.

Charge 2.a.

2. Your actions as set out in charge 1b were not clinically justified in that:
    a. The restraint of Service User A was unnecessary;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had regard to the evidence of Colleague D in her local statement in which she stated the following:

'Manager Janette Donnelly phoned unit 2 midmorning, to inform me to start taking Unit 2 service users to dinning [sic] room in unit 1 for their 2nd dose of

COVID19 vaccine, supported by Support staff on shift. Manager Janette Donnelly also informed me that Service User would receive her 2nd dose of COVID19 vaccine in her bedroom, in Unit 2 and would be left until last to receive Vaccine.'

In your evidence, you told the panel that Service User A did not have to receive her second vaccination on 19 February 2021 and that the NHS nurses would have been returning, and she could have had it then. This was supported by the oral evidence of Colleague D, as well as the NMC witness statement of Ms 1 in which she stated the following:

'The covid injection did not have to be done at that particular time and it could have been rearranged if it was not possible to do it that day. The NHS staff were responsible for doing the covid injections. The NHS staff came to Millport from the local health centre and vaccinated staff and residents at Millport.'

The panel had sight of the Positive Behaviour Support – Sanctuary Care Policy dated 31 March 2020 and had regard to the following:

'1.6 Restraint will only be used in circumstances which are legally and ethically appropriate and in order to ensure the safety of residents, staff and others.

1.8 Any form of restraint is only used as a last resort when all other courses of action have failed.'

The panel was satisfied that it was not essential for Service User A to receive the vaccine on 19 February 2021; it was your evidence that she could have received it at a later date. The panel also noted that the Policy sets out that any form of restraint must only be used as a last resort when all other courses of action have failed. Having found that it was not essential for Service User A to receive her second vaccination on 19 February 2021 the panel found that use of restraint to administer it was not necessary.

Charge 2.b.

2. Your actions as set out in charge 1b were not clinically justified in that:
    b. The restraint of Service User A was not in line with their care plan;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had sight of Service User A's Positive behaviour care plan dated 4 September 2014 in which the following was stated:

> *'Service User A has a Learning Disability and Bipolar Affective Disorder, which has largely been resistant to treatment. There are times when it is necessary for Service User A to be restrained to allow for essential interventions such as feeding and personal care. Service User A is subject to Welfare Guardianship under the Adults With Incapacity (Scotland) Act 2000 and the Guardianship includes the powers for such basic interventions…*
>
> *…When restraint is used, it should be delivered by staff trained in a recognised restraint technique and should be used for the shortest period necessary.*
>
> *… There are times when Service User A requires to be redirected in order to prevent her coming to harm or to protect her dignity… if restraint is necessary, then the use of and duration of restraint should be recorded in Service User A's care notes.'*

The panel found that in applying an unnecessary restraint, your actions were not clinically justified or in line with Service User A's care plan. The panel therefore found this charge proved.

Charge 2.c.

2. Your actions as set out in charge 1b were not clinically justified in that:
    c. You did not have appropriate training in restraint at the time.

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel noted that the NMC had not provided evidence about what training you had undergone at the relevant time. When you gave oral evidence, the panel asked questions about your training record and you did not directly confirm whether you had completed the relevant restraint training. You said that as you are no longer employed by the Sanctuary Group, you were unable to access your training record or provide training certificates.

The panel found that the NMC had not discharged its evidential burden and found this charge not proved.

Charge 3

3. Your actions as set out at charge 1c were dishonest in that you knew that you had a duty to report the administration of the Covid vaccination by Colleague A through Service User A's clothing.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had regard to the Sanctuary Group's Accident Reporting and Investigation – Group Procedure document dated 5 February 2021. It also had regard to the NMC witness statement of Ms 1 in which she stated the following:

> *'Ms Donnelly had ultimate responiblity [sic] for reporting any incident or accident that happened in the supported living areas. Sancutary [sic] Care has an internal electronic reporting system called RADAR. Depending on the type of incident,*

there is email alert sent to the regional manager. If it is a serious incident, then the email alert goes to me and directly to the operations manager.

Depending on severity of incident, Ms Donnelly had to escalate to her regional manager, [Ms 2]. If the incident was an adult support concern then she should notify the Local Authority and the Care Inspectorate.

The Care Inspectorate regulate care providers in Scotland and use a system called eForums. Ms Donelly had to use eForums to notify the Care Inspectorate of any concerns.'

The panel had regard to the evidence of Colleague D who said she observed you telling Colleague A to administer the vaccination through Service User A's clothing which was supported by the evidence of Colleague B. The panel also had sight of evidence from Colleague C who stated that she felt that the vaccination was going to *'happen regardless'*.

