Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 8 April 2025 – Friday 11 April 2025
Monday 2 June 2025 – Friday 6 June 2025
Monday 2 February 2026 – Friday 6 February 2026
Monday 16 February 2026 – Friday 20 February 2026

Virtual Hearing

Name of Registrant:	Julie Gibson
NMC PIN:	11J0092N
Part(s) of the register:	Registered Nurse – Sub part 1 RNA: Adult nurse L1 – September 2011
Relevant Location:	Northern Ireland
Type of case:	Misconduct
Panel members:	Louise Guss (Chair, Lay member) Genevieve Nwanze (Registrant member) Melanie Swinnerton (Lay member)
Legal Assessor:	Paul Housego 8 – 11 April 2025 Gerard Coll 2 – 6 June 2025 Andrew Young 2 - 4, 6, 16 - 20 February 2026 Neil Fielding 5 February 2026
Hearings Coordinator:	Emma Norbury-Perrott 8 – 11 April 2025, 2 – 6 February 2026, 16 – 18 February 2026 Shela Begum 2 – 6 June 2025 & 19 – 20 February 2026
Nursing and Midwifery Council:	Represented by Dr Raj Joshi, Case Presenter
Ms Gibson:	Present and represented by Simon Holborn, HUMANS HR. Supported by Cathryn Watters, RN, 8 – 11 April 2025, 2 – 6 June 2025.

No case to answer:	1a) and 5c)
Facts proved:	1b), 2), 3a), 4), and 5a)
Facts not proved:	3b), 3c), 5b), and 6)
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (12 months – with review)**
Interim order:	**Interim conditions of practice order (12 months)**

Details of charge (as amended)

That you, a registered nurse:

1) On 31 August 2021:

a) Incorrectly recorded the weight of a patient due to receive chemotherapy treatment. **[NCTA]**

b) Refused to record a clinical incident on Datix as requested by Colleague A.

2) On 2 November 2022, whilst working with Colleague B, incorrectly calculated a chemotherapy infusion rate.

3) On 3 November 2022 in a reflective piece sent to Colleague C incorrectly stated that:

a) Colleague B asked you to verify the volume of just one of the drugs

b) Colleague B then set her calculations into the pump

c) you were not chemotherapy trained.

4) On 3 November 2022 in a local statement incorrectly stated that Colleague B had indicated to only one volume of chemotherapy bag

5) On 8 November 2022 incorrectly told Colleague C that:

a) Colleague B did not ask you to calculate the volumes of 2 bags of chemotherapy.

b) you had calculated the volume of 2 bags of chemotherapy.

c) you told Colleague D that you had never checked chemotherapy medication before. **[NCTA]**

6) Your conduct at charges 3- 5 was dishonest in that you admitted to Colleague C on 8 November 2022 that you were lying.

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

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

At the outset of the hearing, Mr Holborn made a request that this case be held partly in private [PRVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Dr Joshi did 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 that the hearing would go into private session in connection with [PRIVATE] as and when such issues are raised [PRIVATE].

Background

You were referred to the NMC in relation to your practice whilst employed by Western Health and Social Care Trust (the “Trust”) as a registered nurse.

The regulatory concerns in this case centre on two key clinical incidents involving an alleged medication error and issues of professional conduct. The first relates to an alleged error on 31 August 2021, where you entered an incorrect patient weight into the electronic system for a patient due to receive chemotherapy. This error created a risk of the patient receiving the wrong dosage. When asked to complete a Datix form reporting the incident, you allegedly refused.

The second incident alleged, on 2 November 2022, involved your role as a registered nurse second checker during medication administration, where an incorrect infusion rate was inputted into a pump, delaying the conclusion of chemotherapy treatment by approximately 45 minutes. Following this, you allegedly gave several inconsistent accounts of the event, later acknowledging that some statements were inaccurate and explaining that you had done so to protect a colleague.

The referral raised concerns about poor medication practice, failure in patient assessment, breaches of the duty of candour and probity issues.

Concerns were also raised by the Trust about how you worked with colleagues and how you raised concerns.

Panel's direction on disclosure and case management arrangements

During the hearing dates in April 2025, the matter of document disclosure arose. The panel directed that any material either party intends to rely upon at the resumed hearing should be disclosed no later than 14 days before the hearing reconvenes on the week commencing 2 June 2025. The panel suggested that parties liaise with one another to agree on the documentation by around 27 May 2025. If agreement is reached and no further issues arise, a preliminary meeting may not be necessary. However, should any issues remain unresolved, the panel suggested that a preliminary meeting be held prior to the resumption of the hearing in June 2025, in order to resolve those matters in advance and avoid using hearing time to deal with case management issues. There has been no request for any such preliminary meeting.

[Hearing adjourned on 11 April 2025].

[Hearing resumed on 2 June 2025].

Submissions on application to adjourn

On day 5 of the hearing, Dr Joshi informed the panel that prior to resuming the hearing, there had been a pre-hearing meeting involving himself, Mr Holborn, Ms Watters, and the legal assessor. He stated that the central issue at hand related to disclosure, which had been raised by Mr Holborn. Dr Joshi reminded the panel that, at the beginning of this hearing during April 2025, Mr Holborn sought various documents and disclosure. He also reminded the panel that, at that time, the then-legal assessor, had observed that Dr Joshi had been taken by surprise by certain disclosure requests.

Dr Joshi referred the panel to the procedural developments since that point, noting that all of the NMC's witnesses had since been called, cross-examined, and questioned by the panel. He emphasised that the NMC had not closed its case earlier specifically to allow for the introduction of any further documentation that might arise as evidence, rather than as unused material or general disclosure.

Dr Joshi acknowledged that, since the initial hearing dates, correspondence had continued between Mr Holborn and the NMC. He explained that Mr Holborn had made a subject access request and continued to seek further documents, which Mr Holborn considered outstanding. Dr Joshi stated that the NMC had responded by confirming that, to the best of its knowledge, all relevant material had already been provided to your representatives. He clarified that the NMC had made best endeavours to meet its disclosure obligations and that, in its view, there was nothing further to disclose.

Dr Joshi acknowledged receipt of an additional 25-page document from Mr Holborn.

[PRIVATE].

Dr Joshi submitted that the four witnesses had been examined and cross-examined, and the panel had had the opportunity to assess their credibility. He reminded the panel that it was their task to evaluate the evidence in accordance with their rules and guidance.

Dr Joshi acknowledged that you have not yet given evidence and that this remained a matter for the defence to determine. He reiterated that the NMC would not be calling further witnesses or recalling any of the witnesses who had already given evidence, and for the avoidance of doubt, he confirmed that the NMC case was now closed.

Mr Holborn submitted that the hearing had been deliberately left open at the conclusion of the last sitting to deal with matters relating to further disclosure. He confirmed that he had submitted a request for additional documentation comprising around 15 documents. He stated that these documents were believed to be relevant both to the NMC's consideration of the case and, more significantly, to your defence. He stated this request was served at the relevant time.

Mr Holborn acknowledged that directions had been made by the panel in respect of disclosure at the end of the hearing dates in April 2025. He accepted that he had not fully engaged with those directions and described that as an error on his part. Nonetheless, he confirmed that efforts had since been made to address this, including reviewing the results of a subject access request.

Mr Holborn submitted that despite those efforts, some of the documents sought may be directly within the control of the NMC and had not yet been disclosed. Although the request was reiterated the previous week, he noted that the original application for disclosure had been made during the April hearing. His understanding was that a substantive response from the NMC regarding the availability of those documents would have been provided by this stage.

Mr Holborn acknowledged that the NMC had now formally closed its case. However, he submitted that two legal duties remained relevant: first, the duty on the NMC to prove its case, and second, the ongoing duty of disclosure. He acknowledged that Dr Joshi had indicated the NMC believes its case has been proved and rested but emphasised that the obligation of disclosure persists.

Mr Holborn submitted that you had carefully reviewed what documentation you do and do not have. The request for disclosure had been made and renewed and was, in his submission, now outstanding and unresolved. He therefore requested that the NMC be specifically tasked with confirming whether it holds the documents in question and, if so, whether they can be disclosed.

Mr Holborn referred the panel to the nature of your defence. He explained that you take the view that your referral to the NMC was motivated by hostility or spite, [PRIVATE]. As such, he submitted that the documentation sought is highly relevant to your defence and includes items such as occupational health records, original incident reports, [PRIVATE].

Mr Holborn submitted that you intended to explore systemic failures within the Trust which might explain or contextualise the circumstances surrounding the allegations. You also intended to raise concerns about procedural irregularities and the apparent reliance on selective or incomplete documentation. He submitted that some of the information in question was time-sensitive and that the absence of a response from the NMC could prejudice your ability to present your defence.

Mr Holborn submitted that the NMC already had the list of documents. He stated that he had sent the list by email and believed he had provided an updated version. That list had

also been sent to an NMC staff member who Mr Holborn identified as panel coordinator. He clarified that this was done based on his understanding that all documentation needed to be submitted through that channel.

Mr Holborn submitted that the NMC should be asked to either confirm or deny possession of the requested documents and clarify whether they intend to disclose them. He submitted that this clarification would provide the necessary context for completing your preparation and finalising your defence.

Mr Holborn submitted in conclusion that the disclosure request was the basis of his application. He explained that you have engaged with the process, cooperated throughout, and are keen to participate fully and fairly. However, you believe that there are underlying issues at play which you should be permitted to evidence using the documents in question. He submitted that it is relevant, reasonable, and fair for you to receive at least a response to the request, if not the actual documents.

Mr Holborn referred the panel to the need to ensure a fair hearing and a balanced evidentiary process. He emphasised that your ability to challenge the charges depends on having access to the full context, including documents which could explain or cast doubt on the motivations for the allegations.

Mr Holborn submitted that the request was not speculative but was made following careful consideration and by proper means. He reiterated that the NMC's duty of disclosure does not end simply because it has closed its case and emphasised that this was an issue of fairness and equality of arms.

Secondary Submissions

Dr Joshi referred the panel to a follow-up email sent by a senior case officer from the NMC, which he read into the record. The email noted that Mr Holborn's request for further document disclosure, originally made on 8 April 2025, had already been addressed and had been raised again more recently. The panel's direction, as referenced in the hearing

transcript, stated that any documentation should be submitted “in good time” before the hearing resumed in June.

Dr Joshi referred the panel to the scheduled resumption date of the hearing: the week commencing Monday 2 June. He clarified that, taking into account the spring bank holiday, documentation should have been provided around Tuesday 27 May to comply with the two-week window set by the panel.

Dr Joshi submitted that no submissions had been received from the defence until an email dated 28 May 2025. He confirmed that the NMC had made inquiries and had no further material to provide. He stated unequivocally that there was no further disclosure available from the NMC.

Dr Joshi acknowledged that, out of courtesy, a further email had been sent to the relevant NHS Trust to check once more for additional material. He explained that the NMC had left the case open in case new evidence arose but reiterated that there was no further material to disclose. He stressed again that Mr Holborn should be under no illusion: there was nothing more that the NMC could provide.

Dr Joshi submitted that the NMC’s position was definitive and not based on any legalistic argument. He stated clearly that the NMC had no further documents in its possession and that any material previously requested had already been obtained and served.

Dr Joshi referred the panel to the distinction between the NMC and the Trust, noting that they are separate entities. The NMC does not hold Trust documents unless those documents are first passed on by the Trust following a specific request. The NMC could only disclose material it had obtained from the Trust and had already done so in this case.

Dr Joshi submitted that any further material must be relevant and fair to be admissible, and that the NMC was not withholding any evidence. He reiterated that all relevant material had already been served to the registrant’s representative.

Dr Joshi referred the panel to the purpose of the witness evidence in the case, explaining that the NMC's position was that the witnesses were providing factual accounts of events. [PRIVATE]

Dr Joshi submitted that it was now for the panel to assess the credibility and reliability of the evidence, particularly if the registrant chose to give evidence. He noted that the panel should weigh the evidence and make findings based on the factual issues and relevant standards, attaching appropriate weight to each piece of evidence and any surrounding context.

Mr Holborn submitted that he wished to be forthright in making his position clear emphasised that his tone and approach were not intended to be obstructive, but rather reflective of the seriousness of the issue.

Mr Holborn expressed concern about whether Dr Joshi's statement meant that there was material that the NMC was choosing not to disclose, or whether he was confirming that there simply was no such material in existence.

Mr Holborn submitted that there was a material distinction between those two positions. If the NMC was saying that it had material but considered the defence was not entitled to it, that was one matter. If, on the other hand, the NMC was saying that it did not possess the material at all, that was a different and significant issue. He invited clarification on that point, emphasising again that he did not wish to appear unreasonable but that he felt obliged to pursue clarity.

[PRIVATE]

Mr Holborn was asked how it could be fair or in the public interest to adjourn the hearing in order to search for documents that the NMC had stated it did not have – particularly given the potential delay and risk of the hearing not concluding that week. Mr Holborn responded that it was appropriate and reasonable. [PRIVATE]

Mr Holborn submitted that his sole and genuine motivation was to ensure that he could properly represent you and present your defence with full access to the relevant material. He acknowledged the NMC's broader role in protecting the public and safeguarding professional standards but emphasised that those aims were not served if relevant information was withheld or simply not considered.

Mr Holborn concluded that he fully understood and accepted the concerns raised about delay but reaffirmed that he believed disclosure of the material in question was critical to ensuring fairness to you in the proceedings.

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

Decision and reasons on application to adjourn

The panel noted that this application to adjourn the hearing arises in the context of a request for disclosure of documents that are said to be relevant to your defence. It was clarified during submissions and legal advice that the application before the panel is not one for the panel itself to order disclosure, but rather a request for an adjournment to allow a disclosure application directed to the NMC to be resolved.

The panel considered the application in the context of Rule 31 of the Rules. This rule provides the panel with broad discretion to receive evidence in any form, provided that the evidence is relevant and fair, or at the very least, not unfair. The panel noted that disclosure principles require clarity. Any delay in proceedings must be purposeful, productive, and necessary for the fair disposal of the case. It also took into account that the test for relevance is not satisfied merely by material that is potentially helpful or interesting; it must assist the panel in determining whether a fact is true or untrue, or in deciding an appropriate outcome once facts have been found. The panel also took into account the public interest in efficient disposal of this case.

The panel carefully considered the application to adjourn and the submissions from both Dr Joshi and Mr Holborn.

