Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 23 – Thursday, 30 October 2025
Friday, 28 November 2025 and Friday, 5 December 2025
Tuesday, 14 – Thursday, 16 April 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Shona Mary Ovenstone**
NMC PIN:	04I0651S
Part(s) of the register:	Nursing Sub Part 1 RNA, Registered Nurse - Adult 18 September 2006
Relevant Location:	Fife
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, lay member) Christine Wint (Registrant member) Brian Stevenson (Lay member)
Legal Assessor:	Alice Robertson Rickard (23 – 24 October 2025 and 30 October 2025) Sharmistha Michaels (27 October 2025) Paul Housego (28 November 2025 and 5 December 2025) William Hoskins (14 – 16 April 2026)
Hearings Coordinator:	Adaobi Ibuaka
Nursing and Midwifery Council:	Represented by Holly Girven, Case Presenter
Mrs Ovenstone:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2 , 3c, 4, 5a, 5c, 6, 7 Charge 8 in relation to charge 6 only

Facts not proved:	Charge 3a, 3b, 5b, 9 Charge 8 in relation to charges 3 and 5
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Ovenstone was not in attendance and that the Notice of Hearing letter had been sent to Mrs Ovenstone's registered email address by secure email on 15 September 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Ovenstone's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Ovenstone.

The panel next considered whether it should proceed in the absence of Mrs Ovenstone. It had regard to Rule 21 and heard the submissions of Ms Girven who invited the panel to continue in the absence of Mrs Ovenstone. She submitted that Mrs Ovenstone had voluntarily absented herself.

Ms Girven referred the panel to a call note dated 1 October 2025 and an email dated 23 May 2025 from Mrs Ovenstone agreeing for the hearing to proceed in her absence stating she was retired and did not want anything to do with this case anymore.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mrs Ovenstone;
- Mrs Ovenstone has deliberately chosen not to exercise her right to be present or to give adequate instructions to enable lawyers to represent her;
- Mrs Ovenstone has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence. She has also stated repeatedly on 13 November 2024, 23 May 2025 and 1 October 2025, that she did not want anything to do with the case;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness has been warned to attend today to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2024.
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Ovenstone in proceeding in her absence. Although the evidence upon which the NMC relies on will have been sent to her at her registered address, she has made no detailed response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Ovenstone's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Ovenstone.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Girven, on behalf of the NMC, to amend the wording of charges 2b and 8.

The proposed amendment was to change the wording of 2b and to rectify a typographical error in charge 8. It was submitted by Ms Girven that the proposed amendments would provide clarity and more accurately reflect the evidence.

Charge 2b currently reads as follows:

> 'You knowingly acted outside the scope of your practice by proceeding to administer the Botox for financial gain.'

The proposed amendment to charge 2b is as followed:

> 'You knowingly acted outside the scope of your practice by **administering Botox which had not been prescribed by a qualified prescriber**.'

Charge 8 currently reads as follows

> 'Your conduct at some or all of charge 4 and/or 5 and/or 6 was in contravention of a requirement set out in an action plan set by Healthcare Improvement Scotland following inspections on 3 October 2023 and 31 January 2024 to improve the standard of the Clinic's record keeping.'

The proposed amendment to charge 8 is as follows:

> 'Your conduct at some or all of **charge 3** ~~charge 4~~ and/or 5 and/or 6 was in contravention of a requirement set out in an action plan set by Healthcare Improvement Scotland following inspections on 3 October 2023 and 31 January 2024 to improve the standard of the Clinic's record keeping.'

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that the amendments did not materially change the case, there would be no prejudice to Mrs Overstone, and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) On 22 March 2024 administered Botulinum Toxin Type A (“Botox”) to Patient A in circumstances where:

   a) A face-to-face consultation with a Prescriber did not occur prior to administration, as required.
   b) A Prescriber had not issued a prescription of Botox for this patient, as required.
   c) You did not adequately enquire about her previous Botox history as part of the consultation process prior to administering the Botox.
   d) The Botox was prescribed for Patient B, but was administered to Patient A.

2) Your conduct at some or all of charge 1 was dishonest as:

   a) You knew the Botox you administered was not prescribed for Patient A and therefore should not have been administered.
   b) You knowingly acted outside the scope of your practice by administering Botox which has not been prescribed by a qualified prescriber

3) On 22 March 2024 failed to keep adequate records of your consultation with Patient A in that you:

   a) Did not take adequate photographs of her face prior to the administration of Botox.
   b) Did not record the date and/or time of the consultation.
   c) Did not ensure a signature box for the prescriber was added to the consultation notes and/or disclaimer form.

4) On 4 April 2024 administered a ‘top-up’ of Botox to Patient A in circumstances where:

   a) The same vial was used from their previous appointment on 22 March 2024, in contravention of instructions that the product was for single use only and any unused solution should be discarded within 24 hours.

b) The vial referenced at charge 4a) had been stored in the fridge for 13 days, in contravention of instructions for storage.

5) On 4 April 2024 failed to keep adequate records of your consultation with Patient A in that you:

a) Did not commence a new consultation record.
b) Did not take any photographs of her face prior to the further administration of Botox.
c) Did not record the date and/or time of the consultation.

6) Following concerns raised by Patient A post-administration of the Botox on 22 March 2024 and 4 April 2024 you:

a) Did not record any details of the discussion/s exchanged with Patient A in her notes.
b) Did not record that she attended a further appointment for lymphatic drainage and/or a facial in her notes.
c) Did not record any details pertaining to her facial swelling and/or reported side-effects in her notes.
d) Did not record any post-care advice given in her notes.

7) Failed to comply with your professional duty of candour, in that you did not disclose to Patient A on one or more of the dates set out in Schedule 1 that she had received Botox intended for another patient and/or that the correct process for administering Botox had not been followed, when she reported adverse side-effects and/or facial swelling.

8) Your conduct at some or all of charge 3 and/or 5 and/or 6 was in contravention of a requirement set out in an action plan set by Healthcare Improvement Scotland

following inspections on 3 October 2023 and 31 January 2024 to improve the standard of the Clinic's record keeping.

9) Your conduct at charge 1a) was in contravention of a requirement set out in an action plan by Health Improvement Scotland following an inspection on 3 October 2023 to ensure a Prescriber was in attendance for consultation, prescription and assessment.

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

Schedule 1

16 April 2024
20 April 2024
21 April 2024
23 April 2024
25 April 2024

Decision and reasons on application to admit multiple hearsay evidence

The panel heard three hearsay applications made by Ms Girven on behalf of the NMC under Rule 31.

The first application was to admit into evidence the written statement of Patient A, together with her exhibits, which included email correspondence between Patient A and Health Improvement Scotland (HIS), screenshots of messages between Patient A and Mrs Ovenstone and photographs of Patient A.

The second application was to admit the written statement of Derek Ramsay (Mr Ramsay) and the third application was to admit Healthcare Improvement Scotland – summary note

of interview record between Alison Smith (Ms Smith), Emma Vaughan (Ms Vaughan) and Mrs Ovenstone, which had not been included in the exhibit bundle, but which had been provided to the panel on the morning of the hearing.

Ms Girven referred the panel to the Rules and to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC1565 (Admin).

