# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Tuesday 5 May 2026 – Thursday 14 May 2026**
**Friday 14 August 2026**

Virtual Hearing

| | |
|---|---|
| **Name of Registrant:** | Sandeep Selvaraj |
| **NMC PIN:** | 21B1107O |
| **Part(s) of the register:** | RN1,Registered Nurse – Adult ( 25 February 2021 ) |
| **Relevant Location:** | Belfast |
| **Type of case:** | Misconduct/Lack of competence |
| **Panel members:** | Derek Artis (Chair, Lay member)<br>Hellen Horton (Registrant member)<br>Mark Allison (Lay member) |
| **Legal Assessor:** | Hala Helmi |
| **Hearings Coordinator:** | Anya Sharma (5-8 May, 12-14 May, 14 August 2026)<br>Monsur Ali (11 May 2026) |
| **Nursing and Midwifery Council:** | Represented by Robert Rye, Case Presenter (5 - 14 May 2026)<br>Represented by Sophia Ewulo (14 August 2026) |
| **Mr Selvaraj:** | Present and represented by Anna Deery, Counsel instructed by the Royal College of Nursing (RCN) |
| **Facts proved by admission:** | Charges 1a, 1d, 1e, 1f, 1g, 1j, 2, 3a, 3b, 4, and 12. |
| **Facts proved:** | Charges 1c, 1i, 6 (in part), 7, 8a, 8b, 9, 13a, 13b and 14 |
| **Facts not proved:** | Charges 1b, 1h, 5, 10 and 11 |
| **Fitness to practise:** | **Impaired** |

| | |
|---|---|
| **Sanction:** | **Suspension order (12 months)** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on application to amend the charge**

The panel heard an application made by Mr Rye, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 1(a), 8(a), 8(b) and 9.

It was submitted by Mr Rye that the proposed amendments would provide clarity and more accurately reflect the evidence.

*That you, a registered nurse:*

1. *Between 5 January 2021 and 16 May 2024 failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 5 nurse, in that you:*

    a. *On or around 30 August 2021 ~~drew up the 30 millilitres of local anaesthetic instead of 15 millilitres as required;~~* ***did not recognise that 30mls of local anaesthetic had been drawn up***

8. *On 2 February 2023:*

    *a. Recorded on Kardex that Patient H had been administered paracetamol at ~~12.30~~* ***14:00*** *when they had not ;*
    *b. ~~Left medication in Patient's H's room at 12.30 when this was not safe to take until 15.30.~~* ***Left Patient's H's paracetamol in their room when it was unsafe.***

*9. Your actions at charge 8a were dishonest in that you recorded that paracetamol had been administered at ~~12.30~~* ***14:00*** *when it had not.*

Ms Deery submitted that there are no issues with the proposed amendments, and that they would more accurately reflect the evidence in this case.

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).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

The panel also made the following typographical amendment to charge 13(b):

*13. On 10 January 2024*

*b. Stated that you had ~~you~~ measured Patient J's fluid output when you had not.*

Mr Rye made a further application to amend charges 6 and 14. He submitted that the proposed amendments would provide clarity and more accurately reflect the evidence.

*6. On an unknown date, stated to Colleague B that you had checked Patient G's skin* ***and/or changed their wound dressing*** *when you had not.*

*14. Your actions at Charge 13 were dishonest in that you stated that you had offered analgesia when you had not and had ~~recorded~~* ***measured*** *the fluid output when you had not.*

Ms Deery indicated in her submissions that she supported the application and that the proposed amendments would more accurately reflect the evidence in this case.

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).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Mr Rye made a further application to amend charge 1c. He submitted that the proposed amendments would provide clarity and more accurately reflect the evidence.

> *1. Between 5 January 2021 and 16 May 2024 failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 5 nurse, in that you:*
>
> *c. On or around 29 October 2021 incorrectly documented the ~~number~~* ***size*** *of swabs present during Patient B's abdominal surgery;*

Ms Deery indicated in her submissions that she supported the application and that the proposed amendment would more accurately reflect the evidence in this case.

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).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

**Details of charge (as amended)**

That you, a registered nurse:

1. Between 5 January 2021 and 16 May 2024 failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 5 nurse, in that you:

a. On or around 30 August 2021 did not recognise that 30mls of local anaesthetic had been drawn up
b. On or around 28 October 2021 removed a Patient A's identification label from the patient notes and stuck this onto a sluice door;
c. On or around 29 October 2021 incorrectly documented the size of swabs present during Patient B's abdominal surgery;
d. Failed to administer medication appropriately, or at all, on one or more of the dates in Schedule 1;
e. Failed to record fluid balances appropriately, or at all, on one or more of the dates in Schedule 2;
f. Failed to complete patient notes appropriately, or at all, on one or more of the dates in Schedule 3;
g. Completed flowcharts retrospectively on more than one occasion;
h. On an unknown date, failed to record a Patient C's hypertensive episode;
i. Failed to provide wound care appropriately, or at all, on one or more of the dates in schedule 4;
j. On 24 November 2023, inaccurately documented information about Patient D's mobility.

2. On or around 20 April 2023 failed to administer Tapentadol to Patient E.

3. Subsequent to your actions at charge 2:
    a. Forged a colleague's signature stating that the Tapentadol had been administered, when it had not.
    b. On or around 25 April 2023, denied to Colleague A that the error at charge 2 had occurred.

4. Your actions at charge 3 were dishonest in that you sought to cover up that you had failed to provide patient care.

5. On or around 11 December 2023 failed to escalate Patient F with a NEWS score of 5.

6. On an unknown date, stated to Colleague B that you had checked Patient G's skin and/or changed their wound dressing when you had not.

7. Your actions at charge 6 were dishonest in that you sought to cover up that you had failed to provide patient care.

8. On 2 February 2023:

    a. Recorded on Kardex that Patient H had been administered paracetamol at 14.00 when they had not ;
    b. Left Patient's H's paracetamol in their room when it was unsafe.

9. Your actions at charge 8a were dishonest in that you recorded that paracetamol had been administered at 14.00 when it had not.

10. In January 2024 stated to Colleague A that you had passed a training course in relation to resuscitation when you had not.

11. Your actions at charge 10 were dishonest in that you sought to mislead Colleague A as to your clinical competence.

12. Copied and pasted information into patient notes on more than one occasion.

13. On 10 January 2024:

    a. Stated that a Patient I had been offered analgesia and refused when they had not;
    b. Stated that you had measured Patient J's fluid output when you had not.

14. Your actions at Charge 13 were dishonest in that you stated that you had offered analgesia when you had not and had measured the fluid output when you had not.

AND, in light of the above, your fitness to practise is impaired by reason of your lack of competence in relation to Charge 1 and your misconduct in relation to Charges 2, and/or 3 and/or 4 and/or , 5 and/or , 6 and/or , 7 and/or , 8 and/or , 9 and/or , 10 and/or 11 and/or 12 and/or 13 and/or 14.

**Schedule 1**

- 23 November 2023
- 24 November 2023
- 27 November 2023
- 4 December 2023
- 5 December 2023
- 12 December 2023
- 16 December 2023
- 22 December 2023
- 28 December 2023
- 30 December 2023
- 10 January 2024
- 16 January 2024

**Schedule 2**

- 7 October 2022
- 17 October 2022
- 23 November 2023
- 13 December 2023
- 22 December 2023 15
- 10 January 2024
- 16 January 2024

**Schedule 3**

- 7 October 2022
- 17 October 2022
- 10 January 2024
- 16 January
- 7 February 2024
- 11 December 2023

**Schedule 4**

- 10 October 2022
- 12 October 2022
- 10 January 2024
- 16 January 2024
- 7 February 2024

**NMC Opening**

You commenced employment as a Band 5 nurse at Ulster Hospital (‘the Hospital’) on 5 January 2021. Concerns were subsequently raised regarding your competence, particularly in relation to medication administration and record keeping, which resulted in you being placed on a number of capability plans. Despite being moved from a day procedure unit (DPU) to a surgical ward on 28 March 2022 in an attempt to support your performance in a different environment, concerns regarding your practice persisted. These alleged concerns are said to include issues relating to medication management, documentation and wound care and candour, identified through a series of reviews and meetings.

The Trust referred you to the NMC on 24 April 2024. The charges before this panel relate to allegations of lack of competence and misconduct. Whilst you have made

admissions to some of the charges, the remaining charges are denied by you and would require determination by the panel.

Mr Rye reminded the panel that the burden of proof rested upon the NMC throughout and that the standard of proof was the civil standard, namely the balance of probabilities. He referred the panel to the evidence relied upon in support of each charge, including witness statements, capability documentation, investigation reports, meeting notes and associated exhibits contained within the hearing bundle.

In relation to the dishonesty allegations, Mr Rye referred the panel to the principles set out in *Ivey v Genting Casinos (UK) Ltd (trading as Crockfords Club) [2017] UKSC 67.* Mr Rye set out that the panel would first need to determine your state of mind at the relevant time and then consider whether, viewed objectively, the conduct alleged would be regarded as dishonest by the standards of ordinary decent people.

**Decision and reasons on application to admit hearsay evidence**

As part of his opening, Mr Rye also addressed the panel on the issue of hearsay evidence within the case. He submitted that certain evidence had been included to provide the panel with the broader context of your competence and practice, particularly in what was described as a pattern of concerns over time. Mr Rye made reference to the authority of *Ogundele v Nursing and Midwifery Council* [2013] EWHC 2748 in support of the proposition that a panel may consider a pattern of alleged incompetence, and that it would not be proportionate in such cases to obtain statements from every individual referred to within management documentation or meeting notes. Mr Rye explained that any potential unfairness arising from hearsay evidence could be mitigated through questioning of witnesses and by the weight ultimately attached to such evidence by the panel.

Ms Deery indicated that she is content with the NMC's position in relation to the hearsay evidence in this case, which has been set out within the opening. She submitted that she does not have any specific arguments to make with regards to any evidence being inadmissible and needing to be removed by the panel. Ms Deery submitted that it is accepted and recognised that there is not any sole or decisive evidence in relation to a charge that is solely hearsay evidence.

Ms Deery invited the panel to be mindful that there is hearsay evidence within this case, and that it is a matter for the panel during its deliberations in relation to the facts stage to place appropriate weight after it has been tested. Ms Deery indicated that she will also address the panel in relation to weight of the evidence when she makes her closing submissions.

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

The panel first considered whether the hearsay evidence was relevant and fair to admit. It determined that the evidence appeared relevant to the issues before it, including the wider context of your clinical practice, documentation, and the dishonesty allegations. The panel considered that a number of the hearsay accounts appeared capable of being corroborated by other evidence within the hearing bundle, including evidence from witnesses with direct knowledge of relevant events.

The panel noted that much of the hearsay evidence originated from senior members of staff involved in supervision, management, and assessment of your clinical practice. The panel considered that such witnesses may be able to provide relevant evidence regarding the expected standards of competence for a Band 5 nurse and the concerns identified during your employment.

