Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting
Wednesday, 11 February 2026 – Friday, 13 February 2026

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

Name of Registrant:	**Yvonne Jane Kearsey**
NMC PIN:	00D0464E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (31 March 2003)
Relevant Location:	Hackney
Type of case:	Misconduct
Panel members:	Isabelle Parasram (Chair, lay member) Elizabeth Coles (Registrant member) Caroline Ross (Lay member)
Legal Assessor:	Emma Boothroyd
Hearings Coordinator:	Audrey Chikosha
Facts proved:	Charges 1b,1c,1d, 1e, 1f, 2b, 2c, 2d, 2e,2h, 3a,3b, 3c, 3d, 3e, 3f, 3g,
Facts not proved:	Charges 1a, 2a, 2f, 2g
Fitness to practise:	Impaired
Sanction:	**Strike-off**
Interim order:	**Suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel accepted the advice of the legal assessor on service of Notice of Meeting.

The panel noted from the *'Proof of Posting'* bundle provided by the Nursing and Midwifery Council (NMC) that the Notice of Meeting had been sent to Mrs Kearsey's registered email address by secure email on 15 December 2025.

The panel took into account that the Notice of Meeting provided details of the allegations, and that the meeting would be held on or after 19 January 2026.

In the light of all of the information available, the panel was satisfied that Mrs Kearsey has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons on proceeding in the absence of Mrs Kearsey

The panel next considered whether it should proceed in the absence of Mrs Kearsey and the NMC. It had regard to Rule 21 and heard the advice of the legal assessor.

The panel noted that there had been no engagement by Mrs Kearsey with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that adjourning and referring this case to a hearing would secure her attendance.

The panel also considered whether on the information before it, it could make decisions on the charges without the assistance of submissions from a case presenter on behalf of the NMC. It noted that there was a substantive bundle of documents before it, including meetings notes from the local investigation and disciplinary proceedings, resident notes, witness statements and exhibits who speak to the charges, together with an evidence matrix from the NMC.

The panel was satisfied that it could make a decision on Mrs Kearsey's fitness to practise in the absence of both the NMC and Mrs Kearsey.

Decision and reasons on admitting hearsay evidence

The panel noted that the NMC within their statement of case made an application for the evidence provided at exhibits CD/01 - CD/08 although exhibited by Witness 1, are documents given to her by another colleague. The NMC submitted that this was hearsay evidence, which the panel ought to admit pursuant to Rule 31(1) of the Rules as it was both relevant to the charges and fair to admit.

The panel therefore took legal advice from the legal assessor on the admissibility of this evidence.

The panel noted that the Investigation report dated 20 May 2021 and Investigation Meeting minutes dated 6 May 2021 were documents created and provided to Witness 1 by the Manager of the referrer Care Home where Mrs Kearsey worked. The panel bore in mind the NMC Guidance on Hearsay and the advice of the legal assessor. It first considered whether this evidence was the sole and decisive evidence for any or all of the charges. The panel had before it, various documents including the resident care notes, a local statement from Mrs Kearsey and disciplinary hearing notes dates 8 June 2021. It noted that these documents speak to the charges and thus exhibits CD/01- CD/08 are not sole and decisive.

The panel then considered if the evidence was demonstrably reliable. It noted that while there is no witness statement from the Home Manager exhibiting these documents, the documents are signed and dated and come from a reliable source. The panel had no evidence before it to suggest that the evidence is fabricated. Furthermore, the panel noted that Mrs Kearsey was given the opportunity to respond to the NMC's case in a case management form sent together with the evidence and it has not been returned nor has she objected to this evidence.

The panel considered that the evidence was highly relevant to the charges, and it could identify no unfairness to Mrs Kearsey, given her non engagement in these proceedings.

Furthermore, the panel was satisfied that when taken together with the other evidence before it, exhibits CD/01-CD/08 could be sufficiently tested.

In light of all of the above, the panel determined to admit exhibits CD/01-CD/08 as hearsay evidence and apply appropriate weight to it.

Details of charge

That you, a registered nurse:

1. Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:
    a. failed to escalate the PEG site infection;
    b. failed to record the PEG site infection;
    c. failed to complete a DATIX to report the infection;
    d. failed to complete an infection care plan;
    e. failed to complete an additional needs care plan;
    f. failed to record any or all clinical care you provided to Resident A;

2. Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:
    a. failed to escalate the PEG site infection;
    b. failed to record the PEG site infection;
    c. failed to complete a DATIX to report the infection;
    d. failed to complete an infection care plan;
    e. failed to complete an additional needs care plan; “
    f. failed to implement a skin integrity care plan;
    g. failed to implement a pressure ulcer management plan;
    h. failed to record any or all clinical care you provided to Resident B. considered care provided and whether there was a record of it:

3. Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. failed to weigh Resident C on a weekly and/or monthly basis;

b. failed to escalate Resident C's weight loss to the dietician and/or GP;
c. failed to record Resident C's malnutrition universal screening tool ('MUST') score;
d. failed to record Resident C's waterlow score;
e. failed to implement a care plan for weight loss;
f. failed to implement a care plan for wound management;
g. failed to record within Resident C's clinical records the request to remove the airflow mattress.