<u>Patient A's evidence including documentary evidence</u>

Ms Girven submitted that Patient's A's evidence is relevant as it speaks to the majority of the charges and it is not sole and decisive when taken together with the email correspondence between Mrs Ovenstone and HIS, screenshots of Facebook messages between Patient A and Mrs Ovenstone, photographs of Patient A and other hearsay evidence. Ms Girven submitted that Mrs Ovenstone has not engaged with proceedings and has not challenged the evidence. Ms Girven referred the panel to the agreed removal form completed and submitted by Mrs Ovenstone to the NMC in which she stated that the allegations were false but in the same form indicated that she accepted the regulatory concerns. Ms Girven informed the panel that the NMC had not received the completed case management form from Mrs Ovenstone and therefore her position was unclear.

Ms Girven submitted that it was apparent from the email communication between the NMC and Mrs Ovenstone that they had made sufficient efforts to secure Patient A's attendance. However, Patient A had stated from the beginning that she was not willing to give evidence in person, including in her signed witness statement. Ms Girven submitted that Patient A's evidence is extremely important to the charges and submitted that the panel should consider the screenshots of the Facebook messages separately as it is objective documentary evidence. She submitted that there was no reason to suggest that the allegations made by Patient A were fabricated. She conceded that Mrs Ovenstone was not aware that Patient A's statement would be read, having been informed that she would be called to give evidence. Balancing the factors identified in the case of *Thorneycroft*, Ms Girven further submitted that Patient A's written statement is corroborated by the

documentary evidence (photographs and Facebook screenshot messages), which is consistent with Patient A's written statement. Therefore, Ms Girven submitted that the panel should admit Patient A's hearsay evidence as a whole.

Mr Ramsay's written statement

Ms Girven submitted that Mr Ramsay's evidence is relevant and speaks to the charges. She submitted that Mr Ramsay's statement is not sole and decisive and is corroborated by other hearsay evidence.

Ms Girven submitted that there was no reason for Mr Ramsay to fabricate his evidence. She conceded that no attempt had been made to secure his attendance at the hearing and there was no reason for his non-attendance, other than that the NMC had made the decision that his statement should be read. Mrs Ovenstone was informed of this but had not challenged this or returned the case management form. Ms Girven further submitted that Mr Ramsay's written statement is corroborated by other hearsay evidence. Ms Girven submitted that the panel should admit Mr Ramsay's hearsay evidence.

Healthcare Improvement Scotland – summary note of interview record

Ms Girven submitted that this document is relevant and speaks to some of the charges. She submitted that it was not sole and decisive when combined with other hearsay evidence.

Ms Girven conceded that there was no good reason why Ms Smith and Ms Vaughan had not been called to give evidence and she could not provide information as to steps taken by the NMC to secure their attendance. However, she submitted that there was no reason for this document to be fabricated as it was an interview conducted by HIS in the course of an official investigation. She further submitted that Mhairi Hastings (Ms Hastings) in live evidence could give more context to this document and process, although she was not present at the interview.

Ms Girven submitted that Mrs Ovenstone will have had sight of this document in an email sent to her by the investigations team at the start of the proceedings. However, it was omitted from the evidence bundle for this hearing which had been served on Mrs Ovenstone and the panel due to an oversight. Ms Girven accepted that the document was not signed or dated.

Balancing the factors identified in the case of *Thorneycroft*, Ms Girven submitted that the panel should admit the HIS – summary note of interview record as hearsay evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. She also referred to the relevant caselaw which included the cases of *NMC v Ogbonna* [2010] EWCA Civ 1216*, R (Bonhoeffer) v GMC* [2011] EWHC 1585*, Thorneycroft v NMC* [2014]*, R (on the application of Husband) v GDC* [2019] EWHC (Admin)*, El Karout v NMC* [2019] EWHC 28 (Admin) *and Mansaray v NMC* [2023] EWHC 730 admin.

Decision on application to admit multiple hearsay evidence

The panel considered each application separately and applied the relevant case law. The panel took the view that the applications made by the NMC appeared to require them to be satisfied that it is fair to admit hearsay evidence on the basis that it is corroborated by other hearsay evidence, there being only one witness, namely Ms Hastings, available to give live evidence. This witness is unable to give direct evidence as to the charges. In coming to its decision, the panel considered the key principles as set out in *Thorneycroft* for each witness and document in turn.

On that basis the panel determined to refuse the applications to allow into evidence the written statement of Patient A, email correspondence between Patient A with HIS, a

screenshot of messages between Patient A and Mrs Ovenstone, Pictures of Patient A, written statement of Mr Ramsay and the Healthcare Improvement Scotland – summary note of interview record interview between Ms Smith, Ms Vaughan and Mrs Ovenstone.

Healthcare Improvement Scotland – summary note of interview record

In relation to the HIS summary note of interview record, the panel was satisfied that this document was relevant and speaks to a number of the charges. Having decided that it was relevant, the panel went on to consider whether it was fair to admit it, considering the factors set out in the relevant case law. The panel noted that the patient care records referred to in this document were not provided to the panel, and that in her statement, Ms Hastings stated there were no physical copies of the records available and HIS had not retained the digital records.

In considering whether it was fair to admit it the panel then went on to assess whether this document was sole and decisive. It was satisfied that this evidence was not sole and decisive to the extent that it could be corroborated by Patient A's hearsay evidence (upon which it had not yet made a decision as to its admissibility). The panel noted that this was a summary note of an interview that was conducted by Ms Smith and Ms Vaughan, who were not called as witnesses by the NMC, and there was no good reason as to why. It also noted that Ms Hastings was the only person called to give context to this document but was not present during the course of the interview.

The panel noted that this was an interview conducted as part of a formal investigation and therefore there was no reason to suggest that the contents of the evidence was fabricated. However, in terms of its accuracy, this was a summary, as opposed to a transcript of an interview which was unsigned and undated, and there was no evidence that Mrs Ovenstone had been given the opportunity to confirm the accuracy of its contents. This cast doubts as to its reliability.

The panel further noted that for reasons that could not be explained, this document had not initially been included in the bundle of evidence to be relied upon for this hearing.

Taking account of all the above the panel was not satisfied that this document was demonstrably reliable and capable of being tested and therefore, the panel concluded that it would be unfair to admit it.

In light of the panel's decision in relation to the summary note of interview it went on to review the record of the conclusion of the HIS investigation report exhibited by Ms Hastings. This had already been redacted by the NMC to exclude the conclusions of the investigation. The panel determined that it would not be fair, having excluded the comments made by Mrs Ovenstone in the summary note of interview, to allow them into evidence in the investigation report. It was clear from the record within this document which detailed the methodology of the investigation, that the findings were based upon the interview of 30 May 2024.

Patient A's evidence:

In relation to Patient A's written statement and Patient A's email correspondence with HIS, the panel was satisfied that these documents were relevant and speak to several of the charges.

Having decided that it was relevant, the panel went on to consider whether it was fair to admit it, considering the factors set out in relevant case law.

The panel first considered whether Patient A's written statement and Patient A's email correspondence with HIS were sole and decisive. It was satisfied that it was not sole and decisive evidence in so far as it was corroborated by other hearsay evidence, (upon which it had not yet made a decision as to its admissibility). When considering the extent of the challenge to Patient A's evidence the panel found that this was unclear. The panel had

regard to an application form Mrs Ovenstone had completed to voluntarily remove herself from the register. Within this form Mrs Ovenstone stated that the allegations were false but also stated that she accepted the regulatory concerns.

