Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 2 June 2025 – Friday, 13 June 2025
Monday, 22 September 2025, Tuesday, 23 December 2025
Monday, 2 February 2026 – Thursday, 5 February 2026

Virtual Hearing

Name of Registrant:	Nirmala Anil Lole
NMC PIN	19G0082O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 3 July 2019
Relevant Location:	Wiltshire
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, lay member) Margaret Stoddart (Lay member) Victoria Head (Registrant member)
Legal Assessor:	Charlotte Mitchell-Dunn (2 June – 13 June 2025) Charles Conway (22 September 2025 and 23 December 2025) Suzanne Palmer (2 – 5 February 2026)
Hearings Coordinator:	Bartek Cichowlas (2 June – 13 June 2025) Ibe Amogbe (22 September 2025)

	Stanley Udealor (23 December 2025) Clara Federizo (2 – 5 February 2026)
Nursing and Midwifery Council:	Represented by Case Presenter Ben Edwards (2 June – 13 June 2025) Mohsin Malik (22 September 2025) Alastair Kennedy (2 – 5 February 2026)
Mrs Lole:	Present and represented by Karl Shadenbury, instructed by UNISON
Facts proved by admission:	Charges 5, 6, and 8
Facts proved:	Charges 1a, 1b, 1c, 1d, 4a, 4b, 7a, 7b
Facts not proved:	Charges 2, 3a, 3b, 3c, 9, 10
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 5.

The proposed amendment was to correct the IV infusion rate in charge 5. It was submitted by Mr Edwards that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

5. On or around 18 October 2020 you incorrectly set a patient's IV infusion rate at around ~~279ml~~ **200ml** instead of ~~200ml~~ **279ml**

The panel heard submissions from Mr Shadenbury on your behalf indicating that you did not oppose the application.

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

The panel was of the view that such an amendment was a minor typographical correction and was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to accurately represent the evidence.

The panel heard a second application made by Mr Edwards, on behalf of the NMC, after evidence had been received from Witnesses 1 and 3, to amend the wording of charges 4 and 7.

Having received further information, and having been provided with further clarification from you, the proposed amendment was to correct the dates on which the charges are alleged to have occurred. It was submitted by Mr Edwards that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

4. On or around ~~6/7 September~~ **6 August** 2020
    a. …
    b. …

7. On or around ~~7 September~~ **6 August** 2020 you:
    a. …
    b. …
    c. …"

Mr Shadenbury, on your behalf, submitted that you did not oppose this application.

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

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

Details of charge (as amended)

That you, a registered nurse:

1. On one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that:

    a. on or around 24 July 2020 when Colleague A was observing you cannulate a patient you:

        i. became annoyed with Colleague A

        ii. pointed your finger at Colleague A

        iii. said to Colleague A in front of a patient words to the effect of '*you are here to supervise me not teach me'* and '*trust me I know what I am doing'*

    b. on one or more unknown dates you raised your voice and/or became confrontational towards colleagues

    c. on or around 22 June 2022 you refused to assist Colleague B to lift a patient into their bed

    d. on or around 31 May 2022:

        i. raised your voice to Colleague C in the presence of patients on the ward

        ii. spoke to Colleague C in a rude manner

2. On one or more occasions you failed to treat patients with dignity and respect in that you:

    a. on or around 7/8 August 2022:

i. pushed Patient A's wheelchair against her wishes

ii. said to Patient A '*don't you ever ask me for help again, I'm not helping you anymore'* or words to that effect

b. on one or more unknown dates:

i. did not respond promptly to Patient C's requests for assistance

ii. spoke to Patient C in a degrading and/or unprofessional manner

c. in or around August 2022:

i. when Patient D asked you to rub his heel you said words to the effect of '*I'm not a physiotherapist'* and '*we don't do massage'*

ii. refused to provide assistance to Patient D

3. Between approximately December 2020 and January 2021 you failed to maintain infection control measures in that you:

a. failed to attend one or more FIT test appointments

b. worked one or more shifts as a bank nurse without wearing appropriate PPE

c. on 13 January 2021 incorrectly told a colleague that you had been FIT tested when in fact you had failed to attend a FIT test appointment on 23 December 2020

4. On or around 6 August 2020:

a. you failed to escalate a patient's deteriorating condition to the senior doctor and/or nurse in charge of the night shift

b. you went on your break without notifying the nurse in charge that the patient had a Glasgow coma score of 3

5. On or around 18 October 2020 you incorrectly set a patient's IV infusion rate at around 200ml instead of 279ml

6. On or around 15 January 2021 you did not correctly dilute a patient's IV medication

7. On or around 6 August 2020 you:

a. made an entry in a patient's notes on the Trust patient record keeping system without logging into the system using your own individual log in details

b. made a retrospective entry in a patient's notes without indicating that you had done so retrospectively

8. On or around 22/23 January 2021 documented that you had given a patient their medication at 16:30 but later told colleagues that you had not administered the medication to the patient

9. Your conduct at charge 7(b) was dishonest in that by not indicating that you had made the entry retrospectively you sought to give the impression that the entry had been made contemporaneously.

10. Your conduct at charge 8 was dishonest in that you sought to give the impression that you had given medication to the patient when you had not done so.

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

Background

On 26 September 2022, you were referred to the NMC by Salisbury NHS Foundation Trust ("the Trust") where you were employed as a Band 5 Registered Nurse since your entry onto the NMC Register on 3 July 2019.

Between your appointment at the Trust in 2019 and August 2022, you had worked within three clinical departments and, within each area, a number of concerns had been raised relating to your practice.

The complaints were raised by both work colleagues and patients over the three-year period and are summarised into the following areas:

- Failures to treat people with professionalism, dignity and respect (including patients).
- Issues with clinical skills incorporating medication administration errors and a failure to escalate a deteriorating patient.
- An unwillingness to work cooperatively and effectively with colleagues including maintaining effective communication.

The Trust began performance managing you on 8 August 2020 and carried out an investigation into your clinical failures between January and February 2021. You were re-deployed to a less acute department in the Trust and had to complete acute medicines management training and ensure that any medications dispensed were double checked by another member of staff.

The Trust commenced a further investigation into behavioural concerns that were raised in August 2022. The investigation was completed on 12 December 2022.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Edwards under Rule 31 to allow the local Interview Statement for Workforce Investigation of Patient A ('Patient A's Interview'), the local Interview Statement for Workforce Investigation of Patient C ('Patient C's Interview') and the note of a telephone call with Patient D in the local Workforce Investigation (Patient D's Phone Call Notes') into evidence.

Mr Edwards submitted that attempts to contact Patient D yielded no positive response. He further submitted that while Patients A and C had previously engaged with the NMC in April 2025, they had since disengaged. Given the NMC's information that these patients had been hospitalised, he submitted it would not have been appropriate to pursue their attendance any further.

Despite numerous attempts, the NMC had not been able to obtain a signed, written statement from Patients C and D. However, Mr Edwards submitted that the evidence is highly relevant and though not provided as part of the NMC's investigation, was produced for the purpose of the internal Trust investigations. With respect to Patient A, Mr Edwards submitted that the NMC had obtained correspondence, for the purpose of these proceedings, from Patient A which attests to the accuracy of the information provided in their interview.

He submitted that although the NMC accepts that the information may form the sole and decisive evidence in respect of charge 2, it should be admitted, and that it should be considered alongside the evidence of Witness 5, to whom the complaints were made, and who will, in due course, give oral evidence to the panel. He submitted that, in the circumstances, the information provided by the patients is relevant, and it would be fair to admit it into evidence.

Mr Shadenbury submitted that you oppose the application. He invited the panel to consider the NMC's rules and the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). He submitted that the information provided by the patients would form the sole

and decisive evidence in respect of charge 2. He submitted that the panel should consider the seriousness of the allegation and take into account the impact that adverse findings might have on the Registrant's career. He submitted that the NMC is seeking your entry on the Register to be struck off and admitting this evidence, without you being afforded the opportunity to challenge the patient's version of events, could have a significant impact on your ability to practise as a nurse. He submitted that depriving you of the opportunity to cross examine these witnesses and challenging their perception of the events would be unfair to you.

Mr Shadenbury further submitted regarding the evidence of Patient A and Patient C, an interview transcript should be regarded as less reliable than a formal signed witness statement and asked the panel to note that the transcript has not been signed or dated by Patient A or C.

In respect of Patient D's Phone Call Notes, he submitted that this document has not been signed or dated by Patient D and it is unclear why the NMC have not exhibited the patient's interview transcript as they have for Patient A and Patient C.