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

Background

On 2 August 2021, the Nursing and Midwifery Council ("NMC") received a referral from Belize Healthcare ("the Referrer") - which owned the care home that employed Mrs Kearsey - raising concerns about Mrs Kearsey's practice between February and April 2021.

The Referrer noted there was a lack of care plans for residents at the Home, including but not limited to, wound care, additional care needs, infection care plans or pressure ulcer management which were alleged to be the responsibilities of Mrs Kearsey.

On 16 April 2021, it is alleged that Residents A and B had infected PEG sites. Both residents were under Mrs Kearsey's care and there had been no escalation of the infections to other health professionals by Mrs Kearsey. Resident B was later admitted to hospital with suspected sepsis. There was no mention of the infection or escalation actions in either of Resident A or B's clinical records. Mrs Kearsey allegedly did not complete a Datix or mention at the Daily Flash meeting either Residents' infection, nor record the infection in their care or additional needs plans. It is also alleged that Mrs Kearsey did not implement a skin integrity care plan for Residents B. It is alleged Mrs Kearsey did not record any care they provided to Residents A and B to manage their infections.

In addition to the failure to deal with the PEG site infection for Resident B, it is alleged that Mrs Kearsay also failed to implement a pressure ulcer management plan.

It is also alleged that Resident C, between 5 February 2021 and 16 April 2021 suffered weight loss of 11.6Kg. There was no evidence within Resident C's clinical records that MUST or Waterlow scores had been calculated during this period by Mrs Kearsey. Further it is alleged that Mrs Kearsey did not refer the weight loss to the GP or dietician.

Resident C on admission on 5 February 2021 had a grade 2 pressure ulcer. It is alleged that there was no airflow mattress on Resident C's bed to manage the pressure ulcer. It is further alleged there were no records of requests by Resident C or their relatives to remove the airflow mattresses. Despite the pressure ulcer being recorded on admission it is alleged there was no wound care plan, Datix or body map completed or recorded plans for dressing and treatment within the clinical records.

A local investigation was conducted in May 2021 and a disciplinary hearing was held on 8 June 2021.

The NMC Case Examiners ("CEs") reviewed the case on 18 July 2024 and recommended undertakings which came into effect on 16 September 2024. On 21 May 2024, the CEs revoked the undertakings because the there was no evidence of compliance with undertakings 4 (reflective account within 4 months) and 5 (Personal Development Plan within 3 months) and there has been no contact with the case officer.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case including a statement from Mrs Kearsey dated 5 May 2021 and the representations made by the NMC.

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

The panel had regard to the written statement and exhibits of the following witness on behalf of the NMC:

- Witness 1: HR consultant at the Home at the time of the concerns and Chair of the disciplinary hearing against Mrs Kearsey.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC including a statement by Mrs Kearsey dated 5 May 2021.

The panel noted that within the local investigation meeting notes dated 6 May 2021, Mrs Kearsey appears to make admissions to some of the matters in the charges. However, the panel was of the view that these do not amount to admissions for the purposes of this fitness to practise hearing and thus the panel considered each of the charges and made findings based on the evidence before it.

Charge 1a

1. "Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:

    a. failed to escalate the PEG site infection;
    b. ...
    c. …
    d. …
    e. …
    f. …"

This charge is found NOT proved.

In reaching this decision, the panel had before it Resident A's PEG site care form. It noted that on 23 February 2021, an entry was made by Mrs Kearsey that she spoke to an Advance Nurse Practitioner (ANP) and sent a photograph and swab of the PEG site as requested by them. It also noted that in the local investigation meeting minutes, Mrs Kearsey confirms that she called the ANP regarding the infected PEG site.

The panel was satisfied that the phone call to the ANP, which is recorded in the patient notes is evidence of escalation of the PEG site infection.

The panel therefore found this charge not proved.

Charge 1b)

1. "Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:
    a. …
    b. failed to record the PEG site infection.
    c. …
    d. …
    e. …
    f. …"

This charge is found proved.

In reaching this decision, the panel first considered whether there was a duty for Mrs Kearsey to record the PEG site infection. It noted that Mrs Kearsey made an entry in Resident A's care notes on 23 February 2021 that she had spoken to an ANP regarding Resident A's PEG site. However, in this entry there is no reference to the PEG site infection. The panel was of the view that, as a registered nurse, Mrs Kearsey had a duty to provide a comprehensive record of Resident A's condition.

The panel was of the view that while the call to the ANP was, as determined in charge 1a, an escalation of the infection – there is no supplementary record of the infection itself to inform others of Resident A's infection and the steps taken by Mrs Kearsey.

The panel therefore found this charge proved.

Charge 1c

1. "Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:
    a. …
    b. ...
    c. failed to complete a DATIX to report the infection
    d. …
    e. …"

This charge is found proved.