The panel considered that Patient A had no reason to fabricate her evidence as she was the one who reported the matters under consideration to HIS. It further considered that the NMC had taken significant steps to encourage Patient A to give live evidence and extensively explained to Patient A the critical importance of her evidence in this case. The panel noted that that there was no good reason as to why Patient A did not attend. It had sight of an email from the NMC to Patient A dated 16 October 2025, which stated the following:

> *'I did want to take a moment to kindly explain the importance of your attendance at the upcoming hearing. As the patient in this case, your evidence is crucial — it is, in fact, the only evidence available to support the charges brought forward. Without your participation, the NMC may be unable to proceed.*
>
> *This case involves serious concerns regarding misconduct by a registrant. Our aim is to ensure that, where risks are identified, appropriate steps are taken to prevent any recurrence and to protect the public. Your testimony is therefore essential in helping us uphold these standards. We are more than happy to put in place any reasonable adjustments to support you. We can also refer you to our in- house Public Support Service team, who are experienced in assisting individuals in similar situations and can help implement special measures to reduce your distress.'*

Despite this, Patient A was not prepared to give evidence to support her allegations.

The panel also took into consideration the fact that Mrs Ovenstone had not been given notice of the application to admit Patient A's evidence as hearsay evidence. Indeed, she had been informed that Patient A would be called to give evidence.

The panel then went on to consider whether Patient A's written statement and email correspondence with HIS were demonstrably reliable or could be otherwise tested. The panel considered that Patient A was aware of how important her evidence was to the case and still chose to not attend without a good reason. The panel considered that by failing to attend this hearing, it called into question the reliability of Patient A's evidence, which could not be tested.

The panel also gave consideration to the screenshot Facebook text messages between Patient A and Mrs Ovenstone, as well as the photographs of Patient A. Whilst they supported the fact that Patient A had received treatment from Mrs Ovenstone, to which she had an adverse reaction, they were of limited relevance to the charges the panel had to decide upon.

Therefore, considering all of the circumstances, the panel concluded that it would be unfair to Mrs Ovenstone to accept any of Patient A's hearsay evidence and rejected the application.

Mr Ramsay's Written statement

In relation to Mr Ramsay's written statement, the panel were satisfied that Mr Ramsay's written statement was relevant and spoke to a number of the charges.

Having decided that it was relevant, the panel went on to consider whether it was fair to admit it, considering the factors set out in the relevant case law.

The panel first considered whether Mr Ramsay's written statement was sole and decisive. After making its decisions on Patient A's hearsay evidence and the summary note of interview, it was satisfied that Mr Ramsay's written statement was sole and decisive evidence. When considering the extent of the challenge to Mr Ramsay's evidence, the panel found that this was unclear for the reasons set out above.

The panel considered that Mr Ramsay had no reason to fabricate his evidence as he was, in his words *'friends'* with Mrs Ovenstone. However, there was no good reason for his non-attendance, and no attempts were made to secure his attendance as the NMC had simply made the decision not to call him. The panel accepted that Mrs Ovenstone had been notified that Mr Ramsay's statement would be read.

The panel then went on to consider whether Mr Ramsay's written statement was demonstrably reliable or could be otherwise tested. The panel concluded that this was the sole and decisive evidence in relation to several of the charges, which could not be tested. Therefore, considering all of the circumstances, the panel concluded that it would be unfair to admit it.

Considerations of Rule 22(5)

Ms Girven reminded the panel of its powers in Rule 22(5) and the guidance set out in DMA 5. She submitted that the panel should consider whether they would wish to use that power to direct the NMC to make contact with Patient A and Mr Ramsay.

Ms Girven submitted that it was not possible to obtain a high court summons for Patient A due to her being based in Scotland, however, a further email could be sent to Patient A requesting their attendance and give a deadline for her response. She further submitted that Mr Ramsay is also a registrant and therefore the panel could direct the NMC to contact him via email, and request that he attends.

The panel heard and accepted advice from the legal assessor.

The panel when considering this matter, had regard to DMA 5.

The panel considered that in relation to Patient A, the NMC do not have the power to request a witness summons of Patient A as she is based in Scotland but were aware that

they could direct that contact could be made with her to ascertain if she was now willing to attend the hearing. The panel considered the evidence before it that Patient A has been contacted multiple times by the NMC and has consistently and categorically stated that she will not be attending this hearing, even going as far as to accuse the NMC of harassment. The panel were of the view that any further attempts would not secure Patient A's attendance and that it would not be fair or appropriate for further contact to be made with her.

The panel went on to consider that in relation to Mr Ramsay, the NMC had decided to not call Mr Ramsay and instead have his evidence read. However, having refused the hearsay application in respect of his evidence, it would be appropriate for the NMC to make enquiries as to whether Mr Ramsay would be available and willing to give evidence at this hearing.

The panel also considered whether evidence from Ms Smith and Ms Vaughan would be of assistance in their consideration of the charges. The panel noted that no attempts have been made by the NMC to contact the potential witnesses despite them being present in the inspection interview with Mrs Ovenstone and potentially being able to give evidence in relation to this. In the absence of these witnesses, the contents of the investigation interview had been excluded. However, if they were to attend to give evidence this document could potentially be relied upon as its reliability could be tested. The panel were of the view that it would assist them if the NMC were to ascertain and make enquiries as to whether Ms Smith and/or Ms Vaughan were available and willing to give evidence at this hearing.

As a result, the panel decided not to make a formal direction for the attendance of any witnesses under Rule 22(5) but has directed the NMC to make the enquiries stated above.

Day 4

Following enquiries contact was made with Mr Ramsay who indicated that he was willing and available to give evidence.

The NMC proceeded to open the case and evidence was given by Ms Hastings and Mr Ramsay.

At the conclusion of their evidence but prior to the NMC closing its case contact was made with Ms Smith and Ms Vaughan.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Girven, on behalf of the NMC, to amend the wording of charge 1d after the live witness evidence of Ms Vaughan.

The proposed amendment was to change the wording of 1d. It was submitted by Ms Girven that the proposed amendment would provide clarity and more accurately reflect the evidence.

Charge 1d currently reads as follows:

> 'The Botox was prescribed for Patient B, but was administered to Patient A.'

The proposed amendment to charge 1d is as followed:

> 'The Botox was prescribed for **another p**atient ~~B~~, but was administered to Patient A.'

The panel accepted the advice of the legal assessor and had regard to Rule 28 .

The panel was of the view that such amendment, as applied for, was in the interests of justice. The panel was satisfied that the amendment did not materially change the case, there would be no prejudice to Mrs Ovenstone, and no injustice would be caused to either

party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (second amendment)

That you, a registered nurse:

1) On 22 March 2024 administered Botulinum Toxin Type A ("Botox") to Patient A in circumstances where:

    a) A face-to-face consultation with a Prescriber did not occur prior to administration, as required.
    b) A Prescriber had not issued a prescription of Botox for this patient, as required.
    c) You did not adequately enquire about her previous Botox history as part of the consultation process prior to administering the Botox.
    d) The Botox was prescribed for another patient, but was administered to Patient A.

2) Your conduct at some or all of charge 1 was dishonest as:

    a) You knew the Botox you administered was not prescribed for Patient A and therefore should not have been administered.
    b) You knowingly acted outside the scope of your practice by administering Botox which has not been prescribed by a qualified prescriber

3) On 22 March 2024 failed to keep adequate records of your consultation with Patient A in that you:

    a) Did not take adequate photographs of her face prior to the administration of Botox.
    b) Did not record the date and/or time of the consultation.

c) Did not ensure a signature box for the prescriber was added to the consultation notes and/or disclaimer form.

4) On 4 April 2024 administered a 'top-up' of Botox to Patient A in circumstances where:

a) The same vial was used from their previous appointment on 22 March 2024, in contravention of instructions that the product was for single use only and any unused solution should be discarded within 24 hours.
b) The vial referenced at charge 4a) had been stored in the fridge for 13 days, in contravention of instructions for storage.