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

The panel was of the view that the evidence was clearly relevant to the charge, but that the appropriate admissibility criteria required as part of the NMC rules and as set out in the case of Thorneycroft were not met in respect of the evidence of all three patients.

The panel first considered whether the evidence of the Patients was the sole and decisive evidence. The panel considered charge 2, and was of the view that the evidence of the

patients was cumulatively the sole and decisive evidence in respect of this charge. The panel noted that Patient C's interview and Patient D's phone call notes were each the sole and decisive evidence in respect of charges 2b and 2c respectively. The panel also considered Patient A's Interview to be the sole and decisive evidence in respect of charge 2a. However, it noted that an interaction with Patient A occurred, for which you apologised, but the exact nature of the events are disputed.

The panel next considered the nature and extent of the challenge to the interview and phone call notes. The panel concluded that in respect of Patient C's interview and Patient D's phone call notes, you dispute the incidents occurred, and would therefore wish to cross-examine these witnesses in respect of the events. The panel considered not allowing you the chance to cross examine the witness would be unfair to you. The panel noted that you dispute the exact nature of the encounter that led to Patient A's allegations, and concluded that while you do acknowledge an interaction occurred, it would be unfair to admit the interview notes without allowing you the chance to cross examine.

The panel next considered the serious consequences of finding the charge proved. The panel was of the view that in light of the NMC's bid of a striking-off order in the event that all of the particulars are found proved, the consequences of admitting such sole and decisive evidence may be serious.

There was no suggestion from you of any reason for any of the patients to fabricate their evidence, and the panel found none.

The panel further considered whether all reasonable steps were taken by the NMC to secure the presence of the Patients. The panel noted the email chains and documentation provided by the NMC which outlined all of the steps taken. The panel noted that both Patients A and C had engaged with the NMC in April 2025, although Patient D had not been contactable. However, it considered that there have been no attempts to contact either Patient A or C since 9 May 2025, just under a month prior to the date of the hearing. The panel concluded that there had been ample time for the NMC to make further

attempts to secure the presence of all three of these witnesses, or to provide further information detailing why their presence could not be secured.

Furthermore, the panel was unable to conclude that there was a good and cogent evidence demonstrating a reason for the non-attendance of any of the patients. The panel took into account the fact that at the time of communication, Patients A and C were both hospitalised. However, the panel was of the view that, given the length of time since the last communication between Patients A and C and the NMC, there was no up-to-date information regarding their wellbeing and whereabouts. There was no positive statement from either patient that they were not well enough to give evidence. It concluded that it was unable to assume that these patients remained hospitalised, and/or that they were too unwell to give evidence. Therefore the panel had insufficient evidence before it to demonstrate a good reason for the non-attendance of Patients A and C. Whilst Patient D did not respond to two attempts by the NMC to contact them, the panel considered there was no evidence of any good or cogent reason for Patient D's non-attendance on the basis that the panel did not consider two emails, and no follow up, to the Patient to be sufficient.

The panel further considered the nature of the documentation it was asked to admit as evidence. The panel had sight of correspondence and a statement prepared by Patient A which attested to the truth of their Interview. Patient C's Interview and Patient D's phone call were not signed and did not contain a statement of truth for the purposes of this hearing. However there was a note at the bottom of each document stating that they had been agreed as true by email.

In these circumstances the panel refused the application. The panel concluded that the evidence is sole and decisive and is disputed by you. The panel considered it would be unfair for you not to be able to cross examine the relevant witnesses and it considered that the consequences of admitting this evidence may be serious.

The panel noted that, given the time since the last correspondence with the patients, it remains open to the NMC to make further inquiries into their availability to attend the hearing.

Decisions and reasons on application to offer no evidence in respect of charge 2

Having made further unsuccessful inquiries following the rejected application to admit hearsay evidence, the NMC made an application to offer no evidence in respect of charge 2.

Mr Edwards provided an update on the further inquiries made to secure the presence of Patients A, C and D. He informed the panel that Patient A did not further engage with the NMC. He also informed the panel that Patient C did engage with the NMC, but was not able to attend due to continuing poor health. He also informed the panel that Patient D had not previously engaged, and that no further inquiries were made of them.

Mr Edwards referred the panel to NMC Guidance reference DMA-3. He submitted there was no realistic prospect of proving the charge in light of rejected hearsay application and the fact that the patients were not able to attend.

Mr Shadenbury indicated on your behalf that there was no opposition to the application.

The panel accepted the advice of the legal assessor.

The panel decided to accept the application. The panel took into account the new attempts made by the NMC to secure the presence of Patients A, C and D which led to no further engagement. The panel noted that it rejected the application to admit the evidence of these patients as hearsay, and further enquiries did not secure the presence of the patients. In light of this, the panel found that there was no reasonable chance of finding the allegations in this charge proved, and therefore accepted the NMC's application to offer no evidence in respect of charge 2.

Resumed hearing on 22 September 2025

The panel had resumed the hearing today to request further information from the NMC in relation to patient records. The panel noted that the NMC bundle did not contain any patient records and the only access the panel had to the patient records were the pages provided by you which were incomplete. You informed the panel that you obtained those pages from the Trust. The panel's request was made in the light of its duty to protect the public and also to ensure a fair hearing.

Resumed hearing on 23 December 2025

On 22 December 2025, the panel received an email from the NMC in response to the panel's request for further information. The NMC stated:

> *'Following the Panel's request for patient records the NMC contacted the Trust to obtain the records for the two periods as requested. The Trust have now responded, and this following information has been provided:*
>
> - *The Trust provided all of the records of patients the Registrant treated on the 5th/6th August 2020. The Trust were able to provide 5 patient records for this period. Having reviewed these documents none of the records relate to the patient spoken to in charges 4 and 7 of the schedule of charges as amended. The NMC therefore does not consider it appropriate or necessary to provide these documents to the Panel, as they are not directly related to the charges. The NMC therefore relies on the previous evidence and submissions provided to the Panel as of the closing of its case on facts.*

- *The Trust have reviewed all sets of notes from the shift of the 22nd/23rd of January 2021 and have been unable to locate any "episode of documented care" by the Registrant. The NMC therefore considers this takes us no further on the charges and relies on the previous evidence and submissions provided to the Panel as of the closing of its case on facts.*

  These disclosures from the Trust have also been sent to the Registrant's legal representative, and they have been notified of the NMC's position. The Representative has outlined they have "nothing further to add in respect of the current stage of these proceedings"

In light of this the NMC does not consider there to be any further submissions to be made to the Panel at this stage, and that the Panel can continue to consider its determination on facts. If however the Panel wish to hear from the parties the representative for the Registrant has outlined that can make themselves available from 10am. A representative for the NMC can also be made available tomorrow.'

In light of the aforementioned, it was unnecessary to hear from the parties, and the panel determined to make its decision on the basis of the evidence presented to it.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Shadenbury who informed the panel that you made full admissions to charges 5, 6, and 8.

The panel therefore finds charges 5, 6 and 8 proved in their entirety, by way of your admissions.

The panel also heard and accepted an application to offer no evidence in respect of charge 2, and therefore finds this charge not proved in its entirety.

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

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

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

- Witness 1: Matron of Emergency Care at the Trust
- Witness 2: Receptionist for the front desk of the Facility Services team at the Trust
- Witness 3: Senior Sister in the Emergency Department of the Trust, clinical lead of shift and safeguarding lead for the department
- Witness 4: A Band 4 Assistant Practitioner/ Apprentice Nurse at the Trust
- Witness 5: Senior Sister at the Trust

- Witness 6: Ward Manager at the Trust
- Witness 7: Senior Nursing Assistant at the Trust
- Witness 8: Clinical Procurement Nurse Specialist at the Trust

The panel also heard evidence from you under oath.

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

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

Charge 1(a)(i)

> "That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on or around 24 July 2020 when Colleague A was observing you cannulate a patient you became annoyed with Colleague A"

This charge is found proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of Colleague A, and the evidence of Witness 1. The panel noted that in your evidence, you accepted that you were being supervised by Colleague A while you were cannulating a patient, that you had a clinical disagreement about the cannulation, and that Colleague A left the cubicle following this disagreement. You stated that you did not become '*annoyed'*, but that you did become '*upset'* when he left as you were then unable to complete the cannulation.

The panel noted that it was a basic duty of nurses to cooperate and communicate effectively with professional colleagues.

The panel was of the view that Colleague A's account of the incident was consistent and clear. The panel took into account that Witness 1's evidence was consistent with the account given by Colleague A.

The panel noted that in Witness 1's written evidence, she states that you 'told [her] that they should not have to be supervised, and not by [Colleague A] for cannulating a patient'. This was inconsistent with the account you gave in your oral evidence in which you stated you were upset but not annoyed by the situation.