The panel further considered that, at this stage of the proceedings, it did not appear that any hearsay evidence constituted the sole or decisive evidence in relation to any particular charge. However, the panel acknowledged that this position may require reconsideration following witness evidence and the precise nature and source of the evidence had been fully explored through questioning of the witnesses.

The panel was mindful that witnesses giving live evidence could be questioned regarding the reliability, credibility and source of the information contained within their statements. It considered that any potential unfairness arising from the admission of hearsay evidence could therefore be addressed through the testing of that evidence during the hearing process and, ultimately, through the weight attached to such evidence at the conclusion of the case.

Accordingly, the panel determined that the hearsay evidence was relevant and fair to admit and therefore granted the application. The panel noted that the weight to be attached to any hearsay evidence would be determined at a later stage of the proceedings following the hearing of all of the evidence.

**Decision and reasons on application for hearing to be held in private**

Ms Deery made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. She submitted that your private interests do outweigh any other consideration, including the panel's interest in hearing these specific matters of this hearing openly, and that you have a right to privacy in relation to these specific issues. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Rye indicated that he does not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised.

**Decision and reasons on facts**

At the outset of the hearing, the panel heard from Ms Deery, who informed the panel that you made admissions to charges 1a, 1d, 1e, 1f, 1g, 1j, 2, 3a, 3b, 4, and 12.

The panel therefore finds charges 1a, 1d, 1e, 1f, 1g, 1j, 2, 3a, 3b, 4, and 12 proved by way of your admissions.

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 Mr Rye on behalf of the NMC and by Ms Deery on your behalf.

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

The panel noted that there are allegations of dishonesty in this case and took into account the NMC Guidance on dishonesty found at DMA-8.

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

- Linda Campbell: Band 6 Sister Theatre Manager at the Hospital at the time of the events
- Michelle McCartan: Lead Nurse for Surgical Speciality at the Hospital
- Cheryl Roberts: Deputy Ward Sister at the Hospital
- Raynel Amora: Band 5 Deputy Charge Nurse at the Hospital at the time of the events
- Ernestina Giovannoli: Staff Nurse at the Hospital
- Gemma Jones: Deputy Sister and Staff Nurse at the Hospital at the time of the events

The panel also heard evidence from you under oath.

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 both the NMC and the RCN.

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

**Charge 1b**

That you, a registered nurse:

1. Between 5 January 2021 and 16 May 2024 failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 5 nurse, in that you:
b. On or around 28 October 2021 removed a Patient A's identification label from the patient notes and stuck this onto a sluice door;

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and written evidence of Linda Campbell, as well as your oral evidence.

The panel took into account Linda Campbell's oral evidence that she had observed a patient's identification label (ID label) attached to a sluice door.

The panel also took into account the following from Linda Campbell's witness statement, which corroborates her oral evidence:

> *'On this day, a patient's identification label ('ID') was found stuck onto a sluice door with specimen details on it, handwritten by Sandeep. In the room was*

*myself, Sandeep and two Nursing Associates. ID labels should only be recorded by registered nurses, which means the Nursing Assistants would not have recorded the ID label. I knew that I had not recorded the ID label, so I deduced that it must have been Sandeep, the only other nurse in the room, who stuck the ID label on the sluice door. However, when I asked Sandeep about this incident, he denied sticking the patients label to the door in this way. A copy of my notes recording this incident is at Exhibit LC-14.*

*The ID label should never be removed from the patient's notes until they are required for labelling of specimens. The ID labels provide the only way of identifying each patient. Staff are advised that if an ID label should be removed for any reason, this action is to be witnessed by another member of staff in line with safety guidance and safe handling of specimens. Sandeep would have been aware of this, as all new members of staff to Theatres are informed of this within their first couple of months.'*

The panel accepted Linda Campbell's oral and written evidence that the ID label contained handwriting, which she identified as being yours. The panel noted that this was not disputed by you.

In considering whether there is sufficient evidence before it to establish that it was you who had removed the ID label from the patient notes and placed it onto the sluice door, the panel took into account the evidence regarding theatre practice and procedure. The panel considered that it had heard oral evidence that labels may occasionally become detached or dropped during busy procedures and that, whilst it is the not appropriate practice, labels may sometimes be temporarily placed elsewhere for hygiene purposes.

The panel also considered the evidence regarding the sterile theatre environment and the practicalities of your role during surgery. It took into account that as circulating theatre nurse, it would have been difficult for you to leave the sterile field during an ongoing procedure in order to place a label on the sluice door.

The panel also considered that a number of individuals were present within the theatre at the relevant time, including other clinical staff. It considered that whilst Linda Campbell's evidence was that the handwriting on the label was yours and that only two nurses in the room would ordinarily deal with labels, the panel noted that there was no direct evidence before it identifying you as the person who physically removed the label and attached it to the sluice door.

The panel also took into account that no evidence had been obtained from any other staff members present in theatre at the time. It considered that there were a number of alternative explanations as to how the label came to be on the sluice door, including that it may have been dropped and subsequently moved by another member of staff.

The panel accepted your evidence that you did not place the label on the sluice door. Whilst the panel was satisfied that the ID label existed and had your handwriting, it was not satisfied that there was sufficient evidence before it to prove that you had removed the label from the patient notes and stuck it onto the sluice door. The panel therefore find this charge not proved.

**Charge 1c**

1c. On or around 29 October 2021 incorrectly documented the size of swabs present during Patient B's abdominal surgery;

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence of Linda Campbell, as well as your oral evidence.

The panel considered both Linda Campbell's oral and written evidence as well as her contemporaneous note of the incident dated 29 October 2021. It accepted Linda Campbell's evidence that you had incorrectly documented the size of the swabs. The panel noted that Linda Campbell was an experienced nurse, had been supervising you

at the time, and gave clear evidence to the panel about the incident which took place and the importance of accurate documentation in relation to theatre swab counts.

The panel had sight of Linda Campbell's note of the incident dated 29 October 2021, in particular:

> *'… Sandeep counted down a bundle of (5) 14x4½ swabs & documented these as 4x3 – Again I reiterated the importance of correct documentation etc!...'*

The panel also took into account your oral evidence in relation to the incident. You stated in your oral evidence that you do not remember the incident clearly, and that Linda Campbell may had misread your handwriting. Despite this, the panel considered that Linda Campbell is experienced, was very familiar with theatre documentation and had worked with you on a number of occasions. The panel considered it unlikely that Linda Campbell would have misread the relevant swab size, especially given the distinction between "14x4" and "14x4½".

The panel also noted that during your oral evidence you appeared to accept that it was possible the size had been incorrectly documented.

Taking into account all of the evidence before it, the panel reached the conclusion that it preferred the evidence of Linda Campbell. The panel was satisfied, on the balance of probabilities, that you incorrectly documented the size of the swabs present during Patient B's abdominal surgery. It therefore finds this charge proved.

**Charge 1h**

1h. On an unknown date, failed to record a Patient C's hypertensive episode;

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the evidence of Gemma Jones, as well as your evidence. The panel also had sight of your review meeting notes dated 22 February 2023, at which yourself, Gemma Jones and Cheryl Roberts were present.

The panel accepted your evidence that you had taken Patient C's blood pressure reading and that the reading was high. The panel also accepted your evidence that the reading was entered into the electronic device used for recording vital signs. It noted that this information was uploaded to the central system and that this was how Gemma Jones was able to identify that you had taken the observations.

The panel therefore considered that there was evidence that you had recorded the hypertensive episode through the electronic observations system.

The panel also considered the issue of whether you should have documented the episode in the patient's notes, MDT notes or other clinical documentation. It noted that you were working under supervision at the time as part of your capability process. The panel heard oral evidence from Gemma Jones that, when working under supervision, there could be limits on what a nurse was permitted to document independently, and that documentation may need to be reviewed and/or countersigned by the supervising nurse.

The panel also took into account your oral evidence. You told the panel that you had escalated the high blood pressure reading to the Band 5 nurse allocated to supervise you, and that a nurse and doctor then attended to Patient C. The panel also noted that the NMC had not called the relevant supervising nurse to give evidence in relation to clarifying what you had been instructed to do, what you were permitted to document, and whether the supervising nurse or doctor had documented the incident after.

The panel considered that there remained uncertainty as to the scope of your duty to document in the circumstances, particularly given that you were under supervision and had also escalated the matter to the appropriate nurse.

The panel was therefore not satisfied, on the balance of probabilities, that you had failed to record Patient C's hypertensive episode as alleged. The panel noted that the hypertensive reading had been entered into the electronic observations system, and that the evidence before it did not clearly establish that you were responsible for making any further record. Accordingly, the panel found charge 1h not proved.

**Charge 1i**

1i. Failed to provide wound care appropriately, or at all, on one or more of the dates in schedule 4;

**Schedule 4**

- 10 October 2022
- 12 October 2022
- 10 January 2024
- 16 January 2024
- 7 February 2024

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Michelle McCartan, Cheryl Roberts, Raynel Amora, as well as your evidence.

The panel first considered whether you had a duty to provide wound care. The panel noted that you were employed as a Band 5 nurse and was bound by the professional duty as set out in the NMC Code to provide safe and appropriate patient care. The panel also accepted that, during parts of the relevant period, you were working under supervision as part of your capability process. However, the panel considered that this did not remove your professional responsibility to ensure that required wound care was provided appropriately.

The panel took into account that the evidence relating to some of the dates set out in Schedule 4 was hearsay in nature, in that Michelle McCartan and Cheryl Roberts had not directly witnessed every incident. However, the panel considered that the documentary records were contemporaneous or near-contemporaneous notes made as part of the capability and progress review process. The panel found that these records formed part of the wider clinical and managerial record of your supervised practice.

In relation to the dates 10 October 2022 and 12 October 2022, the panel considered the report notes referred to by Michelle McCartan dated 10 October 2022 and 12 October 2022, which recorded concerns that wound care and dressing-related tasks had not been completed appropriately, despite you having been reminded. The panel considered that these notes had been compiled by Michelle McCartan from nursing staff, including Cheryl Roberts, who were on duty at the time. The panel noted that it had no reason to consider that these concerns would have been fabricated or inaccurately reported. The panel also noted that these two dates 10 October 2022 and 12 October 2022 relate directly to care. The panel accepted the evidence before it that wound care was required.

In relation to the remaining dates, namely 10 January 2024, 16 January 2024 and 7 February 2024, the panel noted that the evidence referred to wound checks and/or wound assessment documentation not being completed. The panel considered the evidence of Cheryl Roberts and Raynel Amora, including the daily progress review notes. It noted that these records identified the supervising nurse (signed by Cheryl Roberts on 10 January 2024 and 16 January 2024 and by Raynel Amora on 7 February 2024) and recorded concerns regarding the absence of wound care documentation or wound assessment.