The panel had before it the local disciplinary hearing notes dated 8 June 2021 in which the Home Manager states:

> *'nothing had been reported on Datix'*

The panel also noted that the expectation of nurses working in the Home, as set out the Home Manager in the same disciplinary hearing regarding DATIX is as follows:

> *'Datix is in all Four Seasons homes, and it's been in operation since we took over the new provider and that was hardly anything on Datix before, it is the general nurses responsibility to Datix every event that happens in the home, it's their way of evidence in that they've seen something, they've acted upon it and how they've actually dealt with it*.'

The panel noted that it had no evidence of a DATIX report before it and together with the comments from the Home Manager that there had not been a report on DATIX, and Mrs Kearsey's admission in the local investigations that she did not complete a DATIX, it was satisfied that this charge is found proved.

Charges 1d & 1e

1. “Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:

    a. …
    b. ...
    c. …
    d. failed to complete an infection care plan;
    e. failed to complete an additional needs care plan
    f. …”

These charges are found proved.

The panel considered these two charges and the panel noted that it did not have before it any Home policy documents regarding the appropriate plans to be put in place for Residents. However, the panel noted that under the Code, there is a duty for registered nurses to assess need and keep clear and accurate records of care provided to patients. Furthermore, it bore in mind that on 19 April 2021 the Home Manager requested that Mrs Kearsey complete these care plans for Resident A. In the local investigation report dated 20 May 2021, the Home Manager writes:

> *‘During a telephone on the morning of 19th April I had to asked YK to put into place 2 x additional needs and infection care plans, swab both areas and escalate these to the GP.’*

In the local investigation interview on 6 May 2021, this was put to Mrs Kearsey, and she acknowledges that this conversation happened. The panel was satisfied that on balance of probabilities there was a duty for Mrs Kearsey to complete an infection care plan and additional needs care plan.

Furthermore, in particular regarding charge 1e, the panel noted that in the disciplinary hearing notes, the Home Manager sets out the purpose of an additional needs care plan which included PEG care and the reason it was required.

The panel determined that there was a duty for Mrs Kearsey to complete an infection plan and an additional needs care plan both because she was asked to by the Home Manager and because it was the required care for Resident A in the circumstances.

The panel had no evidence before it that Mrs Kearsey completed these plans and as such it found that this charge is proved.

Charge 1f

1. "Between 4 February 2021 and 28 April 2021 failed to provide Resident A with any or any adequate care, in that you:
    a. …
    b. ...
    c. …
    d. …
    e. …
    f. failed to record any or all clinical care you provided to Resident A;"

This charge is found proved.

The panel first considered the care Mrs Kearsey provided to Resident A. It noted that in the disciplinary hearing notes, Mrs Kearsey says:

> '*We'll start with the first one in room two. All I did was, water and meds at lunchtime, meds at tea time. And when I know that this, this lady. The weather is getting warm. I, myself, clean that wound out clean that peg site out twice today. Just, you know, just clean it. it's something I do because I know the lady I've known her since the day she's come in…'*

And:

> *'When it starts to get warm, I automatically have a look. Because the word that came up, which I thought was very good, is "her lady folds" cause her to sweat and*

cause it to get Candida, which is reported to the doctors, because it happens every year.'

However, the panel noted that within the PEG site care form for Resident A, this care is not recorded. Furthermore, in the disciplinary hearing when asked about keeping record of care provided, Mrs Kearsey states:

'*That's all I can say I take full ownership. I didn't write it down, doesn't mean to say that I didn't care. Okay. I understand what the NMC says in record and record keeping. I understand all that…'*

The panel therefore determined that Mrs Kearsey failed to record all of the care provided to Resident A. However, it noted that having found charge 1a not proved, Mrs Kearsey did record some care in that she recorded an escalation of an infection.

Charge 2a

2. "Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. failed to escalate the PEG site infection
    b. …
    c. …
    d. …
    e. …
    f. …
    g. …
    h. …"

This charge is found NOT proved

The panel had before it, Resident B's PEG site care form in which it is recorded that Resident B had an infection. It also noted that within the notes, Mrs Kearsey recorded that the Dietitian called and discussed re-siting the PEG. This is also noted by Mrs Kearsey in

her statement dated 5 May 2021 that she spoke to the Dietitian regarding re-siting and was liaising with the Consultant to get this arranged.

The panel was satisfied that this was sufficient evidence to suggest that Mrs Kearsey escalated the PEG site infection.

The panel therefore determined that this charge is not proved.

Charge 2b

2. "Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. …
    b. failed to record the PEG site infection …
    c. …
    d. …
    e. …
    f. …
    g. …"

This charge is found proved.

The panel considered Resident B's PEG site care form. It noted that on 2 April 2021, it is recorded that there was evidence of infection on the PEG site. However, the panel noted that this entry was not recorded by Mrs Kearsey.

The panel considered whether there was a duty for Mrs Kearsey to have recorded the infection. It had evidence that Mrs Kearsey had escalated the infection and thus she was aware of it and taking action to provide care. The panel was of the view that, as a registered nurse, Mrs Kearsey had a duty to provide a comprehensive record of Resident B's condition. However, the panel had no evidence before it that Mrs Kearsey recorded the infection.

This charge is therefore found proved.

Charge 2c

2. “Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. …
    b. …
    c. failed to complete a DATIX to report the infection;
    d. …
    e. …
    f. …
    g. …
    h. …”

This charge is found proved.