The panel also noted that you considered yourself to be experienced at cannulating patients, having stated you had done '*over 5000 canulations'*.

The panel found the accounts of Witness 1 and Colleague A to be credible. The panel believed that you were annoyed by the situation. The panel took into account that you considered yourself very experienced in cannulating patients, your clinical disagreement with Colleague A, and the fact that he was of a lower band, and not a registered nurse at that time. Given this, and the inconsistencies between your account and the consistent accounts of Witness 1 and Colleague A, the panel found that it is more likely than not that you became annoyed with Colleague A and that this amounted to a failure to cooperate and/or communicate effectively with colleagues.

The panel therefore found this charge proved.

Charge 1(a)(ii)

“That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on or around 24 July 2020 when Colleague A was observing you cannulate a patient you pointed your finger at Colleague A”

This charge is found proved.

In reaching this decision, the panel took into account Mr Edward’s and Mr Shadenbury’s submissions, your oral evidence, and the oral and written evidence of Colleague A, and the evidence of Witness 1. The panel noted that in your evidence, you accepted that you were being supervised by Colleague A while you were cannulating a patient, that you had a clinical disagreement about the cannulation, and that Colleague A left the cubicle following this disagreement.

The panel noted that it was a basic duty of nurses to cooperate and communicate effectively with professional colleagues.

You stated in your oral evidence that, since Colleague A was standing behind you when you were cannulating a patient, there was no possible way in which you could have pointed your finger at him.

The panel considered that Colleague A’s account of the incident was consistent and clear. The panel was of the view that it was unlikely that Colleague A would have supervised you from behind, as he would not have been able to observe the procedure clearly from that position. In his evidence, Colleague A said that you became frustrated, visibly annoyed and you pointed your finger at him. The panel took into account that Witness 1’s evidence was consistent with the account given by Colleague A.

The panel found the accounts of Witness 1 and Colleague A to be credible. The panel believed that you were annoyed and frustrated by the situation. The panel found that it is

more likely than not that you pointed your finger at Colleague A, and that this amounted to a failure to cooperate and/or communicate effectively with colleagues.

The panel therefore found this charge proved.

Charge 1(a)(iii)

> "That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on or around 24 July 2020 when Colleague A was observing you cannulate a patient you to Colleague A in front of a patient words to the effect of '*you are here to supervise me not teach me*' and '*trust me I know what I am doing*'"

This charge is found proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of Colleague A, and the evidence of Witness 1. The panel noted that in your evidence, you accepted that you were being supervised by Colleague A while you were cannulating a patient, that you had a clinical disagreement about the cannulation, and that Colleague A left the cubicle following this disagreement.

The panel noted that in your oral evidence, you accepted that you were not signed off by the Trust as competent to cannulate independently and that this was a process you acknowledged you had to complete. You also accepted saying to Colleague A to '*trust me'* but you denied saying words to the effect of '*you are here to supervise me not teach me*'.

The panel noted that it was a basic duty of nurses to cooperate and communicate effectively with professional colleagues.

The panel was of the view that Colleague A's account of the incident was consistent and clear. The panel took into account that Witness 1's evidence was consistent with the account given by Colleague A.

The panel found the accounts of Witness 1 and Colleague A to be credible. The panel found that, given your acceptance of using the words 'trust me', and the witness evidence consistent with this, it was more likely than not that you said words to the effect of '*trust me I know what I am doing'*. Furthermore, the panel took into account that you considered yourself very experienced in cannulating patients, your clinical disagreement with Colleague A, and the fact that he was of a lower band, and not a registered nurse at that time. The panel also considered the evidence of Witness 1 and Colleague A who both stated that you said words to the effect of '*you are here to supervise me not teach me*'. Given this, the panel considered it was more likely than not that you said words to this effect, and that this amounted to a failure to cooperate and/or communicate effectively.

The panel therefore found this charge proved.

Charge 1(b)

> "That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on one or more unknown dates you raised your voice and/or became confrontational towards colleagues"

This charge is found proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the witnesses.

The panel noted that in your evidence you deny that there were any instances in which you raised your voice and/or became confrontational towards colleagues. Mr Shadenbury submitted that there was no evidence of any specific incidences given by the NMC during which you acted in this way.

The panel noted that it was a basic duty of nurses to cooperate and communicate effectively with professional colleagues.

The panel considered the statement of Witness 6, in which he states '*I have not met a nurse as uncaring as [you], and I have also had a lot of discussions with [you] about [your] communication with staff and patients, however there has been no improvement in [your] practice'*.

The panel considered Witness 1's evidence, in which she states:

'*[You] could also become very angry, raise [your] voice and be very confrontational in relation to something [you] did not agree with.*

…

'*On 24 July 2020, I was made aware of a matter. … [you] approached* [Colleague A] *and began shouting at them in the middle of the Department, in front of patients, and spoke rudely and loudly to* [Colleague A].'

The panel had sight of a letter to you dated 4 November 2020 from Witness 1 summarising your manner of communication/interactions with colleagues especially unregistered nurses. It stated:

> *'You have previously acknowledged that your manner of communication can be abrupt and have been working on using please and thank you and using staff members' given names not he/she.*

However, communication concerns have continued to be raised and addressed in regards to working with [Nursing Auxiliary…], [Senior Sister…], [Nursing Auxiliary…]. It was acknowledged that it was inappropriate for you to physically pull [Nursing Auxiliary…] towards you to engage in conversation.'

The panel also considered Witness 1's exhibited Terms of reference of local investigation, in which it states that '*concerns were raised in regards to Nirmala's communication/interaction with colleagues'.*

The panel was of the view that witness accounts were consistent with this evidence in describing that you would frequently become confrontational when questioned or feeling undermined, and that you would often raise your voice in such situations. The panel determined that it is more likely than not that you did on one or more occasions raise your voice and/or become confrontational towards colleagues, and that this amounted to a failure to cooperate and/or communicate effectively.

The panel therefore found that this charge is proved.

Charge 1(c)

"That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on or around 22 June 2022 you refused to assist Colleague B to lift a patient into their bed"

This charge is found proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of Colleague B.

The panel noted that in your oral evidence, you accept that Colleague B had asked you to move a patient on that date, and you state that you did come back to help Colleague B five to ten minutes after she made this request. It is accepted by Colleague B that although you had completed your drugs round, you may still have had medicines to give to patients who were off the ward at that time.

The panel found the evidence of Colleague B to be reliable and consistent. The panel considered the following from Colleague B's exhibited email of concerns to the local investigation, dated 15 August 2022:

> '*I was working with her about 2 months ago the day before she was going back to Indian on holiday, I was on a long day with her in the morning she didnt do much then on the late there was only 3 of us she kept saying I cant do any manual handling only go home tomorrow and dont want to hurt myself. I told her that she works until 7.30 and we all need to help each other she final came as I finished*' [sic]

The panel was not able to determine the details of your account of the incident due to the inconsistencies in your evidence. The panel noted that you stated you were not able to help Colleague B with moving the patient as you had to complete a drugs round.

However, on the second day of your giving evidence, you stated that Colleague B may have fabricated the date of the allegation. You stated that since the allegation was made some months after the event, Colleague B may have seen from the rota that you went on holiday two days following the incident and used this

information to make a retrospective allegation which was otherwise unsubstantiated.

The panel noted that this was not a position that was advanced in the cross examination of Colleague B, and until you gave evidence, there was no suggestion that Colleague B may have fabricated the whole incident using the dates you were on annual leave to lend veracity to the allegation. The panel concluded that this rendered your account of the events less credible. Moreover, Colleague B gave a more credible explanation as to the timing of her statement. Colleague B was asked to give a statement about this incident as part of the Trust investigation and therefore had a cogent reason for the delay in submitting the statement.

Furthermore, the panel noted that, if Colleague B had understood that you intended to assist with the patient following your drugs round, she would not have had any reason to go through with the manual handling of the patient on her own. Colleague B told the panel that she had to move the patient on her own even though it posed a risk to her own safety and that of the patient. Colleague B's reason for doing so was that the patient was in her chair and developing increasing pain which meant she needed to be urgently moved to her bed. Previous experience had shown that this would alleviate the pain she often experienced while sitting. In your oral evidence, you said you were familiar with the patient as she had been on the ward some time and you would therefore have known about this issue.

Therefore, due to the credibility of Colleague B, and your inconsistent accounts, the panel found that it is more likely than not that you failed to work cooperatively in that you refused to assist Colleague B to lift a patient into their bed. The panel therefore found this charge proved.