The panel also considered your evidence. The panel noted that your position was inconsistent, where at times it appeared to be suggested by Ms Deery that the wound care or checks had been completed by you, but not documented. However, in your own evidence, you also stated that you had not completed them because you were waiting for supervision or assistance from another nurse.

The panel considered that this inconsistency reduces the credibility of your account. It also noted that the witnesses had largely been cross-examined on the basis that you had completed the wound care, rather than on the basis that you had been unable to complete it due to a lack of available supervision. The panel considered that the witnesses were therefore not given a proper opportunity to comment on whether supervision was unavailable to you on those dates.

The panel also accepted that the ward was busy and that there may have been occasions when supervision was not immediately available. However, it considered that the evidence before it demonstrates a repeated pattern of wound care and wound checks not being carried out or documented appropriately. The panel was satisfied that the daily progress records and review notes from Cheryl Roberts and Raynel Amora were reliable evidence of concerns identified by experienced nurses who were supervising your practice.

The panel noted that there were gaps in the evidence before it. It considered that it did not have patient records, a written amended contract, or a detailed written capability plan setting out each task you could or could not perform independently.

However, taking into account all of the evidence, including the evidence of Cheryl Roberts and Raynel Amora, together with the progress review documentation, the panel was satisfied on the balance of probabilities that you failed to provide wound care appropriately in relation to 10 October 2022 and 12 October 2022.

The panel considered the remaining dates set out in schedule 4 that wound checks and associated documentation, part of wound care, had not been carried out and therefore concluded that on the balance of probabilities, there had been a failure to provide wound care appropriately.

The panel also found, on the balance of probabilities, that the concerns recorded on the later dates formed part of the same pattern of failure in relation to wound care and wound assessment.

Accordingly, the panel found charge 1i proved.

**Charge 5**

5. On or around 11 December 2023 failed to escalate Patient F with a NEWS score of 5.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and written evidence of Ms Cheryl Roberts, as well as your evidence.

The panel accepted that, ordinarily, a NEWS score of 5 would require escalation in accordance with the relevant clinical pathway. However, the panel also took into account that you had been working under supervision at the relevant time.

The panel considered your evidence that you had escalated Patient F's NEWS score to a Band 5 nurse, as you believed you were required to do under your supervision arrangements. The panel took into account your evidence alongside the NMC's evidence and found that it was persuasive. The panel noted that you understood that, outside of the supervision arrangements, escalation to a doctor may have been required, but your evidence was that you had been instructed to escalate concerns to the supervising nurse.

The panel noted that the NMC had not provided clear documentary evidence setting out your escalation responsibilities while working under supervision. The panel considered that it did not have before it any revised contract, written capability plan, or written instruction which established that you were required to escalate directly to the F1 doctor, ward doctor or medical team as part of your supervision arrangements.

The panel did not consider that the absence of documentation alone proved that no escalation had occurred. It was therefore not satisfied, on the balance of probabilities, that you had failed to escalate Patient F. The panel was of the view that you had

escalated the NEWS score to a Band 5 nurse, whom you believed to be the appropriate person under the supervision arrangements. Accordingly, the panel find charge 5 not proved.

**Charge 6**

6. On an unknown date, stated to Colleague B that you had checked Patient G's skin and/or changed their wound dressing when you had not.

**This charge is found proved (partly in respect of having checked Patient G's skin when you had not).**

In reaching this decision, the panel took into account the oral and written evidence of Raynel Amora, as well as your evidence.

The panel noted that Raynel Amora's evidence distinguished between a skin check and wound dressing care. It further noted that the evidence in relation to wound dressing appeared to relate to a different patient and/or a different occasion. The panel therefore did not find the wound dressing element of the charge proved.

In relation to the skin check, the panel noted Raynel Amora's evidence that he reviewed the relevant documentation, found no record of the skin check having been completed, asked you about it, and was told that it had been done. Raynel Amora then checked with Patient G and completed the skin check himself.

The panel also took into account the following extract from Raynel Amora's witness statement:

> *'I cannot recall the precise date, but on one occasion I asked Sandeep whether he had checked a particular patient's skin bundle and the patient's skin more generally to ensure up-to-date care was given. Sandeep said that he had checked the patient's skin, but he did not document this on the system. Later, I approached the patient to confirm if care had been given and the patient said no.*

*Also, there were times where the patient needed their wounds dressing. Sandeep said he did already it but when I attended the patients', I saw that the old dressings were still in place and had not been changed. It is important to change the dressings on time to prevent infection to the wounds, which is something I would have expected Sandeep to know. Sandeep would also not have all necessary equipment with him when changing the dressing of patients, and would need to go back to the material supply store, thereby leaving the wound exposed and leaving the patient at risk of infection.'*

The panel also considered your evidence. You told the panel that the conversation did not take place, and that you had said you would complete the skin check, rather than that you had completed it. The panel also considered whether there may have been miscommunication between yourself and Raynel Amora. However, the panel noted that this was not clearly put to Raynel Amora during his evidence.

The panel preferred Raynel Amora's evidence in this regard. It considered that Raynel Amora had no apparent motive to fabricate the conversation, and that his account was consistent with the subsequent steps he took, namely checking with the patient and completing the skin check himself. The panel gave the hearsay evidence of Patient G significant weight because while there was no note of Patient G's account which they gave to Raynel Amora, Raynel Amora's evidence was that Patient G had capacity and Raynel Amora was able to tell the panel clearly what Patient G had said to him. The panel therefore found charge 6 proved in respect of the allegation that you had stated you had checked Patient G's skin when you had not.

With regard to the part of the allegation relating to changing Patient G's wound dressing, the panel noted Raynel Amora's oral evidence that that issue was in respect of a different patient (not Patient G) on a different occasion. The panel noted that there was no application from the NMC to amend this part of the charge to reflect Raynel Amora's oral evidence, and in light of this, and the fact that the NMC had already amended this allegation earlier in the hearing, the panel did not consider it fair or appropriate to amend at this late stage during panel deliberations. On this basis, the panel was unable to find this part of the allegation proved.

**Charge 7**

7. Your actions at charge 6 were dishonest in that you sought to cover up that you had failed to provide patient care.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 6.

The panel reminded itself of the guidance set out in *Ivey v Genting Casinos*. The panel first considered your actual state of knowledge or belief as to the facts and then considered whether your conduct would be regarded as dishonest by the standards of ordinary decent people.

In applying the dishonesty test, the panel considered what your actual state of knowledge or belief at the time was. The panel concluded that as a registered nurse, you knew that you had not checked Patient G's skin when you had told Raynel Amora that you had. In coming to this conclusion, the panel considered alternative explanations such as making a mistake or being confused. The panel concluded that these were not plausible explanations, particularly because there is no suggestion in the evidence that you were unable to remember, because of, for example, intense pressure of work or stress. The evidence however was clear that you were being supervised, and your performance was being assessed daily. In all the circumstances, the panel concluded that, on the balance of probabilities, you were motivated by a wish to conceal that you had not checked Patient G's skin when you knew that you should have done. This desire to conceal would be considered dishonest by the standards of ordinary decent people. The panel therefore found this charge proved.

**Charge 8a**

8. On 2 February 2023:

a. Recorded on Kardex that Patient H had been administered paracetamol at 14.00 when they had not ;

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence of Ernestina Giovannoli, as well as your evidence.

Ernestina Giovannoli's evidence was that, at around 12:30, she walked past Patient H's room, saw a medication cup, entered the room and found paracetamol in the cup. She then checked the Kardex and saw that the 14:00 dose had already been signed as administered.

The panel also considered your evidence that you had administered the paracetamol at around 14:00 and that the conversation with Ernestina Giovannoli at around 12:30 did not occur.

The panel considered whether there was any plausible alternative explanation, such as the medication cup relating to an earlier dose. However, it noted the evidence that the earlier dose had been administered by you at a time prior to 11:30, and there was no evidence that another person had dispensed the 14:00 paracetamol and left it in the room.

Taking into account all of the evidence, the panel preferred Ernestina Giovannoli's clear evidence that she found the paracetamol in the room before 14:00 and that the Kardex had already been signed.
The panel was therefore satisfied, on the balance of probabilities, that you had recorded on the Kardex that Patient H had been administered paracetamol at 14:00 when they had not. The panel find charge 8a proved.

**Charge 8b**

8b. Left Patient's H's paracetamol in their room when it was unsafe.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence of Ernestina Giovannoli, as well as your evidence.

Ernestina Giovannoli's evidence was clear that she found paracetamol in a medication cup in Patient H's room before the medication had been administered. The panel also accepted the evidence that Patient H had dementia and that, in those circumstances, medication should not have been left unsupervised in the patient's room.

The panel noted that a nurse administering medication to such a patient should ensure that the patient actually takes the medication, or otherwise record that it has not been administered. The panel considered that leaving paracetamol unattended in the room creates a risk that the patient may take it at the wrong time, not take it at all, or take it without appropriate supervision.

The panel preferred Ernestina Giovannoli's evidence to your denial. There was no evidence that anyone else had left the medication cup in Patient H's room after you had administered the earlier medication to Patient H. It was satisfied, on the balance of probabilities, that you left Patient H's paracetamol in their room when it was unsafe to do so. Accordingly, the panel find charge 8b proved.

**Charge 9**

9. Your actions at charge 8a were dishonest in that you recorded that paracetamol had been administered at 14.00 when it had not.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 8a.

The panel went on to consider whether your actions in charge 8a were dishonest.

The panel applied the test for dishonesty as set out in *Ivey v Genting Casinos*. The panel first considered your actual state of knowledge or belief as to the facts and then considered whether your conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel found that you knew that Patient H had not been administered paracetamol at 14:00 when you had recorded that it had been administered. It also found that you had signed the Kardex in advance, thereby making it appear that the medication had been administered when it had not.

The panel considered whether recording the administration of paracetamol at 14:00 could have been a mistake. The panel considered that there is no plausible explanation other than you intended that your entry on the Kardex created a knowingly false impression to conceal the fact that you did not administer the medication at the correct time.

The panel then considered whether ordinary decent people would regard your conduct as dishonest and determined that they would because you wished to deliberately present a position that was not true. The panel further considered that medication records are important patient safety documents, and accurately recording administration is a fundamental nursing responsibility. The panel was of the view that recording medication as administered when it had not been administered would be regarded as dishonest by ordinary decent people. Taking all of this into account, the panel find charge 9 proved.

**Charge 10**

10. In January 2024 stated to Colleague A that you had passed a training course in relation to resuscitation when you had not.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and written evidence of Gemma Jones, as well as your evidence.

The panel noted Gemma Jones' evidence that you had told her that you had passed the training course. The panel also noted Gemma Jones' oral evidence that she was familiar with your communication style, that she would often ask you to repeat yourself and that she did not consider there had been a miscommunication with you at the time.

However, the panel also considered your evidence. You told the panel that you had not said that you had passed the training course, but that you had said words to the effect that the training course was "done" or "over". The panel considered whether this was capable of being misunderstood, particularly in the context of the wider evidence about communication difficulties, including from Gemma Jones herself.