The panel was satisfied that you would have been aware of the inappropriate nature of the vaccine's administration and were aware of your duty to report that it had been administered through Service User A's clothing, and you did not. The panel found that in omitting to report the incident, your actions were dishonest in that you sought to conceal the inappropriate administration. The panel found that your conduct was dishonest by the standards of ordinary decent people. Accordingly, the panel found this charge proved.

Submissions on interim order

As this hearing has not concluded in the allocated time and will therefore adjourn before the next stage, in accordance with Rule 32(5) on the Rules, the panel invited submissions on whether or not to make an interim order.

Mr Brahimi submitted that in light of the panel's findings an interim order is necessary. He submitted that the findings raise public protection concerns and that the finding in

respect of dishonesty is significant. Mr Brahimi's primary submission was that an interim suspension order is necessary to protect the public and meet the public interest considerations of this case.

Mr Brahimi submitted that there is a risk of repetition of the behaviour and a consequent risk of harm to patients if you were able to practise without restriction during the adjourned period. He submitted that Service User A was a vulnerable resident and whilst no psychical harm was caused, there is evidence that she suffered emotional harm following the incident. Mr Brahimi submitted that findings of dishonesty are serious and there is a risk that you would repeat this behaviour.

In respect of public interest, Mr Brahimi submitted that a fully informed member of the public would be deeply alarmed if you were able to practise without restriction in light of the panel's findings on the facts. He submitted that an interim order on public interest grounds is required to maintain the integrity of the nursing profession, to uphold proper professional standards and maintain confidence in the profession and the NMC as the regulator.

Mr Brahimi addressed the panel on the principle of proportionality, he submitted that an interim suspension order is likely to impact on your potential income. Whilst his primary submission was that an interim suspension order for 18 months is appropriate and proportionate, if the panel was minded not to impose an interim suspension order, he suggested some conditions that may be appropriate.

Mr McPhee submitted that an interim order is not necessary in the circumstances. She referred the panel to your bundle of documents which contained positive testimonials from past and current peers and managers. Ms McPhee submitted that the charges relate to an isolated incident in a long and previously unblemished career. She submitted that you have worked without incident since the charges arose four years ago and you are currently working for a supportive employer. Ms McPhee submitted that there is no immediate or real risk of harm to patients or the public if you were able to practise without restriction.

In respect of the public interest, Ms McPhee submitted that it is best served by allowing you to continue to practise without any unnecessary restrictions. She submitted that open reflection and learning should be encouraged rather than a punitive approach being taken. Ms McPhee submitted that this hearing is public and that these proceedings provide a degree of scrutiny. She submitted that as we have not reached stages two and three of the hearing, the panel is yet to consider any mitigating factors.

Ms McPhee submitted that as there is no evidence of a continued risk of harm an interim order is not necessary in any form. She submitted that the imposition of an interim order would have a detrimental effect on you financially and reputationally. Ms McPhee also submitted that any interim order should not be imposed for the maximum period of time as sought by the NMC.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the public protection and public interest considerations that have arisen from its findings. The panel found that you inappropriately and unnecessarily restrained a particularly vulnerable service user who lacked capacity. The panel also found that that you instructed another nurse to administer the vaccine through Service User A's clothing. Both of these incidents placed Service User A at a risk of physical harm, and both Service User A and your colleagues at a risk of emotional harm. The panel also found that in concealing what had happened, this raised further public protection concerns.

The panel had sight of testimonials, and noted that you have practised without incident in the four years that have elapsed since the charges arose. However, the nature of the behaviour found proved against you relied on the reporting of the incident by another individual when you were under a duty to report it but chose not to do so. The panel also took into account that you were in a senior role and in position of trust and power

when the charges arose which raised questions about your integrity. The panel therefore determined that there is a real risk of repetition of the conduct and a consequent risk of significant harm if you were able to practise without restriction.

The panel considered that in the light of the seriousness of the charges found proved, the particular vulnerability of Service User A, your senior role and position of power and the findings concerning dishonesty, the public interest is engaged. It was of the view that if you were able to practise without restriction for the adjourned period, public confidence in the profession would be seriously damaged.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the seriousness and nature of the charges found proved. The panel found that no workable conditions could be formulated to address the seriousness of the charges and dishonesty found. It considered that any conditions that would sufficiently address the concerns would be tantamount to a suspension. The panel therefore determined that an interim suspension order is necessary to protect the public and to address the public interest in this case.

The panel had regard to the principle of proportionality, and whilst it acknowledged the financial and reputational damage this order is likely to have, it was of the view that your interests are outweighed by the need to protect patients and the public and to uphold proper professional standards and maintain confidence in the profession and the NMC as the regulator.

As this hearing will be listed to resume as soon as possible, the panel determined than an interim order for 9 months is proportionate.