Charge 1(d)(i) and 1(d)(ii)

"That you, a registered nurse, on one or more occasions failed to communicate effectively and/or co-operate with your professional colleagues in that on or around 31 May 2022

(i) raised your voice to Colleague C in the presence of patients on the ward
(ii) spoke to Colleague C in a rude manner"

This charge is found proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the Witnesses 2 and 6.

The panel noted that you stated you had difficulty in adjusting to the communication customs in the UK, having trained and practised in India for 19 years. Mr Shadenbury submitted on your behalf that you had difficulties in adjusting to the pleasantries used in England, but you have since adapted and learned how to communicate more kindly.

The panel considered the evidence of Witness 2, who stated the following:

'I was just about to sit down to eat my lunch when Mrs Lole came in to the staff room and with a raised voice asked who the cleaner is on the Ward. I told Mrs Lole that I am one of the cleaners on the Ward, and asked if there was a problem. Mrs Lole responded rudely and abruptly that they have not seen a cleaner on the Ward since 07:00

…

I called Mrs Lole over in a polite manner to show them the cause of the sticky table and floor, and Mrs Lole raised their voice at me in front of the patients that they are not going to listen to me because they are busy and do not have the time. I tried to be polite towards Mrs Lole and continued trying to explain why the floor was sticky, but Mrs Lole ignored me. I did not want to make a scene in front of patients so I did what Mrs Lole wanted … However Mrs Lole's rude behaviour towards me made my cry and feel stressed'

The panel considered that in your evidence, you explained that you did not feel like you raised your voice or were rude, but that you were making a request for the floors to be cleaned as this was a job that needed doing.

The panel also considered the evidence of Witness 6 who stated that he had '*not met a nurse as uncaring as Mrs Lole, and I have also had a lot of discussions with Mrs Lole about their communication with staff and patients*'.

The panel considered the accounts of Witnesses 2 and 6 to be consistent and compelling. The panel found that the evidence of Witness 2 described events very clearly and remained consistent under cross-examination. It was also consistent with the overall impression of your communication style experienced by other witnesses as described by Witness 6. The panel therefore found that it was more likely than not that Witness 2's account of the incident was accurate, and that you did raise your voice in the presence of patients and speak in a rude manner.

The panel therefore finds these charges proved.

Charge 3(a)

"Between approximately December 2020 and January 2021 you failed to maintain infection control measures in that you failed to attend one or more FIT test appointments"

This charge is found not proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the Witness 1.

Witness 1 stated that you:

'*had failed a few FIT testing appointments as the masks would not fit [your] face, and [you] had to go back to try on different masks or be provided with a hood to ensure [you] could continue working safely in the Department with potential and known Covid-19 patients. However, [you] would fail to attend your] appointments'*

The panel noted that you accept that you did not attend one FIT testing appointment which you had booked. The panel noted that there was no specific evidence of a failure to attend any other appointments. You also stated to the panel that you always wore Level 1 personal protective equipment (PPE) for the clinical areas in which you were working which provided a sufficient level of infection control in these areas. You stated that you did not take any bank shifts where higher levels of PPE were required.

The panel next considered whether you failed in your duty to maintain infection control measures by failing to attend one FIT testing appointment. You accepted that you did not attend this FIT testing appointment. However, the NMC did not provide sufficient evidence to demonstrate repeated non-attendance at any other FIT testing appointments. Witness 1 accepted that at the appointment that you did

attend, *'the masks would not fit [your] face'*. The NMC did not provide any evidence of you working with inadequate PPE.

While it was poor practice for you not to attend the FIT testing appointment you had booked, in light of the absence of evidence from the NMC, the panel found that you did not fail to maintain infection control measures by not attending your appointment.

The panel therefore found this charge not proved.

Charge 3(b)

> "Between approximately December 2020 and January 2021 you failed to maintain infection control measures in that you worked one or more shifts as a bank nurse without wearing appropriate PPE"

This charge is found not proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the Witness 1.

Witness 1 in her witness statement states that you were '*also working as a bank nurse for the Trust at the time in another department, and worked with patients without appropriate PPE*'

The panel considered whether there was a duty to maintain infection control measures and found that it was a fundamental tenet of the nursing profession to do so.

The panel did not see any evidence of which shifts you worked as a bank nurse, what level of PPE was required on those wards, and whether they would have necessitated a successful FIT test for a FFP3 mask. The panel heard from you, and you stated that you wore level 1 PPE at all times. The panel did not see sufficient evidence to suggest that you failed in your duty to maintain infection control measures by working one or more shifts as a bank nurse without wearing appropriate PPE.

The panel therefore finds this charge not proved.

Charge 3(c)

> "Between approximately December 2020 and January 2021 you failed to maintain infection control measures in that you on 13 January 2021 incorrectly told a colleague that you had been FIT tested when in fact you had failed to attend a FIT test appointment on 23 December 2020"

This charge is found not proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the Witnesses 1 and 3.

The panel considered whether there was a duty to maintain infection control measures and found that it was a fundamental tenet of the nursing profession to do so.

The panel considered an incident during which it is claimed you had raised your hand to indicate that you were FIT tested in response to a question from the nurse in charge of the shift. However, you state that this was a misunderstanding and

that you did not subsequently work on any ward for which FIT testing was required.

Witness 3 stated, when asked about this at the Trust investigation meeting, that:

> *'There is always room for misunderstanding, but I went around the room and asked people that I knew were not FIT tested. I individually went round and looked at each of them, I had a lot of witnesses…, people said "I heard what you said, it was very clear". But can't be 100% certain with full masks on etc'*

The NMC did not provide any evidence that this incident led to a failure to properly maintain infection control measures.

The panel therefore finds that this charge is not proved.

Charge 4(a)

> "On or around 6/7 September 2020 you failed to escalate a patient's deteriorating condition to the senior doctor and/or nurse in charge of the night shift"

This charge is found proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of the witnesses.

The panel took into account that Witness 3 stated that '*[you] verbally escalated the patient's GCS of 3 to the Locum Doctor'* and you also stated you had told the Locum Doctor about the GCS score of 3. The panel found both of these accounts to be consistent and accepted them.

The panel heard in your evidence that you were an experienced nurse who had worked in emergency departments and described yourself as being *'skilled in managing the acute emergencies'* in your application to transfer to the emergency department (ED).

The panel also heard from the NMC Witnesses 1, 3 and 8, all of whom were experienced ED nurses, that if the escalation to the Locum Doctor did not result in effective action on behalf of the patient, there was a further and fundamental duty on you to escalate to the senior clinicians to ensure patient safety.

Witness 1 stated:

> *'Furthermore, although the doctor prescribed intravenous fluids to the patient, I would expect someone with Mrs Lole's level of experience to know that that is not the appropriate action to take for a patient with a GCS of 3, the appropriate action would be to provide the patient with airway adjuncts and move them to resuscitation.'*

Witness 3 also stated:

> *'Mrs Lole had a duty as per section 16 of the NMC Code of Conduct ("the Code") to act without delay if you believe there is a risk to patient safety. Mrs Lole failed this duty by not escalating the patient when they deteriorated to a GCS of 3, and although Mrs Lole had escalated the patient to the doctor, they did not escalate the patient to me as the nurse in charge and left the patient on their own. The patient was completely unresponsive, and before going on their break, Mrs Lole did not tell me of any concerns regarding the patient to handover nor did they ask for another member of staff to oversee their patient whilst they went on their break.'*

Witness 8, in his email to Witness 1 dated 6 September 2020, stated that having discussed the matter with you:

> *'She states that she told the Reg which I believe she did. she feels this is enough. we discussed that the patient was critically unwell and the escalation policy states the nurse in charge must also be made aware, we also discussed that even if the Dr feels the patient is stable 3 GCS of 3 should not be nurse in majors, she appears to have little insight into the meaning and risks of having a GSC this reduced.'*

The panel considered that a GCS of 3 was clearly serious and required you to ensure effective action was taken. The previous GCS score recorded at approximately half an hour before was 13. This indicated a rapid deterioration in the patient's condition and a potentially life-threatening situation. The action that you took did not discharge this duty and you should have further escalated the patient's deteriorating condition to the senior doctor and/or nurse in charge.

The panel therefore finds that this charge is proved.

Charge 4(b)

> "On or around 6/7 September 2020 you went on your break without notifying the nurse in charge that the patient had a Glasgow coma score of 3"

This charge is found proved.

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of Witness 3 and the patient notes dated 7 September 2020 provided by you.

The panel took into account your version of the events presented in your oral evidence. You stated that when you escalated the patient's deterioration to the Locum Doctor, Witness 3 was present, and there was no need to '*verbalise'* the escalation. You also stated you were constantly with the patient between the escalation to the Locum Doctor and the moment the patient was taken to the resuscitation unit and only at that point did you go on your break.