In respect of timing and preparation, the panel was of the view that this issue could and should have been raised significantly earlier. The documents referred to have not been clearly or specifically identified even at this late stage, despite almost two months having elapsed since the previous dates of the hearing. The panel was not presented with an appropriate explanation for this delay and therefore took the view that this could have been avoided had greater efforts been made in a timely way.

In respect of the clarity and relevance, the panel noted that the documents requested (15 in total in April 2025, but with no further detail provided today) were not described with sufficient clarity or specificity. The application lacked detail as to how each document would be relevant to your defence, or what function each document would serve in advancing your case or challenging the NMC's evidence.

In respect of the public interest and procedural fairness, the panel considered that the NMC is pursuing a sanction of striking off, and there is a strong public interest in ensuring that the hearing proceeds in a timely and efficient manner. The panel recognised your right to a fair hearing but also noted that fairness does not require indefinite or continuous delays in the absence of a sufficiently clear and specific reason for the requested material.

[PRIVATE]. There is nothing preventing Mr Holborn from continuing to seek disclosure from the NMC while the hearing proceeds. Moreover, the panel retains discretion to consider any relevant new material if it becomes available at a later stage in the hearing.

Having considered all the circumstances, the panel refuses the application for an adjournment. It concluded that the application lacked clarity, specificity, and a detailed explanation of the relevance of the documents sought. Additionally, it noted that there is no persuasive evidence that the requested documents are in the NMC's possession, nor that any additional time would result in their production. The panel determined that granting the adjournment would cause further delay with no demonstrable benefit and would not serve the public interest or the principle of efficient case management.

The panel remains committed to ensuring that your case is heard fairly and fully. However, that fairness must be balanced with the need for procedural efficiency and the public interest in the expeditious disposal of this case. The panel concluded that, in the circumstances of this case, the appropriate course is for the hearing to proceed. This decision does not preclude Mr Holborn from continuing to correspond with the NMC regarding disclosure, nor does it prevent the panel from considering additional evidence should it become available at a later stage in the hearing.

Decisions and reasons on adjournment

Following receipt of the panel's decision not to adjourn in the context of a disclosure issue, Mr Holborn requested a short adjournment until the following morning to allow time for him to take instructions from you and to prepare a written submissions on an application for a stay of proceedings on the grounds of abuse of process or a no case to answer application. He stated that he was not fully prepared to make the applications immediately and sought time to draft the submission in consultation with you.

Dr Joshi did not oppose the short adjournment but sought clarity on whether the application being made was for an abuse of process, which alleges unfairness in the proceedings or conduct of the parties; or a no case to answer application, which argues there is no case to answer due to insufficient or weak evidence.

Mr Holborn clarified that both applications are in contemplation and his instructions at this stage were that both should be considered.

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

The panel considered that the purpose of the adjournment is to allow Mr Holborn sufficient time to consult with you and to prepare a written application relating to either or both an abuse of process argument and/or a no case to answer application. It noted that the

application was made late in the day and that the adjournment sought was limited in scope, being only until the following morning. The panel also took into account that Mr Holborn indicated he was not fully prepared to proceed immediately and wished to ensure any submission made was clear and properly drafted. In the interests of fairness and to ensure that you are given a full opportunity to make your application with appropriate support, the panel grants the adjournment.

Submissions on abuse of process application

Mr Holborn provided written submissions in respect of his application in which he stated:

> *"1.1. This is an application on behalf of Ms. Julie Gibson (now Doherty) ("the Registrant") for a stay of these proceedings on the grounds that they constitute an abuse of process.*
>
> *1.2.* [PRIVATE]
>
> *1.3. The NMC states on its website*
>
> *1.3.1. "We recognise that nurses, midwives, students or other members of staff may identify risks or malpractice within the workplace that you wish to raise with us. This could be an issue that affects patients, the public, your colleagues or the organisation that you work for.*
> *1.3.2.* [PRIVATE]
>
> *1.3.4.* [PRIVATE]
>
> *1.4. The application is made pursuant to the inherent jurisdiction of the panel to prevent misuse of its procedures in ways that would be manifestly unfair to a party or would bring the administration of justice into disrepute, as established in Hunter v Chief Constable of the West Midlands Police [1982] AC 529.*

1.5. It is submitted that the cumulative effect of serious procedural irregularities, particularly relating to disclosure obligations, [PRIVATE]*, has rendered a fair hearing impossible because a decision will be made without its full inclusion. Further the halt of all proceedings in relation to the registrant's employed status has been halted waiting for the outcome of these proceedings.*

1.6. It would be unfair to leave the registrants employed status be determined this way and this is the likely reason behind the referral to the NMC.

1.7. As a potential cure to the issues the Panel could require the NMC to reconsider its disclosure of relevant material, particularly relating to the registrants protected disclosure made to the NMC.
[…]

2.1. On the NMC website they state as follows

2.1.1. "The panel can decide there is an abuse of process if:

- *it will be impossible for the nurse, midwife or nursing associate to have a fair hearing, or*
- *continuing with the case would, in all the circumstances, offend the panel's sense of 'justice and propriety'.*

- *In deciding whether there has been an abuse of process which means the case should be stopped, the panel will consider whether the alleged abuse of process (such as delay, or a failure to disclose evidence) has caused serious prejudice or unfairness to the nurse, midwife or nursing associate.*
- *In accordance with its overarching public protection objective, the panel will also consider whether there are ways of putting right the serious Prejudice or unfairness, so that the nurse, midwife or nursing associate can have a fair hearing without stopping the case."*

2.2. The doctrine of abuse of process applies to professional regulatory proceedings, as confirmed in Enemuwe v NMC [2015] EWHC 2081

2.3. Applying the test established in R v Maxwell [2010] UKSC 48, proceedings may be stayed where either:

2.3.1. a) It would be impossible for the registrant to receive a fair hearing, OR
2.3.2. b) It would offend the court's sense of justice and propriety to try the registrant in the circumstances.

2.4. In the regulatory context, particular categories of abuse of process include:

2.4.1. Disproportionate pursuit of allegations.
2.4.2. Selective prosecution or enforcement.
2.4.3. Failure to meet disclosure obligations; and
2.4.4. [PRIVATE]
.
2.5. [PRIVATE]

2.6. Disclosure failures may constitute an abuse of process where they prevent a registrant from having a fair opportunity to answer the case against them. In Suddock v NMC [2015] EWHC 3612, the court emphasized that fairness in regulatory proceedings requires proper disclosure of relevant material.
[…]
3.1. The Registrant made protected disclosures regarding patient safety concerns at the Northwest Cancer Centre in September and October 2021, documented in investigation WB0421.

3.2. Following these disclosures, she was temporarily transferred to the Cardiology Department at her own request in December 2021 due to concerns about her working relationships. She has been away from work on pay now for about two

years and no plans to return her to work have been initiated. She is ready willing and able to carry out her lawful work

3.3. The allegations in these proceedings arose after [PRIVATE] *and relate to incidents on 31 August 2021 and 2 November 2022.The allegations took place in 2021 and 2022 and the referral in respect to the Registrant alone was made in 2023.*

3.4. At the hearing in April 2025, the Registrant's representative raised concerns about incomplete disclosure [PRIVATE]

3.5. The panel directed that material should be disclosed 14 days before the resumed hearing in June 2025 and deliberately left the NMC's case open to accommodate any new evidence.

3.6. When the hearing resumed on 2 June 2025, the panel refused an application for adjournment despite unresolved disclosure issues. In this situation the NMC has been apparently relieved of the obligations in respect to disclosure and placed under an unequal and unfair disadvantage.
[...]

4.1. Indicators of a Targeted and Abusive Use of Process
4.2. It is respectfully submitted that this case displays the hallmarks of a process being used not for regulatory protection, but for the strategic detriment of the registrant - [PRIVATE]

4.3. The pattern of events is telling:

4.3.1. A scattergun of allegations was raised, many of which are vague, unsupported, or demonstrably untrue.

4.3.2. The registrant was on long-term leave, yet a series of retrospective allegations emerged well after the events in question.
4.3.3. The most serious concerns are framed without contemporaneous documentary evidence and rely heavily on hearsay or post-hoc interpretation by wat appears to be a collective group (Mindful of Hindle v NMC (2025) EWHC 373 (Admin) 21/2/2025.
4.3.4. [PRIVATE]

4.4. [PRIVATE]

4.5. It is telling that of all those involved in chemotherapy/SACT administration, only Ms Gibson faces regulatory proceedings - despite extensive concerns raised about wider, systemic unsafe practices.

4.6. The cumulative inference is clear: the process may have been co-opted or manipulated to punish protected disclosures, rather than uphold public safety. The absence of meaningful evidence, coupled with selective enforcement and procedural failure, renders the process itself abusive.
[…]
5.1. The NMC has fundamentally failed in its disclosure obligations in ways that prevent a fair hearing, including:

5.1.1. Failing to disclose the original medication incident form allegedly co-signed by the Registrant.
5.1.2. [PRIVATE]*.*
5.1.3. Failing to disclose Occupational Health referrals and reports.
5.1.4. Failing to disclose the Registrant's SACT training records and competency status.
5.1.5. These disclosure failures are particularly serious because:
5.1.5.1. [PRIVATE]

.

5.1.5.2. The NMC has provided no adequate explanation for the non-disclosure.

5.1.5.3. The documents are clearly relevant to issues of witness credibility and motivation.

5.1.5.4. The panel itself had directed disclosure by 27 May 2025, yet failed to enforce its own direction.

5.1.5.5. The Legal Assessor explicitly acknowledged at page 41 of the transcript that "The duty of disclosure is of course ongoing, and so the NMC is obliged to provide the documentation." Yet the panel subsequently excused the NMC from this continuing obligation.

5.2. Applying Suddock v NMC [2015] EWHC 3612, fairness in regulatory proceedings requires proper disclosure of relevant material to enable a registrant to properly defend themselves. That standard has not been met in this case.

6. Disproportionate and Unfair Treatment of Disclosure Issues

6.1. The panel apparently applied a double standard in its treatment of disclosure obligations, as evidenced by:

6.1.1. Holding the Registrant to an exacting standard while accepting the NMC's bare assertions that no further documents exist [PRIVATE]

6.1.2. Criticising the Registrant for the timing of disclosure requests while ignoring that initial requests were made during the April 2025 hearing.

6.1.3. Failing to require the NMC to provide specific responses to each requested document.

6.1.4. Attributing all delays to the Registrant while excusing the NMC's failure to comply with its ongoing disclosure obligations.

6.2. At page 14 of its decision, the panel states: "In respect of timing and preparation, the panel was of the view that this issue could and should have been

raised significantly earlier." This statement ignores that the original application was made during the April hearing, as clearly documented in the transcript.

6.3. The panel's approach violates the principle of equality of arms, a fundamental aspect of the right to a fair hearing under Article 6 ECHR.

7. [PRIVATE]

7.1. [PRIVATE] *the panel failed to:*

7.1.1. [PRIVATE].
7.1.2. Properly investigate potential witness bias arising from the Registrant's protected disclosures.
7.1.3. Address the Legal Assessor's concern expressed at page 33 of the transcript [PRIVATE]

7.2. [PRIVATE]

7.3. [PRIVATE].

8. Procedural Inconsistency and Unfairness

8.1. The panel demonstrated significant procedural inconsistency that amounts to an abuse of process:

8.1.1. Initially agreeing not to close the NMC's case specifically to allow for further documentation, then later deeming documentation requests unnecessary.
8.1.2. Making a direction for disclosure by May 27, 2025, then using the Registrant's
alleged delay as justification to deny the adjournment.

8.1.3. Disregarding the Legal Assessor's advice at page 42 of the transcript that a case management meeting might be necessary to resolve disclosure issues.

8.2. This inconsistent approach undermines fundamental fairness and violates the principle established in R (Khan) v Secretary of State for Foreign and Commonwealth Affairs [2014] EWCA Civ 24 that procedural fairness requires consistency and adherence to established processes.
[…]

9.1. The cumulative effect of these procedural irregularities has caused serious prejudice to the Registrant:

9.2. [PRIVATE]

9.3. She cannot adequately contextualise the alleged incidents without access to relevant documentation about systems issues and training.

9.4. She cannot demonstrate the potential retaliatory motivation behind the referral without access to communications between the Trust and the NMC;

9.5. She faces a fundamental inequality of arms, with the NMC having access to all Trust documentation while she is denied access to potentially exculpatory evidence.
9.6. This prejudice cannot be remedied by any means short of a stay of proceedings, [PRIVATE].

9.7. Applying the principle in R v Crawley [2014] EWCA Crim 1028, where procedural failures prevent a party from having a fair opportunity to present their case, a stay of proceedings may be the only appropriate remedy.
[…]

11. 10.1. Applying the first limb of the Maxwell test, it is impossible for the Registrant to receive a fair hearing because:

11.1. She has been denied access to documents central to her defence.
11.2. The panel has shown a clear unwillingness to enforce proper disclosure.
11.3. [PRIVATE]*.*
11.4. The panel has demonstrated apparent bias in its disproportionate treatment of disclosure issues.

12. 10.2. Applying the second limb of the Maxwell test, it would offend the court's sense of justice and propriety to try the Registrant in these circumstances because:

12.1. [PRIVATE]

12.2. The NMC has failed to meet its disclosure obligations despite clear directions.

12.3. The panel has unfairly attributed all procedural delays to the Registrant.

12.4. [PRIVATE]

14. 11.1. Considering the serious procedural irregularities and fundamental unfairness outlined above, the Registrant respectfully requests that:

15. These proceedings be stayed as an abuse of process; or

16. In the alternative, that the proceedings be adjourned with specific, enforceable directions for disclosure of all documents requested by the Registrant.
[…]

17.1. The public interest in maintaining confidence in the regulatory process is not served by proceedings that fail to uphold basic standards of procedural fairness,

[PRIVATE].

18. As Lord Diplock stated in Hunter v Chief Constable of the West Midlands Police [1982] AC 529, courts and tribunals possess an inherent power "to prevent misuse of [their] procedure in a way which... would nevertheless be manifestly unfair to a party to litigation before it, or would otherwise bring the administration of justice into disrepute among right-thinking people."

19. [PRIVATE].

20. The cumulative effect of the procedural irregularities identified renders it impossible for the Registrant to receive a fair hearing.
21. For these reasons, it is respectfully submitted that the panel should grant the relief sought.'