The panel noted in the disciplinary hearing notes that the Home Manager states:

> *‘Datix is in all Four Seasons homes, and it's been in operation since we took over the new provider and that was hardly anything on Datix before, it is the general nurses responsibility to Datix every event that happens in the home, it's their way of evidence in that they've seen something, they've acted upon it and how they've actually dealt with’*

The panel was of the view that Mrs Kearsey, as a registered nurse working at the Home, had a duty to complete DATIX reports in the circumstances outlined by the Home Manager. It noted that there was an expectation for Mrs Kearsey to complete a DATIX.

The panel had before it the Investigation Report in which it is stated that there was no DATIX report for this resident and it when it was put to Mrs Kearsey in the disciplinary hearing, she accepted that she had not completed one. The panel had no evidence to

suggest that there was a report completed by Mrs Kearsey and therefore determined that this charge is found proved.

Charge 2d and 2e

2. "Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. …
    b. …
    c. …
    d. failed to complete an infection care plan …
    e. failed to complete an additional needs care plan
    f. …
    g. …
    h. …"

This charge is found proved.

The panel considered charges 2d and 2e together as they rely on the same evidence. The panel took into account the local investigation meeting notes in which the Home Manager says to Mrs Kearsey:

> *'If you recall we had a telephone conversation on 19/04/2021 and I asked you to arrange for both PEG sites to be swab tested and 2 x infection care plans to be put into place…'*

Furthermore, when asked why the required paperwork had not been completed for Resident B, Mrs Kearsey stated:

> *'I can't answer that now, I don't know but I have done them now.'*

The panel accepted the suggestion that at the time stated in the charge, Mrs Kearsey had not completed the care plans and accepted that there was a requirement to do so.

The panel therefore finds this charge proved.

Charge 2f

2. “Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. …
    b. …
    c. …
    d. …
    e. …
    f. failed to implement a skin integrity care plan
    g. …
    h. …”

This charge is found NOT proved

The panel had before it, Resident B’s care notes. Amongst these notes, it had no evidence before it that the resident had a skin integrity concern. The panel had no evidence before it that there was a duty for Mrs Kearsey to implement such a care plan either as a result of an instruction from senior staff or as a required part of Resident B’s care.

The panel therefore finds this charge not proved.

Charge 2g

2. “Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

    a. …
    b. …
    c. …

d. …
e. …
f. …
g. failed to implement a pressure ulcer management plan
h. …”

This charge is found NOT proved

The panel had no evidence before it to suggest that Resident B had a pressure ulcer. It therefore could not identify a duty for Mrs Kearsey to implement a pressure ulcer management plan.

It therefore found this charge not proved.

Charge 2h

2. “Between 4 February 2021 and 28 April 2021 failed to provide Resident B with any or any adequate care, in that you:

a. …
b. …
c. …
d. …
e. …
f. …
g. …
h. failed to record any or all clinical care you provided to Resident B”

This charge is found proved.

The panel considered the care provided to Resident B by Mrs Kearsey and whether there was a record of it. It noted that within the local investigation meeting minutes, when asked why she didn’t document that Resident B had a tendency of pulling at his PEG Mrs Kearsey states:

'That is entirely my fault – I will take full blame for that one…'

It also had the handwritten note from Mrs Kearsey dated 5 May 2021 in which she states how she escalated the infection on Resident B's PEG to the Dietician, but this was not recorded by Mrs Kearsey in Resident B's care records.

The panel determined that Mrs Kearsey failed to record all of the care provided to Resident B.

Charge 3a

3. "Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:

    a. failed to weigh Resident C on a weekly and/or monthly basis
    b. …
    c. …
    d. …
    e. …
    f. …
    g. …"

This charge is found proved.

The panel had before it notes from February 2021, March 2021 and April 2021 showing Resident C's weight notes. The panel noted that in March, no weight was recorded for Resident C.

The panel also noted in the investigation report that it states:

'On admission 05/02/2021 care plan states that weighed 47kg. She wasn't weighed again then until 18/04/2021 when she weighed 36.70kg'

The panel considered whether there was a duty for Mrs Kearsey to weigh Resident C on a weekly and/or monthly basis. It took into account the disciplinary meeting notes in which the Home Manager said:

> *‘ …as a minimum, and our nutrition policy is that residents are weighed as a minimum monthly. If they're not weighed, then you would always document that or you'd say refused...’*

The panel was satisfied that there was an expectation for Mrs Kearsey to weigh Resident C monthly in line with the nutrition policy, although it noted that it did not have the nutrition policy before it. Furthermore, the panel noted that Mrs Kearsey was aware that there was a concern with Resident C’s weight loss at admission as stated in her statement dated 5 May 2021.

The panel determined that Mrs Kearsey, as a registered nurse providing care to Resident C and fully aware of the weight loss concern, was responsible for ensuring the resident was weighed regularly to monitor the condition.

Given the panel had Resident C’s notes before it that showed that Resident C was not weighed in March 2021, the panel found this charge proved.

Charge 3b

3. “Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. …
    b. failed to escalate Resident C’s weight loss to the dietician and/or GP
    c. …
    d. …
    e. …
    f. …
    g. …”

This charge is found proved.

