Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 07 September 2026 – Friday, 11 September 2026
Monday, 14 September 2026 - Wednesday, 16 September 2026

Virtual Hearing

Name of Registrant:	**Shehnilabanu Farukbhai Pindhariya**
NMC PIN:	24L0225O
Part(s) of the register:	Registered Nurse - Adult – Sub Part 1 RNA – 4 December 2024
Relevant Location:	Southampton
Type of case:	Lack of competence
Panel members:	Bryan Hume (Chair, Lay member) Richard Luck (Registrant member) Peter Cowup (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Shazmeen Uddin
Nursing and Midwifery Council:	Represented by Iwona Boesche, Case Presenter
Ms Pindhariya:	Not present and not represented
Facts proved:	Charges 1)a), 1)b)i), 1)b)ii), 1)b)iii), 1)d), 1)e)i), 1)e)ii), 1)e)iii), 1)e)iv) 3)a)i), 3)a)ii), 3)b), 3)c), 3)d), 3)f)i), 3)f)ii), 4)a)i), 4)a)ii), 4)b), 5)a), 5)b), 5)c), 5)d), 6)a), 6)b), 6)c),
Facts not proved:	Charges 1)c),2), 3)e), 4)a)iii), 6)d), 6)e), 6)f), 6)g)
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (18 months)**

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Pindhariya was not in attendance and that the Notice of Hearing letter had been sent to Ms Pindhariya's registered email address by secure email on 22 July 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and information about Ms Pindhariya'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 Ms Pindhariya 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 Ms Pindhariya

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

Ms Boesche referred the panel to the documentation from Ms Pindhariya which included an email dated 12 August 2026, where she stated that she does not wish to attend the hearing.

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'*.

The panel has decided to proceed in the absence of Ms Pindhariya. In reaching this decision, the panel has considered the submissions of Ms Boesche and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *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 Ms Pindhariya;
- Ms Pindhariya has informed the NMC that she has received the Notice of Hearing and by way of two emails dated 12 and 14 August 2026, has confirmed that she will not be attending the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Five witnesses are due to attend;
- 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 accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Pindhariya in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no formal response to the allegations, although Ms Pindhariya has sent in brief representations via email. She will not be able to challenge the evidence relied upon by the NMC 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 Ms Pindhariya'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 Ms Pindhariya. The panel will draw no adverse inference from Ms Pindhariya's absence in its findings of fact.

Details of charge

That you, a registered nurse between 1 August 2024 and 6 November 2024, failed to demonstrate the standards of knowledge, skill and judgment required to pass your probation period as a Band 4 nurse in that you:

1) Did not effectively communicate/engage with patients and/or colleagues in that you:

    a) On 5 August 2024, did not take notes during handover and/or ask clarification questions.

    b) On 12 August 2024 and/or 28 September 2024, did not:

        i) Introduce yourself to an unknown patient;
        ii) Did not explain next steps to the patient;
        iii) Did not gain consent for nursing intervention;

    c) On 6 October 2024, did not communicate to an unknown patient that you were going to pre-oxygenate them;

    d) On 28 October 2024, could not answer your colleague's question about an unknown patient's underlying rhythm;

e) On 29 October 2024:

i) Did not gain consent from an unknown patient before shining a pen torch light into their eye;
ii) Did not inform colleagues that an unknown patient needed pain relief;
iii) Did not explain to an unknown patient why their oxygen levels were low;
iv) Did not seek consent from an unknown patient to replace their face mask with a nasal spec.

2) On 23 September 2024, failed to escalate an unknown patient who had hypoglycaemia.

3) Did not maintain patient safety and assessment in that you:

a) Needed prompting to set alarm limits on unknown patients' monitors on:

i) 5 August 2024;
ii) 23 August 2024;

b) Before and/or on 23 August 2024, needed prompting to check under a patient's gown for drains/lines/skin issues;

c) During an OSCE assessment, put on sterile gloves and then touched a non-sterile trolley;

d) On an unknown date, placed on a sterile counter an nasogastric feed giving set that had dropped on the floor;

e) On 3 October 2024, required prompting to complete hourly observations;

f) On 6 October 2024:

i) Silenced an infusion alarm when you were not meant to handle and/or touch any infusions attached to the Central Venous Catheter;
ii) Did not finish bedside safety checks.

4) Did not prioritise your nursing care in that you:

a) Did not address and/or monitor unknown patients' alarms on:

i) 23 August 2024;
ii) 27 September 2024;
iii) 28 October 2024;

b) On 28 October 2024, prioritised a nasogastric tube removal over patient assessment and/or beside safety checks;

5) Did not effectively time manage in that:

a) Before and/or on 23 August 2024, you did not check medications were due and/or needed to be prompted to administer medications;

b) Before and/or on 3 October 2024, you left hourly observations incomplete and/or did not carry out hourly observations in a timely manner on unknown patients;

c) Before and/or on 28 October 2024, you were prompted to do hourly observations;

d) On 28 October 2024, regular hourly observations were taking you 15-25 minutes to complete.

6) Lacked clinical knowledge in that you:

a) On 6 August 2024, during the OSCE exam, did not know what an insulin pen was and what to do with it;

b) On 12 August 2024, did not know about inotropes and/or vasoactive medications;

c) On 23 August 2024, Did not know whether drugs were anti arrhythmic or anti hypertensives;

d) On 23 August 2024, didn't escalate elevated Potassium levels;

e) On 27 August 2024, stopped a syringe pump infusion;

f) On 6 October 2024, did not support an endotracheal tube during endotracheal suctioning.

g) On 29 October 2024, did not know that Aspirin was an anti-platelet drug.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Boesche to amend the wording of the stem of the allegations and also charge 4b.

The proposed amendment was to move 'between 1 August 2024 and 6 November 2024' from the first line of the stem of the allegations to the last line after 'Band 4 nurse'. It was also proposed to correct a typographical error in charge 4b to read 'bedside' instead of 'beside'. It was submitted by Ms Boesche that the proposed amendments would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse, ~~between 1 August 2024 and 6 November 2024~~ failed to demonstrate the standards of knowledge, skill and judgment required to pass your probation period as a Band 4 nurse **between 1 August 2024 and 6 November 2024,** in that you:"

“4) Did not prioritise your nursing care in that you:
b) On 28 October 2024, prioritised a nasogastric tube removal over patient assessment and/or ~~beside~~ **bedside** safety checks;”

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

In relation to the proposed amendments to the stem, the panel was satisfied that this did not amount to a material amendment. It merely clarified that the time period of these allegations was when Ms Pindhariya was a band 4 nurse. The panel also agreed to the second proposed amendment, a simple typographical error.

The panel was satisfied that there would be no prejudice to Ms Pindhariya and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Of its own volition, after the NMC had closed its case, but before the panel made its findings on facts, the panel decided to make 2 further amendments to the charges as follows:

- The panel decided to amend the stem of charge 3 to allow “and/or”. In making this amendment, the panel was mindful that the crux of this charge and the evidence provided in relation to it, concerns patient safety, rather than assessments. Balancing likely prejudice to the NMC’s case if the amendment was not made with any prejudice to Ms Pindhariya if the change were to be made, the panel determined that the balance lay in favour of the NMC, and public protection concerns.

  ‘3) Did not maintain patient safety and**/or** assessment in that you:’

- In relation to charge 6a, the panel noted that clear evidence regarding Ms Pindhariya's mock Objective Structured Clinical Examination (OSCE) exam being undertaken on 21 August 2024 rather than 6 August 2024. The panel considered the current drafting to be a typographical error and decided to make the amendment to insert the correct date of the OSCE mock exam. Lacked clinical knowledge in that you:

  '6) Lacked clinical knowledge in that you:
  a) On ~~6 August 2024~~ **21 August 2024**, during the OSCE exam, did not know what an insulin pen was and what to do with it;'

Details of charge (as amended)

That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgment required to pass your probation period as a Band 4 nurse between 1 August 2024 and 6 November 2024, in that you:

1) Did not effectively communicate/engage with patients and/or colleagues in that you:

   a) On 5 August 2024, did not take notes during handover and/or ask clarification questions.

   b) On 12 August 2024 and/or 28 September 2024, did not:

      i) Introduce yourself to an unknown patient;
      ii) Did not explain next steps to the patient;
      iii) Did not gain consent for nursing intervention;

   c) On 6 October 2024, did not communicate to an unknown patient that you were going to pre-oxygenate them;

   d) On 28 October 2024, could not answer your colleague's question about an unknown patient's underlying rhythm;

e) On 29 October 2024:

i) Did not gain consent from an unknown patient before shining a pen torch light into their eye;
ii) Did not inform colleagues that an unknown patient needed pain relief;
iii) Did not explain to an unknown patient why their oxygen levels were low;
iv) Did not seek consent from an unknown patient to replace their face mask with a nasal spec.

