Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 July 2025 – Thursday, 24 July 2025
Tuesday, 3 February 2026 – Wednesday, 4 February 2026

Virtual Hearing

Name of Registrant:	**Helen McLaughlan**
NMC PIN:	19B1394E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (March 2019)
Relevant Location:	Slough
Type of case:	Misconduct
Panel members:	Richard Youds (Chair, Lay member) Lisa Holcroft (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Charles Apthorp (Monday 14 July 2025 – Thursday 24 July 2025) Lizzy Acker (Tuesday, 3 February 2026 – Wednesday, 4 February 2026)
Hearings Coordinator:	Charis Benefo (Monday 14 July 2025 – Thursday 24 July 2025 Elizabeth Fagbo (Tuesday, 3 February 2026 – Wednesday, 4 February 2026)
Nursing and Midwifery Council:	Represented by Selena Jones, Case Presenter (Monday 14 July 2025 – Thursday 24 July 2025) Represented by Mary Kyriacou, Case Presenter

	(Tuesday, 3 February 2026 – Wednesday, 4 February 2026)
Miss McLaughlan:	Present and represented by Tracey Lambert, Unison
Facts proved by admission:	Charge 1s)ii
Facts proved:	Charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 2, 3a, 3b and 3c
Facts not proved:	Charges 1d)ii, 1h, 1j)i, 1l, 1n)i and 1o)ii
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

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

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

Ms Jones, on behalf of the Nursing and Midwifery Council (NMC), indicated that she supported the application.

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

The panel decided to hold in private the parts of this hearing [PRIVATE], as and when such issues are raised in order to protect your privacy.

Details of charge [as amended]

That you, a registered nurse:

1. Dispensed the following medication from the Omnicell without clinical justification:
    a) On 10 November 2020:
        i. ibuprofen/Co-codamol for Patient B;
        ii. Lorazepam for Patient C;
    b) On 15 November 2020:
        i. Codeine phosphate for Patient D.
        ii. Lorazepam for Patient E;
    c) On 20 December 2020, Diazepam for Patient F;
    d) On 22 December 2020, for Patient H:
        i. Lorazepam

ii. Diazepam;

e) On 28 December 2020, Lorazepam for Patient K;

f) On 10 January 2021:

i. Diazepam for Patient L;

ii. Diazepam for Patient M.

g) On 16 January 2021:

i. Co-codamol for Patient N;

ii. Co-codamol/ Lorazepam for Patient O;

h) On 24 January 2021, Diazepam/Zopiclone for Patient P;

i) On 6 February 2021, for Patient Q:

i. Amoxicillin/Lansoprazole that had been stopped on 4 February 2021;

ii. Paracetamol, that had not been administered to Patient Q since 30 January 2021.

j) On 13 February 2021:

i. Co-codamol for Patient R;

ii. Naproxen for Patient S

k) On 15 February 2021 Lansoprazole/Naproxen for Patient T;

l) On 18 February 2021 Lansoprazole/Naproxen for Patient U;

m) On 27 February 2021, Diazepam for Patient W;

n) On 1 March 2021:

i. Co-codamol/Naproxen for Patient DD;

ii. Co-codamol for Patient X.

o) On 12 March 2021:

i. Diazepam for Patient Y;

ii. Paracetamol, to Patient Z at 18.47 hours:

iii. Naproxen, to Patient Z at 18.47 hours.

p) On 14 March 2021 Lansoprazole for Patient AA.

q) On 21 March 2021 Co-Codamol for Patient BB.

r) On 3 April 2021, Naproxen for Patient CC.

s) On 5 April 2021

i. A quantity of Pregabalin to Patient A

ii. Without a second checker to witness the removal.

2. By your actions at charge 1 you took the medication for a use other than for which it was intended.

3. Your actions at charges 1 and/or 2 were dishonest in that:
   a) you knew the medication was the property of Frimley Health NHS Foundation Trust;
   b) you knew you had permission only to dispense it for the use of patients;
   c) you knew that when you dispensed it you were taking it for a different purpose.