Dr Joshi outlined that the relevant framework for the panel to consider was set out in the NMC's guidance on 'Abuse of Process Ref: DMA-4'. He explained that the central claim was that the case had been unfairly progressed and should be stayed. In such circumstances, the panel was required to ask whether it would be impossible for you to receive a fair hearing, or whether the continuation of proceedings would offend the panel's sense of justice and propriety. These questions required the panel to evaluate whether there had been serious prejudice or unfairness.

Dr Joshi was clear that the abuse of process application was not about delay, but rather about allegations of incomplete or non-disclosure. To assist the panel, he referred it to the relevant guidance on 'Disclosure Ref: PRE-5', which sets out the questions to be considered when assessing disclosure issues. These include whether the information is relevant or essential, what steps you have taken to obtain the material independently, and whether the NMC is better placed to secure it from a third party.

Dr Joshi emphasised that disclosure obligations exist to enable a fair hearing and not to serve as an abstract entitlement. He explained that the guidance requires you to attempt to obtain the information yourself, and, if the NMC is to be asked to help, then full contact details for the holder of the information must be provided. The overarching principle is that only relevant and essential material should be pursued.

Dr Joshi then stated his disagreement with the central premise of the abuse of process argument, asserting that the charges relate to your conduct or omissions, and that this was the proper focus of the panel's attention. He reminded the panel that it had already heard from multiple witnesses, all of whom had adopted their witness statements. The documentary exhibits included contemporaneous material and internal statements, and all of this had been made available to you. Furthermore, your own responses - both in writing and during meetings - formed part of the evidence. [PRIVATE].

[PRIVATE].

As to the suggestion that you could not receive a fair hearing due to non-disclosure, Dr Joshi rejected it. He explained that all disclosure requests to the NMC had been dealt with appropriately. You had also submitted a subject access request to the Trust, which had led to the production of a 25-page document. In his view, this document was a legitimate and potentially relevant piece of material which could help the panel assess whether full and fair disclosure had taken place.

Turning to the specific paragraphs in the abuse of process application, Dr Joshi addressed them in detail. In response to the claim that you were unfairly targeted, he said that this was an issue that Mr Holborn could and should have put to the NMC witnesses during cross-examination. He submitted that the panel would have on record whatever responses were given to such questions. He took issue with the assertion that the NMC had been the recipient of a protected disclosure, stating that any such disclosures had been made to your employer - the Trust - and not to the NMC. He disputed the allegation that serious procedural irregularities had occurred, pointing out that none had been identified with

specificity. He highlighted that the only procedural concerns raised in your submissions related to disclosure decisions, and in his submission, the panel had acted lawfully and reasonably throughout the process. He noted that at the April hearing, the panel gave clear directions concerning disclosure and had sought to ensure that any outstanding matters were resolved in advance of the resumed hearing. While some delays occurred, he noted that Mr Holborn himself had acknowledged that these arose from his own oversight.

On the suggestion that the NMC had failed to comply with disclosure obligations, Dr Joshi stated that everything in the NMC's possession had been disclosed. If the Trust held further material and was unwilling to provide it voluntarily, the appropriate legal channels existed to obtain it. [PRIVATE].
.

Dr Joshi addressed the factual assertion that you were transferred to the Cardiology department in December 2021 at your own request. If that was your position, he said, then it was open to you to give evidence on the matter. He reiterated that you were free to give oral evidence and present relevant documentation, and it was for the panel to decide what weight and credibility to give to that evidence.

Dr Joshi disagreed with the assertion in the application that disclosure issues remained unresolved. He stated that the NMC had disclosed what it had, and dissatisfaction with the content did not amount to procedural impropriety. He also rejected the suggestion that the panel had applied a double standard, noting that in April it had directed both parties clearly on the disclosure process and timeline. There was no evidence that the panel had held you to an exacting or unequal standard.

[PRIVATE].There was no barrier to this being considered by the panel. Finally, in addressing the overarching claim that you had been prejudiced, he noted that there had been opportunities to cross-examine witnesses and to challenge credibility. If there had been instructions to Mr Holborn about certain issues, these could have been used to

frame cross-examination. Dr Joshi concluded that the relief you sought, including a stay of proceedings and enforceable disclosure directions, was not justified based on the material before the panel. Dr Joshi submitted that there has not been any serious procedural irregularities identified to support the application.

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

Decision and reasons on abuse of process application

The panel has carefully considered the application made by Mr Holborn on your behalf for a stay of proceedings on the grounds of abuse of process. In reaching its decision, the panel carefully considered the submissions from both Mr Holborn and Dr Joshi, had regard to the advice of the legal assessor and the relevant NMC guidance, namely 'Abuse of Process: Ref DMA-4'.

In line with DMA-4, a stay of proceedings on the grounds of abuse of process is an exceptional remedy, granted only where:

- It is impossible for you to receive a fair hearing; or
- The continuation of proceedings would offend the panel's sense of justice and propriety.

The panel must consider whether any procedural irregularities have caused serious prejudice or unfairness and whether such prejudice could be cured through less drastic procedural measures, such as targeted disclosure or adjournment. Abuse of process applications must not be used to revisit case management decisions or pre-empt final arguments.

The panel bore in mind that the legal threshold for abuse of process is high and must only be met where a fair hearing is impossible or where continuing the proceedings would

offend the panel's sense of justice and propriety. It took into account that assertions not supported by evidence or reference to the record cannot satisfy this threshold.

The panel has considered each of the substantive arguments raised in your abuse of process application.

The panel acknowledges that disclosure is central to ensuring fairness. However, it noted that the NMC position is that it has disclosed all relevant material within its possession and responded to your requests. The panel accepted Dr Joshi's submission that further information held by third parties (e.g., the Trust) could have been pursued by you through other channels, and that the NMC is not automatically responsible for all Trust records.

In addition, the panel reviewed the disclosure timeline in detail:

- The NMC's evidence bundle was provided to you in November 2023.
- Finalised NMC evidence was provided to you in early February 2025
- Notice of hearing was issued in March 2025.
- A case conference was held on 14 March 2025, during which no further disclosure requests were raised by you or your representatives when asked.
- Your disclosure concerns were raised for the first time in April 2025, after the hearing had begun.
- After hearing arguments from both parties, the panel directed both parties to exchange any outstanding material by 27 May 2025.

The panel was mindful that the direction it issued during the hearing dates in April 2025 regarding disclosure was intended to support the fair and efficient progression of the case. This direction was not an enforceable order requiring the NMC to obtain third-party documents, but rather a procedural step to facilitate orderly preparation for the resumed hearing.

The panel noted that the NMC has confirmed on multiple occasions, on the record, that all relevant documentation in its possession has been disclosed. Furthermore, the panel notes that no evidence has been presented to demonstrate that any undisclosed material both exists and is relevant to the proceedings.

Additionally, the panel observed that you did not take any independent steps to obtain further evidence - for example, through a Freedom of Information (FOI) request or by pursuing legal avenues to compel disclosure directly from the Trust. While the panel acknowledges your expressed dissatisfaction with the adequacy of disclosure, it does not find that any such concerns amount to grave or irremediable procedural failings.

In the absence of evidence demonstrating significant prejudice or a fundamental denial of procedural fairness, the panel does not consider that the disclosure issues raised render a fair hearing impossible.

The panel further considered that the direction made by it during the April 2025 hearing dates, the panel addressed the issue of documentation and suggested that if issues relating to this matter remained unresolved a preliminary meeting would be beneficial. It noted that no request for a preliminary meeting was made by either party following the panel's direction. This suggests that any outstanding issues regarding disclosure or documentation were either resolved independently or not pursued further, despite the panel providing a clear procedural opportunity to address them in advance of the resumed hearing.

The panel is aware that [PRIVATE] has been raised as part of your defence. However, the contemporaneous evidence in the case, including the NMC's charges, witness statements, and internal documentation, [PRIVATE]. Nonetheless, the panel was satisfied that you remain free to give oral evidence or produce documentation to support any claim that the referral was retaliatory. The panel is satisfied that this line of defence has not been precluded.

The panel has reviewed its own case management directions and the chronology of disclosure issues. While some inconsistencies in timing and communication are noted, these do not rise to the level of serious procedural irregularity. The decision not to adjourn on 2 June 2025 was made in light of the procedural history, the disclosures already made, and the need to use hearing time efficiently and proportionately.

The panel also considered that the application contained no formal request for a case management meeting or preliminary legal intervention prior to the resumed hearing. Given these factors, the panel is not persuaded that it applied unequal standards or deviated from fairness in a manner that would render continued proceedings improper.

The panel recognised that you may have experienced delay and uncertainty. However, you have had representation throughout, the opportunity to cross-examine witnesses, and the ability to submit documentation in support of your case.

The panel was mindful that the fairness of proceedings is assessed by what remains possible at the present stage. In this case, the panel is satisfied that the prejudice described would not be incapable of remedy through your continued participation in the hearing, submission of further evidence, and use of appropriate procedural mechanisms. The panel is also satisfied that it has conducted itself in accordance with the Nolan principles and with full regard to its ethical and legal responsibilities.

The panel concluded that the threshold for a stay of proceedings on the grounds of abuse of process had not been met. There was no evidence to suggest that a fair hearing was impossible. You have been present and represented, have had the opportunity to cross-examine witnesses, submit documentation, and participate fully in proceedings. It remained a matter for you and your representatives how you conduct the next stages of the proceedings. The panel concluded that the process has remained fair, transparent, and lawful throughout.

A stay of proceedings would therefore be disproportionate and would not serve the public interest in allowing allegations of fitness to practise to be considered on their merits.

Accordingly, the panel concludes that it is not impossible for you to receive a fair hearing and that continuing the proceedings does not offend the panel's sense of justice or propriety.

The application for a stay of proceedings on the grounds of abuse of process is refused.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Holborn under Rule 24(7) of the Rules that there is no case to answer in respect of charges 1 – 6. He provided written submissions to the panel in which he stated:

> *'1.1. This is an application on behalf of Ms. Julie Gibson (now Doherty) ("the Registrant") that there is no case for her to answer in respect of the charges brought against her.*
>
> *1.2. This application is made pursuant to the principles established in R v Galbraith [1981] 1 WLR 1039 and subsequently applied in professional regulatory proceedings, including those before the Nursing and Midwifery Council.*
>
> *1.3. The Registrant submits that:*
>
> *1.3.1. There is no evidence, or no sufficient evidence, to establish essential elements of the charges; and/or*
> *1.3.2. The evidence presented is of such tenuous character that no reasonable panel, properly directed, could find the charges proven to the requisite standard.*
>
> *2. LEGAL FRAMEWORK*

2.1. The Galbraith principles, while originating in criminal proceedings, have been consistently applied in professional regulatory contexts.
2.2. In CHRE v NMC & Grant [2011] EWHC 927, the High Court emphasized that panels must scrutinise the quality of evidence presented before requiring a registrant to answer allegations.

2.3. The burden of proof rests on the NMC to establish its case to the civil standard (balance of probabilities), and this application contends that the NMC has failed to present sufficient evidence to meet this burden.

3. CHARGE 1: EVENTS OF 31 AUGUST 2021

3.1. Charge 1(a): Incorrectly recorded weight of patient

3.1.1. The NMC has failed to present sufficient evidence that the Registrant incorrectly recorded the weight of a patient on 31 August 2021.
3.1.2. The evidence presented by the NMC is fundamentally flawed for the following reasons:
3.1.3. System Failure: Evidence in the form of a Trust-wide email confirms that on 31 August 2021, there was a documented system failure with the RIOSH electronic system. This critical contextual information undermines the allegation that the Registrant personally and incorrectly entered weight data.
3.1.4. No Direct Evidence of Data Entry: No witness has provided direct evidence that they observed the Registrant entering incorrect weight data. The evidence is entirely circumstantial and assumes the Registrant's responsibility without establishing it.
3.1.5. Lack of Technical Evidence: The NMC has failed to produce any technical evidence (e.g., system logs, audit trails) that would establish who actually entered the data in question.

3.1.6. Absence of Training Records: The NMC has not produced any evidence of the Registrant's training on the RIOSH system, making it impossible to establish whether she was adequately trained to use it.
3.1.7. Furthermore, the evidence of Colleague A is inherently unreliable as it was provided retrospectively and only after direction from management to create a Datix report days after the alleged incident.

4. Charge 1(b): Refused to record clinical incident on Datix

4.1. The NMC has presented no credible evidence that the Registrant refused to record the clinical incident on Datix.

4.2. The evidence reveals that:

4.2.1. No Contemporary Request: There is no contemporaneous evidence that Colleague A asked the Registrant to complete a Datix form on 31 August 2021.
4.2.2. Retrospective Reporting: The evidence shows that Colleague A was directed by [Person 1] to complete a Datix report several days after the incident, not that the Registrant refused a request to do so.
4.2.3. Registrant's Datix Usage: The evidence confirms that the Registrant herself raised a Datix report regarding the system failure, demonstrating her willingness to use the Datix system when appropriate.
4.2.4. The panel has heard no direct evidence that an explicit request was made to the Registrant to complete a Datix form which she then refused.

5. CHARGE 2: EVENTS OF 2 NOVEMBER 2022

6. Charge 2: Incorrectly calculated chemotherapy infusion rate

6.1. The NMC has failed to present sufficient evidence that the Registrant incorrectly calculated a chemotherapy infusion rate on 2 November 2022.

6.2. The evidence presented by the NMC is fundamentally flawed for the following reasons:

6.2.1. Witness Uncertainty: The key witness, [Colleague B], repeatedly stated during testimony "I really cannot remember" when asked about the Registrant's involvement in the alleged incident. At page 31 of the transcript, when directly asked if she had any discussion with the Registrant about the incident, [Colleague B] stated: "I can't remember. You may have. I really cannot remember."

6.2.2. Limitation of Role: The evidence establishes that the Registrant was acting only as a second checker and was not authorized to set or adjust the infusion pump due to lack of SACT training.

6.2.3. Division of Tasks: The Legal Assessor clarified at page 508 of the transcript that what was occurring was "not somebody doing something and somebody checking it, but one task being divided between two people," which reflects a systemic issue rather than individual error.

6.2.4. System Failure: Witness testimony confirmed at page 408 of the transcript that "We've had multiple errors in the past and it was a continuous problem... we were in the middle of changing a process at the time, because there was a number of errors."

6.2.5. The evidence clearly indicates that any error was the result of a flawed system rather than individual misconduct by the Registrant.