2) On 23 September 2024, failed to escalate an unknown patient who had hypoglycaemia.

3) Did not maintain patient safety and/or assessment in that you:

a) Needed prompting to set alarm limits on unknown patients' monitors on:

i) 5 August 2024;
ii) 23 August 2024;

b) Before and/or on 23 August 2024, needed prompting to check under a patient's gown for drains/lines/skin issues;

c) During an OSCE assessment, put on sterile gloves and then touched a non-sterile trolley;

d) On an unknown date, placed on a sterile counter a nasogastric feed giving set that had dropped on the floor;

e) On 3 October 2024, required prompting to complete hourly observations;

f) On 6 October 2024:

i) Silenced an infusion alarm when you were not meant to handle and/or touch any infusions attached to the Central Venous Catheter;
ii) Did not finish bedside safety checks.

4) Did not prioritise your nursing care in that you:

a) Did not address and/or monitor unknown patients' alarms on:

i) 23 August 2024;
ii) 27 September 2024;
iii) 28 October 2024;

b) On 28 October 2024, prioritised a nasogastric tube removal over patient assessment and/or bedside safety checks;

5) Did not effectively time manage in that:

a) Before and/or on 23 August 2024, you did not check medications were due and/or needed to be prompted to administer medications;

b) Before and/or on 3 October 2024, you left hourly observations incomplete and/or did not carry out hourly observations in a timely manner on unknown patients;

c) Before and/or on 28 October 2024, you were prompted to do hourly observations;

d) On 28 October 2024, regular hourly observations were taking you 15-25 minutes to complete.

6) Lacked clinical knowledge in that you:

a) On 21 August 2024, during the OSCE exam, did not know what an insulin pen was and what to do with it;

b) On 12 August 2024, did not know about inotropes and/or vasoactive medications;

c) On 23 August 2024, Did not know whether drugs were anti arrhythmic or anti hypertensives;

d) On 23 August 2024, didn't escalate elevated Potassium levels;

e) On 27 August 2024, stopped a syringe pump infusion;

f) On 6 October 2024, did not support an endotracheal tube during endotracheal suctioning.

g) On 29 October 2024, did not know that Aspirin was an anti-platelet drug.

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

Background

The charges arose whilst Ms Pindhariya was working at Southampton General Hospital (the Hospital). Ms Pindhariya was employed from 8 July 2024 and worked within the Cardiac Intensive Care Unit (ICU).

Between July to November 2024, it is understood that Ms Pindhariya was employed on a probationary basis by the University Hospital Southampton NHS Foundation Trust (the Trust). Ms Pindhariya's start date in the Cardiac ICU was 8th July 2024 and her job title was stated to be Nurse Associate at a Band 4 grade. She had previously completed a university nursing course in India in 2019 and post-qualification, she worked for one year in an 18-bed ICU in India, but during this time she was never assigned her own patients. Ms Pindhariya went on work for three to four months in a COVID ward in 2021 and after a two-year career break, worked in a small and low-acuity ICU for an un-specified period in 2023. Following Ms

Pindhariya's recruitment in the UK, she did not register with the NMC or pass her OSCE until after her probation was terminated by the Trust on 5 November 2024.

It is alleged that concerns arose on a number of shifts, namely 5 August 2024, 23 August 2024 and 27 August 2024, 23 September 2024, 28 September 2024, 3 October 2024, 6 October 2024, 28 October 2024 and 29 October 2024.

The alleged concerns which arose were mainly:

- Lack of communication
- Unable to appropriately conduct patient assessments
- Lack of basic clinical knowledge
- Working too slowly and poor time management
- Unable to work safely without supervision
- Silencing patients' alarms without understanding what they meant and failed to notify supervisory staff

On 23 August 2024, a meeting was held to discuss feedback from the mock OSCE exam where Ms Pindhariya had failed all 10 stations and was unable to complete four stations as she ran out of time. She was deemed not safe to carry on with the exam.

On 27 August 2024, Ms Pindhariya's line manager conducted a wellbeing meeting to see how best she can support her. This resulted in a referral to be made to the Trusts staff line service so that they can further assist Ms Pindhariya in adjusting to the UK. A further meeting was then conducted on 6 October 2024 to address concerns as well as to do a further wellbeing check.

Due to no improvement being made, a probation meeting was held on 5 November 2024 where all the concerns were discussed in detail. As a result of this meeting, Ms Pindhariya was dismissed.

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 Boesche.

The panel has drawn no adverse inference from the non-attendance of Ms Pindhariya.

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 or is true.

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

- Eirini Manali (Ms Manali): Sister in the Cardiac Intensive Care Education team
- Megha Malamel (Ms Malamel): Staff nurse
- Sonia Martins (Ms Martins): Senior Sister in the Cardiac ICU
- Rachael Keane (Ms Keane): Staff nurse
- Kristy Young (Ms Young): Sister in the Cardiac ICU

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

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

Charge 1a)

"1) Did not effectively communicate/engage with patients and/or colleagues in that you:

a) On 5 August 2024, did not take notes during handover and/or ask clarification questions."

This charge is found proved.

In reaching this decision, the panel considered all of the evidence before it.

The panel took into account an email sent from Ms Keane directly to Ms Pindhariya and copied to Ms Martins on 5 August 2024. In this email, Ms Keane set out her feedback to Ms Pindhariya after working with her that day. One observation was:

'Please make sure you listen to handover and take notes. If you do not hear anything or do not understand please ask the nurse handing over to stop/repeat/explain. Not having handover for your patient can be extremely dangerous.'

The panel noted that in Ms Keane's oral evidence under affirmation, she clarified this to the panel and confirmed that Ms Pindhariya was not taking notes during handover and paid *"no attention"* to information being shared during the handover. Ms Pindhariya had been advised to take notes, and the panel were told that materials, such as paper and pens were readily available in the handover area.

The panel also took into account Ms Martins' oral evidence under affirmation where it was further confirmed that Ms Pindhariya did not take notes. The panel found this to be credible evidence as it noted that Ms Martins was a senior nurse in a clinical position, that she had no need to embellish or fabricate any detail and that it was her responsibly to write to Ms Pindhariya outlining the matters related to her performance.

The panel noted the corroborating evidence provided from both Ms Keane and Ms Martins. It noted that in both of their written statements, they spoke about the importance of note taking and in their oral evidence, confirmed that Ms Pindhariya did not make notes and that they had advised her to do so.

The panel noted that the use of note taking at handover facilitates effective communication with patients and colleagues across the duration of the shift. It was of the view that this is a significant requirement of the standards of nursing in clinical practice relating to patient care and safety as it helps to ensure that important information is recorded and available to be shared with others.

In light of all of the evidence, the panel was satisfied that it was more likely than not that Ms Pindhariya did not take notes during handover and/or ask clarification questions on 5 August 2024 and that, by not doing so, she did not effectively communicate or engage with colleagues. The panel was therefore satisfied that charge 1a is found proved.

Charge 1b)

> "1) Did not effectively communicate/engage with patients and/or colleagues in that you:
>
> b) On 12 August 2024 and/or 28 September 2024, did not:
>
> i) Introduce yourself to an unknown patient;
> ii) Did not explain next steps to the patient;
> iii) Did not gain consent for nursing intervention;"

This charge is found proved in its entirety in relation to the shift on 12 August 2024 only.

The panel considered the stem of this sub charge which references two shifts.

The evidence adduced by the NMC in relation to the shift on 28 September 2024 is referred to by Ms Martins in her witness statement as evidence having been reported to her as an issue by Arnold Cinio, another member of staff, who is not a witness in this NMC case and has not provided a witness statement.

The panel considered whether it could admit and properly rely upon the hearsay evidence of Arnold Cinio in relation to this charge.