The panel noted that within Mrs Kearsey's written statement dated 5 May 2021, she acknowledges that there was a concern with Resident C's weight loss. She documents that she updated Resident C's daughter every time she called or visited. However, Mrs Kearsey does not record or state that she referred the weight loss to the dietician and/ or GP. The panel was of the view that the extent of the weight loss, namely 10 kilograms in two months, ought to have been evident to Mrs Kearsey that a referral to the dietician and/or GP was required.

Within the disciplinary hearing notes, Mrs Kearsey states:

'I was totally, totally under the impression the referral had gone to the dietitian'

Furthermore, the panel did not have before it, a referral to the GP or dietician and no reference is made within the investigation report, investigation interview or disciplinary hearing that any such referral was made.

The panel therefore found this charge proved.

Charge 3c

3. "Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:

    a. …
    b. …
    c. failed to record Resident C's malnutrition universal screening tool ('MUST') score
    d. …
    e. …
    f. …
    g. …"

This charge is found proved.

The panel noted that in the investigation interview notes dated 6 May 2021 in which Mrs Kearsey admits that it was an oversight on her part to not look at the weights during monthly reviews. In relation to the MUST score Mrs Kearsey states:

> *'Yes I didn't do that because I have so many care plans to review and that it is really hard to get through them all and if you've been off over the weekend...'*

In the absence of any evidence to the contrary, the panel took the admission at local level to be, on the balance of probabilities, evidence that this charge is proved.

Charge 3d

3. "Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. …
    b. …
    c. …
    d. failed to record Resident C's waterlow score
    e. …
    f. …
    g. …"

This charge is found proved.

The panel had before it the local investigation report dated 20 May 2021 in which it is stated that no Waterlow score was calculated for Resident C although one was recorded on admission and no Waterlow score had been calculated for any resident at the Home between February and April 2021.

The panel had no evidence before it to contradict this report and thus found this charge to be proved.

Charge 3e

3. “Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. …
    b. …
    c. …
    d. …
    e. failed to implement a care plan for weight loss
    f. …
    g. …”

This charge is found proved.

The panel noted that it had before it a nutrition care plan for Resident C. However, in this care plan there was no mention of weight, and it did not have a separate document before it that was a weight loss care plan.

The panel noted that Mrs Kearsey was aware of Resident C’s concern with eating and the subsequent weight loss. It noted that in the local investigation interview, Mrs Kearsey states:

> *‘the first day she was here she refused all food and all the way through her stay she did and the carers especially did everything they could to encourage her to eat but it’s been an almighty struggle with her.’*

In the disciplinary hearing on 8 June 2021, Mrs Kearsey states that Resident C lost over 10 kilograms from the date of admission. She also outlines the attempts made to get the resident to eat:

> *‘this lady has full, full mental capacity. She would refuse food even though we'd say, well if you want some fish and chips. We'll go get you some fish and chips. Do you want this do you want that she would refuse point blank, Fluids were not too bad at all. She liked a cuppa tea, and she just like plain water, I can tell you all about the lady, but she had full mental capacity. And if they say no, it's no…*

…We were trying milkshakes…. fortisips we were trying her with them…"

The panel noted that Mrs Kearsey did provide care for Resident C and tried to get her to eat, however it was not satisfied that these steps constituted the implementation of a care plan for weight loss.

The panel therefore found this charge proved.

Charge 3f

3. "Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. …
    b. …
    c. …
    d. …
    e. …
    f. failed to implement a care plan for wound management
    g. …"

This charge is found proved.

The panel noted that within the investigation report, it states:

'No Wound Care plan was put in place for – no photographs were taken at admission – no DATIX completed - no body map completed – no dressing regime or treatment plan in place'

Within the disciplinary hearing notes, the Home Manager sets out the expectation which is as follows:

'a fully comprehensive skin integrity care plan, which would have been like, what dressing regime, if there were, if there were needed for positioning regime, whether

there was a link to any nutritional insight, whether we'd like fortified diet or what equipment we were putting in place. How we're going to monitor the wound and if it broke down what steps you'd take if it broke down'

The panel also had before it, a skin integrity plan for Resident C but this contained no details of wound management. Mrs Kearsey acknowledges that there was a pressure ulcer on Resident C, and states that she was using an air mattress, but the care given was not recorded in the skin integrity care plan or any care plan to constitute a wound management care plan.

The panel therefore found this charge proved.

Charge 3g

3. "Between 5 February 2021 and 28 April 2021 failed to provide any or any adequate care, to Resident C in that you:
    a. …
    b. …
    c. …
    d. …
    e. …
    f. …
    g. failed to record within Resident C's clinical records the request to remove the airflow mattress."

This charge is found proved.

The panel had before it Resident C's skin integrity care plan which did not include any mention of an airflow mattress. It noted that Mrs Kearsey, in the disciplinary hearing notes states:

'I'm sure it was put in the care plan that she was on it, then we put in that she wanted to come off the air mattress, so it should be in the care plan...'

In addition, when questioned about recording the request during the local investigation interview on 20 May 2021, Mrs Kearsey states that she did not do so.