6.3. Furthermore, the NMC has provided no evidence that the Registrant was the individual who actually calculated the infusion rate incorrectly, as opposed to merely verifying one component of a calculation performed by Colleague B.

7. CHARGES 3–5: ALLEGED INCORRECT STATEMENTS

7.1. Charges 3–5: Statements made in reflective piece and to colleagues

7.1.1. The NMC has failed to present sufficient evidence that the Registrant made incorrect statements as alleged in Charges 3, 4, and 5.

7.2. The evidence is fundamentally deficient for the following reasons:
7.2.1. Hearsay Evidence: The evidence regarding alleged conversations with Colleague C on 8 November 2022 is entirely hearsay. Colleague C was not present during the medication incident and has no direct knowledge of what actually occurred.
7.2.2. No Contemporaneous Records: The NMC has produced no contemporaneous records of the alleged conversations or statements, relying instead on retrospective accounts.
7.2.3. Missing Documentation: The NMC has failed to produce the original reflective piece allegedly sent to Colleague C on 3 November 2022, making it impossible to verify its contents.
7.3. Discrepancy in Dates: There are significant discrepancies in the dates and times of alleged conversations, raising serious questions about the reliability of the evidence.
7.4. In relation to Charge 3(c) regarding the statement that the Registrant "was not chemotherapy trained," the evidence supports the truth of this statement:
7.4.1. No evidence has been presented that the Registrant completed the required SACT theory 2-day training or competency assessment.
7.5. Witness testimony confirms that there were systemic issues with training across the Trust, with various staff administering SACT without proper training.
7.6. The SACT policy did not clearly define who could or could not administer SACT.
7.7. Evidence was produced to the effect that the prior system was recognised as flawed and needed changing.

8. CHARGE 6: DISHONESTY

8.1. The NMC has presented no credible evidence to support the allegation of dishonesty in Charge 6.

8.2. The charge alleges that the Registrant "admitted to Colleague C on 8 November 2022 that you were lying," yet:
9. There is no contemporaneous record of this alleged admission.

10. The evidence of Colleague C is inherently unreliable as she was not present during the original incident and has provided inconsistent accounts.

11. No other witness has corroborated this alleged admission.

12. The NMC has not produced any written or recorded evidence of this alleged admission.

12.1. For a finding of dishonesty, the panel must apply the test established in Ivey v Genting Casinos [2017] UKSC 67, which requires consideration of the Registrant's actual state of mind. The NMC has presented no evidence of the Registrant's state of mind beyond the uncorroborated hearsay testimony of Colleague C.

12.2. [PRIVATE].

13. SYSTEMIC ISSUES VS. INDIVIDUAL RESPONSIBILITY

13.1. The evidence presented by the NMC consistently points to systemic issues rather than individual failings:

13.1.1. Inconsistent SACT Protocols: Evidence confirms that SACT protocols across the UK are not standardized, as acknowledged by the UK SACT Board and UKONS (2022).

13.1.2. Training Inadequacies: Evidence shows that in the same Trust, SACT is administered by ICU registrants and discontinued by District Nurses without specific training, demonstrating inconsistent standards.
13.1.3. Process Changes After Incident: Witness testimony confirms at page 467 of the transcript that processes were changed after the November 2022 incident from "one person calculating and one person putting in the volumes into the pump" to independent calculations by both nurses.
13.1.4. Multiple Previous Errors: [Witness 2] confirmed at page 408 that "We've had multiple errors in the past and it was a continuous problem."
13.2. These systemic issues render it improper to attribute individual culpability to the Registrant for what are clearly organizational and procedural failures.

[PRIVATE]

15. CONCLUSION
15.1. For the reasons set out above, it is submitted that:
15.1.1. There is no evidence, or no sufficient evidence, to establish essential elements of the charges against the Registrant;
15.1.2. Such evidence as has been presented is of such tenuous character that no reasonable panel, properly directed, could find the charges proven to the requisite standard;
15.1.3. The evidence consistently points to systemic issues rather than individual misconduct;
15.1.4. [PRIVATE]*.*
15.2. The panel is therefore invited to find that there is no case for the Registrant to answer and to dismiss all charges."

Mr Holborn supplemented his written submissions with brief oral submissions.

In response to this application, Dr Joshi directed the panel to NMC's guidance on *'Evidence'* (ref: DMA-6) and '*Making decisions on dishonesty charges and the professional*

duty of candour' (ref: DMA-8). He explained that the panel's task was to consider whether there was evidence on which a reasonable panel could properly find the charges proved. In doing so, the panel had to assess the relevance, fairness, consistency, weight, and credibility of the evidence.

Dr Joshi disagreed with a number of claims made in your no case to answer application. For instance, where you stated that the NMC had failed to present sufficient evidence, Dr Joshi pointed out that this presupposed the existence of evidence, and it was for the panel to determine its sufficiency. He took the same position regarding your assertion that the evidence was circumstantial, arguing that circumstantial evidence was still evidence and could form the basis of findings of fact.

Dr Joshi disagreed with your contention that the evidence of Colleague A was inherently unreliable. He maintained that questions of reliability and credibility were for the panel to assess, using standard tools such as consistency with contemporaneous records, internal coherence, and previous accounts. He referenced a particular paragraph in your submission that pointed to evidence about a Datix report being completed under the direction of another staff member. Dr Joshi said this was a concrete example of the fact that evidence had been presented, and that its strength or reliability was a matter for the panel.

Dr Joshi addressed your arguments relating to witness uncertainty and argued that uncertainty is a feature of many hearings, and it is for the panel to determine whether it undermines the essential foundation of a charge. He likewise disagreed with your claim that errors stemmed solely from systemic failings, arguing that while such factors might mitigate personal responsibility, he submitted that they still existed within the framework of evidence to be evaluated.

Dr Joshi challenged the assertion that there was no credible evidence to support allegations of dishonesty. He reminded the panel that the dishonesty guidance in DMA-8 required a consideration of what you knew or believed, what expectations were upon you

at the time, and whether alternative explanations were more likely. The panel would also need to assess whether your actions were dishonest by the standards of ordinary people. He noted that the evidence suggested you had provided inconsistent accounts – at times saying one thing and later revising or contradicting that statement. This, in his submission, was further evidence for the panel to weigh. He acknowledged that assessing dishonesty involves evaluating your state of mind, but he said this must be done in the context of all the evidence, including documentary exhibits and witness statements.

Dr Joshi concluded by stating that your no case to answer submission was premised on challenging the weight and credibility of the NMC's evidence. However, the legal test was not whether the panel found the evidence persuasive at this stage, but whether there was any evidence on which a reasonable panel could find the charges proved. In his respectful submission, such evidence did exist, and the matter should proceed to be determined on its merits.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

The panel has carefully considered the application made on your behalf that there is no case for you to answer in respect of the charges brought against you. This application was made in accordance with the principles set out in *R v Galbraith* [1981] 1 WLR 1039, and the Nursing and Midwifery Council's guidance, particularly at DMA-6.

In reaching its decision, the panel has made an initial assessment of all the evidence that has been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented such that it could find the facts proved and whether you had a case to answer.

The legal test required the panel to consider:

- Whether there is no evidence upon which a reasonable panel could properly find the facts proved, or
- Whether the evidence is so tenuous or inconsistent that no reasonable panel could properly find the facts proved.

The panel was very mindful of its responsibility to act in the public interest and, as a committee of enquiry, to ensure that this case is correctly pleaded. It considered your application carefully and, in respect of each individual allegation, it analysed the evidence relied on by the NMC and decided if there was a case to answer in respect of each particular allegation.

In respect of charge 1a, the panel considered that there was no contemporaneous record of the correct weight of the patient. The panel had no documentation from the consultant who is said to have identified the error, nor were there system audit logs or handwritten notes to corroborate the claim. The key witness (Colleague A) could not provide these details in her witness statement, nor in her contemporaneous local statement from the time of the incident. The panel noted that the contemporaneous electronic or hard copy patient record was not available. Accordingly, the panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of this charge proved. The panel therefore allowed the no case to answer application in respect of charge 1a.

In respect of charge 1b, the panel considered that although you assert that there was no contemporaneous request to complete the Datix form, Colleague A's statement indicated otherwise. There was some evidence that you were involved in the discussion about the incident, and questions surrounding whether you later agreed or refused to complete the Datix form are matters for the panel to determine in full at the fact-finding stage. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

In respect of charge 2, the panel took into account that while you have asserted that your role was only to second check the infusion rate and that you were not SACT trained at the time, there is evidence that you participated in the process and that the checking involved reviewing calculations. Witness statements from colleagues, including Colleague B, addressed your involvement, even where their recall was limited. The panel was of the view that the issue of the extent of your role in respect of this charge and accountability form part of the panel's deliberations at a later stage and are not grounds for a no case to answer at this point. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

In relation to charge 3, the panel heard evidence regarding the reflective piece that you supplied to the Trust and it heard oral evidence from Colleague C regarding this. These are matters to be assessed at the fact-finding stage. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

In respect of charge 4, the panel heard evidence from Colleague B regarding the incident and had the benefit of her local and witness statements. The panel determined that whether those statements were made or accurately reflected your training status is a matter for later evaluation at the facts stage. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

In respect of charges 5a and 5b, the panel noted that the evidence relied upon included that of hearsay evidence presented through Colleague C's account. This constitutes admissible evidence which the panel may consider. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not

prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

In respect of charge 5c, the panel noted that Colleague C, who was present during the relevant meeting, could not recall the statement being made and explicitly said that this was not discussed. The meeting notes contain no reference to the alleged statement. The panel had no statement from Colleague D, nor any other direct or corroborative evidence. As such, the panel concluded that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of this charge proved. The panel therefore allowed the no case to answer application in respect of charge 5c.

In respect of charge 6, the panel was aware that Colleague C's evidence of this alleged admission may be disputed. However, it was recorded in her witness account and formed part of the NMC's case. The panel's assessment of your state of mind and whether ordinary standards of honesty were breached, must be considered after hearing all of the available evidence. At this stage, the panel determined that the evidence is not so weak or tenuous that it cannot be considered further. The panel was of the view that there had been sufficient evidence to support this charge at this stage and, as such, it was not prepared to accede to an application of no case to answer. What weight the panel gives to this evidence remains to be determined.

Decisions and reasons on application to adjourn

[PRIVATE].

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

[PRIVATE].

The panel has decided that the remainder of this hearing will be held in private under Rule 19, [PRIVATE].

Decision and reasons on application to adjourn

[PRIVATE].

[Hearing adjourned on 6 June 2025].

[Hearing resumed on 2 February 2026].

Decision and reasons on application to adjourn

On day 10 of the hearing (2 February 2026, the first day of the resumed hearing), Mr Holborn submitted a second witness statement and second bundle on your behalf, the latter being 1060 pages in total. The panel noted that this bundle would take some considerable time to read. The panel also noted that within your second witness statement, you included part of the NMC Case Examiner's (CE) decision.

The panel invited parties to make submissions on how much time would be required to read the on tables, given the substantial amount of documents. It also requested that the CE decision be provided to the panel by the NMC to give context to the assertions made by you within your on-table bundle.

Dr Joshi submitted that the CE decision is not relevant. He reminded the panel that any decision made at this hearing is the panel's decision, and it should not be influenced by decisions made by anyone else. However, the CE decision could be provided if the panel deemed it necessary.

Dr Joshi submitted that the lateness of the documents being provided to the panel by Mr Holborn today should never have happened. He submitted that Mr Holborn has not identified the relevance of the material contained in the bundles and this must also be considered. He submitted that it would take him some considerable time to read the

documents and go through all of the material which has been disclosed previously. Dr Joshi submitted that as well as reading over 1060 pages, he also has to look at the charges, the previous bundles and the various other relevant material in this case. He submitted that this is something which the panel will also have to do as judges of fact and law. Dr Joshi submitted that the hearing should resume on day 12 (Wednesday 4 February 2026) to allow appropriate time for preparation.

Mr Holborn told the panel that he endorsed Dr Joshi's suggested reading and preparation time. He explained that he would also provide the panel with an index to assist them in navigating the contents of the 1060-page bundle and would in due course identify the relevance of the material contained within the documents.

At the panel's request, Dr Joshi agreed to provide the panel with an NMC evidence matrix.

After considering the submissions made by Dr Joshi and Mr Holborn, the panel decided to adjourn proceedings until 12 noon on day 11 of the hearing (Tuesday 3 February 2026) to allow reading and preparation time. The panel, mindful of its responsibility to ensure that this hearing must be managed both fairly and expeditiously, considered that this would be a reasonable time to allow Dr Joshi to consider the documentation and take instructions as necessary. The panel made it clear that if for any reason Dr Joshi needed extra time to consider the documentation and take instructions, this would be considered. The panel also directed that during this adjournment, it should be provided with an evidence matrix by Dr Joshi, and a registrant bundle index and a registrant's evidence matrix by Mr Holborn.

In conclusion, the panel decided to adjourn proceedings until 12:00 noon on day 11 of the hearing.

Application to exclude the Registrant's 1060-page bundle (Exhibit 15)

Dr Joshi made an application under Rule 31 of the NMC Fitness to Practise Rules 2004 (the 'Rules') to exclude the whole of your 1060-page Registrant bundle, Exhibit 15, submitted by you on 2 February 2026. He submitted that the bundle is irrelevant to the factual charges in this case and a great deal of the contents are prejudicial and incapable of being tested. He submitted that the bundle also contains unverified assertions which require expert witness evidence. Dr Joshi submitted that the NMC invites the panel to exclude the bundle in full.

Dr Joshi referred the panel to Rule 31 of the Rules and reminded the panel that evidence may only be admitted if relevant, the admission is fair, it is effectively capable of being tested and does not cause undue prejudice.

Dr Joshi directed the panel to the charges in this case which relate to refusal to complete a Datix, incorrectly calculating infusion rates, inconsistent statements, and dishonesty. He took the panel through the bundle in detail and submitted that the bundle does not address the charges but instead deals with a number of 'collateral' matters. Dr Joshi submitted that the matters put forward in the bundle are assertions of fact. He submitted that certain matters are not capable of being tested and relate to people who are not witnesses in these proceedings, whose evidence cannot therefore be tested under cross examination, and clinical assertions which require expert witnesses.

Dr Joshi stated that you will have had many of the documents within this bundle at the time of the substantive hearing in April and June 2025 and questioned why you were choosing to submit them now.