The panel had careful regard to Rule 31 of the Rules (admissibility of evidence) and to the key legal principles for admitting hearsay evidence from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). It also had regard to the NMC guidance on Hearsay in a document called Evidence DMA-6 (9 June 2025) which states, *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

Whilst it was clear that this is relevant evidence, the panel determined that it was not fair to Ms Pindhariya to admit this hearsay evidence. In coming to this decision, the panel was mindful that Ms Pindhariya has, on the face of it, disputed all of the allegations; that Arnold Cinio's hearsay evidence in support of this charge is 'sole and decisive'; that Arnold Cinio's evidence is not capable of being tested and the panel could not be satisfied that the evidence is reliable, as per *Thorneycroft*.

As the panel has not admitted into evidence the hearsay evidence of Arnold Cinio, the NMC has not discharged its burden of proof in relation to the shift of 28 September 2024.

In reaching its decision relating to the shift of 12 August 2024, the panel took into account the witness statement of Ms Manali. In her statement she stated:

‘I had observed Shehnila’s practice on 2 different occasions, the first one was on 12 August 2024. Shehnila was working with a senior staff nurse Rachael Keane, and I was there for around 1.5 hours. On this occasion, she did not introduce herself to the patient, and did not explain to the patient what she was going to do next, nor gained any consent for any of the nursing interventions.’

The panel noted that this was also confirmed in Ms Martins’ oral evidence which it found to be fair and reliable evidence.

The panel was therefore satisfied that on the shift of 12 August 2024, it was more likely than not that Ms Pindhariya did not effectively communicate or engage with patients in that she failed to introduce herself, did not explain next steps to patients and did not gain consent for nursing interventions.

The panel therefore found this charge proved in its entirety in relation to the shift of 12 August 2024.

Charge 1c)

“1) Did not effectively communicate/engage with patients and/or colleagues in that you:

c) On 6 October 2024, did not communicate to an unknown patient that you were going to pre-oxygenate them;”

This charge is found NOT proved.

Having heard from the witnesses, the NMC offered no evidence in relation to this charge.

In reaching its decision, the panel took into account the witness statement of Ms Malamel. It noted that her statement does not refer to pre-oxygenation, rather it only

refers to the patient requiring inline suction through an endotracheal tube to clear secretion from the lungs.

The panel noted that in Ms Malamel's oral evidence, she told the panel that Ms Pindhariya did not pre-oxygenate a patient. She had advised Ms Pindhariya that she should have pre-oxygenated the patient, but Ms Pindhariya responded saying the patient's oxygen saturation level was already at 97%. She therefore had not pre-oxygenated the patient.

The panel therefore did not find this charge proved as it did not find any evidence of Ms Pindhariya pre-oxygenating a patient.

Charge 1d)

> "1) Did not effectively communicate/engage with patients and/or colleagues in that you:
>
> d) On 28 October 2024, could not answer your colleague's question about an unknown patient's underlying rhythm;"

This charge is found proved.

In reaching its decision, the panel took into account an email on 28 October 2024 from Ms Young to Ms Martins. In this email, it stated:

> *'She was also unable to communicate effectively with the doctor when they were asking questions during their daily assessment and I regularly had to step in and answer basic questions such as patients underlying rhythm.'*

The panel found this to be reliable evidence that Ms Pindhariya could not answer questions about a patient's underlying rhythm, therefore being unable to effectively communicate and engage with colleagues.

The panel noted that this evidence was corroborated in oral evidence.

Therefore, the panel found this charge proved.

Charge 1e)i)

> "1) Did not effectively communicate/engage with patients and/or colleagues in that you:
>
> e) On 29 October 2024:
>
> i) Did not gain consent from an unknown patient before shining a pen torch light into their eye;"

This charge is found proved.

In reaching its decision, the panel took into account Ms Malamel's witness statement where she stated:

> *'During the pupillary reaction assessment, she had opened the patient's eye and shone a light directly into his eye without gaining consent or any pre-warning. I had to stop her and I asked why she didn't gain consent. She explained that the patient was too drowsy and was not able to give consent. I explained to her the importance of gaining consent, regardless of the patient's condition, I discussed with her the difference between implied and informed consent and that it was good practice to provide the patient with an explanation before performing procedures.'*

The panel noted that this was consistent with an email dated 1 November 2024 that was sent from Ms Malamel to Ms Martins regarding feedback on Ms Pindhariya. In this email, Ms Malamel stated:

> *'During her assessment of the pupillary reaction, she shone a pen torch directly into the patient's eyes without providing any warning. I*

immediately reminded her of the importance of gaining consent before any patient interaction, regardless of the patient's condition. She explained that she had refrained from informing the patient because he was drowsy and unable to give verbal consent…'

The panel found Ms Malamel's evidence to be reliable. It determined that Ms Pindhariya did not effectively communicate or engage with the patient before she shone the torch in the patient's eye.

The panel therefore found this charge proved.

Charge 1)e)ii)

"1) Did not effectively communicate/engage with patients and/or colleagues in that you:

e) On 29 October 2024:
ii) Did not inform colleagues that an unknown patient needed pain relief;"

This charge is found proved.

In reaching its decision, the panel took into account the witness statement from Ms Malamel. She stated:

'I wasn't there so I cannot be sure what happened but it was reported that the patient said he was in pain and Shehnila sat him up straight but didn't give him any pain relief. So, when the patient was seen by the doctor, he mentioned that he asked for pain relief but were not given any. Shehnila said that she knew he was in pain but forgot to tell me or anyone else, I explained to Shehnila that pain should be managed by the primary nurse and we spoke about the importance of pain management and how it was unacceptable for the patient to wait for an hour for pain relief whilst he was in pain.'

The panel also took into account the email Ms Malamel had sent to Ms Martins on 1 November 2024 where it was stated:

> *'During my break, Shehnila, assisted by HCA, repositioned a patient in bed. The patient informed her that he was in pain as they repositioned him, to which she responded by adjusting his position and sitting him upright. However, she did not notify anyone about his need for pain relief. Approximately an hour later, when a doctor asked if he was experiencing pain, the patient confirmed that he had requested pain relied earlier but had not received it. I asked Shehnila about it, and she said she noticed his distress but forgot to inform me upon my return from break…'*

The panel found that Ms Pindhariya did not effectively communicate with her colleague to inform them that the patient needed pain relief.

The panel therefore found this charge proved.

Charge 1)e)iii), 1)e)iv)

> "1) Did not effectively communicate/engage with patients and/or colleagues in that you:
>
> e) On 29 October 2024:
>
> iii) Did not explain to an unknown patient why their oxygen levels were low;
> iv) Did not seek consent from an unknown patient to replace their face mask with a nasal spec."

Both charges are found proved.

In reaching its decision, the panel took into account the following from Ms Malamel's witness statement:

'Regarding the same patient, he was struggling to meet his targeted oxygen level on arterial blood gas, so when he was eating, he needed to go on a nasal spec which is oxygen up his nose, the other times, he would be wearing a face mask. I asked Shehnila to replace the face mask with the nasal spec because it was lunchtime. After the replacement had been done, she told me that the patient's nose was sore so I went to speak to the patient who told me that Shehnila had been rough in handling the nasal spec and didn't seek consent, he stated that the only thing she said was that his oxygen was low. The patient wanted clarification on what that meant.'

In addition to this, the panel took into account the email sent to Ms Martins by Ms Malamel on 1 November 2024. In this email, she stated:

'… He further mentioned that Shehnila had switched his oxygen from nasal specs to a face mask without explaining or seeking consent, simply saying, "Your oxygen is low". He expressed a desire to understand why his oxygen levels were low, what it meant, and the potential risks, but he had lost confidence in her care due to her reluctance to answer his questions…'

The panel found that Ms Pindhariya did not effectively communicate or engage with the patient when she only informed him that his oxygen levels were low. She did not effectively communicate with him the reasons for this observation, even though the patient had asked for clarification regarding what this meant.

The panel therefore found both charges proved.

Charge 2)

"2) On 23 September 2024, failed to escalate an unknown patient who had hypoglycaemia."

This charge is found NOT proved.

The evidence adduced by the NMC in relation to this charge is referred to by Ms Martins in her witness statement as evidence having been reported to her as an issue by Carolina Neves, another member of staff, who is not a witness in this NMC case and has not provided a witness statement.

The panel considered whether it could admit and properly rely upon the hearsay evidence of Carolina Neves in relation to this charge.