The panel also considered that you knew the result of the course would be provided to Gemma Jones shortly afterwards. The panel considered it unlikely that you would deliberately tell Gemma Jones you had passed, when you knew that Gemma Jones would be imminently receiving confirmation at the time that you had not passed.

Taking all of this into account, the panel concluded that there was a realistic possibility of miscommunication or misunderstanding. It was therefore not satisfied, on the balance of probabilities, that you had stated to Gemma Jones that you had passed the training course. The panel therefore finds charge 10 not proved.

**Charge 11**

11. Your actions at charge 10 were dishonest in that you sought to mislead Colleague A as to your clinical competence.

**This charge is found NOT proved.**

In light of the panel's findings at charge 10, charge 11 falls away.

**Charge 13a**

13. On 10 January 2024:

a. Stated that a Patient I had been offered analgesia and refused when they had not;

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and written evidence of Gemma Jones, as well as your evidence.

The panel noted that part of the evidence relied upon by the NMC included comments which have been made by Patient I, which amount to hearsay evidence. The panel approached that evidence with appropriate caution. However, the panel also considered that Gemma Jones gave direct evidence regarding her own observations and interactions with both the patient and with you.

The panel took into account Gemma Jones' evidence that she attended the patient with you present and that the patient stated they had not been offered analgesia. The panel noted there was no apparent reason for either Ms Jones or the patient to fabricate the account.

In this regard, the panel also had sight of your weekly progress review and development plan meeting notes dated 12 January 2024, in particular:

> *'- 10/1 – When I asked you stated the patient in room 11 had been offered analgesia and refused, I informed you that I had been with you in the room with the patient and you had not asked and the patient told me they had not been offered analgesia from lunch time and that there were in pain and would require some, at this you advised that it was earlier in the day you asked the patient however as with every other patient on the medication round you were aware we were talking about at that time and not earlier in the day. Sandeep stated that he*

*has asked this patient 15 minutes prior to this while checking vital signs and the patient had stated nothing was required.'*

The panel also considered your evidence that you had asked the patient earlier in the morning whether analgesia was required and that the patient had declined it at that time. However, the panel noted there was no contemporaneous documentation supporting this account, such as an entry recording that analgesia had been offered and refused.

The panel also noted that the allegation was not simply that analgesia had not been administered, but that you had stated that analgesia had been offered and refused, when this had not occurred.

The panel accepted that the NMC had not produced the underlying patient records in relation to this. However, weighing the evidence before it, the panel found Gemma Jones' account to be more persuasive and reliable than your explanation. Accordingly, the panel find charge 13(a) proved.

**Charge 13b**

b. Stated that you had measured Patient J's fluid output when you had not.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Gemma Jones and Cheryl Roberts, as well as your evidence.

The panel noted that the evidence before it demonstrates concerns regarding Patient J's fluid balance monitoring following catheter removal. The panel accepted the evidence that accurate fluid output measurement was clinically important in those circumstances.

The panel placed particular weight on the daily progress review notes dated 10 January 2024 completed by Cheryl Roberts, who was the supervising nurse on the ward at the relevant time. The panel accepted Cheryl Roberts' evidence that the fluid balance chart

had been retrospectively updated despite there being no proper measurement of the patient's urine output.

The panel also took into account your evidence. It considered your explanation that the patient was independent and mobilising to the toilet independently.

The panel further noted that your explanations regarding the measurement of the patient's urine output were unclear and did not clearly address the evidence before the panel that you had altered the fluid balance chart retrospectively.

The panel found there was no evidence before it that the fluid output had been measured, including any evidence about how.

The panel therefore concluded that, on the balance of probabilities, you had stated that you had measured Patient J's fluid output when you had not done so and found charge 13b proved.

**Charge 14**

14. Your actions at Charge 13 were dishonest in that you stated that you had offered analgesia when you had not and had measured the fluid output when you had not.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 13.

The panel applied the test for dishonesty as set out in *Ivey v Genting Casinos*. The panel first considered your actual state of knowledge or belief as to the facts and then considered whether your conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel considered your actual state of knowledge or belief as to the facts at the relevant time. In relation to charge 13(a), the panel found that you knew that you had not

properly offered Patient I analgesia in the manner later recorded. In relation to charge 13(b), the panel found that you knew that Patient J's fluid output had not actually been measured before the fluid balance documentation was completed.

In coming to these decisions, the panel considered whether there was any alternative explanation, such as the making of an error through tiredness or pressure associated with workload, but there was no evidence of these matters. The panel concluded that you made these statements knowing that they were not true, and as a nurse under supervision and under some level of scrutiny, you wished to conceal your omissions.

The panel considered whether ordinary decent people would regard such conduct as dishonest. The panel concluded that they would as they were deliberate statements made to conceal what you had not done.

The panel therefore reached the conclusion that your actions amounted to attempts to conceal failures in patient care. The panel therefore found charge 14 proved.

**Fitness to practise**

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack

of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct, and/or lack of competence.

**Submissions on misconduct and lack of competence**

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

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.'*

Mr Rye submitted that the panel must first consider whether the facts found proved amount to lack of competence and/or misconduct, and if so, the panel must then decide whether your fitness to practise is currently impaired.

Mr Rye reminded the panel that there is no statutory definition of fitness to practise, but the panel must consider whether you are suitable to remain on the NMC register without restriction. He reminded the panel of its overarching statutory objective to protect the public, maintain public confidence in the profession, and uphold proper professional standards.

Mr Rye submitted that there is no burden or standard of proof at this stage and that the issues of lack of competence, misconduct and impairment are matters for the panel's professional judgment.

In relation to lack of competence, Mr Rye referred the panel to the NMC guidance, which describes lack of competence as usually involving an unacceptably low standard of professional performance which could put patients at risk. He also referred to the

cases of *Calhaem v GMC* and *Holton v GMC*, submitting that the panel must assess your performance against the standard reasonably expected of a competent practitioner in the circumstances.

Mr Rye submitted that you were employed as a Band 5 nurse and that your competence fell seriously short of the standards expected of a nurse at that level. He acknowledged the context that you were new to the UK and unfamiliar with some systems and procedures. However, Mr Rye submitted that, despite significant support over a prolonged period of approximately three years, you continued to make fundamental errors across basic and wide-ranging areas of nursing practice.

Mr Rye submitted that the evidence showed repeated concerns in relation to medication administration, documentation, wound care and basic patient care. He referred to witness evidence that your progress was much slower than expected and that, despite supervision, you were not safe to practise without support. Mr Rye invited the panel to find that the facts found proved at charge 1 demonstrated a lack of competence.

Mr Rye then referred the panel to the relevant provisions of the NMC Code. This included the requirements to deliver fundamentals of care effectively, maintain knowledge and skills, communicate effectively, work with colleagues to preserve safety, complete accurate records, identify risks and reduce potential harm.

Mr Rye then moved on to misconduct. He referred the panel to *Roylance v GMC* and the NMC guidance on misconduct found at FTP-2a. He submitted that misconduct involves conduct falling seriously short of what is proper in the circumstances. Mr Rye reminded the panel that not every breach of the NMC Code amounts to misconduct but submitted that the facts found proved in this case were sufficiently serious.

Mr Rye then addressed the panel in relation to each of the charges in turn.

Mr Rye submitted that the dishonesty charges were particularly serious. In relation to charges 2, 3 and 4, he submitted that you failed to administer medication and then sought to cover this up by forging a colleague’s signature and telling a colleague that

the medication had been administered when it had not. He submitted that this was not at the lower end of dishonesty, and that it was deliberate, premeditated, relates to clinical practice and is a serious breach of trust.

In relation to charges 6 and 7, Mr Rye submitted that you failed to provide basic care by not undertaking a skin check and then acted dishonestly to cover that up. He submitted that this placed a vulnerable patient at risk and breached the duty of candour.

In relation to charges 8a and 9, Mr Rye submitted that recording medication as administered when it had not been administered was serious because other staff would rely on that record, creating a risk of harm.

In relation to charge 8b, Mr Rye submitted that leaving paracetamol in Patient H's room was serious because of the risk that the patient could take medication unsafely or at the wrong time.

In relation to charge 12, Mr Rye submitted that copying and pasting clinical notes failed to provide an accurate picture of care and created a risk that other clinicians would not have the information needed to make appropriate decisions.

In relation to charges 13 and 14, Mr Rye submitted that these involved failures in basic care and dishonesty linked directly to clinical practice. He submitted that you had sought to cover up failures in relation to analgesia and fluid output monitoring.

Mr Rye invited the panel to find that the facts found proved amounted to misconduct, including breaches of fundamental tenets of the profession, conduct which brought the profession into disrepute, and a pattern of dishonesty linked to your clinical practice.

Ms Deery submitted that your position is that your fitness to practise is not currently impaired.

In relation to lack of competence, Ms Deery submitted that the panel should consider the relevant NMC guidance and *Holton v GMC*. She submitted that the panel should

take account of your field of practice, professional background, the policies and procedures applicable to the area in which you worked, and the amount and consistency of support provided to you.

Ms Deery reminded the panel that you are an international nurse from India, with previous experience in outpatient ophthalmology, theatre and emergency department settings, which are not fields that you have experienced at the Hospital. Ms Deery explained to the panel that you faced both professional and personal challenges adapting to nursing practice in the UK.

Ms Deery submitted that support for you was limited at times. She reminded the panel of the evidence that your theatre mentorship and capability process stopped in October 2021 and that no formal support resumed until your move to the ward in March 2022. She submitted that this left a period of around six months, during your early nursing practice in the UK, when there was no formal support in place for you.

Ms Deery further submitted that there was a lack of consistency in supervision and mentorship for you, particularly in the ward environment. You had several mentors and supervisors, and Ms Deery reminded the panel of evidence from Michelle McCartan that more support could have been provided for you in relation to documentation.

Ms Deery invited the panel to find that the concerns may reflect limited or inconsistent support for an international nurse adapting to UK practice, rather than a lack of competence.

Ms Deery then moved on to address the panel in relation to misconduct. Ms Deery accepted that a number of charges related to alleged misconduct, including charges involving dishonesty. She referred the panel to *Roylance v GMC* and *Remedy UK Ltd v GMC [2010] EWHC 1245 (Admin)*. Ms Deery submitted that the panel must assess whether each charge is sufficiently serious to amount to misconduct.

Ms Deery submitted that not every falling short and not every breach of the NMC Code amounts to misconduct. She accepted that the misconduct charges arose in the context of your professional practice and may fall within the first category of misconduct as

identified in *Remedy UK Ltd v GMC*, but submitted that the panel must consider each charge individually and assess the gravity of the conduct.

Ms Deery submitted that whether misconduct is established is ultimately a matter for the panel's judgment.

**Submissions on impairment**

Mr Rye moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2), Grant [2011] EWHC 927 (Admin)* and *Yeong v GMC [2009] EWHC 1923*.