The panel therefore found this charge 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 Mrs Kearsey's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as whether a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.

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

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

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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*.'

The NMC 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.

The NMC identified the specific, relevant standards where Mrs Kearsey's actions amounted to misconduct namely 1,1.1, 1.2, 1.4, 3, 3.1,4,8, 8.1, 8.2, 8.5, 8.6, 10, 10.1, 10.2, 10.3, 11, 11.1, 11.3, 20, 20.1.

The NMC submitted the following in relation to misconduct:

> *'We consider the misconduct to be serious because Mrs Kearsey failed to provide three residents with adequate and appropriate care. Regarding Residents A and B, she failed to record and escalate the PEG site infection, failed to complete a DATIX to report the infection or inform colleagues at the daily flash meetings, failed to complete an infection, wound and additional needs care plans and failed to record any or all clinical care she provided to the residents. In addition to that, with Resident B she also failed to implement skin integrity and pressure ulcer management plans. Resident B was subsequently admitted to hospital with sepsis due to their infection.*
>
> *In relation to Resident C, Mrs Kearsey failed to weigh and/or ensure others were weighing the resident on a weekly and/or monthly basis, failed to escalate Resident C's weight loss to the dietitian and/or GP, failed to record the resident's malnutrition universal screening tool score and waterlow score. Mrs Kearsay also failed to implement a care plan to manage weight loss. Mrs Kearsey failed to ensure that Resident's C's pressure ulcer was appropriately managed with the right equipment and wound management plans. Even when Mrs Kearsey did act on the pressure ulcer when it had reached grade 4, they failed to provide the tissue viability nurse with sufficient information to provide full and proper advice., Mrs Kearsey failed to record within Resident C's clinical records any care or refusals of care.*
>
> *The failings in this case relate to basic and fundamental nursing practice which puts residents in Mrs Kearsey's care at risk of significant harm, and it is likely that actual harm occurred to Residents A, B, and C. The conduct, if found proved, amounts to several serious departures from the standards expected of a registered nurse. If Mrs Kearsey's misconduct were to be repeated, patients would be put at significant risk of harm.*

The panel is invited to find the charges are a sufficiently serious departure from expected standards to amount to misconduct in that Mrs Kearsey's conduct fell far below that which would be expected of a registered professional.'

The NMC reminded the panel to bear in mind its overarching objective to protect 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. The panel was referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mrs Kearsey's fitness to practise impaired on the grounds of public protection and public interest.

Regarding the limbs of the Grant test, the NMC submitted that the first three limbs are engaged. They submitted that Mrs Kearsey has in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm, Mrs Kearsey has in the past brought and/or is liable in the future to bring the nursing profession into disrepute; and Mrs Kearsey has in the past committed a breach of one of the fundamental tenets of the nursing profession and/or is liable to do so in the future.

Regarding the risk of harm, the NMC submitted:

'Poor record-keeping exposes patients to a risk of harm and undermines effective working arrangements with colleagues who are deprived of accurate and up to date information. Failing to escalate a patient's condition to the appropriate medical team/professional has the potential to cause serious harm to the patient and prevents them from receiving the care they require. Further, Mrs Kearsey failed to implement appropriate care plans for residents thereby putting the residents at risk of significant harm. Mrs Kearsey's actions directly impacted on and compromised patient safety and has the potential to cause serious harm to patients in her care. The NMC submits Mrs Kearsey's conduct has in the past put patients at significant risk of unwarranted harm and is liable to do so in the future.'

In relation to bringing the reputation of the nursing profession into disrepute, the NMC submitted:

> *'The misconduct in this case has the potential to cause damage both now and, in the future, where a registrant fails to deliver appropriate care and document accurately the care that has been provided to patients. Mrs Kearsey's omissions are unacceptable and have the potential to damage the reputation of the profession. Registered professionals occupy a position of trust and must provide a high standard of care, always. Mrs Kearsey's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future.'*

The NMC submitted in relation to breaching the fundamental tenets of the profession:

> '*Mrs Kearsey's failings have also breached fundamental tenets of the profession. Nurses are expected to provide a high standard of care and uphold the reputation of the profession. Mrs Kearsey's misconduct completely contradicts those fundamental tenets of nursing. The failings in this case relate to fundamental nursing practice which raises serious concerns regarding Mrs Kearsey's ability to practise safely as a nurse.'*

The NMC submitted that Mrs Kearsey has not provided any evidence of reflection or insight. It is submitted that Mrs Kearsey has displayed a lack of insight and does not appear to understand the seriousness of the misconduct and potential impact her actions could have had on patient safety and public confidence. The NMC also submitted that Mrs Kearsey has not demonstrated remediation or taken any steps to strengthen her practice. Furthermore, the NMC submitted that Mrs Kearsey failed to comply with the undertakings set by the CEs. As such, it is the NMC's position that Mrs Kearsey poses a continuing risk to the public should she be permitted to practice without restriction.