In conclusion, Dr Joshi submitted that the bundle is prejudicial and allowing it into evidence risks confusing the issues in this case. He submitted that the bundle distracts from the factual issues and risks unfairly portraying colleagues. He submitted that as this bundle was not admitted into proceedings prior to hearing evidence from the NMCs witnesses, it would be unfair to admit this bundle into evidence at this stage.

Mr Holborn submitted that it is entirely fit and proper to admit the entire bundle into evidence. He explained to the panel that you regretted the lateness of submitting the bundle. He submitted that you are seeking to provide the panel with a full and open picture of what happened and why, and you are focussed on the issues of the charges and the defeat of those charges. Mr Holborn submitted that it is for the NMC to prove its case and you take the view that there has been a lack of providing suitable and appropriate information by the NMC in this case.

Mr Holborn submitted that the bundle gives wider background context to issues of this case and it is relevant. He submitted that it can be tested and the panel can attribute appropriate weight to the documents included in the bundle as it sees fit.

In conclusion, he submitted that the bundle should be admitted into evidence as it is relevant and fair.

The panel heard and accepted the advice of the legal assessor. He referred the panel to Rule 31 of the Rules and NMC guidance DMA-6 *'Evidence'*, last updated on 9 June 2025. His advice included that Rule 31 provides that, so far as it is 'relevant and fair', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor advised the panel that it should consider the admissibility of each of the documents separately.

The panel considered the submissions of Dr Joshi and Mr Holborn. It had regard to rule 31 of the Rules, NMC guidance DMA-6, *'Evidence'*, and FTP-12 *'Taking account of context'*, last updated on 6 May 2025.

In making its decision, the panel considered each of the itemised documents included in your 1060-page registrant bundle separately, as listed in your registrant index and evidence matrix.

In assessing the 32 documents contained within your second evidence bundle, the panel took into account your submissions in relation to the context of the Trust's referral to the NMC, evidence provided by the Trust to the NMC and noted your submission that your employer made its referral to the NMC purely as a result of concerns you raised with the Trust. However, this context was only taken into account by the panel at this stage where it could reasonably be considered to be relevant to the outstanding charges and the facts stage of these proceedings. The panel also reserved its position as to what, if any, weight it should attach to any of the evidence at this stage.

Decision and reasons on NMC application to exclude the Registrant's 1060-page bundle (Exhibit 15)

Item 1 – *Exchange of emails between you and employee relations at the Trust in December 2021, confirming a temporary transfer of departments*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 2 – *Internal email, dated 29 July 2022, relating to proposed transfer*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 3 – *Email exchange regarding training certificates, dated 16 August 2022*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 4 - *Email exchange regarding training certificates, dated 16 August 2022*

The panel noted that Item 4 is a duplicate of Item 3. Therefore, the panel determined that Item 4 is not relevant and is excluded from evidence.

Item 5 – *Internal email regarding data breach, dated 25 March 2024*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 6 – *Letter from you to the Trust requesting a transfer, dated 19 April 2021*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 7 – *Undated email to you regarding a data breach*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 8 – *Internal email regarding an unknown incident, dated 12 November 2021, without attachment referred to*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 9 – *Trust Adverse Incident Policy, dated June 2021*

The panel considered the document to be relevant to the remaining charges as it gives the panel context of the expectations which are upon staff working at the Trust in relation to incident reporting. The panel noted that it may have expected the NMC itself to produce this document to prove your responsibilities at the time of the incidents. The panel considered that admitting Item 9 into evidence would be fair to both parties as it is a Trust

Policy and it is both in the interest of public protection and public interest to take any relevant Policy documentation into account in this case.

Accordingly, the panel determined that it would be fair to accept Item 9 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Item 10 – *NIPEC Clinical career pathway document, dated November 2025*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it. The panel also noted that Item 10 was not referred to in your evidence matrix as relative to any of the outstanding charges and is dated November 2025 which is some three years after the second incident reflected in the charges.

Item 11 – *Email regarding the disclosure of information to you, dated 28 November 2025*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 12 – *Internal email regarding concerns you raised with the Trust regarding patient care, dated 2 November 2021*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 13 – *National Institute for Health and Care Excellence document 'managing advanced breast cancer', dated September 2021*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 14 - *General Medical Council (GMC) Openness and Honesty Policy, dated June 2015*

The panel noted that this document outlines GMC guidance which you, as a registered nurse, are not subject to. It could not identify how the document is relevant to the remaining charges before the panel to determine on the facts. Therefore, the panel determined that Item 14 is not relevant and is excluded from evidence.

Item 15 – *The Inquiry into Hyponatraemia-related Deaths Report, dated January 2018*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it. The panel noted that this document is in respect of an investigation dated January 2018 and it did not consider it to be relevant to the facts of this case.

Item 16 – *NICAN Guidelines for safe prescribing SACT, dated June 2016*

The panel considered this document to be relevant to the remaining charges as it gives the panel context for the responsibilities of nurses involved in prescribing, administration, and the process of providing SACT treatment and reporting incidents. The panel noted that it may have expected the NMC itself to produce this document to prove your responsibilities at the time of the incidents. The panel considered that admitting Item 16 into evidence would be fair to both parties as it is a Trust Policy and it is both in the interest of public protection and public interest to take any relevant Policy documentation into account in this case.

Item 17 – *Trust's Guideline for the intravenous administration of medicines via peripheral access to adult and paediatric patients, dated October 2015*

The panel considered the document to be relevant to the remaining charges as it gives the panel context for the responsibilities of nurses involved in IV administration of medication and reporting incidents. The panel noted that it may have expected the NMC itself to produce this document to prove your responsibilities at the time of the incidents. The panel considered that admitting Item 17 into evidence would be fair to both parties as it is a Trust Policy and it is both in the interest of public protection and public interest to take any relevant Policy documentation into account in this case.

Item 18 – *Email to you regarding the handling of your concerns regarding patient care, dated 1 October 2021*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 19 – *Your email regarding your concerns over patient care to the Trust, dated 28 September 2021*

The panel considered this document to be relevant as it provides wider context that relates to the facts, in that you told the panel that you believe you were referred to the NMC by the Trust because you made complaints about how you had been treated at the Trust. The panel was of the view that this document is relevant to the facts stage of proceedings and is also contextual to the facts stage. The panel determined it was fair to admit Item 19 into evidence. It noted the person named within the document was not called to give evidence and none of the NMC witnesses have been referred to this document and questioned on the contents of it, which was a concern for the panel. However, the panel considered that this concern could be adequately addressed when deciding what, if any, weight to attach to this evidence. The panel also concluded that the NMC will be able to cross examine you in relation to the document when you give your evidence.

Item 20 – *Document reflecting your views regarding incident on 31 August 2021 – undated*

The panel considered that this document may relate to Charge 1b) but in all the circumstances of this case, it determined that it is not fair to admit this document into evidence at this stage. The panel was of the view that that this document could have been submitted during the first or second sitting of this hearing in April 2025 and June 2025 if contemporaneous, and the NMC witnesses have not been asked about this document or cross examined in relation to its contents. The panel noted that you are at liberty to give any evidence that you wish when giving your oral evidence in chief. Therefore, the panel determined that it would not be fair in all of the circumstances to admit this document as evidence.

Item 21 – *Presentation regarding Palbociclib management of breast cancer, dated 1 September 2021*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

Item 22 – *Incident report (DATIX), dated 2 September 2021*

The panel considered this document to have limited relevance to Charge 1b) which relates to matters not recorded in the document itself. However, as the report relates directly to the incident in question and is first hand reporting of the incident, the panel determined that the document is broadly relevant to proceedings. The panel determined it was fair to admit Item 22 into evidence as it provides overall context regarding the incident. The panel noted that it may have expected the NMC itself to produce this document in its own bundle of evidence.

The panel determined that it would be fair to accept Item 22 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Item 23 - *Email to you regarding the handling of your concerns regarding patient care, dated 1 October 2021*

The panel noted that Item 23 is a duplicate of Item 18. Therefore, the panel determined that Item 23 is not relevant and is excluded from evidence.

Item 24 - *Your email regarding your concerns over patient care to the Trust, dated 28 September 2021*

The panel noted that Item 24 is a duplicate of Item 19. Therefore, the panel determined that Item 24 is not relevant and is excluded from evidence.

Item 25 – *Document reflecting your views regarding incident on 31 August 2021 – undated*

The panel noted that Item 25 is a duplicate of Item 20. Therefore, the panel determined that Item 25 is not relevant and is excluded from evidence.

Item 26 - *Presentation regarding Palbociclib management of breast cancer, dated 1 September 2021*

The panel noted that Item 26 is a duplicate of Item 21. Therefore, the panel determined that Item 26 is not relevant and is excluded from evidence.

Item 27 – *Correspondence regarding arrangements for a Grievance Hearing, dated 7 January 2026*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it. It noted that the document appears to be related to meetings of an employment nature from 2026.

Item 28 – *Correspondence regarding an introductory management meeting, dated 16 January 2026*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it. It noted that the document appears to be related to meetings of an employment nature from 2026.

Item 29 – *Trust Policy on referral of a registrant to the NMC, dated November 2011*

The panel considered this document to be relevant to the remaining charges as it gives the panel information regarding the Trust's Policy on making referrals to the NMC. The panel was of the view that this is useful information in relation to the wider background and contextual matters of the case. The panel considered that admitting Item 29 into evidence would be fair to both parties as it is a Trust Policy and it is both in the interest of public protection and public interest to take any relevant Policy documentation into account in this case. The panel noted however that the implementation date of the Policy was November 2011, with a review set for 2013. The panel noted it was unclear whether this Policy was in place in this exact form at the material time of the incidents.

The panel determined that it would be fair to accept Item 29 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Item 30 - *Incident report (DATIX), dated 3 November 2022*

The panel considered this document to be directly linked to the incident in respect of Charges 2, 3, 4, 5 and 6 and is relevant to the facts stage. The panel was of the view that it was appropriate to see a core document in relation to the incident in question. The panel determined it was fair to admit Item 30 into evidence as it provides overall context

regarding the incident. The panel noted that it may have expected the NMC itself to produce this document in its own bundle of evidence.

The panel determined that it would be fair to accept Item 30 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Item 31 – *Correspondence to you from Hospital Care Directorate, dated 13 January 2026*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it. It noted that the document appears to be a letter from a third party dated 2026 and is not relevant to the facts stage.

Item 32 – *Email correspondence from you to the Trust regarding your NMC revalidation, dated 21 January 2026*

The panel assessed the document carefully and considered that it is not relevant to any of the remaining charges and therefore determined to exclude it from the evidence before it.

In conclusion, the panel determined that it would be relevant and fair to accept items 9, 16, 17, 19, 22, 29, and 30 into evidence. All other items included within Exhibit 15 are excluded from evidence.

Having taken into account submissions by Dr Joshi regarding the relevance of the CE report in this matter, the panel concluded that the document was potentially relevant to its consideration of the facts and accordingly the panel request that the report be provided in its complete form.

Decision and reasons on application to adjourn

Mr Holborn made an application to adjourn the hearing until lunch time tomorrow (day 13) to review the registrant bundle (Exhibit 11) which he submits was submitted in error in June 2025 by Mr Holborn's colleague. He submitted that you only became aware yesterday that this particular bundle had been submitted without your consent. He submitted that you require time to review the bundle and decide what evidence is relevant and supports your case.

[PRIVATE].

Dr Joshi submitted that you and your representative have had since June 2025 to review the evidence submitted on your behalf. He submitted that the consistent delays in this case cannot continue and therefore he opposed your application for an adjournment and submitted that no more time should be wasted.

The panel heard and accepted the advice of the legal assessor who referred the panel to Rule 32 of the Rules.

In making its decision, the panel had regard to the submissions of Mr Holborn and Dr Joshi, and the advice of the legal assessor. It also had regard to Rule 32 of the Rules and NMC Guidance CMT-11, *'When we postpone or adjourn hearings'*, last updated on 13 January 2023.

The panel acknowledges that you wish to consider the content of Exhibit 11 (107-page bundle) prior to commencing your evidence at the facts stage of proceedings. The panel was concerned that this matter had occurred 8 months after the adjournment in June 2025 and that for reasons previously explained, while you had provided a number of documents to your representatives for the purpose of creating a bundle, you did not approve any bundle prior to its submission during the June proceedings. The panel heard that you became aware of the existence of this bundle submission on Tuesday 3 February 2026.

The panel has borne in mind its duty to progress proceedings expeditiously and has balanced this against fairness to you.

The panel determined to allow an adjournment until 10:00am on Thursday 5 February 2026 (day 13). The panel considers, given your familiarity with the documents, that you discovered that this bundle had been submitted yesterday, and that you had this morning (while the panel was determining a separate application) this is a reasonable period to allow you to consider the contents of the bundle and to decide what, if any, reliance you wish to put on the contents. By allowing you until 10:00am tomorrow, this should give you enough time to give instructions to your representative as to what use, if any, you wish to make of the bundle.

The panel is concerned with the delays that have already occurred during the hearing of this case and wishes to make it clear that, in the absence of wholly exceptional circumstances, it is very unlikely to allow any further adjournments at your request.

Decision and reasons on application to amend the charge

The panel, of its own volition, proposed an amendment to the wording of Charge 1b). The panel had regard to its earlier decision in respect of Charge 1a) which resulted in no case to answer. The panel was of the view that the proposed amendment would give clarity to Charge 1b), given that Charge 1a) no longer stands.

The panel invited submissions from Dr Joshi and Mr Holborn on this matter.

Proposed amendment:

'1) On 31 August 2021:

*b) Refused to record ~~the~~ **a** clinical incident ~~at charge 1a~~ on Datix as requested by Colleague A.'*

Dr Joshi and Mr Holborn individually endorsed the panel's suggested amendment to Charge 1b).

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

The panel determined that such an amendment was in the interest of justice. It 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 therefore determined that it was appropriate to allow the amendment to Charge 1b) to ensure clarity and accuracy.

[Hearing adjourned on Friday 6 February 2026]

[Hearing resumed on Monday 16 February 2026]

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Dr Joshi and Mr Holborn.

The panel also had regard to its earlier decision where it determined that there was no case to answer in respect of Charges 1a) and 5c).