5) On 4 April 2024 failed to keep adequate records of your consultation with Patient A in that you:

a) Did not commence a new consultation record.
b) Did not take any photographs of her face prior to the further administration of Botox.
c) Did not record the date and/or time of the consultation.

6) Following concerns raised by Patient A post-administration of the Botox on 22 March 2024 and 4 April 2024 you:

a) Did not record any details of the discussion/s exchanged with Patient A in her notes.
b) Did not record that she attended a further appointment for lymphatic drainage and/or a facial in her notes.
c) Did not record any details pertaining to her facial swelling and/or reported side-effects in her notes.
d) Did not record any post-care advice given in her notes.

7) Failed to comply with your professional duty of candour, in that you did not disclose to Patient A on one or more of the dates set out in Schedule 1 that she had received Botox intended for another patient and/or that the correct process for administering Botox had not been followed, when she reported adverse side-effects and/or facial swelling.

8) Your conduct at some or all of charge 3 and/or 5 and/or 6 was in contravention of a requirement set out in an action plan set by Healthcare Improvement Scotland following inspections on 3 October 2023 and 31 January 2024 to improve the standard of the Clinic's record keeping.

9) Your conduct at charge 1a) was in contravention of a requirement set out in an action plan by Health Improvement Scotland following an inspection on 3 October 2023 to ensure a Prescriber was in attendance for consultation, prescription and assessment.

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

Schedule 1

16 April 2024
20 April 2024
21 April 2024
23 April 2024
25 April 2024

Background

Mrs Ovenstone was referred to the NMC on 6 June 2024 by Healthcare Improvement Scotland (HIS) in relation to 'SO Youthful Beauty Aesthetics' which was a registered

independent healthcare service with HIS. Mrs Ovenstone was the registered manager and practitioner of this service. Regulatory Inspections in October 2023 and January 2024 highlighted an absence of a prescriber carrying out face-to-face consultations prior to administration of Botulin Toxin Type A (Botox) and this had been raised with the provider as a requirement for improvement.

On 22 May 2024 the HIS Independent Healthcare (IHC) regulation team received a complaint from a service user, regarding the Botox treatment they received at this registered service by the registered manager/practitioner Mrs Ovenstone, alleging that this had resulted in the complainant seeking advice and support from their primary care team due to facial palsy.

On 6 June 2024 Mrs Ovenstone completed an HIS form online stating that *"I wish to cancel my registration with health improvement Scotland with immediate effect".* The record of her registration shows that HIS actioned this at noon on 7 June 2024.

Decision and reasons on facts

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Ms Hastings: Associate Director of Nursing and Midwifery at Healthcare Improvement Scotland (HIS).

- Mr Ramsay: Advanced Nurse Practitioner.

- Ms Vaguhan: Inspector at Quality Assurance and Regulation of Health Improvement Scotland (HIS).

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

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

Charge 1

> *"That you, a registered nurse, on 22 March 2024 administered Botulinum Toxin Type A ("Botox") to Patient A in circumstances where:*
>
> *a) A face-to-face consultation with a Prescriber did not occur prior to administration, as required.*
> *b) A Prescriber had not issued a prescription of Botox for this patient, as required.*
> *c) You did not adequately enquire about her previous Botox history as part of the consultation process prior to administering the Botox.*
> *d) The Botox was prescribed for another patient, but was administered to Patient A"*

These charges are found proved in its entirety.

The panel considered each of the sub charges separately whilst noting that they set out a continuum concerning the treatment of Patient A:

> *'a) A face-to-face consultation with a Prescriber did not occur prior to administration, as required.*
> *b) A Prescriber had not issued a prescription of Botox for this patient, as required.*
> *c) You did not adequately enquire about her previous Botox history as part of the consultation process prior to administering the Botox.*
> *d) The Botox was prescribed for another patient, but was administered to Patient A'*

The panel noted that the requirements set out in sub charges a) and b) are set out in Regulation 3(d)(iv) of The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011.

In relation to charge 1a, the panel accepted that Mr Ramsay was a friend of Mrs Ovenstone, and that he believed that he was the sole prescriber for the clinic. Given his friendship with Mrs Ovenstone, it is more likely than not that he would have known had there been another prescriber. There was nothing from Mrs Ovenstone to suggest that this was not the case. Mr Ramsay was clear that he had not had a face-to-face consultation with Patient A. In interviewing Mrs Ovenstone on 30 May 2024 Ms Vaughan pointed out that Mrs Ovenstone had ticked a box *"prescriber not present"* in the record for Patient A. It was clear from the evidence HIS documentary evidence and from Ms Hastings's oral evidence, that such a consultation was a regulatory requirement. Accordingly, the panel found sub charge a) proved.

In relation to charge 1b, Mr Ramsay, the sole prescriber for Mrs Ovenstone's clinic, had not had a consultation with Patient A and was clear that he had not issued a prescription in relation to Patient A. It follows that sub charge b) is also proved.

In relation to charge 1c, in the interview dated 30 May 2024 Mrs Ovenstone accepted that she did not enquire adequately or at all about previous Botox history (*"*[Mrs Ovenstone] *advised the patient had informed her of previous botulinum toxin type A, however no further enquiries about date of last treatment took place")*.

The panel accepted the oral evidence of Ms Vaughan that the extent of enquiry by Mrs Ovenstone as to previous history was limited to a general enquiry as to whether there had been previous Botox treatments.

Ms Vaughan's evidence was that this was not adequate, and the panel accepted that evidence and so the panel found sub charge c) proved.

In relation to charge 1d, in her interview on 30 May 2024 with Ms Vaughan, Mrs Ovenstone accepted that when treating Patient A, she had used Botox prescribed for another patient. The panel accepted the record of interview as accurate. It records that:*"*[Ms Vaughan] *asked SO about vial of botulinum toxin type A used to treat patient. SO advised prescriber* [Mr Ramsay] *was not involved with this patient's prescription/ treatment. SO advised vial of botulinum toxin type A that had been prescribed for another patient had been used to treat this patient (complainant). SO advised she acknowledges that she should not have used this prescription as it was not prescribed for complainant".*

Accordingly, the panel found charge d) proved.

Therefore, taking all into account the information before it, the panel found charge 1 proved in its entirety.

Charge 2a and 2b)

> *"That you, a registered nurse, your conduct at some or all of charge 1 was dishonest as:*

a) *You knew the Botox you administered was not prescribed for Patient A and therefore should not have been administered.*
b) *You knowingly acted outside the scope of your practice by administering Botox which has not been prescribed by a qualified prescriber."*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Mr Ramsay's witness statement and live evidence, the HIS summary note of interview between Ms Vaughan and Mrs Ovenstone dated 30 May 2024, and the investigation reports from HIS.

In relation to charge 2a, the panel was satisfied that no face-to-face consultation with a qualified prescriber had taken place and the medication was not prescribed for Patient A but for another patient. Mrs Ovenstone admitted this during the interview on 30 May 2024 and did not tell Patient A. The panel considered that it was more likely than not that Mrs Ovenstone knew that any Botox being administered had to be specific and individualised to the patient because the documentation accompanying the medication specifies this.

In relation to charge 2b, the panel determined that Mrs Ovenstone was aware that she was acting outside her scope of practice as the Botox she administered to Patient A had not been prescribed for Patient A and therefore did not follow the correct procedure for safe administration of medication as stated in the documentation accompanying the medication. There was no prescription for the Botox administered to Patient A (because it was a medication prescribed for another patient).