Regarding the public interest, the NMC submitted:

> *'…there is public interest in finding impairment being made, in this case, to declare and uphold proper standards of conduct and behaviour, and to maintain public*

confidence in the profession and the NMC as its regulator. Mrs Kearsey's misconduct engages the public interest particularly because of the pattern and repeated nature of the misconduct, the poor standards of care that were provided within the home but particularly, with regards to Residents A, B and C. The public expects a nurse to always uphold proper professional standards and to set the standards for junior colleagues. Mrs Kearsey has shown a complete disregard for the NMC Code, and the values contained therein, which has had a negative impact on the reputation of the profession, and, accordingly, has brought the profession into disrepute.

The public would expect the NMC to ensure that those on its register maintain the required standards of professionalism and deliver appropriate care to patients. The public would therefore expect the NMC to regulate or restrict the practice of nurses who not only fail to make accurate records of care provided but also fail to escalate care when necessary and fail to implement the relevant care plans.

A finding of current impairment is therefore required on public interest grounds to uphold proper standards and maintain confidence in the nursing profession.'

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* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Spencer v General Osteopathic Council* [2012] EWHC 3147 (Admin).

Decision and reasons on misconduct

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

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

'***1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 Treat people with kindness, respect and compassion.

1.2 Make sure you deliver the fundamentals of care effectively.

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.

4 Act in the best interests of people at all times

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues.

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

8.6 share information to identify and reduce risk.

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

To achieve this, you must:

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

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

10.3 complete records accurately… taking immediate and appropriate action if you become aware that someone has not kept to these requirements.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Kearsey's conduct fell significantly short of what is expected of a registered nurse. The panel noted that the facts found proved are in relation to Mrs Kearsey's nursing practice and numerous failings in providing adequate care to three Residents under her care.

The panel determined that professional colleagues would find this conduct to be deplorable and would be shocked at the facts found proved. The panel noted that the conduct in this case is not an isolated incident; there are numerous failings over a period of three months.

The panel was of the view that the conduct in this case was serious and put residents at risk of harm.

In light of the above, the panel found that Mrs Kearsey's 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 whether, as a result of the misconduct, Mrs Kearsey's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 28/01/2026) in which the following is stated:

'To help determine if a professional's fitness to practise is currently impaired, panels should always ask themselves the following questions:

1. *has the professional in the past acted and/or is liable in the future to act as so to put those receiving care at unwarranted risk of harm; and/or*

2. *has the professional in the past brought and/or is liable in the future to bring the profession into disrepute; and/or*
3. *has the professional in the past committed a breach of one of the fundamental tenets of the [nursing/midwifery] profession and/or is liable to do so in the future and/or*
4. *has the professional in the past acted dishonestly and/or is liable to act dishonestly in the future.*

They should also consider:

- *whether the concern can be addressed by taking steps to strengthen practice*
- *whether the concern has been addressed whether it is highly unlikely that the conduct will be repeated.*

Considering all the above questions will ensure that the panel considers:

- *Public safety (any risk of harm to people in the professional's care or to their colleagues)*
- *Any risk to the public's confidence in the professions and/or to professional standards.'*

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

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

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

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

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

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

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

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

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

d) *…'*

The panel determined that the first three limbs of the Grant test are engaged.

The panel noted that the misconduct related to Mrs Kearsey's nursing practice involving numerous instances where she failed to provide adequate care to three residents between February and April 2021. The panel noted that the charges include failures to provide clear and comprehensive records on the care given to residents, their conditions and implementing appropriate care plans. It was of the view that Mrs Kearsey's misconduct posed a real risk of significant harm as it potentially deprived colleagues of the full information regarding the residents' care needs and was likely to impact other professionals' ability to provide continuity of care.

The panel was of the view that these are failings of basic elements of nursing practice. It determined that, given the nature and numerous instances of the failings, Mrs Kearsey has brought the nursing profession into disrepute. Looking forward, the panel had no evidence before it that Mrs Kearsey has strengthened her practice and thus it determined that there remains a risk for Mrs Kearsey to repeat her misconduct.

The panel has found that Mrs Kearsey failed to provide adequate care to three residents. Providing adequate care is the cornerstone of the nursing profession which Mrs Kearsey has found to have failed to do. Furthermore, having earlier set out the elements of the Code breached by Mrs Kearsey, the panel was satisfied that this constituted a breach of fundamental tenets of the nursing practice.

The panel next considered whether the misconduct in this case is remediable. It was of the view that clinical failings can be remediated through strengthened practice. The panel noted that Mrs Kearsey had the opportunity to complete undertakings to remediate her practice, but the panel has no evidence of compliance. Furthermore, it had no evidence before it that Mrs Kearsey had completed any further training or taken steps to strengthen her practice.

The panel noted that at local level, Mrs Kearsey made some admissions to the concerns that give rise to the charges. The panel therefore determined that Mrs Kearsey demonstrated limited insight into the misconduct at local level. However, Mrs Kearsey has not engaged with the NMC in relation to these proceedings, has not provided any evidence of reflection and has failed to comply with the undertakings.