Fitness to practise

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

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

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

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

Evidence

Before hearing submissions on misconduct and impairment, you gave evidence under affirmation and called three witnesses:

- Ms 1 Quality Assurance Manager at your current employment
- Ms 2 You Regional Manager from 2009 to 2013
- Ms 3 Your Current Line Manager

You also provided the panel with a number of additional documents which included the following:

- Further reflective statement
- Record of training
- Testimonials.

Your oral evidence

In your oral evidence, you provided the panel with information about your career as a nurse which started in 1986. You told the panel that you have worked as a registered nurse in a number of settings including the NHS and the private sector, which included caring for patients with learning disabilities and the elderly. You said that there have never been any complaints about your practice prior to and since these charges arose.

You told the panel that prior to the imposition of the interim suspension order in May 2025 you were working as a Clinical Deputy Manager. After May 2025, you were redeployed within the same service as a Non-Clinical Deputy Manager. You said that since the panel handed down its decision on facts, you have had time to reflect on the events of 2021. You told the panel that you accept the panel's findings, and you take responsibility for your actions. You said that you have undertaken further study to update your skills and you have revisited areas such as capacity, duty of candour and your responsibility to report. You told the panel that in your current role you support the team to work within the law, policies and procedures.

When asked what went wrong on the day in question, you said that it was a very unusual time, and you allowed organisational pressure and the desire to get everyone vaccinated to cloud your judgement. You told the panel that you had a *"gut feeling"* that the vaccination should not have gone ahead and *"had not gone well"* but you failed to stop. You told the panel that you should have told everyone to stop when Service User A slid to the floor and interpreted this *"subtle"* sign as a lack of consent. You stated that you should have asked the staff to leave the room. You accepted that your actions were compounded by not reporting what happened, *"that it had not gone well"*, honestly. You said you accepted that your actions fell below the standards expected of a registered nurse and manager and you had not been a role model for your team.

You told the panel that you made the other staff present vulnerable by not stepping up and saying that the procedure should finish and everyone should leave. You said that you understand that Service User A would have felt frightened and would not have known what was happening with the vaccination and felt powerless. You told the panel that when Service User A took herself down to the floor, you should have taken this as a sign of a refusal to have the vaccination. In failing to recognise the signs, *"read between*

the lines" and act upon this, you said that Service User A would have felt ignored, instead of feeling reassured and protected which would have caused her to feel anxious and upset. Whilst you told the panel that consent for the vaccination had been given by Service User A's family in her paperwork, you said that you now recognise that Service User A, through her actions, had not consented to the vaccination being administered. You told the panel you now accepted Service User A's dignity and human right to refusal had been compromised.

You told the panel that you are very sorry for your actions and extended an apology to Service User A and her family. You said that you are sorry to Service User A's family for betraying their trust and that you accepted that you let them down very badly and you did not lead the team effectively, follow policy or treat Service User A in a dignified way. You said that you should have protected Service User A's best interests. You told the panel that this was a one-off incident, and you would never let it happen again.

In respect of the inappropriate restraint, you told the panel that you understand that restraint is always the last resort and should only be used if there is imminent risk and danger to the service user or someone else. You said that restraint should only be used when everything else such as distraction, diversion and attempts to settle the service user had failed. You told the panel that the level of restraint must be proportionate and in accordance with a care plan. You said that restraint is not the only option and often moving away from the situation can stop the situation from being dangerous.

You accepted that the use of restraint on Service User A in the circumstances was not appropriate as no-one was in danger if she did not receive the vaccination that day. You said that upon reflection, you would now handle a situation like this differently in that you would give the service user space, meet with a Multi-Disciplinary Team (MDT) and arrange for the vaccination to be re-arranged. You said that you would have also invited the guardian or next of kin to attend and offer further reassurance. You told the panel that you could have offered an alternative place for the vaccination to be administered and would always respect the right to refuse.

You told the panel that you accepted that as the most senior member of staff involved in the incident, your actions could have impacted junior members of the team's perception of what is acceptable and could have resulted in them adopting this example of poor practice into their own practice. You said that since the incident, you have changed your practice and that you now lead by example and advise your team in how to recognise subtle, non-verbal signs of distress.

You said that it was wrong to not report what had happened when you became aware of it. You told the panel that you have fully reflected on your actions and omissions and accepted that you placed a resident at risk. You accepted that you breached your duty of candour, you said that you should have reported that the vaccination did not go to plan and discussed what went wrong. As this was not reported, you said that the opportunity to review in detail and learn from the mistakes was missed.

You told the panel that you understand that it is important to be open and honest when things go wrong. You said that the whole ethos of nursing is underpinned by honesty and openness to ensure that patients are told the truth and to ensure that they can trust what they are being told. You told the panel that being dishonest, even on one occasion, is unacceptable and undermines confidence in the profession and in the relationship between nurses and patients. You said when mistakes happen, you should always be honest and say what went wrong. You told the panel that you would not act in a similar way in the future and you provided examples of when you have acted with openness and honesty since the charges arose.