The patient records suggest that the observations you took to calculate the GCS score were taken before 2:33 when they were recorded on the Trust electronic recording device (POET).

Witness 3, who was the nurse in charge, stated, in relation to your escalation of the patient's GCS score of 3 to the Locum Doctor, the following:

> *'I was not present when this happened, and the locum doctor prescribed Patient …. with intravenous fluids. Mrs Lole did not escalate the patient to me, as the nurse in charge that Patient …'s condition had deteriorated.'*

In her written evidence, Witness 3 stated:

> *'Whilst both I, and Mrs Lole were on our break, the sister who was standing in for me noticed Patient…'s blood pressure deteriorate. According to Patient …'s nursing notes, at 03:10am, the Sister went to check on Patient…, and noted that the patient was unresponsive with a GCS sitting at 3 with no response to pain. It is also noted in the patient's nursing notes that the sister had seen that, at 02.33am the patient's neuro-observations had been recorded on POET as GCS of 3 and had not been escalated. The Sister escalated Patient… to the Department doctor and me, and at 03:15am the patient was moved into resuscitation where they were nursed and further treatment had to*

be provided. Patient… was now so unconscious that they required a Guedel airway, which they tolerated, to ensure that their airway was protected.'

In her oral evidence, Witness 3 stated she sent you on your break just before she went on her break at about 2:40 to 3:10 and you did not tell her about the deterioration in the patient's condition at this time. She said she returned from her break at about 3:10 and was informed by another Sister about the deterioration in the patient's condition at which point she immediately ensured the transfer of the patient to the resuscitation unit. Furthermore, she stated she would not have gone on a break if she had been aware that there was a patient with a GCS of 3 and a NEWS score of 7 in the department.

The panel found that it had no clear contemporaneous evidence about the time you went on your break. The panel noted a lack of clarity about the timings of the events particularly in your evidence.

The panel was not able to find a clear account of the chronology events from your evidence or Mr Shadenbury's submissions on your behalf. The panel found your account that you stayed with the patient from approximately 2:33 till 3:10 when they were moved to the resuscitation unit to be implausible. Further, the panel noted that at 3:10, the patient blood pressure dropped and the Sister entered the cubicle where she discovered the patient with a life-threatening GCS. The panel found this to be inconsistent with your account that you were with the patient until the moment they were moved to the resuscitation unit.

The panel found Witness 3 to be a credible and consistent witness who provided a clear account of events consistent with the timings on the extracts of the patient records provided to the panel. The panel preferred Witness 3's evidence to your account and found that you went on your break without escalating the Patient's Glasgow Coma Score of 3 to the nurse in charge.

The panel therefore finds this charge proved.

Charge 7(a)

> **"**On or around 7 September 2020 you made an entry in a patient's notes on the Trust patient record keeping system without logging into the system using your own individual log in details"

This charge is found proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, and the oral and written evidence of Witness 8.

In your evidence, you accepted that you logged in to the POET system without using your own individual log-in details. You explained to the panel that on this night shift, it was 2am, and since your login was not working on the POET device, you asked a colleague to use her log-in details. During the Trust investigation, you stated that you used their log-in details by mistake, '*I went quickly, logged in (but failed & went by mistake on ….'s log-in) and entered neuro observation'*.

Witness 3 stated in her witness statement that:

> *'When I reviewed Patient…'s notes, I found that Mrs Lole had documented the patient's observations, under another nurse's log in,... When I questioned Mrs Lole regarding this, they informed me that their pin to enter POET had been working, and that they had used their own pin to log the observations. However, I had overheard ….. say to Mrs Lole earlier on in the shift, that they are logged in to POET currently and Mrs Lole should ensure that their pin is logged out before using*

POET to log the patient's observations. Mrs Lole did not log out of …'s pin which is a failure to keep clear and accurate records. Mrs Lole told me that their log in for POET had been working that night but then it had suddenly stopped working, and that they would discuss this with IT. Mrs Lole then spoke to Senior Charge Nurse, [Witness 8] and asked if I had blocked/ locked their account on POET as they were no longer able to access it.'

The panel noted that you initially had concerns that Witness 3 had blocked your access to this device. However, it had evidence from Witness 8 that this would not have been possible.

On the basis of Witness 3's evidence and your account, the panel found this charge proved.

Charge 7(b)

"On or around 7 September 2020 you made a retrospective entry in a patient's notes without indicating that you had done so retrospectively"

This charge is found proved

In reaching this decision, the panel took into account Mr Edward's and Mr Shadenbury's submissions, your oral evidence, the oral and written evidence of Witnesses 1 and 3, and the patient records dated 6 August 2020 provided by you.

The patient records stated that the relevant observations were done at 2:27. In your oral evidence, you accepted that you wrote these observations. However,

you accepted that you wrote them sometime after 2:27. You explained that you were not aware of the requirement to document the note as made retrospectively.

The panel could not accept this explanation given your long experience as a registered nurse and the standard practice of recording notes contemporaneously or clearly identifying when records are written retrospectively.

Therefore, given your acceptance of the incident occurring, the absence of a marking on the patient notes that the observation was written in retrospect, and the witness evidence which is consistent with this, the panel found this charge is proved.

Charge 9

> "Your conduct at charge 7(b) was dishonest in that by not indicating that you had made the entry retrospectively you sought to give the impression that the entry had been made contemporaneously."

This charge is found not proved

The panel considered the submissions of Mr Edwards' and that of Mr Shadenbury, your oral evidence, the test in the case of Ivey v Genting Casinos [2017] UKSC 67 and the panel's findings at charge 7(b).

The panel considered your state of mind at the time of writing the note in the medical records. The panel considered the witness statement of Witness 3, in which it states that when you returned from your break, Witness 3 '*also told [you] that [you] had documented that the patient was at GCS of 3 before [you] went on [your] break, and [you] told me that [you] had made that entry retrospectively'*.

The panel found that you knew you had made the entry retrospectively and that you had told Witness 3 at the time that this was the case. While the panel noted that it was poor practice, it concluded that it was not a dishonest action. The panel found that, given the fact that you had told your manager that you had written it retrospectively, the ordinary reasonable person would not consider omitting to write a note that it is retrospective to be dishonest. The panel heard no suggestion from any witness that they were given the impression that you were intending to deceive them.

The panel therefore finds that this charge is not proved.

Charge 10

> "Your conduct at charge 8 was dishonest in that you sought to give the impression that you had given medication to the patient when you had not done so."

This charge is found not proved

The panel considered the submissions of Mr Edwards' and that of Mr Shadenbury, your oral evidence, the test in the case of *Ivey v Genting Casinos* [2017] UKSC 67 and your admission in respect of charge 8.

The panel reminded itself of the context in which the events of charge 8 occurred. The patient was admitted to the hospital with chest pain and shortness of breath. The admitting medical team was uncertain if the patient was suffering from either a pulmonary embolus or pneumonia. Following tests, there was a diagnosis of pneumonia. When the patient was reviewed by the medical team on the post take ward round at 15:35 the plan was to give IV antibiotics. Antibiotics were prescribed to be given at bedtime and the following morning. The bedtime antibiotics were given at 20.30 in accordance with the prescription. It is not clear from the

incomplete patient notes if an immediate dose of IV antibiotics was prescribed to be given at 15:35 in addition to the prescription for ongoing antibiotics.

The panel took into account your oral evidence. You stated that when you recorded you had started the intravenous (IV) medication at 16:30, that this was a mistake and you did not know exactly when or why you made this mistake. In your oral evidence, you stated that you think you could have mistakenly picked up an incorrect file as the files of different patients were kept close together and you recorded drugs that you had given to a different patient on this patient's records. Previously, you stated that the medical team had prescribed the IV medication after the post-take ward round, which you said was after 16:30, the time you had documented that you had given the medication. However, in your reflective statement you say the post-take ward round took place at 15:35, which you confirmed in your oral evidence. You stated that you were unaware of the error until Witness 8 made you aware the next day.

The panel noted that it did not have the complete patient records and could not make a precise finding on the specific timings of any prescriptions and/or administration of the medication. The panel did take into account, however, that on the patient records, that you provided to the panel, there was a note that the relevant medication was administered at 16:30, and that you admitted that this timing was incorrect and you did not administer the medication at that time, or at all. A colleague took over the administration of that medication after the end of shift handover meeting at around 20:00.

The panel considered what you knew at the time of the events. While it could not determine at what time you completed the documentation, it noted Witness 1's evidence that at handover, you had told the staff that this patient's antibiotics were not completed, and in your evidence, you confirmed that you had said this at that time. The panel therefore concluded that at the end of your shift, you were aware that you had not administered the prescribed antibiotics.