The panel had careful regard to Rule 31 of the Rules (admissibility of evidence) and to the key legal principles for admitting hearsay evidence from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). It also had regard to the NMC guidance on Hearsay in a document called Evidence DMA-6 (9 June 2025) which states, *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

Whilst it was clear that this is relevant evidence, the panel determined that it was not fair to Ms Pindhariya to admit this hearsay evidence. In coming to this decision, the panel was mindful that Ms Pindhariya has, on the face of it, disputed all of the allegations; that Carolina Neves' hearsay evidence in support of this charge is 'sole and decisive'; that Carolina Neves' evidence is not capable of being tested and the panel could not be satisfied that the evidence is reliable, as per *Thorneycroft*.

As the panel has not admitted into evidence the hearsay evidence of Carolina Neves, the NMC has not discharged its burden of proof in relation to this particular of the allegation. The panel therefore found this particular charge not proved.

Charge 3)a)i)ii)

"3) Did not maintain patient safety and/or assessment in that you:

a) Needed prompting to set alarm limits on unknown patients' monitors on:
    i) 5 August 2024;
    ii) 23 August 2024;"

This charge is found proved.

In reaching its decision, the panel took into account the email sent by Ms Keane to Ms Pindhariya and copied to Ms Martins on 5 August 2026. This email, which contained feedback that had also been given verbally to Ms Pindhariya by Ms Keane, stated:

> *"Now in your second week on the unit you should be initiating setting the alarm limits on the monitor within safe parameters for the specific patient. These setting will be overseen by the RN working with you during your supernumerary period so if you are unsure we are there to support and guide you."*

In a follow up email sent by Ms Keane to Ms Martins on 23 August 2026 regarding the setting of safe alarm limits, Ms Keane mentioned concerns she had about Ms Pindhariya's practice. She stated:

> *'Still not confident/ competent to set alarm limits in the context of our individual patients and often reverts back to setting alarm limits for what I would say is "the average person" despite explaining the importance of setting alarms specific to each individual patient previously.'*

The panel noted that Ms Pindhariya had not improved her ability to independently set safe alarm limits between Ms Keane's first email sent on 5 August 2024 to her follow up email on 23 August 2024, even though it was clear to the panel that she had been informed of her errors and provided with advice and support.

The panel was satisfied that it was more likely than not that Ms Pindhariya did not maintain patient safety or involve an assessment of a patient in that she needed prompting to set alarm limits correctly for individual patients.

The panel therefore found this charge proved.

Charge 3)b)

"3) Did not maintain patient safety and/or assessment in that you:

b) Before and/or on 23 August 2024, needed prompting to check under a patient's gown for drains/lines/skin issues;"

This charge is found proved

In reaching its decision, the panel took into account Ms Keane's emails to Ms Pindhariya, copied to Ms Martins from 5 August 2024 and an email from Ms Keane to Ms Martins on 23 August 2024.

In the email dated 5 August 2024, Ms Keane had told Ms Pindhariya:

'You showed good initiative and demonstrated a thorough patient assessment of a level 2 patient- please remember to physically check under the patients gown to check for drains/lines/skin issues- which you did do after prompting.'

Further, in the email sent to Ms Martins dated 23 August 2024, Ms Keane stated:

'Does not complete full patient assessment, needs reminding to complete full assessments. She does try to complete A-E assessments but tends to leave out doing for example GCS assessment or checking under gown/sheets to check patients skin/wounds.'

In her oral evidence, Ms Keane indicated that as a part of routine checks of patients in the ICU it was practice to check for *"drains/lines/skin issues".* She further stated that this would be an expectation of any nurse on the ICU and also in a general medical environment.

The panel accepted this evidence that these checks are fundamental to basic, good nursing practice and that this should be standard practice carried out by any qualified nurse.

The panel was satisfied that Ms Pindhariya did not maintain patient safety and assessment in that she needed prompting to check under patients' gowns for drains, lines or skin issues.

The panel therefore found this charge proved.

Charge 3)c)

> "3) Did not maintain patient safety and/or assessment in that you:
>
> c) During an OSCE assessment, put on sterile gloves and then touched a non-sterile trolley;"

This charge is found proved.

In reaching its decision, the panel took into account the witness statement of Ms Manali who stated:

> *'During another station she was asked to change a wound dressing. She proceeded to put on sterile gloves but then started touching the non-sterile trolley and opening non-sterile equipment, contaminating the already sterile gloves she was wearing. The assessor stopped her and asked her if she knew what she'd done wrong. Shehnila replied 'no I don't know'. Shehnila not realising that she cannot touch a non-sterile surface or equipment with sterile gloved was an alarming concern, as this is basic knowledge even for a nursing student.'*

The panel also took into account the email sent from Ms Manali to Ms Martins dated 22 August 2024, which stated:

'The stations she was stopped before completing were:

- *ANTT (changing a dressing) where she did not adhere to any IP principles, did not wear apron and after wearing sterile gloves she contaminated them by touching other surfaces and equipment without realising what she has done. After she was stopped the assessor asked her 'have you realised what you have done?' and she was unaware of her error…'*

The panel was in no doubt that infection control is an important part of the role of a nurse, and that this can have serious consequences for patients if not carried out stringently. Cross contamination can pose a serious risk to already compromised patients and as such, correct knowledge of procedures are of significant importance. The panel noted that the mock OSCE is testing for maintenance of patient safety and assessment and that in this test Ms Pindhariya put on sterile gloves and touched a non-sterile trolley.

The panel took into account Ms Manali's witness statement where she stated that:

> *'Shehnila not realising that she cannot touch a non-sterile surface or equipment with sterile gloves was an alarming concern, as this is basic knowledge even for a nursing student. The mistakes Shehnila made were very concerning as she was recruited as an experienced critical care nurse'.*

The panel was satisfied that Ms Pindhariya did not maintain patient safety and assessment in that she put on sterile gloves and touched a non-sterile trolley.

The panel therefore found this charge proved.

Charge 3)d)

> "3) Did not maintain patient safety and/or assessment in that you:
>
> d) On an unknown date, placed on a sterile counter a nasogastric feed giving set that had dropped on the floor;"

This charge is found proved.

In reaching its decision, the panel took into account an email sent from Ms Keane to Ms Martins dated 10 October 2024 where she stated:

> *"On point 10: …The same day she was attempting to set up NG feed and dropped the giving set on the floor which she subsequently picked up and put on the counter that was being used to prepare the drug rather than into a bin. She also was then going to use the same gloves that she has just touched the floor with to then prepare the new giving set to which I pointed out she would need to change her gloves and clean the surface before proceeding".*

The panel found that Ms Pindhariya did not maintain patient safety in this case as proceeding to use gloves that had touched the floor is a breach of the principle of basic hygiene and created a risk of infection for a patient who was already vulnerable.

Charge 3)e)

> "3) Did not maintain patient safety and/or assessment in that you:
>
> e) On 3 October 2024, required prompting to complete hourly observations;"

This charge is found NOT proved.

The evidence adduced by the NMC in relation to this charge is referred to by Ms Martins in her witness statement as evidence having been reported to her as an issue by Lucy Kyte, another member of staff, who is not a witness in this NMC case and has not provided a witness statement.

The panel considered whether it could admit and properly rely upon the hearsay evidence of Lucy Kyte in relation to this charge.

The panel had careful regard to Rule 31 of the Rules (admissibility of evidence) and to the key legal principles for admitting hearsay evidence from the case of

Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin). It also had regard to the NMC guidance on Hearsay in a document called Evidence DMA-6 (9 June 2025) which states, *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

Whist it was clear that this is relevant evidence, the panel determined that it was not fair to Ms Pindhariya to admit this hearsay evidence. In coming to this decision, the panel was mindful that Ms Pindhariya has, on the face of it, disputed all of the allegations; that Lucy Kyte's hearsay evidence in support of this charge is 'sole and decisive'; that Lucy Kyte's evidence is not capable of being tested and the panel could not be satisfied that the evidence is reliable, as per *Thorneycroft*.

As the panel has not admitted into evidence the hearsay evidence of Lucy Kyte, the NMC has not discharged its burden of proof in relation to this particular of the allegation. The panel therefore found this particular charge not proved.

Charge 3)f)i)

> "3) Did not maintain patient safety and/or assessment in that you:
>
> f) On 6 October 2024:
> i) Silenced an infusion alarm when you were not meant to handle and/or touch any infusions attached to the Central Venous Catheter;"

This charge is found proved.