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

Background

The NMC received a referral in respect of your conduct on 27 April 2021. You first entered onto the NMC's register on 29 March 2019.

The allegations in this case arose whilst you were employed by Frimley Health NHS Foundation Trust (the Trust) at Wexham Park Hospital (the Hospital) as a band 5 nurse. You started working at the Trust on 6 January 2014 as a healthcare assistant.

On 6 April 2021, it was discovered after a routine medication check that controlled medication stock, namely, pregabalin, was incorrect and that a quantity of the medication had gone missing. It was alleged that you were the last nurse to dispense pregabalin from the Hospital's Omnicell medication dispensing unit.

The Trust commenced an investigation.

A full investigation began, and medication discrepancies were allegedly found under your log in to the Omnicell unit on more than 30 occasions. You had allegedly dispensed various medications over a period of time to patients that were not in your care, not on your ward or not in the Hospital at the time of dispensing.

You were asked to provide reasons and you stated that you could not explain it other than suggesting that someone else had taken the medication under your log in after you had failed to log out of the Omnicell system.

It is alleged that between 20 December 2020 and 6 April 2021, you took a series of medications from the stock of the Accident and Emergency (A&E) department on about 30 separate occasions.

On 7 April, 2021, a meeting was arranged by the Trust to discuss its concerns with you. You did not attend this meeting and on 19 April 2021, you resigned from your position before the Trust's investigation had concluded. You did engage with the investigation to the extent that you submitted a written statement, and a union representative attended the hearing on your behalf.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Jones, on behalf of the NMC, to amend the wording of charge 1s)i.

The proposed amendment was to specify '*a quantity*' of pregabalin and remove diazepam from the charge, as set out in the evidence. It was submitted by Ms Jones that the proposed amendment would more accurately reflect the evidence, and that there would be no injustice to you or prejudice caused by the proposed amendment being allowed.

The proposed amendment is as follows:

"That you, a registered nurse:

1. Dispensed the following medication from the Omnicell without clinical justification:
    s) On 5 April 2021
        i. **A quantity of** Pregabalin~~/Diazepam~~ to Patient A
        ii. ..."

The panel heard from submissions from Ms Lambert that the application was not opposed.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

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

Decision and reasons on facts

Following the conclusion of your oral evidence and during the Ms Jones' application to amend charge 1s)i, Ms Lambert informed the panel that you made an admission to charge 1s)ii.

The panel therefore found charge 1s)ii proved, by way of your admission.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Jones, on behalf of the NMC, and by Ms Lambert, 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: Head of Nursing of Emergency and Acute Medicine at the Hospital at the time of the concerns;

- Witness 2: Respiratory Matron who managed the Medical Acute Dependency Unit (MADU) and cross-covered the Emergency Assessment Centre at time of the concerns;

- Witness 3: Junior Sister on the MADU at time of the concerns;

- Witness 4: Lead Respiratory Pharmacist at the Hospital at the time of the concerns; and

- Witness 5: Head of Nursing for the Directorate of theatres and critical care at the Trust who conducted a fact-finding investigation into the Trust's Omnicell system in September/October 2021.

The panel also took account of the witness statements from the following witnesses on behalf of the NMC, which was read into the record with the agreement of both parties:

- Witness 6: Band 6 Staff Nurse on the MADU at the time of the concerns;

- Witness 7: Junior Sister at the Hospital at the time of the concerns.

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

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification*

In considering sub-charges 1a to 1s, the panel had regard to Witness 1's witness statement dated 7 July 2023, which described what she did after it was discovered that medication had gone missing from the Trust's Omnicell dispensing system:

> '*I then asked the Pharmacist to run a report for Miss McLaughlan for the previous six (6) months and all transactions had her fingerprint access to open the cabinets. ...*
>
> *When I received the printout report for Miss McLaughlan, I was shocked at the number of discrepancies found and I could see a pattern where most of the patient's names that had been dispensed medication by Miss McLaughlan had surnames beginning with 'A'.*

I then cross referenced those patients with their MAR Charts and from Symphony, which is the A&E hospitals electronic patient record system and found that some medications dispensed had not been prescribed to the patients.