The panel considered that ordinary decent people would find Mrs Ovenstone to have been dishonest in respect of both charges 2a and 2b, because she concealed this information from Patient A and knowingly did not follow the correct policies and/or procedures.

The panel found this charge proved in its entirety.

Charge 3a)

'That you, a registered nurse, on 22 March 2024 failed to keep adequate records of your consultation with Patient A in that you:

> a) *Did not take adequate photographs of her face prior to the administration of Botox.'*

This charge is found NOT proved

In reaching this decision, the panel took into account the HIS inspection reports, Ms Vaughan's witness statement and live evidence, and the summary note of interview between Ms Vaughan and Mrs Ovenstone.

When considering this charge, the panel had particular regard to the wording of the charge, in particular the use of the word *"adequate"*.

The panel noted that Ms Vaughan in her witness statement stated that *'A photograph of Patient A's face was stored within the record.'* This was further confirmed in the summary note of interview with Mrs Ovenstone which stated that *'One photograph was taken and available within patient care record…'* In Ms Vaughan's live evidence, she further stated that some practitioners will take a before and after treatment photo of their patients, but it is not a requirement.

The panel further noted that the NMC had provided no evidence as to what constituted "*adequate*" photographs. It determined that as there was evidence of a photograph having been taken, the NMC had not discharged the burden of proof to show that this was inadequate, and the panel therefore found this charge not proved.

Charge 3b)

'That you, a registered nurse, on 22 March 2024 failed to keep adequate records of your consultation with Patient A in that you:

b. Did not record the date and/or time of the consultation.'

This charge is found NOT proved

In reaching this decision, the panel took into account the HIS Inspection Reports, Ms Vaughan's witness statement, Ms Vaughan's live evidence and the summary note of interview between Ms Vaughan and Mrs Ovenstone.

The panel noted that in the HIS documentation, there was a requirement for the date and time of every consultation to be recorded.

'Requirement 3
The provider must ensure a record is made in the patient care record of the date and time of every consultation with examination, the outcome of the consultation or examination. The details of every treatment provided with the details of every medication ordered for the patient with the date and time it was administered.

Regulation 4(2)(a)(b)(c) The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011'

The panel considered Ms Vaughan's oral evidence during which she stated she had reviewed the records and noted that a date was recorded in relation to the two treatments but could not recall whether the time was also recorded.

The panel had not been provided with the electronic record and was informed by Ms Hastings and Ms Vaughan that they were no longer available.

For these reasons, namely the inadequate witness recall and without the source documentation the panel determined that the NMC had not discharged the burden of proof and found this charge not proved.

Charge 3c)

> *'That you, a registered nurse, on 22 March 2024 failed to keep adequate records of your consultation with Patient A in that you:*
>
> *a) Did not ensure a signature box for the prescriber was added to the consultation notes and/or disclaimer form.'*

This charge is found proved

In reaching this decision, the panel took into account the HIS inspection reports, Ms Vaughan's witness statement, Ms Vaughan's live evidence and the summary note of interview between Ms Vaughan and Mrs Ovenstone.

The panel noted that it was not provided with the care records and could decide only on the evidence before it. The panel noted that in Ms Vaughan's witness statement she stated that she reviewed the electronic record and noted that the form did not include a signature box nor a signed record.

> *'The form did not contain a signature box for the prescriber to indicate that they had reviewed the disclaimer and authorised the prescription.'*

The panel further noted the summary note of interview with Ms Vaughan and Mrs Ovenstone, where Ms Vaughan put this to Mrs Ovenstone, however, Mrs Ovenstone did not respond.

> '[Ms Vaughan] *noted with SO that SO had ticked 'prescriber was not present' for this patient's consultation.* [Ms Vaughan] *advised SO consultation notes/disclaimer form did not contain signature box for prescriber and this should be added.'*

The panel were conscious that the evidence presented for this charge relied on the evidence of Ms Vaughan who had inspected the documentation contemporaneously. The panel had no reason to doubt the evidence of Ms Vaughan and found her to be a credible witness whose evidence had been consistent throughout. The panel found that the NMC had discharged its burden of proof and so the panel found this charge proved.

Charge 4a and 4b

> *'On 4 April 2024 administered a 'top-up' of Botox to Patient A in circumstances where:*
>
> *a) The same vial was used from their previous appointment on 22 March 2024, in contravention of instructions that the product was for single use only and any unused solution should be discarded within 24 hours.*
> *b) The vial referenced at charge 4a) had been stored in the fridge for 13 days, in contravention of instructions for storage.'*

This charge is found proved in its entirety.

The panel considered these charges separately but noted that they are interconnected.

In relation to charge 4a, the panel took into account the medication documentation produced by Ms Hastings, Ms Vaughan's written statement and the summary note of interview between Ms Vaughan and Mrs Ovenstone.

The panel noted Ms Vaughan’s witness statement in which she recorded that Mrs Ovenstone admitted administering the top up of Botox to Patient A from the same vial used for the initial treatment some two weeks earlier.

> *During the complaint interview, Ms Ovenstone advised that opened vials of Botulinum Toxin would be stored for up to two weeks and then used for a patient’s “top-up” treatment. I advised her that this practice is not in accordance with the product’s Summary of Product Characteristics (SmPC), which states that a vial should be used for a single patient treatment and disposed of within 24 hours of reconstitution.’*

This was further confirmed in the summary note of interview,

> *‘SO advised she would use remainder of botulinum toxin type A for ‘top up’ appointment.* [Ms Vaughan] *discussed summary of products characteristics (SPC) for botulinum toxin type A and advised one vial should be used for one patient for one treatment, disposed within 24 hours. SO advised she unaware of this.* [Ms Vaughan] *asked how many patients attend for ‘top up’ treatments. SO advised not many patients.’*

The panel noted the medication documentation exhibited by Ms Hastings, which states that:

> *‘This product is for single use only and any unused solution should be discarded. The most appropriate vial size should be selected for the indication.’*

The panel noted her admission that she had retained the vial in her fridge between the first and second appointment, the first appointment having taken place on 22 March 2024 and the second appointment 2 April 2024. A period of 13 days had elapsed between these two dates.

For these reasons the panel found charge 4a proved.

The panel found charge 4b proved by reasons of the findings of facts in charge 4a.

Charge 5a

> *'On 4 April 2024 failed to keep adequate records of your consultation with Patient A in that you:*
>
> *a) Did not commence a new consultation record.'*

This charge is found proved

In reaching this decision, the panel considered the summary note of interview between Ms Vaughan and Mrs Ovenstone, Ms Vaughan's written statement and Ms Vaughan's live evidence.

The panel considered the HIS investigation requirement which stated that, *'Patient care records must be fully completed for every consultation and treatment provided.'* It noted that HIS had given SO Youthful Beauty Aesthetics an *'Unsatisfactory'* grade for failing to meet this requirement.

The panel noted that in Ms Vaughan's live evidence she stated that the records from the 4 April 2024 appointment were added to the notes from 22 March 2024 in a different font instead of being contained in a new consultation record. In addition, the same facial map was used. The panel accepted that Ms Vaughan was a credible witness, and her evidence was consistent with Mrs Ovenstone's responses recorded in the summary note of interview.

For these reasons, the panel found this charge proved.

Charge 5b

'On 4 April 2024 failed to keep adequate records of your consultation with Patient A in that you:

b) Did not take any photographs of her face prior to the further administration of Botox.'

This charge is found NOT proved

In reaching this decision, the panel considered the summary note of interview between Ms Vaughan and Mrs Ovenstone, Ms Vaughan's written statement and Ms Vaughan's live evidence.