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

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

- Witness 1: Senior Registered Nurse at the Trust

- Witness 2: Colleague A. Deputy Sister and Registered Nurse at the Trust
- Witness 3: Colleague B. Registered Staff Nurse at the Trust
- Witness 4 : Colleague C. Registered Nurse and Ward Manager at the Trust

The panel received two witness statements and two bundles of documents from you. It 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 by you, and the relevant NMC Guidance set out for Fitness to Practise panels.

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

Charge 1b)

'1) On 31 August 2021:

b) Refused to record a clinical incident on Datix as requested by Colleague A.'

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to the written and oral evidence of Witness 1

and Colleague A, the Trust's Adverse Incident Reporting Policy, dated June 2021, and the Datix relating to the incident.

The panel noted the evidence of Colleague A, who was senior to you on the Ward, in which she stated that she asked you to complete a Datix relating to the incident but you refused. She told the panel that you stated that you did not believe it was necessary to complete a Datix in relation to the incident but if Colleague A felt it necessary, she should fill in the Datix herself.

The panel noted your evidence in which you stated that you did not believe it was necessary to complete a Datix, and a medical colleague told you that they did not believe a Datix was warranted in the circumstances which also informed your decision making.

The panel heard that Colleague A completed the Datix after you did not.

Having reviewed the Trust Adverse Incident Policy, the panel was of the view that a Datix was necessary in line with the Policy. The panel was of the view that your assertions in relation to a medical colleague's opinion does not negate your duties as a registered nurse in following Policy regarding the reporting of incidents.

You told the panel that on your reading of the Adverse Incident Policy, anyone could complete a Datix report – so Colleague A could complete one if she chose. Having considered the Policy, the panel noted that all staff were responsible for reporting adverse incidents. The panel was of the view that the fact remains that you were asked to complete a Datix report by a nurse senior to you as you were directly involved in the incident, and you did not do so.

The panel noted your evidence in which you stated that you did not *refuse* to complete the Datix. However, the panel was of the view that your words to Colleague A were such that, in effect, you were refusing to complete a Datix in relation to the incident.

Therefore, the panel found this charge proved.

Charge 2

> *'2) On 2 November 2022, whilst working with Colleague B, incorrectly calculated a chemotherapy infusion rate.'*

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to the written and oral evidence of Witness 1, Colleague B, and Colleague C.

The panel acknowledged your evidence that you gave Colleague B the volume of one bag of IV medication as you believed that was what you were being asked for. However, Colleague B told the panel that she asked you for the total volume of both bags of IV medication.

The panel took into account an email provided by Colleague C during the course of her evidence, dated 4 November 2022, from a deputy sister in the Sperrin Suite. It outlined that you had undertaken on 31 October 2022 *'on the ward'* training as second checker of haematology chemotherapy. However, the panel acknowledged that this was not the identical chemotherapy administered on the day of the incident.

Having considered the oral and written evidence provided in this case, on the balance of probabilities, the panel preferred the evidence of Colleague B. It determined that it is more likely that Colleague B, as a SACT trained nurse, would request the volume of both bags of IV medication to calculate the rate of the infusion at the pump particularly as Colleague B gave evidence, which the panel accepted, that she had not carried out her own calculations. The panel was of the view that Colleague B was an experienced SACT trained nurse and she would therefore know that the volumes of both bags of IV

medication would be required for her to then calculate the rate of administration. Given this, the panel determined that it was inherently improbable that Colleague B would have only asked for the volume of one bag of IV medication.

The panel determined that you did have a responsibility as the second checker to ensure that the correct calculations were made in respect of the medication being administered correctly in line with Policy.

Therefore, the panel found this charge proved.

Charge 3a)

> *'3) On 3 November 2022 in a reflective piece sent to Colleague C incorrectly stated that:*
>
> *a) Colleague B asked you to verify the volume of just one of the drugs.*
>
> *b) …*
>
> *c) …'*

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece, dated 3 November 2022, and the written and oral evidence of Witness 1, Colleague B, and Colleague C.

The panel heard evidence, which was not challenged, that at the time of the incident the process was that SACT trained nurses administering IV medication did not calculate volumes of IV medication, this was the responsibility of a second checker nurse who calculated the total volume of the IV medication and confirmed this to the Nurse administering the medication. Shortly after this incident, this process was reviewed and

changed on the Ward (partly as a result of the incident) so that both nurses independently calculate the volume of IV medication and check calculations together.

The panel accepted your statement that you were new to the ward and the processes on that ward.

The panel had regard to Colleague B's oral and written evidence in which she consistently stated that she asked you to confirm the total volume of the two bags of IV medication.

In your reflective piece, dated 3 November 2022, you stated:

> *'However, after hanging the bags the RGN asked me to verify the volume of just one of the drugs.'*

The panel was of the view that Colleague B's evidence in regard to the volume of IV medication has been consistent. Additionally, the panel was of the view that Colleague B's evidence was supported by the evidence of Colleague C who explained that Colleague B was an experienced SACT trained nurse whom she had worked with for a year. Colleague C stated that she had observed Colleague B's practice and in respect of adding the volume of the two bags of IV medication, saying:

> *'[Colleague B] does it this way every time'.*

The panel was of the view that it was inherently improbable on this one occasion that Colleague B would not follow her usual practice and the standard practice used throughout this department in respect of following medication administration Policy. The panel also noted that Colleague B displayed candour during the investigation of the incident in that she agreed that she did not calculate the volume of the IV medication herself and was relying solely on your calculation. The panel determined it was highly unlikely that Colleague B would only ask for one of the IV medication bags volume as this would inevitably lead to unsafe administration of medication to a patient.

Therefore, the panel found this charge proved.

Charge 3b)

'3) On 3 November 2022 in a reflective piece sent to Colleague C incorrectly stated that:

a) ...
b) Colleague B then set her calculations into the pump
c) ...'

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece, dated 3 November 2022 and the written and oral evidence of Witness 1, Colleague B, and Colleague C.

Having considered all the evidence before it, the panel concluded that Colleague B did set calculations into the IV medication pump following an exchange with you regarding IV medication volumes. This was not disputed by either party. Colleague B undertook additional calculations in regard to the hourly infusion rate and, as a consequence, it was not incorrect for you to state in your reflective piece, dated 3 November 2022, that:

'[Colleague B] then set her calculation into the pump and went ahead with starting pump'.

Consequently, this charge is found not proved.

Charge 3c)

‘3) On 3 November 2022 in a reflective piece sent to Colleague C incorrectly stated that:

a) ...

b) ...

c) you were not chemotherapy trained.’

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece, dated 3 November 2022 and the written and oral evidence of Witness 1, Colleague B, and Colleague C.

It was not disputed in these proceedings that you were not SACT trained.

The panel had regard to your reflective piece, dated 3 November 2022, in which you stated:

‘as I am not chemotherapy trained, I could not handle medication’.

The panel noted that the NMC provided a copy of your training record, as of 10 December 2021, which contained no reference to you having completed any chemotherapy training, and there was no further information provided by the NMC regarding any such training completed since 10 December 2021.

The panel noted an email provided by Colleague C, dated 4 November 2022, which confirmed that you undertook ‘on the ward’ training on 31 October 2022 regarding some aspects of chemotherapy administration. However, it was not proposed by the NMC that this was ‘formal’ chemotherapy training of the type that would be recorded in training records and if it had been, the panel would have expected to see the updated records as at the date of the incident.

The panel concluded that when you stated you were not ’chemotherapy trained’, on balance of probabilities, this was correct.

Consequently, this charge is found not proved.

Charge 4

> *‘4) On 3 November 2022 in a local statement incorrectly stated that Colleague B had indicated to only one volume of chemotherapy bag’*

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your local statement, dated 3 November 2022 and the written and oral evidence of Witness 1, Colleague B, and Colleague C. The panel noted that this charge relates to the contents of your local statement, dated 3 November 2022 at 13:05, which was provided to Colleague C.

The panel heard evidence, which was not challenged, that at the time of the incident the process was that SACT trained nurses administering IV medication did not calculate volumes of IV medication, this was the responsibility of a second checker registered nurse who calculated the total volume of the IV medication and confirmed this to the Nurse administering the medication. Shortly after this incident, this process was reviewed and changed (partly as a result of the incident) so that both nurses calculate the volume of IV medication and check calculations together.

The panel accepted your statement that you were new to the ward and the processes on that ward.

The panel had regard to Colleague B’s oral and written evidence in which she consistently stated that she asked you to confirm the total volume of the two bags of IV medication.

In your local statement, dated 3 November 2022, you stated:

> *'She asked me for the volume I stated 266mls. She was entering the details into the pump. She asked for the volume again. I asked for both or one of the bags? She pointed to one of the bags so I called out the volume in and around 250mls.'*

The panel was of the view that Colleague B's evidence in regard to the volume of IV medication has been consistent. Additionally, the panel was of the view that Colleague B's evidence was supported by the evidence of Colleague C who explained that Colleague B was an experienced SACT trained nurse whom she had worked with for a year. Colleague C stated that she had observed Colleague B's practice and in respect of adding the volume of the two bags of IV medication, saying:

> *'[Colleague B] does it this way every time'.*

The panel was of the view that it was inherently improbable on this one occasion that Colleague B would not follow her usual practice and the standard practice used throughout this department at the time. The panel also noted that Colleague B displayed candour during the investigation of the incident in that she agreed that she did not calculate the volume of the IV medication herself and was relying solely on your calculation. The panel determined it was highly unlikely that Colleague B would only ask for one of the IV medication bags volume as this would inevitably lead to unsafe administration of medication to a patient.

Therefore, the panel found this charge proved.

Charge 5a)

> *'5) On 8 November 2022 incorrectly told Colleague C that:*

a) *Colleague B did not ask you to calculate the volumes of 2 bags of chemotherapy.*
b) *…'*

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece, dated 3 November 2022, and subsequent local statement, also dated 3 November 2022. It also had regard to the written and oral evidence of Witness 1, Colleague B, and Colleague C. The panel noted that this charge relates to a meeting which took place on 8 November 2022 at 14:00 with Colleague C.

The panel heard evidence, which was not challenged, that at the time of the incident the process was that SACT trained nurses administering IV medication did not calculate volumes of IV medication, this was the responsibility of a second checker who calculated the total volume of the IV medication and confirmed this to the Nurse administering the medication. Shortly after this incident, this process was reviewed and changed (partly as a result of the incident) so that both nurses calculate the volume of IV medication and check calculations together.

The panel accepted your statement that you were new to the ward and the processes on that ward.

The panel had regard to Colleague B's oral and written evidence in which she consistently stated that she asked you to confirm the total volume of the two bags of IV medication.

The panel was of the view that Colleague B's evidence in regard to the volume of IV medication has been consistent. Additionally, the panel was of the view that Colleague B's evidence was supported by the evidence of Colleague C who explained that Colleague B was an experienced SACT trained nurse whom she had worked with for a year. Colleague

C stated that she had observed Colleague B's practice and in respect of adding the volume of the two bags of IV medication, saying:

'[Colleague B] does it this way every time'.

The panel was of the view that it was inherently improbable on this one occasion that Colleague B would not follow her usual practice and the standard practice used throughout this department at the time. The panel also noted that Colleague B displayed candour during the investigation of the incident in that she agreed that she did not calculate the volume of the IV medication herself and was relying solely on your calculation. The panel determined it was highly unlikely that Colleague B would only ask for one of the IV medication bags volume as this would inevitably lead to unsafe administration of medication to a patient.

Therefore, the panel found this charge proved.

Charge 5b)

'5) On 8 November 2022 incorrectly told Colleague C that:
a) …
b) you had calculated the volume of 2 bags of chemotherapy.'

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece and local statement, both dated 3 November 2022, and the written and oral evidence of Witness 1, Colleague B, and Colleague C.

The panel considered that the NMC had not demonstrated to the panel through evidence that you did not calculate the volume of two bags of chemotherapy. The panel noted that it

had been provided with evidence to support that you did not pass on the volume calculation of both bags of IV medication to Colleague B, but there was no evidence to suggest that you did not complete the calculation for both bags. You told the panel that you had calculated the volume of both bags *'in your head'* and wrote a note of this on a piece of paper and the panel had no reason to reject this evidence.

On balance, the panel determined that from the evidence you gave, you did calculate the volume of two bags of chemotherapy - but you did not pass this information on to Colleague B.

The panel found this charge not proved.

Charge 6

> *'6) Your conduct at charges 3-5 was dishonest in that you admitted to Colleague C on 8 November 2022 that you were lying.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence in this case. It had particular regard to your reflective piece and your local statement, both dated 3 November 2022, the meeting notes from 8 November 2022 and the written and oral evidence of Colleague C.

The panel acknowledged that charges relating to dishonesty can be particularly serious. It had regard to the case of *Ivey v. Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, which sets out the test for dishonesty. It also had regard to the NMC Guidance DMA-8 '*Making decisions on dishonesty charges and the professional duty of candour'*, [last updated on 6 May 2025].

The panel also took into account the advice of the legal assessor and in particular the need to make a finding of fact as to your state of mind in relation to the charge of

dishonesty. In other words, did you know that you were being asked about the volume of both bags and not just of one bag? If you knew that you were being asked about the volume of both bags, did you know that you were giving an inaccurate answer? If you knew that you were giving an inaccurate answer, would your action be regarded as dishonest by the standards of ordinary decent people?

The panel considered this charge with great care, mindful that a charge of dishonesty is one of the most serious charges that a registrant can face. The panel found many aspects of the NMC's case against you in relation to this charge unsatisfactory. First, the evidence matrix that was supposed to indicate the NMC evidence in support of this charge was completely blank. Secondly, Colleague C is the only witness who attended the meeting on 8 November 2022 at which you are alleged to have admitted making a dishonest statement but her witness statement does not refer to this meeting at all or to your alleged admission of dishonesty. Nor has any explanation been provided for her failure to address this omission, either in her witness statement or in her oral evidence. The only witness who did address this issue was Witness 1, but she was not present at the meeting so her evidence was hearsay evidence to which the panel felt unable to attach much weight, given that you strongly denied that you had made any admissions at this meeting. The panel was also troubled by the fact that there was one other person present at the meeting, the practice educator, who could have made a witness statement but did not do so and no explanation was given for this omission either.