Mr Rye submitted that all four limbs of the *Grant* test were engaged, in that you had placed patients at an unwarranted risk of harm, brought the profession into disrepute, breached fundamental tenets of the profession, and acted dishonestly.

Mr Rye submitted that although some clinical failings may be remediable, dishonesty is more difficult to address, particularly where it is serious, repeated and directly linked to clinical practice. He submitted that there was insufficient evidence that you had fully remediated the concerns. Mr Rye noted that you had been subject to restrictions and there was no evidence that you had since worked in a healthcare role where you have demonstrated a period of safe practice, competence, openness or transparency.

Mr Rye submitted that there remained a risk of repetition and therefore a finding of current impairment was required on public protection grounds.

Mr Rye further submitted that a finding of impairment was required on public interest grounds. He submitted that, given the seriousness of the clinical failings and dishonesty, a well-informed member of the public would be concerned if impairment were not found.

He submitted that public confidence in the profession and proper professional standards would be undermined without such a finding.

Mr Rye invited the panel to find your fitness to practise currently impaired on both public protection and public interest grounds.

In relation to impairment, Ms Deery submitted that a finding of lack of competence, misconduct or a breach of the NMC Code does not automatically lead to a finding of current impairment. She reminded the panel that impairment is a forward-looking assessment, and that it must decide whether your fitness to practise is impaired as of today. Ms Deery submitted that context is of particular importance in this case and that the panel should consider your personal and professional circumstances surrounding the concerns.

Ms Deery submitted that you had taken steps to strengthen your practice. She referred the panel to your reflective statement and submitted that it demonstrated insight, remorse and engagement with relevant areas of the NMC Code.

Ms Deery reminded the panel that you made 11 admissions at the outset of the hearing, which amounted to nearly half of the charges against you. She submitted that you had fully engaged with the hearing, the NMC and your previous employer. Ms Deery further submitted that you had completed training in wound management, medication management and administration, and honest communication and referred the panel to the corresponding training certificates included within your registrant's bundle.

Ms Deery invited the panel to take into account your previous professional background, including your unblemished record in India with no previous regulatory issues. She also referred the panel to a positive testimonial from a previous nursing colleague dated 30 March 2025.

Ms Deery accepted that this case involved dishonesty, but submitted that it was not dishonesty sustained over a significant period and did not demonstrate a deep-seated

attitudinal issue. She reminded the panel that one dishonesty matter had been admitted by you, and related to events that took place more than three years ago.

Ms Deery submitted that a perceived need for sanction should not drive a finding of impairment. She submitted that the panel must make a finding of current impairment only if it is satisfied that you are currently impaired.

Ms Deery invited the panel to find that there may not be a lack of competence. She accepted that misconduct was a matter for the panel's judgment. She submitted however that if the panel did find a lack of competence and/or misconduct, that your fitness to practise is not currently impaired on either public protection or public interest grounds.

The panel heard and accepted the advice of the legal assessor, which included reference to a number of relevant judgments.

**Decision and reasons on misconduct and lack of competence**

The panel had regard to the submissions made by Mr Rye on behalf of the NMC and by Ms Deery on behalf of you. The panel was aware that there is no burden or standard of proof at this stage and that the issues of lack of competence, misconduct and impairment are matters for the panel's own professional judgment.

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

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

In respect of lack of competence:

*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*

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

*8.2 maintain effective communication with colleagues*
*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*

*9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

*10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
*10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

*19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*
*To achieve this, you must:*
*19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
*19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*
*Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive.*

*22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance*

In respect of misconduct:

*1.2 make sure you deliver the fundamentals of care effectively*

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

*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*

*19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice*

*20.1 keep to and uphold the standards and values set out in the Code*
*20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
*20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
*20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

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

The panel first considered whether the facts found proved amounted to lack of competence. It had regard to the NMC Guidance on Lack of competence found at FTP-2b. The panel noted that lack of competence usually involves an unacceptably low standard of professional performance, judged on a fair sample of the registrant's work, which could put patients at risk.

The panel also had regard to *Calhaem v GMC* and *Holton v GMC.* It reminded itself that a single instance of substandard performance will not necessarily amount to lack of competence, and that the panel must assess whether there was a fair sample of work demonstrating performance below the standard expected of a competent practitioner in the circumstances.

The panel considered the charges found proved in relation to charge 1, including concerns relating to medication administration, fluid balance monitoring, clinical documentation and wound care. The panel considered that these are fundamental aspects of nursing practice that would be expected of a Band 5. The panel found that these were not isolated incidents and had occurred across a prolonged period and across different clinical settings as demonstrated by the dates in schedules 1 to 4. They related to repeated failures in basic nursing care, documentation, medication safety, wound care, communication and professional accountability.

The panel noted that you had been subject to a prolonged period of supervision and capability management. It accepted that you were an international nurse adapting to practice in the UK and that there had been some inconsistency in the support provided to you. The panel also took into account that there had been a gap in formal support for you between October 2021 and March 2022. However, the panel considered that this did not adequately explain the repeated and fundamental nature of the concerns, particularly as many of the proved matters occurred outside that time period, and after significant support had been provided to you.

The panel accepted the NMC witness evidence from senior nursing colleagues that, despite support, supervision and attempts to assist you to improve, fundamental errors continued to occur. The panel considered that, over a period of approximately three years, there should have been clear evidence of sustained competence, but there was not.

The panel concluded that the facts found proved in charge 1 demonstrated an unacceptably low standard of professional performance across a fair sample of your

work. The panel therefore found that the facts found proved amounted to lack of competence.

The panel then considered whether the facts found proved amounted to misconduct. It had regard to the NMC guidance on misconduct found at FTP-2a and to the case of *Roylance v GMC*, which describes misconduct as conduct falling short of what would be proper in the circumstances. The panel reminded itself that not every breach of the NMC Code, and not every clinical failing, will amount to misconduct, and that the conduct must be sufficiently serious.

The panel then considered the misconduct charges in groups.

**Charges 2, 3 and 4**

In relation to charges 2, 3 and 4, the panel found that you failed to administer medication and then dishonestly sought to cover this up, including by forging a colleague's signature and denying the failure. The panel considered this conduct to be very serious. It involved falsification of clinical records, dishonesty through attempting to implicate a colleague in a critical matter of patient care, a breach of trust with colleagues, and a risk to patient safety through the non-administration of a critical medication.

**Charges 6, 7, 13 and 14**

In relation to charges 6 and 7, the panel found that you dishonestly stated that you had checked a patient's skin when you had not.

In relation to charges 13 and 14, the panel found that you dishonestly stated that analgesia had been offered and refused, and that fluid output had been measured, when that was not the case.

The panel considered that these matters involved basic care, misleading colleagues, inaccurate clinical information and dishonesty linked directly to clinical practice.

**Charges 8a, 8b and 9**

In relation to charges 8a, 8b and 9, the panel found that you recorded medication as administered when it had not been, and left medication in a patient's room when it was unsafe. The panel considered this to be serious because medication records are relied upon by colleagues and inaccurate records create a direct risk to patient safety. The dishonesty in this case was serious due to the potential direct consequences of incorrect recording of pain relief medication to a patient.

**Charge 12**

In relation to charge 12, the panel found that copying and pasting clinical notes was serious because it failed to provide an accurate picture of the care provided and could affect future clinical decision-making.

The panel found that your dishonesty was deliberate and that you had intended to protect yourself from scrutiny or criticism. It considered that your conduct placed your own interests above patient safety and professional candour. The panel found that the dishonesty was not a single isolated incident, but a pattern of dishonest conduct linked to your clinical practice.

Taking all of this into account, the panel concluded that the facts found proved fell seriously short of the standards expected of a registered nurse. It found that your conduct breached fundamental tenets of the profession, including honesty, integrity, patient safety, accurate record keeping and the duty of candour.

The panel therefore found that the facts found proved amounted to misconduct in charges 2, 3, 4, 6, 7, 8, 9, 12, 13 and 14.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct and lack of competence, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: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.'*

The panel also had regard to the NMC Guidance on Insight and strengthened practice, found at FTP-16, Can the concern be addressed at FTP-16a, Has the concern been addressed at FTP-16b and Is it highly unlikely that the conduct will be repeated at FTP-16c.

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

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

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

In paragraph 76, Mrs Justice Cox referred to the test of impairment which reads as follows:

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

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

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

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

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

The panel found all four limbs of Grant to be engaged in this case. The panel finds that patients were put at risk of physical harm as a result of your misconduct and lack of competence. Your misconduct and lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel accepted that some of the clinical failings were capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you has taken steps to strengthen your practice. It noted that you have fully engaged with the NMC process, made admissions to a number of the charges, provided a reflective piece, and completed some training in wound management, medication management and honest communication.

However, the panel considered that the evidence of remediation was limited. It was of the view that the training you have undertaken, evidenced by your training certificates, was not sufficient to address the seriousness of the clinical concerns identified in this case. The panel also had no recent evidence of safe practice in a healthcare setting, no recent relevant workplace references, and no evidence that you had demonstrated sustained competence, honesty and candour in nursing practice since the events took place.

The panel also considered your reflective piece. The panel found that it demonstrated some insight and some remorse. However, the panel considered that your insight was limited, and at times, you continued to attribute your failings to external factors, including supervision arrangements, communication difficulties and workplace structure, rather than fully accepting personal accountability as a Band 5 registered nurse.

The panel then considered whether there was a risk of repetition. It found that the clinical concerns were wide-ranging and repeated, relating to fundamental nursing responsibilities, including medication administration, wound care, documentation, escalation, fluid balance and patient care. The panel noted that these concerns occurred despite you being subject to extensive supervision, mentoring and a capability process.

The panel also considered the aspect of dishonesty. It noted that dishonesty is particularly serious and is difficult to remediate. It found that you had acted dishonestly on more than one occasion, and that the dishonesty was linked directly to patient care, clinical records and your interactions with colleagues.

The panel was of the view that it did not have sufficient evidence before it that you had fully remediated the dishonesty concerns or that there was a minimal risk of repetition in this case. The panel was therefore of the view that there remained a real risk that you could repeat similar conduct if you were permitted to practise as a nurse without restriction. The panel therefore found your fitness to practise impaired on public protection grounds.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

The panel also had regard to the need to promote and maintain public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions, as set out in *Grant* and *Yeong v GMC*.

The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made in a case involving repeated clinical failings, inaccurate records, medication concerns and dishonesty linked to clinical practice. It concluded that public confidence in the nursing profession and in the NMC as regulator would be seriously undermined if a finding of current impairment were not made. The panel therefore also finds your fitness to practise impaired on the grounds of public interest.

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

The hearing adjourned on 14 May 2026 and resumed on 14 August 2026.

**Sanction**

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance including The purpose of and approach to sanctions (reference SAN-1), The sanctions available (reference: SAN-2), deciding between suspension and strike-off (reference SAN-3), and Sanctions for the highest risk cases (reference SAN-4).