You told the panel that you accepted that your behaviour undermined trust in the profession. You said that nurses are held in high esteem by the public, and when the trust is broken, the profession is judged and is subject to scrutiny. You said that you have acknowledged your failings, changed your practice and consistently acted openly and safely for the past four years.

You told the panel that since its findings on facts in May 2025, you have undertaken refresher courses on various relevant topics and also mandatory training. You said that you have also undertaken detailed reflection and personal reading, as well as

discussing the panel's factual findings with your colleagues. You said that you have changed your practice and are continuously reflecting and plan more meticulously in order to perceive where things could go wrong and to have a plan in place for if they do. You told the panel that you are more receptive to *"subtle"* non-verbal communication from clients and are more aware of matters relating to consent.

You told the panel that there is no risk of repetition and your past conduct resulted from a gross error in judgement which you should never allowed to have happened. You said that you have embedded the principles of dignity and consent in the care home that you currently manage. You told the panel that if you are found in a similar high-pressure situation in the future, dignity and consent would never be compromised, and you would take a step back and ask yourself whether a plan needs to be made at that time. If a decision is not urgent then you would put off making a decision and you would ensure that patient safety was not compromised. You told the panel that it is not okay to *"bend the rules"*.

You told the panel that you would like the opportunity to return to practise as a registered nurse to further embed your learning, improve your practice and to show that you are a skilled nurse who looks after people with care and compassion.

When asked what reassurance you can give to the panel that you would not act in a similar way in the future, you said that there is no way you would repeat your conduct. You told the panel that you would prioritise the dignity of a service user. You said that you realise that you prioritised the timely vaccination over the dignity of Service User A, and that you understand that this should not have happened and that it would never happen again. You also told the panel that you accepted that you should have taken the lead in reporting when you became aware that the vaccination had been administered through clothing.

The evidence of Ms 3

During the evidence of Ms 3, some concerns were raised about the scope of your role as a Deputy Home Manager. Since May 2025, you have been subject to an interim suspension order and are therefore not permitted to undertake any nursing tasks.

Ms 3 was recalled to clarify her evidence in respect of your role and responsibilities as a Non-Clinical Deputy Home Manager.

Ms McPhee provided a number of employment documents including the job description of a Non-Clinical Deputy Home manager.

Mr Brahimi submitted that whether an interim order has been breached is not a matter for this panel's consideration. He informed the panel that if there were concerns that you had been practising as a registered nurse while the interim order has been in place, this would have to be investigated by the NMC.

The panel accepted the advice of the legal assessor.

The panel noted that when Ms 3 was initially asked by the panel to set out your current duties, she referred to what appeared to be registered nursing duties. However, when she was recalled, she appeared to retract this and did not include these same tasks. After hearing submissions from both parties and taking legal advice, the panel noted the direction from the NMC that this matter should be set aside for the purpose of this hearing.

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 Brahimi submitted that the facts found proved amount to misconduct. He drew the panel's attention to 'The Code: Professional standards of practice and behaviour for

nurses and midwives 2015' (the Code) and referred the panel to specific parts which, in Mr Brahimi's submission, had been breached.

In his written submissions he stated the following:

> *'The NMC submit that the proven charge amounts to misconduct. The following submissions are collectively made in respect of the Registrant's conduct:*
>
> *a. Vaccination through clothing (particularly during Covid) is improper and puts the patient at risk of infection. Such behaviour is not proper in the circumstances.*
> *b. Restraining a user's head in a manner that was not clinically justified, unnecessary and contrary to a care plan was reckless. This conduct was further aggravated by directing others to partake in the restraint. Such behaviour connotes a serious breach by the Registrant.*
> *c. For medical care to function properly, it relies on transparency and contemporaneous records. To have acted dishonesty by not reporting the vaccination incident leaves a gap in records and others have no knowledge of the original incident. This conduct is further aggravated by involving others (Colleague A) in the reporting concealment. Such behaviour would be regarded as deplorable by fellow practitioners…*
>
> *Overall, the NMC further submits that the Registrant's actions as proven fall far short of what would be expected of a Registered Nurse. The public would expect that medical staff will uphold a professional reputation. The Panel may find that most in breach are that of "1" and "20" above. The Registrant has put into question as to whether nurses can be trusted around vulnerable patients and discharging their duties.*
>
> *The NMC therefore invite the Panel to find misconduct.'*

Ms McPhee submitted that it is accepted that the facts found proved are serious and amounted to misconduct.