A third unsatisfactory aspect of the evidence was the notes of the meeting on 8 November 2022 which were unsigned and undated and, according to you, had not been shared with you to afford you the opportunity to comment on or agree the contents. Also, the contents themselves were inconsistent and did not appear to make sense. For example, it is alleged that you initially admitted that you had lied in the statement of events you made at 13:05 in which you claimed that you had told Colleague B not only that the volume of one bag was 250ml but also that the total volume of 2 bags was 550ml. It is further recorded that you said that you had lied in this way in order to protect Colleague B and avoid her getting into trouble, but the panel finds this explanation impossible to understand because,

if you had said what is recorded, this would have been more likely to get Colleague B into trouble, rather than the opposite. Moreover, later in the notes it is recorded that you effectively withdrew this alleged admission and stated that the statement of events was an accurate account of what had happened and, insofar as they were different, it was your earlier reflection which was inaccurate.

The panel also took into account the fact that you are reported as saying in the meeting note, when confronted by Colleague C with the apparent inconsistency between your reflection and your statement of events, that you could not remember which statement was correct. In all the circumstances, the panel is not satisfied that you knew that any of the statements that you allegedly made during this meeting was inaccurate, in which case there is no proper basis for a finding of dishonesty being made against you.

The panel also took into account that you had been of previous good character with no allegations previously made against you regarding your honesty and you were consistent in refuting the claims of Colleague C that you had lied during the meeting on 8 November 2022.

Overall, the panel concluded that the evidence about your alleged dishonesty was so unclear and internally inconsistent that it was not possible for the panel to be satisfied that the allegation of dishonesty was made out against you.

Therefore, the panel found this allegation not 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, 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. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

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

Dr Joshi referred the panel to the NMC Guidance FTP-2a, *'Misconduct'*, last updated on 6 May 2025. During the course of his submissions, he identified the specific, relevant standards where he submitted that your actions amounted to misconduct, namely: 1.2, 2.1, 8, 8.1, 8.2, 8.4, 8.5, 8.6, 9.2, 9.3, 10.1, 11.1, 19, 20.3.

Dr Joshi submitted that the facts found proved relate to incidents which were completely avoidable and there was no reason why you could not have done what was expected of you at the time. He submitted that the NMC witnesses stated that these incidents were 'learning points', and whether you filled in a Datix or not would not have led to anything of

great seriousness. He submitted that it would have been possible for you to remediate and take steps to address the issue arising at the Trust level.

Dr Joshi submitted that the patients in your care were vulnerable undergoing Chemotherapy treatment for Cancer. He submitted that patients undergoing such treatment want reassurance that administration of medication is undertaken carefully and that those administering the medication act with integrity at all times. Dr Joshi submitted that as a result of what took place, a patient suffered in that he had to wait some 45 minutes to complete his treatment.

Dr Joshi reminded the panel that it is required to determine whether you have maintained the professional standards expected of a registered nurse and whether you have upheld public confidence in the nursing profession. He submitted that the panel also needed to determine whether there are deep seated attitudinal issues present which could put patients at risk.

Dr Joshi submitted that the NMC remained concerned that your behaviour following the incidents suggested an arrogant attitude. He suggested that this increased the risk to patients.

Mr Holborn submitted that you accept the panel's findings in relation to Charge 1b) and now see that you should have completed the Datix and going forward, you would do things differently in the future. He submitted this is a minor issue and does not amount to misconduct. He further submitted that the panel should consider the context including that you were new on the Ward, were not SACT trained, and the RISOH system was down and you were not able to access it.

In respect of the infusion rate error, Mr Holborn submitted that you were not SACT trained and the process at the time was flawed, resulting in a change of process on the Ward. He submitted that patients were not harmed and this was human error due to a flawed system.

Mr Holborn submitted that the charges in respect of your inaccurate accounts were not found to be dishonesty by the panel. However, he submitted that your actions in respect of the inaccurate accounts represents mild-moderate misconduct.

Mr Holborn concluded by submitting that you apologised to the patients in relation to the two incidents at the material times.

Submissions on impairment

Dr Joshi 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. He referred the panel to the NMC Guidance DMA-1 *'Impairment',* last updated on 28 January 2026.

Dr Joshi submitted that you have displayed an attitude of arrogance throughout these proceedings in that as far as you are concerned, you are '*always right'*, and there is no room for any other view. He submitted that patients in your care were dealing with the reality of Cancer and Chemotherapy treatment and they would be concerned if a nurse providing care to them simply decided she would choose which tasks to complete in respect of their care, followed by justifying those actions and not being open to being *'wrong'*.

Dr Joshi submitted that patients receiving care at the time of the incidents were at risk of unwarranted harm. He submitted that you have not taken any steps to strengthen your practice despite the fact that there was no reason why the concerns could not have been addressed by you at any time since the incidents occurred. Further, he submitted that this was due to you believing you were always 'right' and that that if you were to return to the clinical setting, it is likely this conduct would be repeated by you.

Dr Joshi submitted that your conduct was demonstrative of attitudinal issues. He submitted that this places patients at risk of harm and undermines public confidence in the profession and the standards of the nursing profession.

Mr Holborn submitted that you do not accept the NMCs submission that you believe yourself to always be right and never ‘wrong’. He referred the panel to the documentary evidence provided by you in which he stated that you accept what you did and gave explanations for your actions.

Mr Holborn submitted these were one off events with no other issues arising throughout your career. He told the panel that the Datix disagreement was a minor matter and going forward you would do things very differently. Mr Holborn submitted that medication errors are serious and clinical errors create risk, although no actual harm occurred. Mr Holborn told the panel that going forward you would never take on a task that you were not trained for.

[PRIVATE].

Mr Holborn told the panel that you reported the medication error immediately and escalated it appropriately, and the clinical error occurred in a specific set of circumstances. He submitted that you have engaged in reflective practice, demonstrating insight into how you would act differently in the future, and you have completed CPD through your own initiative. He submitted that patients would not be at risk under your care.

In conclusion, Mr Holborn submitted that you acknowledge the comments submitted by the NMC regarding your behaviour. He submitted that you take this on board but you reject the comments made in respect of your behaviour.

During the course of hearing submissions on misconduct and impairment, Mr Holborn submitted a 9-page document and a 37-page bundle that you wished to submit at this stage of proceedings. The panel invited Mr Holborn to review the document and bundle,

removing documents that were irrelevant to this stage in the proceedings. Mr Holborn subsequently submitted a 9-page bundle on your behalf.

As Dr Joshi had already made his submissions on misconduct and impairment before having sight of this information, he was invited to make further submissions in light of the new information provided by you.

Dr Joshi submitted that the contents of the bundle further demonstrated your very limited insight into the facts found proved. He addressed the training completed by you since the time of the incidents and submitted that the training does not specifically address the facts found proved. Dr Joshi submitted that it was difficult to see how the reflections submitted by you relate to the allegations found proved, and how they relate to the concerns in regards to impairment.

In response, Mr Holborn submitted that the documents provided are intended to enlighten the panel and demonstrate that you accept matters, wish to move on, and return to work.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Remedy UK Ltd, R (on the application of) v The General Medical Council* [2010] EWHC 1245 (Admin), *Preiss* [2001] 1WLR 1926, *Grant* [2011] EWHC 927 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code, the NMC Guidance FTP-2a *'Misconduct',* last updated on 6 May 2025, and relevant case law including *Roylance, Remedy UK* and *Preiss.*

The panel noted that in respect of the incidents on 31 August 2021 and 2 November 2022, it is generally accepted by all of the witnesses that these were minor incidents which

ultimately resulted in no harm to patients. The panel accepted this; however, the panel is concerned about your reaction and response to the incidents. Firstly, your refusal to complete a Datix report when asked to do so by a senior colleague and secondly, being part of an incorrect calculation of a Chemotherapy infusion rate and then attempting to blame your colleague who administered the medication and avoid responsibility for your part in the incident. You gave inaccurate statements on three separate occasions regarding the second incident and it is this continued refusal to accept your responsibility for your part in the incident that causes the panel concern.

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

In considering whether your response to the incidents can be described as serious misconduct, the panel reviewed the NMC code of practice and identified the following areas where they determined that your practice fell below the standards expected of a registered nurse:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
>
> ***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> ***8.2** maintain effective communication with colleagues*

8.4 *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*

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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'*

The panel noted that in your bundle submitted to the panel at this stage in the proceedings, you state that you rely on 8.1 of the Code in your defence. However, the

panel does not accept that your behaviour following the incident, when you refused to submit a Datix report, is compliant with this standard and therefore disagree with your interpretation. The panel also noted that it heard no evidence from the medical colleague, whom you purport to have taken advice from, to support your assertions.

The panel considered the Trust Adverse Incident Policy and consider that your failure to comply with the Policy in relation to reporting the incident or near miss that occurred on 31 August 2021, amounts to misconduct, particularly when asked to do so by a senior member of nursing staff. Regarding your actions following the second incident in November 2022, the panel noted that you gave, on three occasions, versions of events to your manager which were incorrect, seeking to minimise your responsibility for your actions and blaming your colleague with whom you were working. This is viewed by the panel as misconduct. Considering the totality of the misconduct found proved in respect of both incidents, the panel was satisfied that the two incidents, and your subsequent and continued response to them, amount cumulatively to serious misconduct.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance DMA-1 *'Impairment'*, last updated on 28 January 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.'*

It also had regard to the NMC Guidance FTP-15 *'Insight and strengthened practice',* last updated 14 April 2021, FTP-15a *'Can the concern be addressed?'*, last updated 27 February 2024, FTP-15b *'Has the concern been addressed?',* last updated on 29 November 2021, FTP-15c *'Is it highly unlikely that the conduct will be repeated?'*, last updated 14 April 2021, and the case law of *Grant* and *Cohen.*

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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) *...'*

The panel determined that limbs a), b) and c) are engaged in this case.

Although no patient was reportedly harmed as a result of your actions, the panel determined that the clinical error, and refusing to report an adverse incident, represent a potential risk of harm to patients. The panel was of the view that this misconduct, coupled with your continued refusal to accept your earlier mistakes, breached a fundamental tenet of the nursing profession and therefore brought its reputation into disrepute.

The panel determined that you have not demonstrated a satisfactory understanding of how your actions put patients at a risk of harm, nor why your conduct impacted negatively on your colleagues and the reputation of the nursing profession. [PRIVATE]. However, the panel was of the view that as a nurse with 14 years' experience, you must have understood the importance of incident reporting and the necessity of ensuring that an intravenous medication rate was correctly calculated and verified when acting as a second checker, irrespective of whether you were SACT trained.

The panel took account of your reflective pieces. It noted your assertions that you expressed apologies to the patients involved in the incidents. However, it was unclear to the panel whether these apologies were to take ownership and express remorse for your part in the incidents, or to simply apologise for any inconvenience caused to the patients.

However, on balance, it appeared to the panel that your apologies related to the latter. It also noted that during the local investigation, you gave differing accounts of the second incident on three separate occasions and that you attempted to shift blame to a colleague for your part in a medication calculation error.

Overall, the panel consider that there is limited evidence to persuade it that you fully understand why your behaviour was unacceptable, how it could undermine team working at the heart of the nursing profession, or the impact it had on colleagues and patients.

The panel considered your Reflection/Action plans relating to both incidents (one of one paragraph in length and the other, two thirds of a page in length) but found them to be lacking depth. It considered that the documents did not adequately address the risk of harm to patients, the impact on colleagues, or the wider impact on the nursing profession. The panel was not satisfied that you fully understand how your behaviours were wrong, nor how they could undermine trust in the nursing profession.

The panel concluded that you have provided little evidence of remorse and demonstrated limited insight and reflection as to your part in the incidents and your subsequent reactions.

The panel considered whether or not you have taken steps to strengthen your practice. The panel considered the concerns regarding your behaviour following the incidents and, particularly in the light of your previous unblemished career, was of the view that they could have been remediated with the right mindset. The panel was satisfied that the misconduct in this case is still capable of being addressed with meaningful and committed engagement in respect of remediation and reflection. The panel determined that insight and reflection is particularly important in the context of the overriding concerns being to do with your behaviour and how you respond to incidents.

Regarding insight, the panel found that you had not yet demonstrated sufficient insight into your misconduct. It was particularly concerned by the pattern of deflection and a failure to

take responsibility for your actions. While the panel acknowledged that you are entitled to deny the allegations put to you, and some of the charges were not proved, the panel noted your ongoing tendency to attribute blame to circumstances or other individuals rather than accepting your own part in the incidents and recognising the potential risk in your actions.

The panel noted that you have had a limited opportunity to strengthen your practice in the workplace as you have not been working within healthcare since your referral. It considered the evidence provided by you regarding your learning since the incidents in the form of your CPD log, formulated for the purposes of revalidation with the NMC. The panel noted there were no certificates before it in respect of any of the training as evidence of completion. The panel also noted that only one entry in your CPD log relates to the regulatory concerns and charges found proved, namely, a one-hour lecture in July 2025 entitled '*wellbeing in healthcare places'*, provided by the Royal College of Surgeons Ireland. The panel also noted that it did not have any reflections from you on the training which you reportedly completed, what you learned, how you reflected upon it, and how you viewed that it has improved and strengthened your practice. The panel noted that the other training listed in your CPD log did not appear to be directly relevant to the concerns of this case.

As a consequence of your limited insight and reflection, and in the absence of evidence of strengthened practice, the panel is of the view that there remains a risk of repetition of your past misconduct.

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

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

in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the ground of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on 'The purpose of and approach to sanctions' (Reference: SAN-1 Last Updated: 28/01/2026), *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026) and accompanying guidance on individual sanctions.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Dr Joshi referred the panel to SAN-1, explaining that the purpose of sanctions is to promote, protect and maintain the health, safety and wellbeing of the public, and to promote and maintain proper professional standards, otherwise in the public interest.

Dr Joshi informed the panel that it must begin with the least restrictive sanction capable of achieving public protection, ensuring that any risk posed by the professional is

appropriately reduced. He submitted that the panel would need to consider the reasons why you were found to be impaired, and in doing so assess the aggravating and mitigating factors.

Turning to aggravating features, Dr Joshi submitted that the principal concern in this case was the absence of, or at best limited, insight. He informed the panel that this issue had been brought into sharp focus over the previous two or three days by the evidence presented on your behalf. He further referred the panel to the vulnerability of the persons receiving care, a matter he indicated had already been addressed. In addition, he submitted that there had been a failure to work collaboratively with colleagues in relation to the matters found proved.