In reaching its decision, the panel took into account the email dated 6 October 2024 from Ms Malamel to Ms Martins. In this email, she stated:

> *'At the start of the shift, I confirmed with Shehnila that she is not able to administer any IV medications. As a result, anything related to the central line*

would be handled by myself or other colleagues, meaning she will not need to touch any of the infusions connected to it. Despite this, when one of the infusions alarms went off, she silenced it without informing me. Fortunately, I walked in as soon as I heard the pump beeping and saw her silencing and informed me that the potassium infusion was about to finish. I reiterated that only I would manage any stopping, pausing, or restarting of infusions attached to the CVC.'

The panel accepted the evidence that Ms Pindhariya was aware that she was supernumerary and that her supervising nurse gave explicit instruction not to touch infusions or equipment as this was the role of a registered nurse. As such, Ms Pindhariya did not maintain patient safety in that she silenced an infusion alarm when she was not meant to handle and/or touch any infusions attached to the Central Venous Catheter (CVC).

The panel therefore found this charge proved.

Charge 3)f)ii)

"3) Did not maintain patient safety and/or assessment in that you:

f) On 6 October 2024:
ii) Did not finish bedside safety checks."

This charge is found proved.

In reaching its decision, the panel took into account email sent from Ms Malamel to Ms Martins on 6 October 2024. In this email, Ms Malamel stated:

'At the start of the shift, Shehnila performed the bedside safety checks correctly. However, after completing the checks on the left side of the bed space, she transitioned into a head-to-toe assessment, which quickly became an A-E assessment. She exposed the patient adequately and, despite a few

challenged, completed the A-E assessment. However, she did not return to finish the remaining bedside safety checks.

I provided feedback, suggesting that having a structured approach would help ensure all bedside safety checks are completed'.

The panel was satisfied that Ms Pindhariya did not maintain patient safety in that she did not complete bedside safety checks.

Therefore, the panel found this charge proved.

Charge 4)a)i)ii)

"4) Did not prioritise your nursing care in that you:

a) Did not address and/or monitor unknown patients' alarms on:

i) 23 August 2024;
ii) 27 September 2024;

This charge is found proved.

In reaching its decision in relation to the date 23 August 2024, the panel took into account the email sent by Ms Keane to Ms Martins. In this email, Ms Keane stated:

'Frequently unaware of patient monitor alarms and so these go unattended despite multiple reminders to always be able to see both the patient and the monitor. I made a point of this to her the last time I worked with her but there did not seem to be any improvement on this today. The last time I worked with her the patient had a run of VT and this went unnoticed by her'.

The panel also took into account Ms Keane's oral evidence where she told the panel that she was sitting with Ms Pindhariya when the alarm actuated and that they could both hear and see the alarm trace. Ms Keane explained that she wanted to see how

Ms Pindhariya would respond but she did not respond appropriately. Ms Pindhariya failed to check the patient and made no attempts to establish what had caused the alarm to actuate. She also made no attempts to escalate the matter. Ms Keane also told the panel that the second time this happened was in a side room. She said they could both see the patient and the monitor but Ms Pindhariya did not know what the alarm meant or what to do in response. Ms Pindhariya did not suggest an Echocardiogram (ECG) or attempt to check what might have caused the alarm to actuate even though what had been seen could have been life-threatening for the patient. Ms Keane expressed that this response was significantly below her expectations. Even a nurse operating at a basic level without cardiac experience would have known how to respond in such situation.

In reaching its decision in relation to the date 27 September 2024, the panel took into account the witness statement of Ms Manali. In her statement, she stated:

> *'The second occasion I had observed Shehnila in practice, was on 27 September 2024 where I believe she was working with Rachael again, but I cannot remember with certainty. On this occasion, a post operative cardiac patient was admitted and an alarm on the monitor was going off, she did not acknowledge this alarm to see what had happened. Addressing alarms in critical care is extremely important as this could have meant the blood pressure of the patient was so low that they could go into cardiac arrest…'.*

The panel was of the view that Ms Pindhariya did not prioritise her nursing care in that she did not address and/or monitor unknown patients' alarms appropriately on the dates in question.

Therefore, the panel found this charge proved.

Charge 4)a)iii)

> "4) Did not prioritise your nursing care in that you:
>
> a) Did not address and/or monitor unknown patients' alarms on:

iii) 28 October 2024;"

This charge is found NOT proved.

The evidence adduced by the NMC in relation to this charge is referred to by Ms Martins in her witness statement as evidence having been reported to her as an issue by Matt Barber, another member of staff, who is not a witness in this NMC case and has not provided a witness statement.

The panel considered whether it could admit and properly rely upon the hearsay evidence of Matt Barber in relation to this charge.

The panel had careful regard to Rule 31 of the Rules (admissibility of evidence) and to the key legal principles for admitting hearsay evidence from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). It also had regard to the NMC guidance on Hearsay in a document called Evidence DMA-6 (9 June 2025) which states, *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

Whilst it was clear that this is relevant evidence, the panel determined that it was not fair to Ms Pindhariya to admit this hearsay evidence. In coming to this decision, the panel was mindful that Ms Pindhariya has, on the face of it, disputed all of the allegations; that Matt Barber's hearsay evidence in support of this charge is 'sole and decisive'; that Matt Barber's evidence is not capable of being tested and the panel could not be satisfied that the evidence is reliable, as per *Thorneycroft*.

As the panel has not admitted into evidence the hearsay evidence of Matt Barber, the NMC has not discharged its burden of proof in relation to this particular of the allegation. The panel therefore found this particular charge not proved.

Charge 4)b)

"4) Did not prioritise your nursing care in that you:

b) On 28 October 2024, prioritised a nasogastric tube removal over patient assessment and/or bedside safety checks;

This charge is found proved.

In reaching its decision, the panel took into account an email sent from Ms Young to Ms Martins dated 28 October 2024. She stated:

'When I asked Shehnila for her plan for her shift she did struggle with priorities and was focusing on removal of NG tube over that of regular glucose monitoring while the patient was on an Actrapid infusion. Even after I stressed the importance of hourly checks (patient was a poorly controlled diabetic requiring VRII) this was still not completed on the early shift and I regularly needed to do this to ensure patient safety'.

In her oral evidence, the panel questioned whether it would be appropriate to prioritise the removal of a nasogastric tube over a patient assessment or bedside safety checks. Ms Young responded that this would never be appropriate and that on 28 October 2024, there was no immediate issue with the tube so its removal was not urgent.

The panel determined that Ms Pindhariya did not prioritise her nursing care in that she prioritised a nasogastric tube removal over patient assessment and/or bedside safety checks.

Therefore, the panel found this charge proved.

Charge 5)a)

"5) Did not effectively time manage in that:

a) Before and/or on 23 August 2024, you did not check medications were due and/or needed to be prompted to administer medications;"

This charge is found proved.

In reaching its decision, the panel took into account the email from Ms Keane to Ms Pindhariya, which was copied to Ms Manali and Ms Martins after she worked with her on 5 August 2024. She stated:

> *'Don't forget to check "Doses and tasks" regularly to ensure drugs are given in a timely manor. Although you may not be able to administer drugs yet you should be trying to take responsibility for checking what is due and asking the RN to administer these'.*

The panel further took into account the follow up email sent by Ms Keane to Ms Manali and Ms Martins on 23 August 2024 where she stated:

> *'Poor management of giving medications on time with lack of awareness of when drugs are to be given/withheld'.*

The panel noted that these two emails corroborate each other and show that despite receiving feedback, Ms Pindhariya failed to manage the administration of medication to her patients safely and effectively unless she was prompted.

The panel was satisfied that Ms Pindhariya did not effectively time manage in that she did not check medications were due and/or needed to be prompted to administer medication.

The panel therefore found this charge proved.

Charge 5)b)

"5) Did not effectively time manage in that:

b) Before and/or on 3 October 2024, you left hourly observations incomplete and/or did not carry out hourly observations in a timely manner on unknown patients;"

This charge is found proved.