The panel first noted the wording of this charge which stated that Mrs Ovenstone *"failed to keep adequate records"*. The panel noted its earlier findings in charge 3a where Ms Vaughan, in both witness statement and live evidence, stated that most prescribers take a before and after picture, but this was not a requirement.

The panel accepted that there was a photograph taken, however, there was no requirement to take before and after photos. In relation to charge 5b the panel determined that since there was no requirement there was no failure by Mrs Ovenstone.

For all these reasons, this charge is found not proved.

Charge 5c

'On 4 April 2024 failed to keep adequate records of your consultation with Patient A in that you:

c) Did not record the date and/or time of the consultation.'

This charge is found proved

In reaching this decision, the panel had sight of HIS Documentation, Summary note of interview, Ms Vaughan's written statement and Ms Vaughan's live evidence.

The panel noted the HIS inspection report, particularly requirement 2 which stated that,

> *'The provider must ensure a record is made in the patient care record of the date and time of every consultation with examination, the outcome of the consultation or examination. The details of every treatment provided with details of every medicine ordered for the patient with date and time when it was administered …'*

This requirement is contained at:

> *'Regulation 4(2)(a)(b)(c) The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011'*

The panel further noted that Ms Vaughan in her witness statement, stated that,

> *'Patient A attended a second appointment for a "top-up" treatment on 4 April 2024. This entry was added in a different coloured font to the original consultation notes of 22 March 2024 but did not include a date, time, or record of discussion.'*

The panel also had regard to the summary note of interview, which stated that,

> *'SO advised patient messaged to arrange 'top up'. Attended on 4 April 2024… SO advised 6 units of botulinum toxin type A was administered to crow's feet area.* [Ms Vaughan] *reviewed consultation notes with SO for 'top up' treatment. Consultation notes for this date were added to initial consultation notes of 22 March 2024. Facial*

map used was same as first consultation, but different font (colour) used to show areas injected. [Ms Vaughan] *advised no date/ time was recorded in the patient care record.* [Ms Vaughan] *discussed this should be a new consultation record with new date and time of entry as this treatment was provided on different day. '*

The panel was of the view that this was a duty imposed by HIS in their inspection reports of 3 October 2023 and 31 January 2024, recorded as a requirement, with which Mrs Ovenstone had not complied. When asked about it, during the interview by Ms Vaughan, she did not provide a response.

The panel noted that it had not been provided with the patient care records but referred to their earlier findings that Ms Vaughan was a credible witness and her evidence had been consistent throughout.

The panel considered that an adequate record would contain the date and time of the consultation.

For these reasons, the panel found this charge proved.

Charge 6a, 6b, 6c, 6d

'Following concerns raised by Patient A post-administration of the Botox on 22 March 2024 and 4 April 2024 you:

a) Did not record any details of the discussion/s exchanged with Patient A in her notes.
b) Did not record that she attended a further appointment for lymphatic drainage and/or a facial in her notes.
c) Did not record any details pertaining to her facial swelling and/or reported side-effects in her notes.

d) Did not record any post-care advice given in her notes.'

This charge is found proved in its entirety.

The four sub charges all relate to failures to document various aspects of Patient A's concerns raised subsequent to the treatments administered by Mrs Ovenstone. The panel considered them separately but records one decision, as the evidence in respect of each of them was the same.

In reaching its decisions, the panel took into account the summary note of interview between Ms Vaughan and Mrs Ovenstone, and all of Ms Vaughan's evidence.

The panel noted from the summary note of interview that,

> *'SO advised patient made contact following 'top up' appointment' on 22 April 2024 via Facebook messenger to advise of her concerns. SO advised 'Facetime' call took place. SO advised the patient reported droop of right hand side of face and had attended her GP. SO agreed to send information regarding side effects and discussed need to follow aftercare advice. SO asked patient if she had followed aftercare advice (no sunbeds/ make up/ gym) which the patient advised she had followed. SO states she now queries if patient had in fact followed this. SO shared picture of herself with patient following aesthetic procedure to help reassure patient that side effects would wear off. SO offered patient appointment for facial/ lymphatic drainage.* [Ms Vaughan] *advised SO she could see no record of this discussion with patient within patient care record. SO advised patient attended service on 24 April 2024 for facial. SO advised this was offered free of charge. SO advised she noted injection sites were red and inflamed. SO Asked patient if she had used make up, sunbeds or had been to the gym. Patient denied.* [Ms Vaughan] *advised SO there was no record of patient attending service for facial within patient care record.'[sic]*

The panel further noted that Ms Vaughan in her written statement stated,

> *'Patient A attended a second appointment for a "top-up" treatment on 4 April 2024. This entry was added in a different coloured font to the original consultation notes of 22 March 2024 but did not include a date, time, or record of discussion. There was also no documented record of the FaceTime call that took place on 22 April 2024, nor of Patient A's attendance at the service on 24 April 2024. No further documentation existed beyond that date.'*

The panel considered the evidence before it and noted that even though Mrs Ovenstone gave detail relating to the concerns raised in the interview, when Ms Vaughan put to her that there was no record of Patient A's post administration, Mrs Ovenstone appeared not to respond. The panel determined that the evidence of Ms Vaughan was sufficient for the panel to be satisfied that the NMC had discharged its burden of proof in respect of the whole of charge 6.

For these reasons, the panel found each sub charge proved.

Charge 7

> *'That you, a registered nurse failed to comply with your professional duty of candour, in that you did not disclose to Patient A on one or more of the dates set out in Schedule 1 that she had received Botox intended for another patient and/or that the correct process for administering Botox had not been followed, when she reported adverse side-effects and/or facial swelling.'*

This charge is found proved.

In reaching this decision, the panel took into account the SO Youthful Beauty Aesthetics' Duty of Candour Policy, NMC Code of conduct, the summary note of interview between Ms Vaughan and Mrs Ovenstone, Ms Vaughan's witness statement and Ms Vaughan's live evidence.

The panel noted that Mrs Ovenstone in the interview, admitted that she did not tell Patient A that she had not carried out the correct procedure when treating Patient A.

Mrs Ovenstone had used unprescribed medication and reused medication after 13 days, neither of which was in accordance with the correct procedure.

In addition:

> '*SO informed patient all patient information/ photographs are sent to prescriber before prescription is generated. SO advised today that she acknowledges that although she advised the patient this was the procedure, she in fact did not carry this out.'*

The panel further noted that this Duty of Candour Policy describes the duty of candour in the following terms.

> *'1.Reason*
> *The Duty of Candour is a statutory legal duty to be open and honest with patients or their families when something goes wrong during a treatment that appears to have caused or could lead to significant harm in the future…*
> *S.O Youthful Beauty Aesthetics has a duty to be open and honest with patients when something appears to have gone wrong with their treatment.'*

The panel were of the view that Mrs Ovenstone had a duty to be open and honest with Patient A and disclose that the Botox she was using was for another patient and that she did not follow the correct procedure for administering that Botox to Patient A. The panel also considered the NMC guidance note DMA 5 and the NMC Code of conduct and found that Mrs Ovenstone had failed to uphold duty of candour as a registered nurse.

For all these reasons, the panel found this charge proved.

Charge 8

> *'That you, a registered nurse, your conduct at some or all of charge 3 and/or 5 and/or 6 was in contravention of a requirement set out in an action plan set by Healthcare Improvement Scotland following inspections on 3 October 2023 and 31 January 2024 to improve the standard of the Clinic's record keeping.'*

This charge is found proved in relation to charge 6 only.

In reaching this decision, the panel took into account the HIS Announced Inspection Reports.