The panel accepted the advice of the legal assessor.

**Submissions on sanction**

Ms Ewulo submitted that whilst sanction is a matter for the panel's independent professional judgment, the NMC's position is that the appropriate and proportionate sanction in this case is a striking-off order. She reminded the panel that it should exercise its own independent judgment when determining what sanction, if any, to impose, having had regard to the NMC's Sanction Guidance.

Ms Ewulo submitted that the purpose of sanction is not punitive, but rather to protect the public and satisfy the wider public interest. She submitted that the panel should also have regard to the principle of proportionality and balance the need for public protection and the maintenance of public confidence and professional standards against your own interests.

Ms Ewulo then addressed the panel in relation to the aggravating features of this case.

Ms Ewulo submitted that there has been repeated and deliberate dishonesty, and that the panel had found dishonesty proved on four separate occasions across the time period covered by the charges, involving different patients and occurring on different dates between February 2023 and January 2024. She submitted that this was not a single lapse of judgment and represented a pattern of dishonest conduct.

Ms Ewulo then referred the panel to the falsification of clinical records and forgery in relation to charge 3(a), where you had forged a colleague's signature so as to make it appear that critical medication had been administered, when it had not. In relation to charges 2, 3 and 4, the panel had found that you had failed to administer medication and had dishonestly sought to conceal that failure, including by forging your colleague's signature and denying that the failure had occurred.

Ms Ewulo submitted that the panel in its findings had regarded this conduct as very serious, involving the falsification of clinical records, dishonesty, an attempt to implicate

a colleague in a critical matter of patient care, a breach of trust with colleagues and a risk to patient safety arising from the non-administration of critical medication.

Ms Ewulo submitted that a further aggravating feature is that the dishonesty identified in this case is directly connected to clinical practice and patient safety, concerning the concealment of failures in direct patient care, including medication administration, wound checks, analgesia and fluid balance monitoring.

Ms Ewulo submitted that in relation to charges 6, 7, 13 and 14, the panel had considered that the matters involved basic care, misleading colleagues, inaccurate recording of information and dishonesty directly linked to clinical practice.

Ms Ewulo also identified a breach of the professional duty of candour. She submitted that in relation to charges 7 and 14, the panel had found that you were motivated by a wish to conceal that you had not provided care which you ought to have provided.

Ms Ewulo in her submissions referred to the involvement of a vulnerable patient, Patient H, who had dementia. Patient H's paracetamol had been falsely recorded as administered and the patient had been left unsupervised in their room with the paracetamol. In relation to charges 8(a), 8(b) and 9, the panel had considered the dishonesty to be serious because of the potential direct consequences arising from the incorrect recording of pain relief medication as having been administered to a patient.

Ms Ewulo also identified a sustained pattern of lack of competence over a significant period. She submitted that the panel's findings in relation to charge 1 spanned from August 2021 to November 2023 and concerned medication administration, fluid balance recording, documentation, wound care and record keeping, all of which are fundamental aspects of safe nursing practice.

Ms Ewulo submitted that these are all not isolated incidents but rather occurred over a prolonged period and across different clinical settings, as demonstrated by the dates and matters contained within Schedules 1, 2, 3 and 4. She submitted that there had

been repeated failures concerning basic nursing care, documentation, medication safety, wound care, communication and professional accountability.

Ms Ewulo submitted that the panel was of the view that, over a period of approximately three years, there ought to have been clear evidence of sustained competence from you, but there is not.

Ms Ewulo also relied upon the panel's finding of limited insight. She submitted that whilst you have provided a reflective statement, the panel had found that your insight remained limited and that you continued to attribute your failings to external factors rather than accepting personal accountability. She also submitted that there is limited evidence of remediation, and the panel had also identified a continuing risk of repetition.

Ms Ewulo then moved on and addressed the panel in relation to the mitigating features of this case.
Ms Ewulo submitted that at the outset of the hearing, you had made substantial admissions, which included admissions to charges involving dishonesty. You have also fully engaged with the regulatory process, including attending throughout the hearing, giving evidence, undertaking training and providing a reflective statement. She also submitted that whilst the panel had found that your reflective statement demonstrated some insight and remorse, it maintained that your insight remained limited.

Ms Ewulo also referred the panel to the context surrounding your transition into UK nursing practice. You were an international nurse who had come to the UK having previously worked in different clinical settings. She submitted that the panel had accepted that formal support and mentorship had been inconsistent for you, including a six-month period between October 2021 and March 2022 during which there had been no formal capability support in place.

Ms Ewulo referred the panel to your reflective piece, in which you stated that you had felt undermined and criticised, and that you felt as though everyone was waiting for you to make your next mistake. You accepted however that this did not excuse your actions.

Ms Ewulo acknowledged in her submissions that the lack of competence in this case had occurred against a background of insufficient support and supervision.

Ms Ewulo then addressed the panel in relation to the sanctions available.
Ms Ewulo submitted that taking no further action would not be appropriate or proportionate in this case, and that such an outcome is reserved for rare cases where a finding of current impairment coexisted with there being no continuing risk requiring management or marking. She referred the panel to its finding of a real risk of repetition and that your fitness to practise is impaired on both public protection and public interest grounds. She submitted that taking no further action would leave the public unprotected and would fail adequately to mark the seriousness of repeated and deliberate dishonesty directly connected with patient care.

Ms Ewulo submitted that a caution order would also be insufficient in this case. She submitted that a caution order would ordinarily be appropriate where there is no real risk to the public requiring restriction of a registrant's practice, and where the case sat towards the lower end of the spectrum of impaired fitness to practise. Ms Ewulo submitted that this is not the position in this case, given that the panel has found a real risk of repetition and the dishonesty had been repeated and deliberate. She submitted that a caution order would neither protect the public nor sufficiently satisfy the public interest and was therefore not appropriate nor proportionate.

In relation to a conditions of practice order, Ms Ewulo submitted that the key question for this panel is whether workable, relevant, proportionate and measurable conditions could be formulated which would adequately address the concerns identified. She submitted that it is accepted that if this case concerned lack of competence alone, conditions of practice might potentially be capable of addressing those concerns.

Ms Ewulo submitted that the concerns in this case however are not confined to clinical competence, and also involve misconduct, including deliberate dishonesty directly linked to clinical record keeping and communications with colleagues. She submitted that in these circumstances, to impose conditions of practice would therefore be

inappropriate, and that conditions of practice are more suitable where there is no evidence of deep-seated attitudinal concerns.

Ms Ewulo then addressed the panel in relation to a suspension order. She referred the panel to the NMC Sanction Guidance on Suspension order (Reference SAN-2d), which sets out that suspension might be appropriate where misconduct was very serious, but was not fundamentally incompatible with continued registration, and where an outcome less severe than striking off would nevertheless satisfy the overarching objective.

Ms Ewulo submitted that it is the NMC's position that the seriousness of this case required more than a temporary removal from the NMC register. She submitted that this case involved repeated dishonesty, including the forgery of a colleague's signature, which was directly connected to patient care. She further submitted that there had also been a pattern of repeated dishonesty and deliberate breaches of the duty of candour through covering up failures and falsifying records. Ms Ewulo submitted that there is no recent evidence capable of satisfying the panel that a period of suspension, however long, would by itself resolve the risk of repetition, particularly given the panel's finding that your insight remained limited.

Ms Ewulo submitted that a striking-off order is the appropriate and proportionate sanction in this case.

Ms Ewulo invited the panel to consider whether the charges found proved raise fundamental questions about your professionalism, namely whether public confidence in the profession could be maintained if you were not removed from the NMC register, whether any amount of insight and reflection could sufficiently protect people receiving care, maintain public confidence and uphold professional standards, and whether there was a realistic prospect that, following a period of suspension, you would gain sufficient insight and strengthen your practice so that the risk you posed would reduce.

Ms Ewulo submitted that it is the NMC's case that the repeated and deliberate nature of the dishonesty, spanning four separate incidents and including the forgery of a colleague's signature, raises fundamental questions about your professionalism. She

submitted that the dishonesty directly concerned the accuracy of clinical records upon which colleagues relied for patient safety.

Ms Ewulo submitted that public confidence in the nursing profession would be undermined if a registrant who had repeatedly concealed failures in direct patient care were permitted to remain on the NMC register. She further submitted that there was no realistic amount of insight or reflection presently demonstrated which could adequately address the public protection and public interest concerns. Ms Ewulo submitted that there is therefore no realistic prospect that a period of suspension would result in you gaining sufficient insight and strengthening your practice to such an extent that the identified risk would be reduced.

Ms Ewulo submitted that this panel has already found your insight to be limited and the evidence of remediation provided to be insufficient. In particular, the panel had found that the training evidenced by the certificates provided was not sufficient to address the seriousness of the clinical concerns identified in this case. The panel had also noted that there was no real evidence of safe practice in a healthcare setting, no recent relevant workplace references, and no evidence that you had demonstrated sustained competence, honesty and candour in nursing practice since the events in question.

Ms Ewulo referred the panel to the NMC Guidance on Sanctions for the highest risk cases (Reference SAN-4), and Making decisions on dishonesty charges and the professional duty of candour (Reference FtP-2a-iii). She submitted that this guidance identified dishonesty and breaches of the professional duty of candour amongst the categories of concern most likely to attract the strongest sanctions because of their impact upon public safety, public confidence and the maintenance of professional standards.

Ms Ewulo submitted that this panel had found that your dishonesty was deliberate and that you had intended to protect yourself from scrutiny or criticism. She submitted that your conduct placed your own interests above patient safety and professional candour. The dishonesty was not an isolated incident but constituted a pattern of dishonest conduct connected directly with your clinical practice.

Ms Ewulo submitted that the NMC Guidance identified particular forms of dishonesty which were likely to require consideration of striking off. These included deliberately breaching the professional duty of candour by covering up matters when things had gone wrong, particularly where this caused or created a risk of harm to people receiving care, as well as premeditated, systematic or longstanding deception.

Ms Ewulo submitted that having regard to the repeated dishonesty over an extended period, the panel's finding of limited insight, the limited evidence of remediation and the prolonged pattern of lack of competence, nothing short of striking off would be sufficient to protect the public and maintain public confidence in the nursing profession.

Ms Ewulo therefore submitted that a striking-off order is the appropriate and proportionate sanction, and such an order is necessary to protect the public, maintain public confidence in the profession and uphold proper professional standards by making clear that your conduct is unacceptable for a registered professional. She submitted that a striking-off order is the only order capable of adequately meeting the public protection and public interest concerns identified in this case.

Ms Deery submitted that it is your primary position that a conditions of practice order would be the appropriate and proportionate sanction in this case. She submitted that if the panel was not with her on conditions of practice, that a suspension order would be appropriate.

Ms Deery submitted that it is strongly contended that, in all the circumstances of the case, you should not be subject to the most onerous sanction of a striking-off order.