In reaching its decision, the panel took into account the email from Ms Keane to Ms Pindhariya, which was copied to Ms Martins with the feedback after she worked with her on 5 August 2024. She stated:

> *'Patient observations need completing ideally on the hour EVERY HOUR. These are to include but not limited to: respiratory obs, HR, BP, urine output, drain output, RASS score. You need to show improved time management to achieve this and ensure observations are not missed- these need to be prioritised over doing any VLE'*

The panel further took into account the follow up email sent by Ms Keane to Ms Manali and Ms Martins on 23 August 2024 where she stated:

> *'Poor time keeping with hourly observations frequently not done on time or needs reminding to do them every hour- this was fed back previously but remains an issue.'*

The panel was satisfied that Ms Pindhariya did not effectively time manage in that she left hourly observations incomplete and/or did not carry out hourly observations in a timely manner.

Therefore, the panel found this charge proved.

Charge 5)c)

"5) Did not effectively time manage in that:

c) Before and/or on 28 October 2024, you were prompted to do hourly observations;"

This charge is found proved.

The panel was of the view that the evidence from Ms Young in relation to the shift on 28 October 2024 was insufficiently specific to discharge its burden of proof in relation to that date. The panel next considered evidence put forward in relation to shifts prior to that date in accordance with the wording of the charge.

In reaching its decision, the panel took into account email sent by Ms Keane to Ms Manali and Ms Martins on 23 August 2024 where she stated:

> *'Poor time keeping with hourly observations frequently not done on time or needs reminding to do them every hour- this was fed back previously but remains an issue.'*

The panel was satisfied that Ms Pindhariya did not effectively time manage in that she needed to be prompted to do hourly observations, despite the fact she had received repeated feedback that this was an area of her practice where she needed to show improvement to achieve the required standard.

Therefore, the panel found this charge proved.

Charge 5)d)

"5) Did not effectively time manage in that:

d) On 28 October 2024, regular hourly observations were taking you 15-25 minutes to complete."

This charge is found proved.

In reaching its decision, the panel took into account the email sent by Ms Young to Ms Martins dated 28 October 2024 where she stated:

> *'I find Shanila struggles with her time management and efficiency as regular observations on a Level 2 patient was regularly taking Shanila 15-25 minutes to complete.'*

The panel noted that Ms Young's oral evidence provided further corroborating details when she confirmed her expectation that a nurse at Ms Pindhariya's stage of development should be taking a maximum of 10 minutes to complete these observations. Ms Young also stated that the excessive time taken to complete hourly observations meant that Ms Pindhariya did not have sufficient time to deliver the patient care identified as necessary from these observations.

The panel determined that Ms Pindhariya did not effectively time manage in that regular hourly observations were taking her 15-25 minutes to complete.

The panel therefore found this charge proved.

Charge 6)a)

"6) Lacked clinical knowledge in that you:

a) On 21 August 2024, during the OSCE exam, did not know what an insulin pen was and what to do with it;"

This charge is found proved.

In reaching its decision, the panel took into account the witness statement of Ms Manali. In her statement, she stated:

> *'During another station, Shehnila could not recognise what was in front of her, she did not understand what an insulin pen was and what to do with it. She was also unaware what to do with the insulin vial and syringe*

that was in front of her. This was a great concern as administering insulin via a pen or an insulin syringe is a very basic skill even for a newly qualified nurse, let alone an experienced critical care nurse'.

The panel was of the view that Ms Pindhariya lacked clinical knowledge in that on 21 August 2024, during the mock OSCE exam, did not know what an insulin pen was and what to do with it.

The panel therefore found this charge proved.

Charge 6)b)

"6) Lacked clinical knowledge in that you:

b) On 12 August 2024, did not know about inotropes and/or vasoactive medications;"

This charge is found proved.

In Ms Manali's witness statement, she stated:

'On the same day I asked Shehnila to tell me a little bit about a group of medication we use on the Unit almost daily, which is, inotropes or vasoactive medication. Shehnila could not explain or give me any information about these medications. I asked her if she has any time to study anything after the study days, but she explained she was stressed and would study harder. I explained to her that these medications, which we use with almost all cardiac surgical patients, are very high risk, and the patient can go into cardiac arrest after a few seconds if not administered properly.'

The panel determined that Ms Pindhariya lacked clinical knowledge in that on 12 August 2024, she did not know about inotropes and/or vasoactive medications.

Therefore, the panel found this charge proved.

Charge 6)c)

"6) Lacked clinical knowledge in that you:

c) On 23 August 2024, Did not know whether drugs were anti arrhythmic or anti hypertensives;"

This charge is found proved.

In reaching its decision, the panel took into account the email sent from Ms Keane to Ms Martins dated 10 October 2024. In the email she stated:

> *'On point 7, Shehnilla did not seem to gave knowledge on basic cardiac drugs for example whether drugs were anti arrhythmics or anti hypertensives. Another example was with aspirin, she was unable to tell me that aspirin was an anti platelet drug and unable to identify the need to check patient platelet levels when asked what on the formal bloods would we look to be effected by giving aspirin.'*

The panel found that Ms Pindhariya lacked clinical knowledge in that she did not know whether drugs were anti arrhythmic or anti hypertensives.

The panel therefore found this charge proved.

Charge 6)d)

"6) Lacked clinical knowledge in that you:

d) On 23 August 2024, didn't escalate elevated Potassium levels;"

This charge is found NOT proved

In reaching its decision, the panel took into account the email sent from Ms Keane to Ms Martins dated 10 October 2024. In the email she stated:

> *'I asked specifically about potassium levels and asked if she would be worried if someone had a potassium level of 6 or 7 which she said no. So I then explained how dangerous this would be for the patient and how we might manage high potassium levels.'*

This statement was further confirmed in Ms Keane's oral evidence.

The panel noted that the discussion referred to by Ms Keane was a hypothetical question, when she had asked Ms Pindhariya what she would do if a patient had a high potassium level. The panel was of the view that this did not relate to a patient having high potassium levels and that there would therefore be no requirement for Ms Pindhariya to escalate this matter.

Therefore, the panel found this charge not proved.

Charge 6)e)

"6) Lacked clinical knowledge in that you:

e) On 27 August 2024, stopped a syringe pump infusion;"

This charge is found NOT proved.

The evidence adduced by the NMC in relation to this charge is referred to by Ms Martins in her witness statement as evidence having been reported to her as an issue by Jade Ajaoud, another member of staff, who is not a witness in this NMC case and has not provided a witness statement.

The panel considered whether it could admit and properly rely upon the hearsay evidence of Jade Ajaoud in relation to this charge.

The panel had careful regard to Rule 31 of the Rules (admissibility of evidence) and to the key legal principles for admitting hearsay evidence from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). It also had regard to the NMC guidance on Hearsay in a document called Evidence DMA-6 (9 June 2025) which states, *'Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.'*

Whilst it was clear that this is relevant evidence, the panel determined that it was not fair to Ms Pindhariya to admit this hearsay evidence. In coming to this decision, the panel was mindful that Ms Pindhariya has, on the face of it, disputed all of the allegations; that Jade Ajaoud's hearsay evidence in support of this charge is 'sole and decisive'; that Jade Ajaoud's evidence is not capable of being tested and the panel could not be satisfied that the evidence is reliable, as per *Thorneycroft*.

As the panel has not admitted into evidence the hearsay evidence of Jade Ajaoud, the NMC has not discharged its burden of proof in relation to this particular of the allegation. The panel therefore found this particular charge not proved.

Charge 6)f)

"6) Lacked clinical knowledge in that you:

f) On 6 October 2024, did not support an endotracheal tube during endotracheal suctioning."

This charge is found NOT proved

In reaching its decision, the panel took into account the witness statement from Ms Malamel. In her statement, she stated:

'The process is that you are supposed to inform a patient what you are doing, even if they are sedated you are still supposed to inform them that you are going to make them cough. Shehnila was also not supporting the tube which was also a lack of safety. In order to support the tube, she would have needed to hold it securely, which is an extra safety measure, I had asked her why she did not provide extra support, and she said because the patient had an anchor faste which is a product that is designed to keep the tube safe in their mouth'.

The panel was of the view that this did not support lack of clinical knowledge.

There was no hospital policy or manufacturer instructions on how to operate this piece of equipment before the panel. In questioning, Ms Malamel stated that she does not recall being instructed to support the tube, this is something she does in her own practice as an extra measure to ensure the tube remains in the mouth along with the anchor faste which is designed to keep the tube in the mouth. She also stated that she is not aware if other clinicians support the tube or not during this process. The panel therefore did not find that a lack of clinical knowledge on Ms Pindhariya's part was established by not supporting the tube.