Furthermore, the medications that Miss McLaughlan had dispensed from the Omnicell units were not medications you would normally have used on the Ambulatory Emergency Care Unit ("ACEU"). There was a lot of lorazepam and diazepam that had been dispensed and these medications wouldn't be used in the ambulatory care unit.'

The panel also considered the expectations of a nurse working at the Trust, dispensing medication from the Omnicell. It decided that dispensing began with the process of removing medication from the Omnicell machine for a particular patient in line with a current prescription. The process is complete when the correct patient is given the correct medication and their prescription chart is updated. The evidence before the panel was that the nurse would first have to check the specific patient's prescription, go to the Omnicell and then select that particular patient's name or hospital number. It noted from Witness 1's witness statement that:

'*Once you have logged in and have chosen a route you select the medication and dosage/number of tablets and then and a green-light flashes on the drawer containing the medication and the door unlocks and opens. You take out the medication and the required number of tablets/capsules needed to be dispensed, close the drawer and then hit the exit button on the screen which logs you out.*

When you hit the exit button this logs you out of the system. Failing to hit the exit button, Omnicell will automatically log you out after ninety (90) seconds.'

In respect of charges 1a to 1r, the panel noted your evidence that the quickest route to dispense medication at the time of the allegations was to select any patient's name on the

Omnicell screen, and remove the medication to administer to the correct patient who required it and whose prescription you had checked. You told the panel that you used the Omnicell in this manner because you were conscious that the department was busy and you needed to work quickly. You gave evidence that you did not feel you were properly trained to use the Omnicell.

You also asserted that you frequently logged on for others and accepted that you had been careless in doing so. You maintained that some of the agency staff did not have their own log in details for Omnicell. On some occasions, you said that the Omnicell "*bins*" were in fact empty and the medication was not dispensed, or the wrong medication was dispensed.

The panel took into account your evidence that there was not always a formal prescription available for the patients in instances where the doctors and prescribing nurses were busy, so they would often give you a post it note with the name of the medication and the patient who required it.

You told the panel that after removing medication from the Omnicell, you did not always make sure that you had logged out or that it had timed out. However, despite this practice, you said that the medication would be administered to the patient it was intended for.

The panel noted your acceptance that it was your responsibility to ensure that the prescribers had updated the patient records accordingly.

The panel did not accept your evidence that agency staff were not provided with their own log in details, having heard evidence from a number of NMC witnesses to the contrary. Having found the NMC witnesses to be credible, consistent and reliable, the panel preferred their account to yours.

Charge 1a)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   a) *On 10 November 2020:*
      i. *ibuprofen/Co-codamol for Patient B*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 10 November 2020 at 17.14 and 17.15 Miss McLaughlan dispensed 1 x Ibuprofen tablet and 1 x Co-Codamol tablet from AECU for patient B who was not prescribed the medications and was not at the hospital at the time the medications were dispensed.*'

The panel took into account the Omnicell report which indicated that one tablet of ibuprofen and one tablet of co-codamol had been dispensed from the Omnicell under your username for Patient B on 10 November 2020 at 17:14 and 17:15, respectively. The panel was therefore satisfied that you had, in fact, dispensed ibuprofen and co-codamol from the Omnicell on that occasion, and that it was purported to be for Patient B.

The panel had regard to Patient B's emergency department attendance summary, which did not indicate that either ibuprofen or co-codamol had been prescribed for Patient B. Further, it noted that at 04:11 on 10 November 2020, Patient B was discharged from the hospital to their usual place of residence, so they were not in hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed ibuprofen and co-codamol for Patient B without clinical justification because neither of these medications were prescribed to them

and they were no longer in hospital when you dispensed this medication from the Omnicell on 10 November 2020.