Submissions on impairment

Mr Brahimi 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 Brahimi provided written submissions in respect of current impairment which included:

> *'The NMC submit that there is a serious departure from the standards expected of a nurse and that the behaviour is incompatible with unrestricted registration until such time as the Panel are satisfied restrictions are no longer required. The Panel should consider impairment on the following grounds:*
>
> ***Public protection***
> *a. There is a risk of harm in this case where the patient was physically restrained and therefore could have sustained injuries as a result of being held by 3 people. The vaccination through clothing was a significant risk where it was not known to the Registrant of whether the skin underneath was suitable for vaccination (such as there being a potential scab/wound). The conduct was amplified where other staff members were directed to participate in the restraint.*
> *b. There is a risk of repetition in this case because the Registrant has shown to be dishonest and was unlikely to report such matters until they came to light. It was only until the finding of the Panel, that the Registrant said that she understood her wrongdoing. This means that there is a risk of the Registrant repeating such behaviour.*
>
> ***Otherwise in the public interest***

a. Public knowledge of the Registrant's conduct and breaches will adversely reflect on registered nurses and in turn affect the public's trust in the medical profession. Nurses are a symbol of reliance and trust when it comes to an individual's health. Using restraint has been described as one of the last resorts and this is what was erroneously used by the Registrant at a time when it was not clinically justified. The Registrant's conduct will have affected the public's trust when they learn that the Registrant deliberately did not report a significant incident. It is unacceptable that others were directed to take part in restrain that was not clinically justified.

b. It is appreciated that the Registrant has provided testimonials as to her practice, however the dishonest nature of failing to report is not easily remedied and there is case law, such as PSA v NMC CSIH 19 which assist Panels in making the point that long service and good character cannot outweigh conduct that might be deemed as deliberate (in this case dishonesty). The Panel are reminded not to take an unduly lenient approach of not finding impairment purely on the basis that insight has been demonstrated. Rather, the Panel should strongly assess all the evidence when deciding upon a serious charge such as dishonesty. The number of individuals involved, coupled with failure to report, indicate a need for restriction based on public protection and public interest concern. From this case, members of public would question the quality of responsibility that registered nurses take when seeing to vulnerable patients. As a result of the Registrant's conduct, the NMC submit the medical profession has been challenged and evidently been put into disrepute.

As such the NMC invite the Panel to find that the Registrant is currently impaired.'

Ms McPhee submitted that you have fully and unequivocally accepted of the panel's findings on facts. She submitted that you have taken full responsibility for your actions and you have not sought to minimise them. Ms McPhee submitted that you have

acknowledged the panel's findings and that you have been open with your employer about these. You have been redeployed to a non-clinical post since May 2025.

Ms McPhee submitted that serious misconduct does not mean that a finding of impairment must be made. She submitted that you recognise your wrongdoing, you have demonstrated genuine remorse and full and deep insight. Ms McPhee submitted that you have been a role model for others by sharing your past mistakes and learning from them.

In respect of the dishonesty found, Ms McPhee submitted that there is a spectrum of seriousness. She submitted that the context in which the dishonesty occurred was relevant as it was a one-off incident in an otherwise unblemished career. Ms McPhee submitted that you have provided a full and detailed apology and there is evidence of change.

Ms McPhee submitted that in the light of your acceptance of the panel's findings, your full apology and recognition of the consequences of your actions, the risk of repetition is no longer present. She drew the panel's attention to your training certificates and positive testimonials, Ms McPhee submitted that if you were faced with a similar situation, you would act differently and not repeat the conduct.

Ms McPhee submitted that when the charges arose, there was a mass COVID-19 vaccination programme in which a large number of residents needed to vaccinated. She submitted that you were overwhelmed and you made the wrong decision in a pressurised situation.

Ms McPhee submitted that since the charges arose, and prior to the interim order being imposed in May 2025, you worked as a registered nurse without incident for approximately four years. She submitted that you have strengthened your practice, you have worked with openness and honesty and embedded your learning. Ms McPhee submitted that a finding of impairment is not required on public protection or public interest grounds.

The panel accepted the advice of the legal assessor.

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 your actions fell significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> > ***1.1** treat people with kindness, respect and compassion*
> > ***1.2** make sure you deliver the fundamentals of care effectively*
> > ***1.5** respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
>
> *To achieve this, you must:*
>
> > ***2.6** recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> *To achieve this, you must*
>
> > ***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

4 Act in the best interests of people at all times

To achieve this, you must:

> ***4.3*** *keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process*

7 Communicate clearly

To achieve this, you must:

> ***7.2*** *take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs*

8 Work co-operatively

To achieve this, you must:

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

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

To achieve this, you must:

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

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

To achieve this, you must:

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

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

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system'

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 the facts found proved are very serious and involved a breach of a position of trust and power and dishonesty.