Therefore, did not find this charge proved.

Charge 6)g)

"6) Lacked clinical knowledge in that you:

g) On 29 October 2024, did not know that Aspirin was an anti-platelet drug."

This charge is found NOT proved.

In reaching its decision, the panel took into account the witness statement of Ms Malamel. In her statement, she stated:

'One of the patient we were looking after needed aspirin and I asked Shehnila if she knew what aspirin was and why we needed to give it, she

said that aspirin was an anti-coagulant but it is in fact an anti-platelet I asked her if she knew what the difference was between the two and she stated that she did but when I asked her to explain, she was unable to do so. Anti-coagulants and anti-platelets are both blood thinners, anti-coagulant stops the clot formation which an anti-platelet stops the platelet coming together. I wasn't expecting her to know the difference, it was the fact that she stated that she knew when she didn't. if she had said that she didn't know, it wouldn't have been a problem, I would just explain it to her'.

The panel determined that this does not prove that Ms Pindhariya lacked clinical knowledge in that she did not know that Aspirin was an anti-platelet drug. This is because Ms Malamel explicitly stated that she did not expect Ms Pindhariya to know the difference between an anti-coagulant and anti-platelet drug and that it would not have been a problem and that she would explain the difference to her.

The panel therefore did not find this charge proved.

The panel then considered the stem of the allegation and determined that, on the basis of its factual findings in relation to the sub-particulars, this established that Ms Pindhariya had failed to demonstrate the standards of knowledge, skill and judgement required to pass her probation period between 1 August 2024 and 6 November 2024 as a Band 4 nurse.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether Ms Pindhariya'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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Ms Pindhariya's fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Boesche submitted that the sample here is sufficient. Ms Pindhariya had performed numerous tasks in which she demonstrated a lack of competence over a 3-month period and that these were reported by a number of witnesses.

Ms Boesche invited the panel to take the view that the facts found proved amount to a lack of competence. Ms Bosche invited the panel to have 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 Boesche submitted when looking at the instances of lack of competence, the panel would normally look at their practising history and not just at the period of time when the concerns arose. The only record of Ms Pindhariya's practising history is

only from herself in relation to when she was a nurse in India. As Ms Pindhariya has not attended this hearing, her practising history could not be confirmed and expanded upon by her.

Ms Boesche submitted that, mindful that the panel has heard from the witnesses about other overseas nurses coming from India and managing well within the English system, the panel may be careful when considering the veracity and/or accuracy of what Ms Pindhariya had stated in her emails.

Ms Boesche asked the panel to consider that Ms Pindhariya had received high levels of support, which had included formal training that had been provided immediately before and during her probationary period.

Ms Boesche submitted that Ms Pindhariya was made aware of what was expected of her from the start of her induction. She submitted that the expectations were set out to her clearly for the role she was working and that the induction had been repeated several times. She submitted that Ms Pindhariya also received various feedback on her performance from the nurses she worked alongside with.

Ms Boesche identified the specific, relevant standards where Ms Pindhariya's actions amounted to a lack of competence.

Ms Boesche submitted that the facts found proved show that Ms Pindhariya's competence at the time was below the standard expected of a Band 4 registered nurse, when her probation was terminated in November 2024.

Submissions on impairment

Ms Boesche 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.

Ms Boesche submitted that Ms Pindhariya's conduct, as set out in the charges, was by and of itself so serious that a finding of impairment is necessary to maintain the public's confidence and trust in the professions and to uphold, declare and maintain professional standards.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included: *General Medical Council v Meadow* [2007] QB 462 (Admin), *Holton v General Medical Council* [2006] EWHC 2960 (Admin), *R (on the application of Remedy UK Ltd) v General Medical Council* [2009] EWHC 2294 (Admin), *McDermott v The Health and Care Professions Council* [2017] EWHC 2899 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin), and *Grant*.

The legal assessor also referred the panel to the NMC's guidance: 'Lack of competence' (Reference: FTP-2b, Last Updated 14/04/2021) and 'Impairment' (Reference: DMA-1, Last Updated 28/01/2026).

Decision and reasons on lack of competence

In accordance with NMC guidance FTP-2b, the panel considered whether there was evidence of an unacceptably low standard of professional performance judged on a fair sample of Ms Pindhariya's work, which could put people receiving care at risk of harm.

It asked itself:

1) if it had been presented with a fair sample of Ms Pindhariya's work to be able to assess her standard - sufficient to assess her work over a period of time
2) How and to what extent she had breached the NMC Code in the proved charges
3) Whether Ms Pindhariya's performance was unacceptably low as expected of a probationary Band 4 nurse on an ICU ward

The panel determined that the charges found proved clearly demonstrated significant ongoing deficiencies in Ms Pindhariya's practice with evidence from her line manager, an education lead and numerous colleagues, during the period of August 2024 to November 2024, across six themes, despite having supervision and support, which are:

1) Poor communication/engagement with colleagues
2) Poor communication/engagement with patients
3) Failure to mitigate risk and preserve safety of patients
4) Not prioritising nursing care
5) Poor time management
6) Lack of clinical knowledge

The panel heard evidence that Ms Pindhariya had failed to undertake essential nursing duties during a lengthy period of time. The panel concluded that the types of concerns raised, the seriousness of those concerns and the number of examples of her work provided over the period in question. It was considered that this represented a fair sample of Ms Pindhariya's work, sufficient for the panel to be able to assess the standard of Ms Pindhariya's work.

The panel went onto consider to what extent Ms Pindhariya had breached the Code in relation to the charges found proved.

The panel determined that Ms Pindhariya breached:

> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

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

7 Communicate clearly

To achieve this, you must:

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

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

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

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
To achieve this, you must:
9.1 provide honest, accurate and constructive feedback to colleagues
9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

10 Keep clear and accurate records relevant to your practice
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure
13.4 take account of your own personal safety as well as the safety of people in your care

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.1 only act in an emergency within the limits of your knowledge and competence

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient and public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel bore in mind, when reaching its decision, that Ms Pindhariya should be judged by the standards expected of her as an overseas probationary Band 4 nurse, i.e. the position to which she had been appointed when she joined the Trust, as per *Holton*, and not by any higher or more demanding standard, albeit she was qualified as a registered nurse in India.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Ms Pindhariya's practice was unacceptably below the standard that one would expect of a probationary Band 4 nurse.

The evidence presented established that Ms Pindhariya lacks the necessary knowledge, skills, and judgment expected of a probationary Band 4 nurse. Despite being repeatedly advised both orally and via written feedback of her underperformance by supervising staff and receiving substantial additional support and training, Ms Pindhariya consistently failed to meet the required professional standards. Ms Pindhariya's performance remained below the competence expected of a probationary Band 4 nurse and had an impact on patients and the care provided to them placing them at risk of harm.

While there were some instances where the evidence suggested that Ms Pindhariya on occasion showed improvement, such improvement was not consistent and not representative of her overall performance. Reports from her colleagues, line manager and assessors as well as direct observations by her supervisors highlighted recurring and wide-ranging deficiencies in her practice. Her underperformance occurred despite her operating under continuous supervision in a supernumerary capacity as well as extended supernumerary status. The panel received no evidence of workplace pressures, but it did note that at the start of her employment, Ms Pindhariya had experienced difficulties transitioning into her new role. These

difficulties were identified by Ms Pindhariya's manager and a referral was made to the Trust's Staffline counselling service dated 28 August 2024, as well as putting her in touch with two other international nurses. Ms Pindhariya's interaction with Staffline is confidential, but the panel was told that Ms Pindhariya did not follow up the offer of support from the two peer nurses.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Ms Pindhariya's practice was unacceptably below the standard that one would expect of a probationary Band 4 nurse acting in her role.

In all the circumstances, the panel determined that this demonstrated a lack of competence.

Decision and reasons on current impairment

The panel next went on to decide if as a result of the lack of competence, Ms Pindhariya'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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) *…*

The panel considered each of the above limbs in turn.

In relation to limb (a), on whether patients were put at unwarranted risk of harm, in the past, as a result of Ms Pindhariya's lack of competence,

the panel was satisfied that Ms Pindhariya's lack of competence placed patients at a risk of harm.