In light of the above, the panel determined 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 determined that a finding of impairment on public interest grounds is required because Mrs Kearsey's misconduct fell significantly short of the standards expected of a registered nurse and put three residents at significant risk of harm. In the absence of any reflection or strengthened practice, the panel was of the view that public confidence in the profession would be undermined if a finding of impairment was not made today.
Having regard to all of the above, the panel was satisfied that Mrs Kearsey's fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the meeting bundle sent with the Notice of Meeting, dated 15 December 2025, the NMC noted that it would seek the imposition of a suspension order for a period of 12 months if it found Mrs Kearsey's fitness to practise currently impaired.

Regarding mitigating and aggravating factors, the NMC submitted:

> '*There appears to be no mitigating features in this case.*
>
> *The following aggravating features are present:*
>
> - *The misconduct in this case occurred over a sustained period of time.*
> - *Mrs Kearsey's actions put patients at significant risk of harm.*
> - *Mrs Kearsey's failures indicate a pattern of misconduct.'*

The NMC submitted the following in relation to its sanction bid:

'The NMC guidance on Suspension Orders (SAN-3d) provides a checklist of factors that indicate when a Suspension Order may be appropriate. This includes:

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

As the allegation relates to repeated conduct, it does not constitute a single instance of misconduct. This case concerns neglect of vulnerable patients in Mrs Kearsey's care and a failure to escalate and keep accurate records of care. There appears to be a pattern of misconduct over a period of weeks, which suggests there is a repetition risk and some attitudinal concerns.

Whilst the concerns are remediable, Mrs Kearsey has failed to provide any evidence of developed insight and a willingness to engage with retraining. The failings in this case relate to basic and fundamental nursing practice and put residents in their care at significant risk of harm. There is a continuing risk at present to patient safety which can only be managed by a period of suspension. It is submitted that a suspension order for a period of 12 months is sufficient in this case to protect the public and maintain public confidence in the profession. The maximum length is required to mark the seriousness of the misconduct and to provide Mrs Kearsey the opportunity to undertake meaningful reflection and training on their failings...'

Decision and reasons on sanction

Having found Mrs Kearsey's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. 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 panel had careful

regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- There is a pattern of misconduct
- Failure to comply with the undertakings
- Failure to engage with these proceedings
- Limited evidence of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm
- The misconduct relates to vulnerable residents.

The panel also took into account the following mitigating features:

- Early admissions at local level
- Some level of apology at local level
- There was some evidence that the Home environment was challenging and going through a transition of ownership which meant the appropriate policies that may have supported Mrs Kearsey were not in place.

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

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

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

The panel considered that Mrs Kearsey's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Kearsey's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Mrs Kearsey's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026):

- *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)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *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 noted that while there is no evidence of deep-seated personality or attitudinal problems and there are identifiable areas of Mrs Kearsey's practice in need of retraining, Mrs Kearsey's lack of insight and engagement in these proceedings suggested that there is not a willingness to respond positively to retraining. Furthermore, the panel noted that Mrs Kearsey has previously been subject to undertakings which she has failed to comply with. The panel determined that a conditions of practice order would not be appropriate in the circumstances.

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

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

Whilst the panel acknowledged that the risks identified could be managed by Mrs Kearsey being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Mrs Kearsey's lack of engagement and limited insight, together with no evidence of training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely. The panel noted that the charges relate to events that date back to February 2021 and since that time, there has been no evidence of strengthened training or developed insight. The panel noted that there has been no engagement from Mrs Kearsey with these proceedings, including a failure to comply with undertakings. The panel determined that while a period of suspension would protect the public, it was not satisfied that it would serve a useful

purpose given there is no evidence that Mrs Kearsey is willing to address the underlying misconduct.

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

In reaching this conclusion the panel had regard to NMC Guidance on 'Deciding between suspension and strike off' (Reference SAN-3 Last Updated: 28/01/2026) which reads:

'…

- *Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*
- *Professionals are under an obligation to cooperate with their regulator.4 Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight…'*

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

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

The panel found that the charges raise fundamental questions about Mrs Kearsey's professionalism as they relate to numerous failings of nursing practice in relation to three vulnerable residents who were put at a serious risk of harm. It was of the view that removal from the register is needed to maintain public confidence in the profession and maintain nursing standards. The panel had no evidence before it of any reflection or insight into the misconduct. Furthermore, it noted that there has been no engagement from Mrs Kearsey at all in relation to these proceedings and thus could not be satisfied that there is a realistic prospect that after suspension, she will have gained insight and strengthened her practice such that the risk of harm and repetition will have reduced.

The panel was of the view that the findings in this particular case were serious and to allow Mrs Kearsey to continue practising in the absence of any evidence of strengthened practice, insight or reflection would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs Kearsey's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

In making this decision, the panel carefully considered the submissions in relation to the sanction that the NMC was seeking in this case. However, the panel considered that in compliance with the recent guidance update, a suspension order for a period of 12 months was not the appropriate sanction in the circumstances. The panel could not be satisfied that there is a realistic prospect that a period of suspension would serve any useful purpose.

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

This will be confirmed to Mrs Kearsey in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that:

> *'If a finding is made that the Mrs Kearsey's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's

determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the period of appeal and to allow any such appeal should it be lodged to be heard and concluded.

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

That concludes this determination.