Ms Deery reminded the panel that the principle of proportionality should be at the core of any decision on sanction. She submitted that rights had to be fairly balanced against the overarching objective identified by the panel, and any sanction imposed should go no further than necessary to achieve that objective.

Ms Deery also submitted that the sanction should be proportionate both to the facts of the case and to the impairment found proved. It should be the least restrictive sanction capable of protecting the public by reducing any risk posed by you, while also taking account of the reasons for the finding of impairment and the relevant aggravating and mitigating factors.

Ms Deery further reminded the panel that the purpose of sanction is to protect the public, through public protection, maintaining confidence in the nursing profession or upholding proper professional standards, and it is not to punish you.

Ms Deery then addressed the panel in relation to aggravating features. She referred the panel to the NMC Guidance on The purpose of and approach to sanctions (reference SAN-1), which provides the following examples of potential aggravating factors: abuse of a position of trust, conduct which deliberately or recklessly placed patients at risk of harm, deliberate breaches of the Code, a pattern of misconduct over time, previous regulatory or disciplinary findings, dishonesty when giving evidence, failure to engage with the fitness to practise process, limited or absent insight, the vulnerability of patients, premeditated or predatory behaviour and a failure to work collaboratively with colleagues.

Ms Deery submitted that a number of these factors are not present in this case, and that there is no evidence that you had abused a position of trust, no evidence of predatory behaviour and no evidence that you had failed to work collaboratively with colleagues.

Ms Deery submitted that you otherwise had a positive professional history. She informed the panel that there had been no concerns raised by previous employers and no previous regulatory findings against you. She reminded the panel that you had worked as a registered nurse in India for approximately seven years without difficulty.

Ms Deery addressed the fact that the panel had found proved a number of charges which you had denied. She submitted that the fact that those charges had been found proved did not mean that you had been dishonest in giving evidence to the panel. Ms Deery reminded the panel of the applicable burden and standard of proof in regulatory

proceedings and emphasised that you were entitled to defend yourself and maintain your defence throughout these proceedings.

Ms Deery submitted that you have fully engaged with the fitness to practise process. She noted that this substantive hearing was an adjourned hearing, having previously been adjourned in May 2026 due to a lack of time, and that you had continued to engage with the NMC and attend throughout the proceedings. She further submitted that you had also demonstrated some insight and remorse, which is evidenced by your reflective statement which had been acknowledged by the panel within its decision on impairment.

Ms Deery then addressed the panel in relation to mitigating features. She referred the panel to the NMC Guidance on The purpose of and approach to sanctions (reference SAN-1), which identifies mitigating factors falling into two categories: insight and strengthening of practice, and personal mitigation. Ms Deery submitted that both categories are relevant to your circumstances.
In relation to insight and strengthening practice, Ms Deery referred to factors including early admissions, apologies to those affected, attempts to prevent recurrence or put matters right, evidence of safe and professional practice in the same or a similar role, relevant training, reflective accounts and evidence of maintaining professional knowledge.

Ms Deery submitted that many of these features applied to you. She submitted that you had made 11 full admissions at the outset of the hearing, representing nearly half of the charges against you. Ms Deery also reminded the panel of admissions you made at local level in 2023 in relation to charges 2, 3 and 4, which included one of the dishonesty matters.

Ms Deery submitted that you have also completed a number of e-learning courses that you should receive credit for doing so. The courses included training concerning wound management, communication and medication administration and are included within your registrant’s bundle. She submitted that this demonstrated an effort undertaken by

you to maintain your knowledge and remain up to date with your area of practice, as you have not worked as a registered nurse for some time.

Ms Deery also referenced your reflective statement. She submitted that it is noted that the panel had recognised that this demonstrated some remorse. Ms Deery submitted that you had also briefly addressed the impact of your behaviour and had also considered the relevant provisions of the NMC Code.

Ms Deery also referred the panel to the personal mitigation identified within the NMC Guidance at SAN-1, including periods of stress or illness, personal and financial hardship, the registrant's level of experience at the relevant time and the level of support available within the workplace.

Ms Deery reminded the panel that you are an internationally educated nurse from India, whose previous background had been in outpatient ophthalmology and an emergency department. She explained that you have faced both professional and personal challenges when adapting to nursing practice in the UK.

Ms Deery submitted that the support available to you had not been consistent and had, at times, been limited. You began working as a Band 5 nurse in theatres in February 2021, with your mentorship and capability process stopped in October 2021, and formal support did not resume until your delayed transfer to the ward in March 2022. Ms Deery submitted that there had therefore been a period of approximately six months during your first year of UK nursing practice when you had no formal support in place. There had been some inconsistency in supervision and mentorship, with a number of different supervisors and mentors involved in your development. Ms Deery reminded the panel that it had itself recognised this gap in formal support within its impairment decision. Ms Deery submitted that it is accepted that some aggravating factors are engaged in this case. She submitted that despite this, there is also a significant degree of mitigation which the panel should take into account when assessing sanction.

Ms Deery submitted that it is accepted that taking no further action would not be appropriate, and that such an outcome was reserved for exceptional cases. She also accepted that the conduct in this case is required to be marked by a sanction.

Ms Deery then addressed the panel on a caution order. She submitted that it is acknowledged that a caution would ordinarily be appropriate where there was no risk to patients or the public requiring restriction of a nurse's practice. She submitted that given that the panel had found your fitness to practise impaired on public protection grounds, a caution order would not be an appropriate sanction in this case.
Ms Deery submitted that a conditions of practice order is the appropriate sanction in this case. She referred the panel to the relevant NMC Guidance on Conditions of practice order (Reference SAN-2c), and the factors which may indicate that conditions are suitable, including where there is no evidence of deep-seated personality or attitudinal concerns, where there are identifiable areas of practice requiring assessment or retraining, where there is a realistic likelihood that concerns can be resolved, where the professional has the potential and willingness to respond positively to training, where patients can be kept safe; and where workable, measurable and monitorable conditions can be formulated.

Ms Deery submitted that there is no evidence of deep-seated personality or attitudinal concerns in this case. She further submitted that whilst the findings and admissions concerning dishonesty are acknowledged, the existence of dishonesty is not of itself sufficient to establish a deep-seated attitudinal problem.

Ms Deery submitted that there is a realistic prospect that the concerns regarding your clinical practice could be resolved. She reminded the panel that, within its impairment determination, it had recognised that some of the clinical failings were capable of being addressed. Ms Deery submitted that you are willing to undertake any further training required of you, and that workable and measurable conditions could be formulated which would adequately manage the identified public protection risk. She submitted that you would comply fully with any conditions imposed upon your practice.

Ms Deery provided the panel with example conditions of practice, requiring you to work for one substantive employer, prohibiting bank or agency work, and requiring appropriate supervision. She submitted that supervision could include direct supervision when administering or managing medication, undertaking wound care and completing clinical records until assessed as competent, with indirect supervision at other times. She further submitted that you could also be required to complete a further personal development plan and undertake additional relevant training.

Ms Deery acknowledged that the case also involved dishonesty concerns. However, she reminded the panel that those concerns arose within the context of matters such as medication administration and skin checks. She submitted that direct supervision within those areas of practice could mitigate the identified risks.

Ms Deery submitted that if the panel did not consider conditions of practice sufficient, the appropriate alternative would be a suspension order. She referred to the NMC Guidance indicating that suspension may be appropriate where the impairment is very serious but not fundamentally incompatible with continued registration, and where a sanction short of striking off would still satisfy the overarching objective. Ms Deery submitted that both considerations applied in this case.

Ms Deery accepted that the charges admitted and found proved were serious. However, she submitted that it remained entirely possible for you to become fit to practise safely in the future. She submitted that a period of suspension would allow you further opportunity to reflect, develop your professional skills, strengthen your insight and undertake further remediation.

Ms Deery addressed the panel's findings that your current insight was limited and that there was limited evidence of remediation and recent safe practice. She submitted that the panel should distinguish between your present position and your future potential. Ms Deery submitted that the fact that your insight and evidence of remediation are limited at present did not necessarily mean that this would remain the position following a period of suspension. She submitted that a suspension order could provide you with the

opportunity to address the outstanding concerns and demonstrate sufficient remediation in the future.

Ms Deery submitted that a striking-off order would be wholly disproportionate in the circumstances and that a lesser sanction was sufficient. She referred the panel to the NMC Guidance on Striking-off order (reference SAN-2e) which sets out that striking off is likely to be appropriate where a professional's conduct is fundamentally incompatible with continued registration. Ms Deery submitted that your conduct does not reach that threshold. She further submitted that striking off is both unnecessary and wholly disproportionate when considered against the circumstances of this case as a whole.

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

Ms Deery submitted that a conditions of practice order, or alternatively a suspension order, was capable of addressing the risks identified by the panel and meeting the justice of the case. She submitted that either sanction would also provide you with an opportunity to undertake further remediation and demonstrate that remediation to the NMC.

Ms Deery strongly contended that a striking-off order was neither necessary nor proportionate in all the circumstances. She invited the panel primarily to impose a conditions of practice order and, if it was not with her on that submission, to impose a suspension order.

**Decision and reasons on sanction**

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your repeated and deliberate dishonesty, involving four separate incidents between February 2023 and January 2024.
- The fact that your dishonesty was not a single isolated lapse of judgement, but formed a pattern of dishonest conduct connected with your clinical practice.
- The serious incident involving the forgery of a colleague's signature in connection with the recording of medication administration.
- A serious breach of trust with colleagues, particularly arising from the falsification of a colleague's signature and the creation of an inaccurate clinical record.
- Aspects of the dishonesty were directly connected with patient care and patient safety.
- Your attempts to conceal failures in care by recording that care had been provided when it had not.
- Your dishonesty involved breaches of the professional duty of candour.
- The involvement of a vulnerable patient, Patient H, who had dementia. You had falsely recorded Patient H's paracetamol as administered and the patient had been left unsupervised in their room with the paracetamol.

- Repeated failures concerning fundamental aspects of nursing care, including medication administration, record keeping, wound care, fluid balance monitoring, communication and professional accountability.
- A sustained period of lack of competence, rather than isolated clinical failings.
- Your limited insight and remediation, including limited reflection upon the wider impact of your dishonest conduct.

- The absence of any significant additional evidence of strengthened insight or remediation since the panel's previous determination and the last sitting of the hearing in May 2026.

The panel also took into account the following mitigating features:

- You made 11 admissions at the outset of the hearing, which represented a significant proportion of the charges against you.
- You had also made admissions at a local level in relation to some of the matters.
- You have engaged fully with the NMC fitness to practise process and have continued to attend and participate in the proceedings, including following the adjournment of the hearing in May 2026.
- [PRIVATE]
- You have provided a reflective statement which demonstrated some insight and remorse. Within that reflective piece, you have expressly acknowledged that you have been dishonest, rather than seeking to avoid or minimise that issue.
- You have provided evidence of undertaking some relevant training, including e-learning concerning medication administration, wound management and communication.
- You have demonstrated a willingness to undertake further training and strengthen your practice.
- There had been a significant period during your early UK practice, between approximately October 2021 and March 2022, when formal mentorship and capability support was absent.
- You also experienced inconsistency in the supervision and mentorship available to you while adapting to UK nursing practice.