In relation to mitigation, Dr Joshi informed the panel that it should consider whether there had been any early admission of the facts; he submitted there had not. He stated that there had been no apology to those affected. He submitted that there had been very little, if any, effort to prevent a recurrence or to remedy the concerns identified. As to evidence of safe and professional practice in a similar role since the events in question, he informed the panel that, as it had been told by Mr Holborn, you had been off work on paid leave during the relevant period.

Dr Joshi acknowledged that reflective accounts had been provided and placed before the panel. He submitted that the panel would also need to consider any evidence of relevant training undertaken and whether you had kept your practice up to date, bearing in mind the oral and written evidence provided over the previous days.

Dr Joshi submitted that the panel could take into account periods of stress, illness, or personal or financial hardship. He referred to what had consistently been said by you regarding the level of support in the workplace, [PRIVATE]

Dr Joshi submitted that the central issue for the panel was the appropriate sanction. He informed the panel that, in the NMC’s view, the decision lay between suspension and

striking off, and he referred the panel to SAN-3 for guidance. He submitted that the panel would need to weigh all relevant aggravating and mitigating factors and consider the practical implications of a suspension order, including what a future reviewing panel might do. He emphasised that the panel could not bind any future reviewing panel.

Dr Joshi further submitted that the panel must consider whether public confidence would be maintained if you were to return to practice after a period of suspension, or at all. He stated that a key consideration was your insight and attitude towards addressing the concerns. He quoted from the guidance, submitting that the panel must consider whether it was realistically possible that these concerns would change positively during a period of suspension. If it were considered unlikely that you would seek to address the concerns, he submitted that suspension might not be appropriate if imposed in the hope of an eventual return to practice.

Dr Joshi submitted that the panel had found a lack of full acceptance of your conduct and an absence of evidence of strengthened practice. While it was open to the panel to consider a suspension order with review, he reminded the panel that it had found insufficient insight and a pattern of deflection.

Dr Joshi submitted that a conditions of practice order would not be appropriate, given that any conditions must be workable and relevant. He argued that the concerns identified were attitudinal in nature. Although the case arose from two clinical incidents, he submitted that the evidence demonstrated attitudinal difficulties. The impairment was serious, and the panel would need to determine whether it was fundamentally incompatible with remaining on the register.

Dr Joshi submitted that there was a distinction between professional confidence and what he described as conceit, and he argued that this case fell into the latter category. He stated that no lesser sanction than a suspension would be appropriate in the circumstances.

In conclusion, Dr Joshi submitted that it was a matter for the panel to determine whether the appropriate and proportionate order was one of suspension or striking off. He submitted that the impairment was serious, and the panel would need to decide whether it remained compatible with you continuing to be registered.

Mr Holborn began by acknowledging the panel's findings of misconduct and impairment. He submitted that the underlying clinical incidents had been described by the NMC's own witnesses as learning points and that no patient had been harmed. However, he accepted that the panel had found that what elevated the case was your reaction and response: the refusal to complete a Datix, the provision of inaccurate accounts of the circumstances of the medication error, and what the panel described as an ongoing tendency to attribute blame rather than accept responsibility. He stated that he did not seek to go behind those findings and that they formed the starting point for sanction.

Mr Holborn informed the panel that you had engaged and cooperated throughout. He submitted that the panel had made a critical finding which framed the sanction decision, namely that the misconduct remained capable of being addressed through meaningful and committed remediation and reflection. He described that finding as encouraging and significant. He submitted that the question for the panel was not whether change was required, but what the least restrictive sanction would be that could achieve that change whilst protecting the public and maintaining public confidence.

Mr Holborn adopted the panel's characterisation of seriousness. He submitted that the clinical incidents were minor, that no patient had been harmed and that no dishonesty had been found. He accepted that the seriousness lay in the behavioural response: deflection, inaccurate accounts and reluctance to accept responsibility. He acknowledged that the panel had described this as an attitudinal concern. He submitted that insight had been found to be limited, but not absent.

Mr Holborn informed the panel that you had apologised to both patients at the time and had reported the infusion error immediately, prior to any investigation. He submitted that

you had engaged in continuing professional development. He accepted that the panel had found this insufficient but submitted that it was not nothing and formed a foundation upon which remediation could build.

Turning to aggravating features, Mr Holborn acknowledged that the case involved a vulnerable patient group, namely cancer patients, and that this was serious. He accepted the panel's concerns regarding the inaccurate accounts, the pattern of deflection and the limited insight to date.

In relation to mitigation, Mr Holborn submitted that no patient had been harmed and no physical injury had resulted. He reiterated that the NMC's witnesses had referred to the incidents as learning points. He emphasised that there had been no dishonesty and that the panel had been satisfied that you did not know your accounts were inaccurate.

Mr Holborn referred the panel to your 14-year unblemished career with no prior complaints, concerns or regulatory action. He submitted that you had reported the infusion error immediately, apologised to the patient and escalated the matter appropriately. He noted that you had not been SACT trained, that you were new to the ward and that the checking process had subsequently been changed by the Trust.

[PRIVATE]. He submitted that you had maintained approximately 35 hours of CPD over three years without employer support, funding or clinical access, and that you had effectively been excluded from work for nearly three years without a formal interim order or review process.

[PRIVATE]. He emphasised again the panel's own finding that the misconduct remained capable of being addressed.

Mr Holborn submitted that the mitigating factors substantially outweighed the aggravating features.

Mr Holborn then addressed the sanctions in ascending order. He accepted that taking no further action would be insufficient in light of the findings of serious misconduct and impairment. He submitted that a caution order would also be insufficient, given the panel's findings of limited insight and risk of repetition, and because a caution would not provide a supervisory or remedial framework.

Mr Holborn submitted that a conditions of practice order was the appropriate and proportionate sanction. He acknowledged that the sanctions guidance distinguishes between clinical failings, which are often amenable to conditions, and attitudinal or values-based concerns, where conditions may be less suitable. However, he submitted that this case did not involve deep-seated or irremediable attitudinal problems. He emphasised that the panel had found the misconduct capable of being addressed, which in his submission meant that it was not fundamentally incompatible with continued registration.

Mr Holborn submitted that limited insight is precisely the territory in which conditions of practice operate. He argued that structured supervision, mentoring and reflection could develop limited insight into full insight. He distinguished the case from those involving discriminatory attitudes, sexual boundary violations or fundamental values failures. He submitted that the attitudinal concern identified by the panel - reluctance to accept responsibility and a tendency to deflect blame - was specific and capable of being addressed through targeted professional development.

[PRIVATE].

Mr Holborn proposed workable and enforceable conditions. He suggested supervision with regular reports addressing professional accountability, response to incidents and team working; maintenance of a reflective journal focused on accountability; regular discussions with a mentor; and restrictions preventing you from undertaking SACT-related duties until appropriately trained and signed off. He proposed medicines management updates, drug calculation assessments, incident reporting refreshers, no agency or bank work and standard conditions regarding disclosure to employers and review after 12 months. He

submitted that these conditions were specific, targeted and directly linked to the concerns identified.

[PRIVATE].

Turning to a suspension order, Mr Holborn submitted that it would be disproportionate. He advanced a number of reasons. First, suspension would not address the attitudinal concerns; it would simply exclude you for a further period and generate no evidence of remediation. Conditions, by contrast, would produce objective evidence for a reviewing panel. Secondly, you had already experienced years of ‘exclusion’ from practice albeit by your employer and not by the regulator. Thirdly, the misconduct was not fundamentally incompatible with continued registration. Fourthly, limited insight was capable of development through conditions. Fifthly, he submitted that the public interest was better served by proportionate regulation than by further exclusion. Finally, he argued that if the panel were minded to impose a suspension order, it would need to explain what aspects of the misconduct could not be addressed through the specific conditions proposed.

In relation to striking off, Mr Holborn submitted that this would be wholly disproportionate. He submitted that striking off is reserved for behaviour fundamentally incompatible with continued registration, such as serious dishonesty, sexual misconduct, or persistent lack of competence despite opportunities to remediate. He reminded the panel of your unblemished 14-year career, the absence of dishonesty or patient harm, and the panel’s finding that the misconduct remained capable of being addressed. He submitted that none of the indicators typically justifying striking off were present.

In conclusion, Mr Holborn submitted that sanctions must go no further than necessary to meet the overarching objective. He argued that conditions of practice would protect the public through supervision and restriction, uphold professional standards, and maintain public confidence through proportionate and targeted regulation. Suspension, he submitted, would add severity but not effectiveness and would be punitive without

advancing remediation. He therefore urged the panel to impose a conditions of practice 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:

- Deliberate breaches of the Code, namely;
    - The provision of incorrect statements in relation to the second incident
    - Refusal to complete a Datix when requested to do so by a senior nurse following the first incident
    - Failure to follow Trust policies and procedures
- Limited insight
- The vulnerable patient group with whom you were working
- Failure to work collaboratively with colleagues, in particular a tendency to deflect blame rather than accept responsibility
- Premeditation in providing incorrect information on three occasions

The panel also took into account the following mitigating features:

- You apologised to both patients involved in the incidents
- [PRIVATE]
- A 14-year nursing career without any previous concerns regarding behavioural or attitudinal issues
- No actual harm occurred to patients
- Your perception of a lack of support in the workplace

In weighing the aggravating and mitigating factors, [PRIVATE], the absence of actual harm to patients, and your previous 14-year career without regulatory findings. The panel also took into account the context of the incidents, including the vulnerable patient group and your failure to follow Trust procedures. However, the panel noted that an unblemished career is the expected standard and, while it was relevant that there had been no prior indication of attitudinal or behavioural concerns, this attracted only limited weight. The panel determined that the aggravating factors outweighed the mitigating factors, in particular your insight which remains limited and your failure to work collaboratively with colleagues, including a tendency to deflect responsibility for your actions.

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 had found that your fitness to practise is currently impaired by reason of misconduct and that there remains a risk of repetition, particularly in light of the limited insight demonstrated. The panel determined that to take no further action would fail to protect the public, would not address the concerns identified, and would undermine public confidence in the profession and the regulatory process. The panel therefore 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. The panel had found misconduct in relation to refusing to complete a Datix report,

administration and checking of intravenous medication and your professional accountability following the incidents. The panel also found that you currently have limited insight into the concerns identified and that there remains a risk of repetition unless appropriate safeguards are put in place. The panel therefore determined that a sanction that does not restrict your practice would not protect the public. Further, a caution order would not address the areas of clinical practice and professional behaviour requiring remediation. 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 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 determined that this case met the criteria for a conditions of practice order. The panel found that the concerns identified relate to specific areas of your professional practice, including medicines management, intravenous medication administration, incident reporting, professional accountability, and professional conduct. These were

identifiable areas capable of remediation through training, supervision, and fully engaged reflective practice.

The panel was satisfied that there was no evidence of deep-seated attitudinal or personality problems that would render remediation unlikely. While the panel found that you currently have limited insight, it accepted that insight is capable of development and that structured reflection, training, and supervision would support this process.

The panel also had regard to the fact that, prior to these incidents, you had worked as a nurse for a significant period of time without any known regulatory concerns. The panel noted that the clinical errors identified occurred within a lengthy nursing career, and there was no evidence of a pattern of repeated clinical failings or dishonesty. This provided reassurance that these concerns were capable of remediation and were not indicative of fundamentally unsafe practice.

The panel accepted the submissions made on your behalf that you are willing to engage with training, supervision, and any conditions imposed. The panel was satisfied that there is a realistic prospect that the concerns identified can be remedied and that you can return to safe and unrestricted practice.

The panel was further satisfied that appropriate conditions could be formulated which are relevant, proportionate, workable, and measurable. The panel determined that conditions requiring supervision of intravenous medication administration until competency is demonstrated, completion of relevant medicines management and professional accountability training, and the maintenance of a reflective profile would directly address the concerns identified and support the development of insight and competence.

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

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

In making this decision, the panel carefully considered the submissions of Dr Joshi in relation to the sanction that the NMC was seeking in this case. However, the panel considered that to impose a suspension order or a striking-off order would be disproportionate as in the panel's view your misconduct, while serious, can be appropriately managed through conditions of practice, with a review in order that a future panel can assess insight and strengthened practice. The panel also determined that a period of suspension would serve no useful purpose in this case. A suspension order would prevent you from practising. The panel considered that the concerns identified are best addressed through supervised practice, training, and reflection, which can only occur while you remain in practice under appropriate conditions.

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

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

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You will send the NMC a report at least seven days in advance of the next NMC hearing or meeting from your line manager, mentor or supervisor setting your progress regarding the following conditions.

2. You must ensure that you are directly observed by another registered nurse whenever you undertake intravenous medication administration, until you have been formally assessed as competent to calculate and administer intravenous medication independently by your supervisor, line manager or mentor.

3. You will send your case officer evidence that you have successfully completed training in the following areas as soon as possible and in any event within 9 months of the imposition of this order:
    a) Medicines management
    b) Intravenous therapy passport
    c) Incident reporting and duty of candour
    d) Professional accountability

4. You must keep a reflective profile and discuss this with your supervisor/line manager/mentor during a 1:1 session on a monthly basis. The profile will include:
    a) Progress in relation to training undertaken in connection with condition 3, what you have learnt from training and how it has enhanced your practice
    b) Your professional practice, specifically how you have worked collaboratively with colleagues
    c) Any clinical incidents, near misses or learning points that have arisen whilst on duty, how you have dealt with them and your learning from them

5. You must limit your nursing practice to one substantive employer which must not be via an agency or bank.

6. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your case officer your employer's contact details.

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

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

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

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

The period of this order is for 12 months.

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

Any future panel reviewing this case would be assisted by:

- Your engagement and attendance at any future hearing
- Evidence of any training undertaken with certificates of completion
- up-to-date testimonials from a line manager or supervisor that detail your current work practices
- Reflective piece commenting on how your insight has developed during the period of the order in respect of concerns identified

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Dr Joshi who made an application for an interim conditions of practice order. He submitted that, as there would otherwise be a period during the 28-day appeal window when the substantive order would not yet be in force, an interim order was necessary. He contended that such an order was required on the grounds of public protection and in the wider public interest.

The panel also took into account the submissions of Mr Holborn who did not oppose the application and agreed that an interim conditions of practice order was appropriate. He submitted that it was sensible for the interim order to mirror the substantive order and made no further representations.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 12 months to cover the 28-day appeal period and, in the event that an appeal is lodged, to ensure that appropriate safeguards remain in place pending the final determination of any appeal.

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

That concludes this determination.