The panel considered that your actions and omissions in prioritising the needs of the service above those of Service User A were very serious. It noted your own evidence at the facts stage that this was not a pressured situation, that it had not been necessary for

Service User A to be vaccinated that day and that it could have been rescheduled for a later date. The panel rejected Ms McPhee's assertion that you had been "*overwhelmed"* at the time; rather, the panel concluded that your actions were driven by a desire for convenience. In failing to respond appropriately to Service User A's obvious distress and in proceeding to be involved in and direct other junior members of staff to carry out and continue an inappropriate restraint to administer the vaccination, the panel found that your actions were a serious departure from the standards expected from a registered nurse. In directing the vaccination nurse to administer the vaccine through Service User A's clothing, you placed Service User A at risk of infection and consequent physical harm.

Your actions caused Service User A, who was a very vulnerable patient who lacked capacity, emotional harm and placed her at risk of physical harm. The panel also considered that this was exacerbated by Service User A's history of suffering abuse which you would have been aware of. You also placed members of your team at a risk of harm, and the panel noted its earlier finding that as a result of the inappropriate intervention, members of staff were caused emotional harm.

In seeking to conceal what had gone wrong and colluding with the vaccination nurse to ensure that the incident was not reported, the panel found your actions and omissions to be very serious, and fell far below the standards expected of a registered nurse.

The panel found that your actions 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, your fitness to practise is currently impaired.

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

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

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”

If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

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

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

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

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

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

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

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

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

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

The panel found all limbs engaged. The panel found that you caused emotional harm to Service User A, and you placed her at risk of physical harm resulting from an inappropriate restraint and directing that the vaccination be administered through her clothing. The panel also found that you placed junior colleagues at risk of physical harm, and did cause them actual emotional harm in that you were instrumental in directing an inappropriate restraint to take place. The panel's assessment of the evidence was that this had been a chaotic, distressing and *"horrific"* incident that led to whistleblowing and that your descriptions have sought to minimise it. The panel considered that anyone who was involved in or witnessed the incident was placed at a risk of suffering physical and emotional harm.

The panel was of the view that in your position of trust and power, you failed to prioritise Service User A, you failed to practise effectively, preserve safety and promote professionalism and trust. The panel therefore found that you brought the profession into disrepute and breached fundamental tenets of the profession. In colluding with another professional and seeking to conceal what had gone wrong, the panel considered that you acted dishonestly.

The panel went on to consider whether the misconduct found is capable of remediation. The panel considered that your actions and omissions were very serious and compounded by your protracted dishonesty.

The panel noted that you have stated at this stage that you accept the panel's findings of fact, including the dishonesty. However, it considered that your ongoing minimisation of the nature of the incident, your part in it and the explanations for your dishonest actions were, at best, *'disingenuous'* (*Sawati v GMC* [2022] EWHC 28 (Admin)). The panel was of the view that the misconduct and dishonesty found raised serious attitudinal concerns which, although not impossible, are inherently difficult to remediate.

The panel also considered where the dishonesty found sits on the spectrum of seriousness. It had regard to the NMC Guidance on *'Sanctions for particularly serious cases'* (Reference: SAN-2 Last Updated: 06/05/2025) which sets out the following factors to consider in determining seriousness:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *…*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception.*

The panel considered that all of the above points are engaged in your case. You deliberately covered up what had gone wrong and colluded with the vaccination nurse to ensure that it was not reported. The panel noted that even at this stage of the hearing, you have stated that you should have reported that the vaccination had been given through clothing when you *"had become aware of it",* which, in the panel's view seeks to go behind the facts found proved. The panel noted that it had only been because of whistleblowing that the incident had ever come to light. You were the most senior member of staff involved in the incident. Service User A was a very vulnerable

patient who lacked capacity and in not reporting what had gone wrong, you deprived her of receiving appropriate care and support following the incident. This was evidenced by Colleague D's witness statement in which she stated the following:

> *'As a result of this incident, there was a large shift in Service User A's behaviour. The resident was not manageable and required sessions with a psychiatrist'.*

The panel had regard to Colleague D's oral evidence in which she was asked about this:

> *'Q. Can you expand upon that, please? What did you observe?*
>
> *A. Her behaviour became very unsettled on a daily basis after that. The consultant psychiatrist who she was under, I was never allowed, any time she was due to visit, I was never allowed near her. I was kept away from her. One day she came, and I was – my cell phone was on. Nobody else was there to see the psychiatrist and talk to her in regard to Service User A. I was – I let that psychiatrist – I told the psychiatrist exactly what happened. She asked me about her behaviour, if there was anything that triggered it. I told the psychiatrist about the incident in regard to receiving the Covid vaccine.'*

Whilst the panel acknowledged that the dishonesty related to a one-off incident, it considered that you continued to act dishonestly in the years after and maintained your position at this hearing in May 2025. The panel therefore considered that this was a longstanding deception. Having regard to all of the above, the panel considered that the dishonesty found was particularly serious.