In relation to limb (b) and (c), in respect of the past, Ms Pindhariya's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. At least one patient was unhappy with Ms Pindhariya's care and more generally, the panel noted that Ms Pindhariya had repeatedly failed to prioritise patient care. It also acknowledged the fact that Ms Pindhariya did not practise effectively in that she needed prompting and was not independently delivering patient care. The panel was of the view that Ms Pindhariya did not promote professionalism or trust.

Regarding insight, the panel considered that it had no evidence before it which reflected on the events that took place or that she had learnt from them. It noted Ms Pindhariya provided the NMC with briefly worded denials of the charges, stating that she was harshly treated and received unfair feedback. No evidence was provided to support any of these claims.

The panel however noted that in the oral evidence of the witnesses, it was made clear that Ms Pindhariya was treated fairly and was given guidance and advice on how to improve her practice. The panel noted that despite this, there were minimal isolated examples which demonstrated improvements in her care. There was no evidence before the panel of remorse or remediation.

The panel took into account that impairment is a forward-looking exercise, and it should consider whether Ms Pindhariya's fitness to practise is currently impaired.

The panel next considered whether Ms Pindhariya is liable, in the future, to place patients at unwarranted risk of harm, to bring the nursing profession into disrepute or breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. In reaching its decision, the panel also considered the principles derived from *Cohen* and as outlined in the NMC Guidance, '*Impairment'* (DMA-1)*,* namely:

- Whether the concern is easily remediable;

- Whether it has in fact been remedied; and
- Whether it is highly unlikely to be repeated.

The panel was of the view that the concerns in this case are not easily remediable as the concerns are so wide-ranging and relate to the basic fundamentals of nursing practice.

The panel noted that the concerns have not been remedied.

The panel determined that there is a risk of repetition because the wide range of failings shown by Ms Pindhariya had been repeated on multiple occasions. Ms Pindhariya has not shown any insight into her actions or any remorse or remediation. 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 are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was required. It determined that if a reasonable member of the public was to be made aware that Ms Pindhariya was able to practise with no restriction, with the concerns amounting to lack of competence, the public's confidence in the profession and the NMC as its regulator would be seriously undermined.

Having regard to all of the above, the panel was satisfied that Ms Pindhariya's fitness to practise is currently impaired.

Submissions on sanction

Ms Boesche informed the panel that in the Notice of Hearing, dated 22 July 2026, the NMC had advised Ms Pindhariya that it would seek the imposition of a conditions of practice order for 12 months if it found Ms Pindhariya's fitness to practise currently impaired.

Ms Boesche submitted that the aggravating factors in this matter include the real risk of harm to patients, lack of insight and lack of remorse.

Ms Boesche submitted that the panel may find that the cultural differences, cultural barrier and language may provide some mitigation.

Ms Boesche took the panel through all the available sanctions in ascending order of restriction.

Ms Boesche submitted that taking no further action or a caution order are not suitable as the matter is too serious to be addressed by either of those. She submitted that there remain public interest and confidence that requires addressing. She submitted that there are also clear public protection concerns.

Ms Boesche submitted that in relation to a conditions of practice order, conditions must be workable, measurable and proportionate. She submitted that in this case, there are clearly identifiable areas of concern in relation to Ms Pindhariya's practice. She submitted that they may be remediable in that they relate to clinical failings.

Ms Boesche submitted that conditions in this case might be numerous and voluminous in their range, but it may be that workable conditions can be formulated that would provide the necessary level of public protection.

Ms Boesche noted that Ms Pindhariya did have a supernumerary period working with experienced members of staff and additional time had been provided above and beyond the normal training period with minimal improvement.

Ms Boesche submitted that given that the concerns took place over a relatively short period of time, a suspension order would be overly punitive and would not assist Ms

Pindhariya to return to her role as a registered nurse. She submitted that a lengthy period of conditions should be a suitable starting point as there appears to be no evidence of attitudinal problems. Although Ms Pindhariya did lack complete insight to date and limited appreciation of the risk she posed, she submitted that the errors are remediable with training, assessment and practice.

Ms Boesche submitted that the panel may consider that the lack of competence is so transversal in this case that its seriousness would call for a suspension order. However, practically and pragmatically, a period of suspension would not be conducive to strengthening practice.

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

Decision and reasons on sanction

Having found Ms Pindhariya'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:

- Pattern of failings over an extended period
- Repeated safety/critical failings despite feedback and support
- Limited insight demonstrated during the probation period
- Patient safety risk in a high-acuity (critical care) environment
- Impact on patients and colleagues
- Minimal progress despite enhanced support
- Failed to properly engage with colleagues when they raised concerns with Ms Pindhariya about her performance (nodded her head to indicate that information was understood when her subsequent performance indicated it was not understood)

The panel also took into account the following mitigating features:

- Ms Pindhariya was provided with feedback, but this was not codified into a single, coherent development plan
- Ms Pindhariya was not provided with a consistent mentor for the duration of her probationary period
- It is possible that cultural and language issues may have been a barrier to Ms Pindhariya making herself understood and/or having the confidence to fully express herself in the workplace
- Ms Pindhariya was placed in a high-acuity area

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

The panel next considered whether placing conditions of practice on Ms Pindhariya's registration would be appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *…*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel had regard to the fact that the incidents took place during Ms Pindhariya's probationary period. Since then, Ms Pindhariya has passed her NMC test of competence including the OSCE and multiple-choice question paper and is now a nurse on the NMC register.

The panel determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case.

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

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of Ms Pindhariya's case as it would be overly punitive.

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

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

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must limit your nursing work to one substantive NHS employer in a generalist environment. You must not work in a specialist environment such as Intensive Care Unit, Intensive Treatment Unit, High Dependency Unit or Emergency Department etc.
>
> 2. You must not be the sole nurse on duty or the nurse in charge on any shift.
>
> 3. You must ensure that you are directly supervised in the following areas until formally assessed and deemed competent by another registered nurse:
>
>   - A-E assessment and prioritisation
>   - Recognition and escalation of the deteriorating patient (including hypoglycaemia)
>   - Safe management of infusions, syringe pumps and alarms
>   - Airway support (ETT / basic airway)
>   - Aseptic Non-Touch Technique (ANTT) and infection prevention
>   - Medicines management and communication / escalation

You must send evidence of competence in each area to the NMC within seven days of each assessment.

4. You must be indirectly supervised any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by another registered nurse.

5. Work with your line manager or supervisor to create a Performance Development Plan (PDP) in relation to your learning needs, including but not limited to:

    - A–E assessment and prioritisation
    - Recognition and escalation of the deteriorating patient (including hypoglycaemia)
    - Safe management of infusions, syringe pumps and alarms
    - Airway support (ETT (endotracheal tube) / basic airway))
    - Aseptic Non-Touch Technique (ANTT) and infection prevention
    - Medicines management and communication / escalation

6. You must have fortnightly meetings with your line manager or supervisor including but not limited to:

    - A–E assessment and prioritisation
    - Recognition and escalation of the deteriorating patient (including hypoglycaemia)
    - Safe management of infusions, syringe pumps and alarms
    - Airway support (ETT / basic airway)
    - Aseptic Non-Touch Technique (ANTT) and infection prevention
    - Medicines management and communication / escalation

7. You must send the NMC a report from your line manager, mentor or supervisor, prior to any review hearing, including but not limited to:

- A–E assessment and prioritisation
- Recognition and escalation of the deteriorating patient (including hypoglycaemia)
- Safe management of infusions, syringe pumps and alarms
- Airway support (ETT / basic airway)
- Aseptic Non-Touch Technique (ANTT) and infection prevention
- Medicines management and communication / escalation
- Record of any assessments you have undertaken

8. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

9. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your NMC case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

12. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

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

Any future panel reviewing this case would be assisted by:

- Ms Pindhariya's attendance at the review hearing
- A reflective piece from Ms Pindhariya on how her previous work during her probation affected nurses and patients whilst working at the Trust, her understanding of the seriousness of the concerns and any measures taken to address them
- Completed PDP and additional evidence related to the PDP
- References from employers she has worked for since working at the Trust
- Evidence of any additional training she has undertaken

This will be confirmed to Ms Pindhariya in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is necessary 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 Ms Pindhariya's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Boesche. She submitted that it is necessary to protect the public and the public interest. Ms Boesche submitted that it would be inconsistent with the decision made, if the panel did not impose an interim order.

Decision and reasons on interim order

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

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any appeal period.

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

That concludes this determination.