- You were an internationally educated nurse adapting to different clinical settings and systems in the UK.
- [PRIVATE]

Before moving on to consider the individual sanctions, the panel carefully considered the nature and seriousness of the dishonesty found proved, and where this conduct fell on the spectrum of seriousness.

In reaching its decision, the panel had particular regard to the NMC Guidance concerning Sanctions for the highest risk cases (reference SAN-4). It noted that the Guidance recognises the importance of honesty to professional practice and that cases involving dishonesty require careful assessment because not every instance of dishonesty is equally serious.

The panel also had particular regard to the following extract set out in the NMC Guidance:

> *'Cases involving dishonesty*
>
> *Honesty is of central importance to a professional's practice because of the large degree of trust placed in them. Therefore, allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy; because of this a professional who has acted dishonestly will always be at risk of strike-off. However, in every case the Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
> - *misuse of power*
> - *personal or financial gain from a breach of trust*
> - *direct risk to people receiving care*
> - premeditated, systematic or longstanding deception.

*Dishonest conduct will generally be less serious in cases of:*

- *one-off incidents*
- *spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice.*

*This is not an exhaustive list.*

*Professionals who have behaved dishonestly can engage with the Committee to:*

- *show that they feel remorse*
- *recognise that they acted in a dishonest way*
- *explain, with evidence, how this will not happen again.'*

The panel considered that you had deliberately concealed failures relating to patient care and, in particular, the medication incident involving the falsification of a colleague's signature created a direct risk in the context of patient care.

It also considered the NMC Guidance relating to dishonesty undertaken for personal or financial gain. It considered that your dishonest actions were intended to protect yourself from criticism or professional consequences arising from failures in your practice, and in that sense, there was a personal benefit to concealing those failures.

However, the panel did not consider that the evidence demonstrated an elaborate, systematic or pre-planned scheme of deception on your part. It however maintained its earlier findings that your dishonesty had been deliberate.

The panel recognised that the individual incidents were not necessarily of equal seriousness. In particular, the incident involving the failure to administer medication, the falsification of the clinical record and the forgery of a colleague's signature was more serious. The panel was of the view that when all four incidents are considered together, they demonstrate repeated dishonest behaviour over a period of approximately a year.

The panel remained satisfied, consistently with its earlier findings, that this represented serious and deliberate dishonesty, and it was not a single lapse or one-off error.

The panel also considered your insight into your dishonesty. It had sight of your reflective piece, which expressly states *'I deeply regret that I was dishonest'.* It also considered it significant that you had addressed dishonesty directly and had not entirely sought to avoid the issue. It also noted that your reflection also specifically addressed the forging of your colleague's signature.

The panel however was of the view that your insight remained limited, with much of your reflection concerning dishonesty focused upon the medication incident which you had admitted. The panel had subsequently found three further instances of dishonesty proved. It was of the view that there remained a need for substantially greater reflection upon the pattern of dishonest conduct as a whole, why it had occurred, its impact upon patients, colleagues and public confidence, and how you would ensure that such conduct would not happen again in the future.

The panel determined that whilst your dishonesty is sufficiently serious to require a significant restrictive sanction, it did not consider that all instances of dishonesty automatically required removal from the NMC register.

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 your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your 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 your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. 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 accepted that a number of the clinical concerns were potentially remediable, with identifiable areas of practice requiring further development, including medication administration, record keeping, wound care and other fundamental aspects of nursing practice.

The panel also took account of your willingness to comply with conditions and Ms Deery's suggested conditions, including working for one substantive employer, avoiding

bank or agency work, undertaking further training and being directly supervised in specified areas until assessed as competent.

The panel considered that conditions might have been capable of adequately addressing the concerns had this case concerned lack of competence alone. However, your impairment is not confined to clinical competence, and in part, arose from repeated and deliberate dishonesty directly connected with those clinical failings. The panel was of the view that there is evidence of an attitudinal concern arising from the repeated dishonesty. It was therefore not satisfied that restrictions upon clinical tasks, supervision or retraining by way of conditions of practice could adequately manage that concern.

The panel considered that conditions could not adequately address the public interest concerns arising from repeated dishonesty, falsification of records and the forgery of a colleague's signature. It therefore concluded that it could not formulate conditions which were sufficiently relevant, proportionate, workable and measurable to address the totality of the impairment.

The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

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

- *‘the charges found proved are at the most serious end of the spectrum and call into question the professional’s suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.’*

The panel recognised that this required particularly careful consideration because of the seriousness and repeated nature of the dishonesty.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with you remaining on the register, for the reasons set out below.

The panel was of the view that your sustained engagement with the regulatory process is significant. You had attended and participated in the proceedings throughout. [PRIVATE] The panel considered that this provided evidence of your commitment to engaging with the regulatory process.

The panel also noted that you had also made a significant number of admissions and had expressly confronted the issue of dishonesty within your reflection. It was of the view that whilst your insight remained limited, it was not absent.

The panel considered that there was an important distinction between accepting that conduct occurred and developing full insight into why it occurred, its impact and how

recurrence would be prevented. It was of the view that whilst you had begun that process, you had not yet completed it.

The panel was mindful that there was no further documentary evidence produced by you since the adjournment of the hearing in May 2026. It had previously identified limited insight and remediation and considered that further reflection could have been undertaken, even in the absence of nursing employment.

However, the panel also took account of the additional information by way of Ms Deery's submissions concerning your circumstances, your continued engagement and your expressed desire to return to nursing. The panel considered that there remained a realistic prospect that your insight could develop positively during a period of suspension.

The panel considered that a period of suspension would provide immediate and complete public protection, as you would be unable to practise as a registered nurse during the period of suspension. It was also of the view that public confidence in the profession could be maintained if you were ultimately permitted an opportunity to demonstrate remediation rather than being removed permanently from the NMC register.

The panel was of the view that a period of suspension would also provide you with an opportunity to undertake meaningful reflection upon all four findings of dishonesty, address the outstanding attitudinal concerns, strengthen your clinical knowledge and demonstrate that the risk of repetition had reduced.

The panel therefore considered that a period of suspension was capable of protecting the public, maintaining public confidence and upholding professional standards while providing you with a final opportunity to demonstrate that you could safely and honestly return to the profession.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a

suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel accepted that the charges found proved raised questions about your professionalism. It was of the view that repeated dishonesty, falsification of clinical records and the forgery of a colleague's signature were extremely serious matters.

The panel however considered that public confidence in the profession could still be maintained without immediate removal from the register. It also considered that there remained an amount of insight and reflection which you could develop which was capable of protecting patients, maintaining public confidence and upholding professional standards.

The panel took into account the nature of your entering the UK through an international program, the unfamiliar clinical settings, the six-month gap in consistent supervision and mentoring during the first 12 months within the NHS, the breadth and depth of mitigations put forward by you, including the challenges you faced in the workplace, and the absence of a premeditated and sophisticated plan to be dishonest, which indicated an absence of a deep-seated attitudinal issue. The panel also took into account your willingness to continue to engage with the NMC in finding a solution to allow you to practise in the future in a way to ensure public safety and public confidence.

The panel therefore determined that striking off would, at this stage, be disproportionate.

The panel considered the decision between suspension and striking off to be finely balanced. It was fully cognisant of the seriousness of the dishonesty, its repetition across four incidents, its connection with patient care, the forgery of a colleague's signature, the continuing risk of repetition and the limited evidence of developed insight and remediation.

Having balanced all of the aggravating and mitigating circumstances and applied the relevant NMC guidance, the panel determined that a suspension order for a period of 12 months was the appropriate and proportionate sanction.

The panel considered 12 months to be appropriate given the seriousness of the concerns. In addition, such a period would provide sufficient time for you to undertake the substantial reflection, remediation and strengthening of practice required.

The suspension order would provide immediate public protection, adequately mark the seriousness of the misconduct and lack of competence and maintain public confidence in the nursing profession, while giving you a defined opportunity to demonstrate that you are capable of returning safely to registered nursing practice.

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

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

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.
Any future panel reviewing this case would be assisted by:

- Evidence of your developed insight into all four findings of dishonesty, rather than reflection limited to the incident involving the forged signature.
- A detailed reflective account addressing why the dishonest conduct occurred, including the factors which led you to conceal clinical failings.

- Reflection upon the impact of your dishonesty upon patients, colleagues, the nursing profession and public confidence.
- Evidence demonstrating how you would respond differently if faced with similar pressures or clinical errors in the future.
- Evidence of a clear understanding of the professional duty of candour, including the obligation to acknowledge and report errors honestly.
- Examples of relevant training addressing the clinical concerns identified in this case.
- Practical rather than solely e-learning training addressing the fundamental areas of clinical competence identified by the panel, including medication administration, record keeping, wound care and other relevant aspects of safe nursing practice.
- Evidence demonstrating that you have maintained or developed your understanding of the requirements for a safe return to nursing practice.
- Evidence of trustworthy and responsible conduct in any employment, voluntary work or other structured environment undertaken during the period of suspension.
- Testimonials or references from employers, managers, supervisors or those responsible for overseeing any voluntary activity, particularly addressing your honesty, integrity, reliability and trustworthiness.
- Any other evidence capable of demonstrating that your insight has developed, your practice has strengthened and the risk of repetition has reduced.

This will be confirmed to you in writing.

**Interim order**

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension 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 Ewulo. She submitted that in light of the panel's findings, an interim suspension order is necessary on the grounds of public protection and is otherwise in the public interest to cover any period of appeal.

The panel also took into account the submissions of Ms Deery. She submitted that it is your position that an interim order is not appropriate in the circumstances of this case. She submitted that an interim order is not necessary on the grounds of public protection or the public interest.

Ms Deery reminded the panel that an interim suspension order should not be an automatic decision every time a substantive suspension order is imposed. She submitted that the risk of any repetition is low, and that the charges relate to incidents between January 2021 and May 2024, which is between two and five and a half years ago. Ms Deery submitted that you have since shown insight, understanding, learning and training into these since.

Ms Deery submitted that the substantive order does enough to uphold public confidence in the nursing profession, and to impose an interim order on top of this is not necessary.

Ms Deery submitted that the purpose of an interim order is different from the purpose of a substantive order, and whilst a substantive order will focus on what is required to bring a registrant back to practice, an interim order is focused on whether the registrant is likely to repeat the misconduct or show further lack of competence in a relatively short period of time that it would take to exhaust any right of appeal. She submitted that your position is that whilst an interim suspension order may be seen as desirable by the panel, it is not necessary today with the circumstances of this case.

**Decision and reasons on interim order**

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to allow for any appeal process to be concluded on the grounds of public protection and in the wider public interest.

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

That concludes this determination.