The panel found that on 3 October 2023 there was a requirement that patient records had to be improved immediately. This had not been done by the follow up inspection on 31 January 2024, however, in the January 2024 report the timescales for compliance with the one outstanding requirement was stated as 16 April 2024.

The panel noted that charge 3 stated that the failure was on 22 March 2024. At that date there was no failure to comply with the requirement. This was because in January 2024 HIS had imposed a timescale for compliance of 16 April 2024, and this had not expired. This would have been a breach of the requirements had it occurred between 3 October 2023 and 31 January 2024 because the requirement imposed on 3 October 2023 had been for immediate compliance. The panel found that the extension of time for compliance given by the 31 January 2024 inspection report meant that there was no breach subsequent to the January 2024 report. This is because it occurred prior to the expiry of the 16 April 2024 deadline, and so at the dates stated in charges 3 and 5 there could be no breach of a requirement as it had not yet come into force.

For all these reasons, the panel found that charge 8 could not be proved in respect of charge 3 and charge 5.

The panel found that charge 6 was not affected by the same difficulty. This is because charge 6 relates to concerns raised by Patient A in May 2024 which was subsequent to expiry of the April deadline. The panel therefore found charge 8 is proved, in as far as it relates to charge 6 as there was a failure to comply with HIS requirement after the deadline of April 2024, which had been imposed in January 2024.

Charge 9

> *'That you, a registered nurse, your conduct at charge 1a) was in contravention of a requirement set out in an action plan by Health Improvement Scotland following an inspection on 3 October 2023 to ensure a Prescriber was in attendance for consultation, prescription and assessment.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the HIS Announced Inspection Report. It had particular regard to requirement 3 which stated,

> *'The provider must ensure that there is a responsible healthcare professional available in the service who is able to prescribe and administer prescription-only medicines as part of a response to complications or an emergency situation, if required … Regulation 12(a)(b)) The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011'*

The panel also had regard to the wording of charge 9 which stated that Mrs Ovenstone's conduct at charge 1a was *"in contravention''* of a requirement set out by HIS following an inspection on *"3 October 2023"*. This charge requires Mrs Ovenstone to be in contravention of a specific requirement contained in the report of 3 October 2023 inspection. However, the follow up inspection report dated 31 January 2024 stated that

three of the four requirements contained in the 3 October 2023 report had been met. The remaining requirement was not as set out in this charge.

For these reasons, the panel could not find this charge proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this resumed hearing that Mrs Ovenstone was not in attendance and that the Notice of Hearing letter had been sent to Mrs Ovenstone's registered email address by secure email on 18 November 2025.

Ms Girven, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 32(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Ovenstone's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Ovenstone has been served with the Notice of Hearing in accordance with the requirements of Rule 32(3).

Decision and reasons on proceeding in the absence of Mrs Ovenstone.

The panel next considered whether it should proceed in the absence of Mrs Ovenstone. It had regard to Rule 21 and heard the submissions of Ms Girven who invited the panel to

continue in the absence of Mrs Ovenstone. She submitted that Mrs Ovenstone had voluntarily absented herself.

Ms Girven submitted that there had been no engagement at all by Mrs Ovenstone with the NMC in relation to these proceedings and has previously stated that she had retired and did not want to take part in these proceedings. As a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mrs Ovenstone;
- Mrs Ovenstone has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing. She had indicated in correspondence that she intended to fully retire;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2024;
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Ovenstone.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Ovenstone's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct

Ms Girven referred the panel to the cases 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'* and *Nandi v General Medical Council [2004]* EWHC 2317 (Admin).

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

Ms Girven identified the specific, relevant parts of the Code that were breached and amounted to misconduct. Ms Girven submitted that in charge 1 Mrs Ovenstone's conduct fell below the standards of the profession and put patients at a risk of harm, as she did not follow the process for administering Botox and was not a prescriber. She further submitted that in charge 2 the panel found that Mrs Ovenstone's conduct was in charge 1 was dishonest, impacting patient care for financial gain.

Ms Girven submitted that charges 3c, 5a, 5c and 6 in their entirety, all relate to record keeping which is an important and fundamental skill of the profession. She submitted that failure to keep adequate records impacted patient safety and put Patient A at risk of harm. She further submitted that in charge 4, Mrs Ovenstone failed to follow medication guidance, which specified that the vial of Botox used which was for 'single use only' and to be discarded after use, was instead stored in the fridge for 13 days and administered to Patient A as a 'top-up'.

Ms Girven submitted that in charge 7 Mrs Ovenstone failed to comply with the duty of candour, which is an important part of the nursing profession and in charge 8, was in contravention of the requirements set out in the action plan by HIS.

Ms Girven submitted that Mrs Ovenstone's behaviour would be seen as deplorable by a member of the public, and a serious departure from the fundamental tenets of the profession and the professional standards and behaviour expected of a registered nurse. Therefore, Ms Girven submitted that misconduct should be found on each of the proven charges.

Submissions on impairment

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

Ms Girven referred the panel to the HIS summary note of interview record and submitted that although Mrs Ovenstone did show some insight in the initial investigation done by HIS, it was not sufficient. She submitted that Mrs Ovenstone since then has not adequately engaged with the NMC process and when she did respond, would only focus on the impact this process has had on herself.

Ms Girven submitted that there is no evidence of a reflection or remorse from Mrs Ovenstone, who had blocked Patient A on Instagram, cutting off Patient A's only way of communication to address the issues that occurred with Mrs Ovenstone. Ms Girven submitted that there was no evidence that Mrs Ovenstone had taken steps to strengthen her practice, or complied with the action plan set by HIS.

Ms Girven submitted that it is clear that Mrs Ovenstone put Patient A at an unwarranted risk of harm and breached multiple fundamental tenets of the profession. She submitted that Mrs Ovenstone has not remediated the risk or shown sufficient insight, therefore, there remains a real risk of repetition in the future. Ms Girven further submitted that Mrs Ovenstone's had acted in this way for financial gain, which has the ability to bring the profession into disrepute. Ms Girven submitted that the dishonesty found proved by the panel was a serious departure from the standards required of the profession and could impact the trust and confidence the public places in nurses, midwives, and nursing associates. Therefore, Ms Girven submitted that a finding of impairment is needed to protect the public.

Ms Girven further submitted that considering the nature of the concerns, particularly the dishonesty and breach of duty of candour. A member of the public would be extremely concerned if there was not a finding of impairment on public interest grounds also, especially where the registrant has been dishonest and potentially put patients at risk of harm. Therefore, Ms Girven submitted that a finding of impairment is also needed to satisfy the public interest in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
>
> *2.1 work in partnership with people to make sure you deliver care effectively*

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

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
10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

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

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

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then went on to consider whether the charges found proved amounted to misconduct.

In relation to charges 1a, 1b, 1c, and 1d the panel found that these charges amounted to misconduct. Mrs Ovenstone failed to follow procedure by working cooperatively with Mr Ramsay who was the prescriber and by this omission put Patient A at risk of harm.

In relation to charges 2a and 2b the panel found that these charges amounted to misconduct. The panel considered that Mrs Ovenstone demonstrated a clear disregard for patient safety and acted outside the scope of her competency, breaching fundamental tenets of the profession.

In relation to charge 3c, the panel found that this charge did not amount to misconduct. The panel determined that although this was a departure of the standards expected of a

nurse, not ensuring that a signature box was on the patient notes, was not so serious as to amount to misconduct.