However, even though your explanations to the panel are confusing and contradictory, the panel find that there is insufficient evidence to infer or conclude that this was anything other than a record-keeping mistake on your part. In considering whether a reasonable person would find that you were dishonest in completing the documentation, the panel could find no cogent reason to infer that you sought to give the false impression that you had administered the medication. If you were seeking to give that false impression, you would not have told your colleagues, and the nurse in charge, at handover that the medication had not been given.

The panel therefore finds that, on the balance of probabilities, this charge is 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 kindly, safely and professionally.

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

Mr Kennedy, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) and identified the specific, relevant standards where your actions amounted to misconduct.

Mr Kennedy submitted that your conduct fell well below the standards expected of a nurse and was sufficiently serious to amount to misconduct. He submitted that you breached numerous provisions of the NMC Code, including duties to treat people with kindness and respect, deliver fundamental care effectively, communicate appropriately with colleagues, share information to reduce risk, escalate concerns, maintain accurate records, make timely referrals, protect vulnerable patients, reduce the likelihood of harm, and uphold professional standards and values.

While Mr Kennedy accepted that not every breach of the Code automatically amounts to misconduct, he submitted that, taken together, the breaches found proved in your case do. In particular, Mr Kennedy highlighted your 'unacceptable' communication with colleagues, including on occasions in front of patients, your refusal to assist with a patient, and your failure to escalate a deteriorating patient with a potentially life-threatening presentation. He submitted that the medication errors were not isolated incidents and must be viewed as part of a wider pattern of unsafe practice.

Mr Kennedy further submitted that context does not mitigate the seriousness of your behaviour. Although you were an experienced nurse and had held a senior role overseas, you were undergoing performance management in the UK and yet further concerns arose. He submitted that your conduct fell well below the standard expected of a nurse and was sufficiently serious to amount to misconduct.

Mr Shadenbury submitted that, while several of the charges found proved and admitted may have been conduct which fell short of the standard expected of a nurse, these did not reach the threshold of misconduct that another professional would find deplorable.

In relation to charge 1, Mr Shadenbury submitted that although the charge demonstrated failures to communicate and cooperate effectively with colleagues, it was important for the panel to consider the context, that you had initial difficulties with communication while adapting your practice from India to the UK. He also noted that this charge related to three incidents over a two-year period. He accepted that your conduct fell below the required standard, but he submitted that this does not amount to behaviour that another nurse would find deplorable.

Regarding charge 4, Mr Shadenbury accepted that the concern is inherently serious, given the deteriorating condition of the patient. He acknowledged that your actions fell below the required standards and accepted that this conduct is more likely to be regarded as deplorable by another nurse, notwithstanding that you had escalated the patient's condition to the locum doctor. However, he accepted that the decision about misconduct and deplorability remains a matter for the panel.

For charges 5 and 6, which were admitted at the outset and relate to IV medication errors, Mr Shadenbury submitted that no patient came to harm and that you apologised to both patients. He noted that one error was identified and corrected immediately, while the other came to light the following day. In his submission, although the conduct fell below the required standard, he submitted that this does not amount to deplorable misconduct.

In respect of charge 7, concerning record-keeping errors arising from a single incident, Mr Shadenbury submitted that while the standard fell short, this in itself does not reach the threshold of deplorable misconduct.

Regarding charge 8, which was also admitted, Mr Shadenbury submitted that you accepted making a record-keeping error by documenting that medication had been

administered when it had not been prescribed or given. Although you were unable to explain why the error occurred, you corrected the record during the handover. He submitted that this conduct, while falling below the required standard, does not amount to deplorable misconduct.

Mr Shadenbury submitted that while misconduct may likely to be found in respect of charge 4, he invited the panel to find that the threshold of serious and deplorable conduct is not met for the remaining charges.

Submissions on impairment

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

Mr Kennedy acknowledged that you admitted some of the charges and that this demonstrates a degree of insight. However, he submitted that beyond those admissions there is very limited evidence that you fully understand why your behaviour was unacceptable, how it undermined the ‘bond of trust’ at the heart of the nursing profession, or the impact it had on colleagues and patients. He submitted that there is no clear evidence that you appreciate how your behaviour could cause colleagues and members of the public to be reluctant to engage with you.

Mr Kennedy submitted that if the panel is not satisfied that you have developed sufficient insight, then there is a risk of repetition. He acknowledged that your behaviour is capable of remediation, but submitted that the evidence relied upon, including positive feedback forms and a review from October 2025, amount only to a snapshot of recent practice and does not demonstrate sustained improvement. He submitted it is a matter for the panel

whether it can be satisfied that the clinical, communication, and record-keeping concerns have been fully addressed such that regulatory intervention is no longer required.

Mr Kennedy submitted that the medication errors, failure to escalate a very unwell patient, and poor communication put patients at a real risk of physical harm and risked emotional harm to colleagues. Further, without full insight and evidence of strengthened practice, he submitted that a risk of repetition remains. Therefore, Mr Kennedy submitted that a finding of current impairment was necessary for the protection of the public.

Mr Kennedy submitted that a finding of current impairment is also necessary to uphold the wider public interest. He submitted that a finding of no impairment would send the wrong message and could undermine public confidence in the nursing profession and the regulator. He emphasised the public must be confident that nurses are safe, professional, and appropriately regulated. For all the above reasons, he invited the panel to agree that a finding of current impairment is required to protect the public, uphold confidence in the profession and the NMC, and maintain proper professional standards.

Mr Shadenbury submitted that although, in the past, you acted in ways engaging the first three limbs in the case of *Grant*, you are not liable to do so in the future.

Although Mr Shadenbury accepted that the panel may find that the patient in charge 4 was placed at unwarranted risk of harm, he submitted that there is no evidence of actual harm to patients. He emphasised for the panel that this as an isolated incident occurring during the pressures of COVID in A&E. Further, he submitted there is no evidence of similar failures before or since, and highlighted for the panel that you completed training on recognising a deteriorating patient in March 2025. On that basis, he submitted that this showed you are not liable in the future to put patients at unwarranted risk of harm.

Mr Shadenbury also accepted that your past conduct, particularly in relation to charge 4, brought the profession into disrepute, but submitted that, for the same reasons above, you are not liable to do so in the future.

In respect of the third limb, Mr Shadenbury accepted that you breached fundamental tenets of the profession in the past, particularly in relation to communication under charge 1. However, he submitted that the positive testimonials before the panel demonstrate improved relationships with colleagues and that communication is no longer an active concern. He also referred the panel to evidence of training in communication skills and submitted you are not liable to breach these tenets in the future.

Regarding insight, Mr Shadenbury submitted that you have demonstrated a good level of insight through early admissions, reflective statements, and acceptance of where your practice fell short. He emphasised for the panel to consider your explanation that adapting to UK communication styles was initially challenging, but that you have since learned and improved which, in his submission, is supported by character references.

Regarding remediation and strengthened practice, Mr Shadenbury submitted that you have completed extensive relevant training, including safe drug administration, intravenous medication principles and communication skills. He highlighted for the panel the positive testimonials from colleagues and patients, which describe you to be professional, respectful and effective within a team.

Mr Shadenbury further submitted that the charges are historic, with the most recent dating back to 2022, and that you have demonstrated almost four years of incident-free practice. He emphasised that you have worked on a post-operative surgical ward since February 2025 without any new concerns arising, and with confirmation from your line manager that no issues have been raised.

Mr Shadenbury submitted that the risk of repetition is very low, that there is no continuing risk to the public, and that you have demonstrated sustained insight and strengthened practice over a prolonged period. Further, regarding public interest, he submitted that a well-informed member of the public would take into account your improvements, training, testimonials and sustained safe practice, and form the view that you are fit to practise

without restriction. For these reasons, he invited the panel to find that your fitness to practise is not currently impaired on either public protection or public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v GMC* (No 2) [2000] 1 A.C. 311, *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin), *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *(1) Sarah Elizabeth Johnson & (2) Lynette Maggs v NMC* [2013] EWHC 2140 (Admin), *Nandi v GMC* [2004] EWHC 2317 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin), *Kimmance v GMC* [2016] EWHC 1808 (Admin), *Schodlok v GMC* [2015] EWCA Civ 769 and *Grant.*

Decision and reasons on misconduct

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

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

*'**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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

7 Communicate clearly

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

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

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

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

Charges 1a(i), 1a(ii) and 1a(iii)

The panel found that your behaviour towards Colleague A, including raising your voice and pointing your finger during a disagreement about cannulation in front of a patient, fell below the standards expected of a nurse. However, the panel concluded that this amounted to unprofessional behaviour rather than misconduct. While the conduct was inappropriate and risked undermining patient confidence in the nursing profession, the panel was not satisfied that it reached the threshold of conduct that another nurse would find deplorable when considered in isolation.