With regard to insight, the panel had regard to your reflective statements and your oral evidence. The panel considered that whilst you stated that you accept the panel's findings, you have sought to minimise your actions and go behind the findings of fact. In your reflective statement and evidence, you said that you failed to recognise the subtle signs of distress that Service User A exhibited in sliding to the floor. As set out in its facts determination, the panel found that the incident was extremely volatile and that

Service User A was displaying obvious signs of distress through shouting, screaming and struggling. It noted that Service User A's shouting and screaming had continued even after the incident had ended when she left her bedroom. It had taken three members of staff to hold Service User A down during the vaccination. The panel also noted that you maintained that you were only trying to *"support"* and *"reassure"* Service User A during the procedure and that you now state that you understand that she had demonstrated her refusal to the procedure by lying down, but that you "*hadn't registered this at the time"* and *"should have read between the lines".* The panel noted that it had found that you inappropriately restrained Service User A's head with your hands between your knees, and had directed others to continue the inappropriate restraint against Service User A's obvious signs of acute distress. In your evidence the panel found that you were unable to articulate why you acted in the way you did and reiterated that you had missed the *"subtle"* signs of distress and had been trying to *"reassure"* Service User A. You told the panel that "*the vaccinator had made a mistake*" and that you "*don't know why this happened*".

The panel had regard to your current manager, Ms 3's evidence at this stage of the hearing, when asked about whether you had discussed the findings of the panel with her and reflected upon them, she said, *"that's difficult to assess. I am sure she has reflected on what's happened. I don't want to answer this one"*. With regard to the dishonesty, you told the panel that you *"had not been fully aware of what had happened*" at the time. The panel therefore found that your blanket acceptance of the charges was at odds with your explanations to demonstrate insight and therefore found your insight to be very limited at this stage.

The panel acknowledged that you have stated that you are remorseful for your actions and that you apologised to Service User A, her family and colleagues in this hearing.

The panel noted that you have provided evidence of training and attempts to strengthen your practice. Having assessed all of the evidence of training, the panel found that despite the incident dating back to 2021, you have only very recently undertaken any training that might be related to the charges apart from what has been mandatory. The panel noted that you had still not undertaken any training in restraint. The panel had

regard to the numerous positive testimonials and that there have been no incidents of a similar nature prior to or after the incident. However, in light of your limited insight and lack of evidence that you have fully addressed the concerns, the panel found that there is a risk of repetition and a consequent risk of harm if you were able to practise without restriction. The panel therefore found that your fitness to practise is currently impaired on the ground 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.

The public expect nurses to prioritise patient safety and to create a safe environment for patients and colleagues. You abused your position of power and trust and brought the profession into dispute. In the panel's view, your actions and omissions were compounded by the sustained dishonesty to conceal what had gone wrong, prioritising your own interests above the safety and wellbeing of Service User A. The panel considered that a member of the public, appraised of these facts, would be shocked and public confidence in the profession and its regulator would be damaged if a finding of impairment was not made. The panel therefore found that a finding of impairment on public interest grounds is also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

Submissions on sanction

Ms Churaman, on behalf of the NMC, submitted that a striking off order, is appropriate given the panel's earlier findings on impairment. Drawing the panel's attention the NMC Sanction Guidance, SAN-1, she submitted that your actions deliberately or recklessly put vulnerable service users at risk of harm and they caused significant distress to Service User A. She submitted that the dishonesty identified in this case was sustained

over a period of years, up to and including giving evidence at this hearing and there were repeated attempts by you to minimise your conduct. While she noted that at the sanction hearing your reflective piece and shown some development with regard to insight, this is still limited and not fully developed.

Ms McPhee submitted that a conditions of practice order would be the most appropriate sanction. She outlined to the panel the extensive training certification you have achieved since 2025, along with up to date character references from your current line manager, and other colleagues. She submitted that you have now accepted the panel's finding on facts and impairment in full and recognise that your actions were not appropriate. She submitted that you have produced a recent reflective piece which comments on the panel's earlier findings and the ways in which you now accept that your practice fell short of the expected standards.

Ms McPhee submitted that the points of the case in *Sawati* are engaged in your case and that your defence should not be considered dishonest, but it is your right to defend the charges against you.

Ms McPhee submitted that your current employer, where you have remained employed and working in compliance with the interim suspension order, would be supportive of you returning to practice and has considered supportive measures such as direct supervision, should the panel impose any conditions. She outlined a number of suggested conditions that would address the remaining concerns of the panel and enable you to strengthen your practice.