In relation to charges 4a and 4b the panel found that these charges amounted to misconduct. The panel noted that Mrs Ovenstone knowingly stored the same vial of Botox used for Patient A's first appointment for 13 days and then re-administered the same vial in a second 'top-up' appointment with Patient A. The panel considered that this was a fundamental breach of the tenets of the profession as Mrs Ovenstone was in contravention of the medication administration instructions, which stated the vial of Botox was for 'single use only' and to be discarded straight away; putting Patient A at an unwarranted risk of harm.

In relation to charges 5a, 5c, 6a, 6b, 6c, and 6d the panel found that these charges amounted to misconduct. The panel considered that these charges together related to record keeping, which is a fundamental tenet of the nursing profession. It considered that Mrs Ovenstone's failure to keep adequate records of her consultation with Patient A or detail what was discussed at the appointment within Patient A's notes, was a serious departure from the standards of the profession and placed Patient A at a risk of harm.

In relation to charge 7, the panel found that this charge amounted to misconduct. The panel considered that Mrs Ovenstone failed to immediately inform Patient A that she had received Botox that was prescribed for another patient and did not immediately try to rectify it, therefore breaching a fundamental tenet of the profession by failing to comply with the duty of candour.

In relation to charge 8 as it pertains to charge 6, the panel considered that Mrs Ovenstone's behaviour, in contravening a requirement of the HIS action plan, was a serious departure from the standards expected of a nurse and was serious enough to amount to misconduct.

Consequently, the panel found that individually and collectively, Mrs Ovenstone's actions in charge 1 in its entirety, charge 2 in its entirety, charge 4 in its entirety, charge 5a, charge 5c, charge 6 in its entirety, charge 7 and charge 8 in relation to charge 6, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Ovenstone's 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:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel finds that limbs a – d of the *Grant* test are engaged in this case. The panel found that Patient A was put at risk and was caused physical and emotional harm as a result of Mrs Ovenstone's misconduct. Mrs Ovenstone's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession and the regulator would be undermined if the charges relating to dishonesty were not found to be extremely serious.

In deciding whether Mrs Ovenstone's fitness to practice is currently impaired the panel went on to consider whether she had demonstrated any insight into her failures.

The panel had regard to the HIS summary note of interview, where Mrs Ovenstone stated to the HIS interviewers that she should not have used a prescription prescribed for another patient on Patient A, and admitted that she had contacted Mr Ramsay advising him that she had administered Botox without a prescription. The panel also had regard to the Voluntary Removal Application form submitted by Mrs Ovenstone in which she admitted to a number of the charges and accepted that her practice was impaired. However, within the same form Mrs Ovenstone wrote an initial paragraph denying the allegations and claiming that they were false. The panel noted that Mrs Ovenstone had shut down her business and blocked Patient A on social media making no attempts to try to address the concerns. The panel determined that she had shown very little insight in relation to her failings. The panel next considered whether there was evidence of remorse and noted that whilst Mrs Ovenstone had expressed some remorse during her communication with the NMC, this was focused on the impact to herself. The panel determined that there was no evidence before it of remorse as to how her actions had affected Patient A, the nursing profession or the NMC as its regulator.

The panel then considered whether there was evidence before it of steps taken to strengthen her practice. The panel noted that Mrs Ovenstone had indicated in her communications with the NMC that it was her intention to retire from the nursing profession. There was no evidence before the panel of any efforts made to strengthen her practice.

The panel was satisfied that the misconduct in this case relating to her clinical practice was remediable, however acknowledged that findings of dishonesty are more difficult to remediate. The panel was of the view that due to Mrs Ovenstone's limited insight into the her failings, lack of remorse and absence of any remediation, there was a real risk of

repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC is 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 panel determined that a finding of impairment on public interest grounds is required because the public would be concerned if a nurse who had been dishonest, breached the fundamental tenets of the nursing profession and had not sufficiently demonstrated insight and remediation with regard to their failings, after a period of two years, was allowed to practice unrestricted. The panel also determined that members of the public would be hesitant, or even reluctant, to engage with members of the profession if they knew that there was a risk of them not receiving proper safe and adequate care when needed.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Ovenstone’s fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Ovenstone’s fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Ovenstone’s off the register. The effect of this order is that the NMC register will show that Mrs Ovenstone has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *‘The sanctions available’* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Girven informed the panel that in the Notice of Hearing, dated 18 November 2025, the NMC had advised Mrs Ovenstone that it would seek the imposition of a striking-off order if it found Mrs Ovenstone’s fitness to practise currently impaired.

Ms Girven submitted the following aggravating features are relevant to this case:

- Mrs Ovenstone’s misconduct recklessly put a Patient at risk of harm;
- Mrs Ovenstone has failed to attend the hearing or engage with the NMC;
- Mrs Ovenstone has demonstrated limited insight into the concerns; and
- Mrs Ovenstone’s case involved financial gain.

Ms Girven submitted the following mitigating features are relevant to this case:

- Mrs Ovenstone made some admissions to the concerns at local stage in her interview with HIS.

Ms Girven referred the panel to SAN-3 in the sanctions guidance and submitted that as Mrs Ovenstone has not engaged with the fitness to practice process, has not demonstrated sufficient insight into her failings and there is no evidence of remorse, a striking off order would be the most appropriate order in this case.

Decision and reasons on sanction

Having found Mrs Ovenstone’s 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:

- Conduct which deliberately or recklessly put Patient A at risk of suffering harm;
- Limited insight;
- Failure to attend hearings, or to engage in the Fitness to Practise (FtP) process, without good reason;
- Failure to respond or act upon the recommendations of the HIS report; and
- Acting outside her scope of competence.

The panel also took into account the following mitigating features:

- Some admissions made locally.

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

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 Mrs Ovenstone's 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 Mrs Ovenstone's practise would not protect the public. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place conditions of practice on Mrs Ovenstone's 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 regard to the nature and seriousness of Mrs Ovenstone's conduct, which included dishonesty and breaching the duty of candour, as well as Mrs Ovenstone's lack of engagement in the FtP process, the panel determined that a conditions of practice order would not be appropriate. Mrs Ovenstone had shown only limited insight into her own behaviour and had given no indication that she had any intention of remediating her practice. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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 weigh up 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.’*

Whilst the panel acknowledged that the risks identified could be managed by Mrs Ovenstone being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved.

Given Mrs Ovenstone’s lack of engagement, meaningful insight, remorse, remediation and earlier communication that she has retired from nursing, the panel considered that there is no realistic possibility that Mrs Ovenstone would address the concerns to such a level where she could return to practise safely.

The panel had regard to a summary call note between Mrs Ovenstone and the NMC case officer, dated 13 November 2024, where she stated that she did not know what the point of all of this was, as she was now fully retired and had no desire to work as a registered nurse. She further stated in the call that she would not be attending the hearing or any hearing and that she is done with the whole process.

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

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). The panel had regard to its earlier findings and determined that this case falls within the definition of being a '*highest risk case'*.

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 determined that the charges found proved, raised fundamental questions about Mrs Ovenstone's professionalism, as she has not engaged with the FtP process and there was no evidence of sufficient insight or reflection into her failings.

The panel determined that Mrs Ovenstone's actions, which included dishonesty, were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Ovenstone's actions were

serious and to allow her 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 appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Ovenstone's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered 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 standard of behaviour required of a registered nurse.

This will be confirmed to Mrs Ovenstone 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 Mrs Ovenstone's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Girven. She submitted that the panel should impose an interim suspension order for a period of 18 months to cover any potential period of appeal.

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 due to cover any potential period of appeal. If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Mrs Ovenstone is sent the decision of this hearing in writing.

That concludes this determination.