Charge 1b

The panel accepted the evidence before it which indicated that your communication style could be abrupt and that you acted in a confrontational manner towards junior colleagues,

including physically pulling a colleague towards you to speak to them. This behaviour was found to fall below professional standards. However, the panel determined that, taken individually, the incidents did not reach the level of seriousness required to constitute misconduct and were better characterised as poor professional behaviour.

Charge 1c

The panel determined that this charge did amount to misconduct as you deliberately refused to assist a colleague (Colleague B) with moving a patient who was in pain and needed to be returned to bed. The panel found that your refusal led Colleague B to proceed alone, thereby placing both the patient and Colleague B at risk of harm. The panel determined that this was not merely a communication failure but a direct refusal to provide necessary care in circumstances of urgency. The panel concluded that your actions in this charge were serious and amounted to misconduct.

Charge 1d

The panel found that your actions towards Colleague C were rude and unprofessional. It noted that this appeared to be your general conduct towards junior colleagues. While the conduct was unacceptable, the panel concluded that it did not reach the threshold of misconduct when considered on its own, as it was not sufficiently serious or deplorable to be regarded as misconduct.

Charges 4a and 4b

The panel found that your actions in respect of these charges did amount to misconduct. The panel considered that the context of the situation concerned a patient who was critically unwell, with a Glasgow Coma Score of 3, and had deteriorated rapidly. Despite this, you failed to appropriately escalate concerns to senior staff and went on a break, leaving the patient without adequate oversight for a long period. Although the panel noted that you informed the locum doctor of the patient’s condition, the panel concluded that

your actions in failing to further escalate the patient's deteriorating condition, and going on a break without notifying the nurse in charge, were wholly inadequate given the seriousness of the situation.

The panel determined that this behaviour was deplorable, placing the patient at significant risk of harm, and a serious departure from the professional standards. Therefore, the panel found that your actions in this charge, individually and cumulatively, amounted to misconduct.

Charge 5

The panel found that this was a medication error. It resulted in an infusion being administered more slowly than intended which meant that the infusion was incomplete. This was a clinical error which the panel considered more likely to have arisen from a lack of competence. The panel also considered that there was a limited risk of harm in this particular incident. The panel concluded that your actions in this charge did not reach the level of seriousness required to amount to misconduct.

Charge 6

While the panel recognised that medication errors can, in some circumstances amount to remediable competence issues, the panel placed significant weight on the context of this charge. It considered that you had previously made medication errors and were subject to performance management measures requiring you to have IV medications double-checked before administration. The panel determined that in this instance, you were aware of what was expected of you and that you had a specific requirement regarding pre-administration checks by a registered colleague, but you deliberately chose not to follow this safeguard. The panel concluded that this was a conscious departure from established safety measures, placing the patient at a significant risk of harm where this could have been avoided. Therefore, the panel concluded that your actions in this charge were sufficiently serious to amount to misconduct.

Charges 7a and 7b

The panel considered that your actions in making entries in a critically unwell patient's records while logged in under another staff member's details, and failure to clearly mark entries as retrospective, was conduct which fell short of the standard expected of a registered nurse. The panel emphasised the importance of accurate, attributable, and contemporaneous record-keeping in the emergency department, particularly for a patient who was gravely ill and at risk of death. The panel rejected your explanation that you were unaware of the need to record entries retrospectively and concluded that your actions undermined accountability and patient safety. Therefore, particularly in the context of this patient's grave condition, the panel concluded that your actions in this charge were sufficiently serious to amount to misconduct.

Charge 8

Although the panel noted that you admitted that you made a record-keeping error by documenting that medication had been administered to a patient when you had not administered it, the panel during its consideration of the facts found insufficient evidence to determine how the error occurred or to conclude that it was deliberate or reckless. Given the uncertainties surrounding the circumstances, the panel concluded that although the conduct fell below professional standards, it could not conclude that this error, in isolation, met the threshold of misconduct.

Overall, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse. However, the panel concluded that misconduct was only established in relation to charges 1c, 4a and 4b, 6 and 7 as these involved either a failure to provide necessary care to a patient, exposed patients to an unwarranted risk of harm, or a conscious departure from patient safeguarding requirements you were subjected to. The panel considered that the remaining charges, while reflecting poor practice and

unprofessional behaviour, did not individually reach the threshold required to amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> > *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
>
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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 first determined that limbs (a), (b) and (c) of the test in *Grant* were engaged in the past. It concluded that your misconduct placed patients at an unwarranted risk of harm, breached fundamental tenets of the nursing profession including the requirement to prioritise patient safety above all else, and thereby brought the profession into disrepute. In particular, the panel considered this to be evident in the most serious findings, including leaving a critically unwell patient with a Glasgow Coma Scale of 3 without appropriate escalation, going on a break at that time, refusing to assist a colleague with a patient in

pain, deliberately not using a required IV medication administration safeguard and failures in accurate record keeping. It considered that these were instances where you demonstrated a failure to put patient safety first.

Regarding insight, the panel found that you had not demonstrated sufficient insight into the seriousness of 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 were entitled to deny the allegations and that some charges were not proved, the panel noted changes in your explanations during these proceedings and an ongoing tendency to attribute blame to circumstances or other individuals rather than accepting your own fault and recognising the risk of your actions.

The panel considered your reflective statements from January 2025 but found them to be lacking depth. It considered that the reflections did not adequately address the risk of harm to patients, the impact on colleagues or the wider impact on the nursing profession. The panel considered that the reflections focused largely on the effect and impact on yourself, rather than on patients and/or colleagues as well. The panel also noted the absence of any clear expression of remorse, particularly in relation to the critically ill patient. The panel was not satisfied that you fully understood why your actions were wrong, nor how they undermined trust in the nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed. It considered the steps you have taken to strengthen your practice, including your completion of mandatory and relevant training in communication skills, medication administration, intravenous drug administration and recognising a deteriorating patient. The panel also considered your character references and the note of discussion with your line manager dated 28 October 2025:

> *“Nirmala has completed her phased return and is now back to full time hours. There have been no concerns in relation to the above NMC requirements and she has received some positive feedback from patients.”*

However, the panel placed limited weight on this evidence. It noted that much of the feedback came from patients or senior colleagues, rather than peers or junior colleagues which would have been more relevant to the charges. The panel noted that the feedback from your line manager on 28 October 2025 outlined that this was a *"monthly review meeting"*:

> *"Nirmala Lole monthly review meeting to discuss the following NMC requirements;*
>
> *a. Medication administration and management*
> *b. Escalation of deteriorating patients*
> *c. Communication with patients and colleagues*
> *d. Effective teamworking*
> *e. Record keeping and documentation*
> *f. Professional conduct"*

In considering all the material before it, the panel was not satisfied that you had demonstrated sustained safe practice in high-pressure clinical environments or addressed the underlying attitudinal issues it had identified.

The panel concluded that there remains a significant risk of repetition. Although it noted that no actual patient harm occurred, the panel considered that the fundamental issues underpinning your misconduct, particularly the failure to prioritise patient safety, and the lack of full insight, have not yet been adequately addressed and puts patients at a real risk of harm. 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 grounds of public interest.

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

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 careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

In the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Kennedy outlined that, following the panel's finding that your fitness to practise is currently impaired, the purpose of any sanction is to protect the public and uphold the wider public interest, not to punish you, and this should be proportionate and no more than necessary.

Mr Kennedy pointed the panel to mitigating factors it may consider, such as that there had been no previous or further referrals to the NMC and that you had made some

admissions. However, he submitted that the aggravating features were significant, including that you had shown a lack of insight, there were attitudinal issues, a potential for patient harm, and limited evidence of safe and effective practice.

Mr Kennedy submitted that taking no action or imposing a caution order would be inappropriate given the panel's findings of current impairment on the ground of public protection and a significant risk of repetition. He submitted these would only be suitable where there is no ongoing risk to the public, which did not apply in this case and could not be justified.

Mr Kennedy acknowledged that the panel found some issues to be remediable. However, he submitted that conditions of practice would still be unsuitable because of the attitudinal concerns identified, including a tendency to deflect blame rather than take responsibility, and your deliberate failure to follow safeguards in relation to IV medications despite undertaking performance management. He submitted that attitudinal issues are difficult to remediate, supervision had not been effective in the past, and limited weight had been placed on the testimonials provided. On this basis, he submitted that conditions of practice are not workable and would not adequately protect the public or satisfy the public interest.