In the alternative, Ms McPhee submitted that a suspension order could be an appropriate sanction given the meaningful insight you have now demonstrated, as well as the lack of repetition, and that the misconduct was an isolated incident. She submitted that the panel should consider the some 11 months you have been subject to an interim suspension order during the course of this hearing when deciding the length of any substantive order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Conduct which deliberately or recklessly puts people receiving care at risk of suffering harm
- Deliberate breaches of the Code
- A pattern of sustained dishonesty over a period of time
- Dishonesty in giving evidence
- Limited insight.
- Vulnerability of the person receiving care
- Premeditated behaviour

The panel also took into account the following mitigating features:

- Acceptance of the panel's findings and remorse.

The panel considered the advice of the legal assessor in coming to its decision on dishonesty when giving evidence and had particular regard to paragraph 108 of *Sawati* quoted below.

'It is going to require some thought to be given to the nature of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a

different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?'

The panel was of the view that your sustained deceit in your accounts of the incident in previous sittings of the hearing, including repeated attempts to implicate and blame others, were deliberate attempts to deflect from the objective facts and amounted to genuine acts of manufactured dishonesty before your regulator. The panel concluded that these were not failed attempts to tell the story in a better light, but were deliberate lies on your part to cast the incident in an entirely different light to what had been the *'horrific*' reality. By continuing the dishonesty you sought to avoid the consequences. It determined that these actions amounted to misconduct in their own right.

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

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). Having found that your actions amounted to a serious attitudinal concern involving protracted and self-serving dishonesty, including dishonesty towards the NMC as your regulator, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel had regard to the submissions on your behalf but was not satisfied that, given the prolonged attitudinal nature of the concerns, that relevant, proportionate, measurable, and workable conditions could be formulated to address the public protection issues identified.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to consider before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*

- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel gave careful consideration to your most recent reflective statement at the start of this stage of proceedings, as well as taking into account the supportive testimonials and the training you have undertaken. At first glance, the reflective statement appeared to indicate that you have undergone a very recent and significant shift in attitude, insight and reflection since the panel's determination on Impairment some five months ago. However, the panel noted that there was little evidence of any real progression, or 'journey' to your shift in insight. Rather, it was a sudden and 180 degree about-turn. It noted that over the four years since the incident to the start of these proceedings in May 2025 you manufactured and maintained a dishonest and self-serving account of what had happened and that it had only been because of a whistleblower that the true nature of incident had ever come to light. Your account was a set of deliberate lies that you repeated during the Facts stage of this hearing. Despite a lengthy five month adjournment between the Facts stage and the Misconduct/Impairment stage, in October 2025, you did not make use of this time to reflect upon the panel's factual findings and instead continued to repeat the same lies and seek to go behind these findings. Only at the very last moment, a further five months on in March 2026 and some five years after the incident leading to the allegations, did you at the start of the Sanction stage undergo an apparent polarised and sudden shift of attitude, insight and honesty with regard to your previous conduct. The panel considered that the timing of such a turnaround in attitude cannot be ignored and, given your former entrenched dishonesty over the past five years, in the light of the circumstances and urgency you now face, raises significant concerns regarding its authenticity. The panel concluded that the content of this new reflection appeared to be

reactionary to the panel's previous findings rather than a genuine and meaningful insight into your actions.

Notwithstanding this assessment of your reflection, the panel acknowledged that the public protection risks identified might be managed by you being temporarily removed from the Register. However, it considered that this would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness, nature and gravity of the facts found proved. It noted the high number of aggravating features of your misconduct and concluded that, given your limited insight, a suspension order would not fully protect the public or maintain and uphold the public confidence in the nursing profession.

The panel took note of the NMC guidance document, 'Sanctions for the highest risk cases, Reference: SAN-4' and that the forms of dishonesty which are most likely to require consideration of striking-off will involve. It found that all of the below points are engaged in your case:

- *'deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- *misuse of power*
- *personal …. gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception.'*

In light of all the above and the seriousness of the attitudinal concerns relating to sustained dishonesty that the panel found, the planned nature of the misconduct, the extreme vulnerability of the service user who lacked capacity, to whom you placed at risk of physical harm and to whom you caused actual emotional harm, and the lack of meaningful insight or reflection, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel determined that given the long-standing and protracted dishonesty in relation to the incident, as well as in your evidence towards the panel, public confidence in the NMC as a regulator would not be maintained with a temporary removal of your name from the register.

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

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel found that your actions were significant and serious departures from the standards expected of a registered nurse, and are fundamentally incompatible with remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were so serious that to allow you to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a

registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Churaman. She submitted that an interim suspension order of 18 months is necessary in the public protection and otherwise in the public interest to cover any potential appeal period.

Ms McPhee made no submission in regard of an interim order.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise maintain the public confidence.

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

That concludes this determination.