Mr Kennedy then referred the panel to the NMC guidance which suggests that a suspension order may be appropriate where misconduct is a single incident, there is insight, no deep-seated attitudinal problems, and no significant risk of repetition. He submitted that your case did not meet the criteria as there had been multiple instances of misconduct, a lack of full insight, attitudinal problems and an ongoing risk of harm to patient safety and a risk of repetition. In those circumstances, he submitted that a temporary period of suspension would be insufficient. He invited the panel to consider that the only appropriate sanction to protect the public and uphold confidence in the profession was a striking off order.

Mr Shadenbury emphasised that there are no rigid rules on sanction and that the panel must consider the individual circumstances of your case. He outlined that this should be a

balancing exercise between the possibility of you returning safely to practice and the need to protect the public and maintain public confidence in the profession, and that any sanction must be proportionate and go no further than necessary.

Mr Shadenbury accepted that there were aggravating features, in particular the significant risk of harm to patients and the failure to escalate a deteriorating patient's condition. However, he highlighted a number of mitigating factors, including that you had no previous regulatory or disciplinary findings, you made early admissions to some charges, you undertook relevant training, and provided a number of positive character references from colleagues and patients. He also stressed that you had worked for approximately three and a half years since the incidents without further concerns. Mr Shadenbury noted that the matter in charges 4 and 7 was an isolated incident.

Further, Mr Shadenbury pointed the panel to mitigating features such as that the incidents occurred while you were working in A&E during the COVID-19 pandemic, which was an exceptionally stressful period for healthcare professionals. He also informed the panel about your longstanding health condition, which requires workplace adjustments and regular breaks, noting that these were difficult to implement in a pressured emergency department environment.

Regarding sanction, Mr Shadenbury accepted that neither taking no action nor imposing a caution would be appropriate given the panel's findings. However, he invited the panel to consider imposing a conditions of practice order and strongly submitted that this would be workable, practical and proportionate. He submitted that the panel found the misconduct was capable of remediation and met the NMC guidance criteria for conditions, including the absence of deep-seated attitudinal problems, having identifiable areas for retraining, your willingness to improve, and produce verifiable conditions that would protect patients.

Mr Shadenbury suggested that the panel may consider conditions which focus on patient safety and prioritisation, record-keeping, and might include further reflective statements to demonstrate developing insight. He proposed a period of around nine months as sufficient

to mark the seriousness of the misconduct while allowing you to strengthen your practice and evidence working safely. He also outlined possible supervision arrangements and limitations to substantive employment within a Trust.

Mr Shadenbury submitted that suspension would be neither appropriate nor proportionate because you were capable of remediation, had shown some insight, had previously had an unblemished career and had continued working without further incident for several years. Finally, he outlined that striking off is reserved for conduct fundamentally incompatible with remaining on the register, which he submitted was not the case here. He maintained that public confidence and professional standards could be properly upheld through the imposition of a conditions of practice order, and that there was a realistic prospect you would further develop insight and reduce any risk with such a sanction in place to help you return to safe practice.

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

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 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:

- A lack of fully developed insight into your failings
- Attitudinal concerns, in particular a tendency to prioritise your own needs over patient safety and to deflect responsibility rather than take accountability
- Despite efforts made towards reflection and remediation, this is limited as it has not

yet addressed concerns identified
- Conduct which placed patients at risk of suffering harm, including failure to escalate a deteriorating patient appropriately and a failure to follow an IV medication administration safeguard

The panel also took into account the following mitigating features:

- Early admissions to some of the charges
- Evidence of training undertaken since the incidents, including in some relevant areas such as recognising patient deterioration and medication administration
- Some evidence of efforts to strengthen your practice
- Previous good history and a period of approximately three and a half years since the incidents without further regulatory concerns being raised
- Positive feedback and character references, particularly from patients
- Personal mitigation, including the difficult and pressured working environment at the time of the incidents, some of which took place during the COVID pandemic

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and risks identified. The panel decided that it would neither protect the public nor satisfy the wider public interest considerations to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the misconduct and the ongoing public protection concerns, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would neither

protect the public nor satisfy the wider public interest considerations to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

Although the panel found that there were attitudinal concerns, it did not consider these to be deep-seated or incapable of remediation. Further, the panel considered that you had demonstrated some willingness to engage with retraining and learning. Though it noted that you had not always responded well to supervision, it was of the view that you would be able to respond positively to conditions and there was no evidence of general incompetence. The panel concluded that patients could be protected through structured supervision, undertaking further reflections, and monitoring.

The panel was satisfied that it could identify areas of practice where appropriate and practical conditions could be formulated that would be capable of review and assessment, including patient prioritisation, escalation, medication safety, record keeping and professional accountability. The panel determined that it would be possible to formulate

appropriate and practical conditions which would address the failings highlighted in this case whilst protecting the public.

The panel also took into account that the incidents occurred several years ago and that you have continued working since that time without further proven concerns. The panel considered that it was in the public interest for you to be supported to remediate and demonstrate improvement, rather than being removed from practice altogether, provided appropriate safeguards were in place.

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

The panel determined that a suspension order would be more restrictive than necessary and would not best serve public protection, as it would prevent you from demonstrating improvement in day-to-day clinical practice under supervision.

In reaching this decision, the panel also carefully considered the submissions made on behalf of the NMC in support of a striking-off order. The panel concluded that a striking-off order would be wholly disproportionate, as your misconduct, while serious, was not fundamentally incompatible with remaining on the register and there remained a realistic prospect of remediation.

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

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

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

1. You must limit your nursing practice to a single substantive NHS employer and you must not undertake any bank or agency work.

2. You must not work in an Accident and Emergency department and you must not be the nurse in charge of any shift.

3. At any time you are working, you must be indirectly supervised on every shift by either:

    a) A registered nurse of Band 5 with a minimum of three years’ experience; or
    b) A registered nurse of Band 6 or above.

4. You must work with your line manager or nominated supervisor to create a personal development plan (PDP). Your PDP must address the concerns identified below and you must meet monthly with your supervisor to review progress against your PDP:

    a) Recognition of mistakes, near misses, incidents and accountability
    b) Duty of candour
    c) The wider impact of your actions on patients, colleagues and the wider nursing profession
    d) Understanding the needs of colleagues within a team
    e) Creating and maintaining psychologically safe working environments for all members of the multidisciplinary team

f) Continuing professional development in the areas of escalation, medication administration safety and record-keeping

You must provide a copy of your PDP to your NMC case officer within 14 days of returning to work.

5. You must complete monthly reflective accounts addressing any clinical incidents, near misses or learning points, including how you have demonstrated accountability and learning. These reflections must be discussed in meeting with your line manager or nominated supervisor.

   You must also provide a written report from your line manager or nominated supervisor to your NMC case officer every three months, detailing your progress and compliance with these conditions.

6. You must undertake appropriate training in the recognition and escalation of patient deterioration and provide evidence of completion and reflective learning to your NMC case officer prior to any review hearing/meeting.

7. You must complete a 360-degree appraisal every three months, with participants selected from the multidisciplinary team in discussion with your line manager or nominated supervisor. You must provide the appraisals to your NMC case officer prior to any review hearing/meeting.

8. You must keep your NMC case officer informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.
b) Giving your case officer your employer's contact details.

9. You must keep your NMC case officer informed about anywhere you are studying by:

a) Telling your case officer within seven days of accepting any course of study.
b) Giving your case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.
b) Any employers you apply to for work (at the time of application).
c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your NMC case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.
b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

12. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a) Any current or future employer
    b) Any educational establishment
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 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 review hearing/meeting.
- Documentary evidence of your compliance with all the above conditions.
- Further reflections on the charges found proved demonstrating the development in your insight since this hearing.

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.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy, who made an application for an interim conditions of practice order for 18 months to cover the appeal period. He submitted that an interim order is necessary to protect the public and satisfy the wider public interest as any substantive order, if appealed, would not take effect until the conclusion of the appeal proceedings.

Mr Kennedy submitted that if there is no interim order you would be able to work without restriction, which would mean that the public would not be protected and public interest would not be satisfied in the way that the panel has found to be necessary in its determination of the substantive sanction. He invited the panel to consider a period of 18 months as the appeal proceedings can take a considerable length of time.

Mr Shadenbury did not oppose the application.

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

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. In light of the ongoing risks identified and your limited insight at this stage, the panel considered that an informed member of the public would be concerned if no restrictions were imposed during the appeal period. It determined that the public would reasonably expect the regulator to take action in these circumstances. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months. This duration reflects the fact that appeal proceedings can take a considerable length of time and are not within the control of the NMC.

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.