Charge 1a)ii

That you, a registered nurse:

2. *Dispensed the following medication from the Omnicell without clinical justification:*
   a) *On 10 November 2020:*
      ii. *Lorazepam for Patient C*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*At 21.09 the same day, Miss McLaughlan dispensed 2 x Lorazepam 1mg tablets from AECU for patient C who was not prescribed the medications and was not at the hospital at the time the medications were dispensed.*'

The panel took into account the Omnicell report which indicated that a total of two tablets of lorazepam had been dispensed from the Omnicell in two separate transactions under your username for Patient C on 10 November 2020 at 21:09. The panel was therefore satisfied that you had, in fact, dispensed lorazepam from the Omnicell on that occasion, and that it was purported to be for Patient C.

The panel had regard to Patient C's emergency department attendance summary, which did not indicate that lorazepam had been prescribed for Patient C. Further, it noted that at 15:38 on 10 November 2020, Patient C was discharged from the hospital to their usual place of residence, so they were not in hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed lorazepam for Patient C without clinical justification because lorazepam was not prescribed to them and they were no longer in hospital when you dispensed this medication from the Omnicell on 10 November 2020.

Charge 1b)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   b) *On 15 November 2020:*
      i. *Codeine phosphate for Patient D.*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 15 November 2020 at 11:59 Miss McLaughlan dispensed 1 x Codeine Phosphate tablet from AECU which was not prescribed for patient D. Miss McLaughlan administered two (2) other medications to the patient which were prescribed.*'

The panel took into account the Omnicell report which indicated that one tablet of codeine phosphate had been dispensed from the Omnicell under your username for Patient D on 15 November 2020 at 11:59. It noted that this was in addition to other medications you dispensed for Patient D. The panel was therefore satisfied that you had, in fact, dispensed codeine phosphate from the Omnicell on that occasion, and that it was purported to be for Patient D.

The panel had regard to Patient D's emergency department attendance summary, which did not indicate that codeine phosphate had been prescribed for Patient D. Further, it noted that at 11:39 on 15 November 2020, Patient D was admitted to a ward, so they were

not in the department at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed codeine phosphate for Patient D without clinical justification because codeine phosphate was not prescribed to them and they were no longer in the department when you dispensed this medication from the Omnicell on 15 November 2020.

Charge 1b)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    b) *On 15 November 2020:*
        ii. Lorazepam for Patient E

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*At 18:21 on the same day, Miss McLaughlan dispensed 1 x Lorazepam 1mg tablet from AAU which was not prescribed to patient E and was not recorded as being administered on the patient's MAR Chart.*'

The panel took into account the Omnicell report which indicated that one tablet of lorazepam had been dispensed from the Omnicell under your username for Patient E on 15 November 2020 at 18:21. The panel was therefore satisfied that you had, in fact, dispensed lorazepam from the Omnicell on that occasion, and that it was purported to be for Patient E.

The panel had regard to Patient E's adult prescription and administration chart, which did not indicate that lorazepam had been prescribed for Patient E.

The panel therefore found that you had dispensed lorazepam for Patient E without clinical justification because lorazepam was not prescribed to them when you dispensed this medication from the Omnicell on 15 November 2020.

Charge 1c

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   c) *On 20 December 2020, Diazepam for Patient F*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 20 December 2020 at 18:55 Miss McLaughlan dispensed 1 x Diazepam 5mg tablet from AAU which was not prescribed to patient F and was not at the hospital at the time the medication was dispensed.*'

The panel took into account the Omnicell report which indicated that one tablet of diazepam had been dispensed from the Omnicell under your username for Patient F on 20 December 2020 at 18:55. The panel was therefore satisfied that you had, in fact, dispensed diazepam from the Omnicell on that occasion, and that it was purported to be for Patient F.

The panel had regard to Patient F's emergency department attendance summary, which did not indicate that diazepam had been prescribed for Patient F. Further, it noted that at 21:09 on 19 December 2020, Patient F was discharged from the hospital to their usual

place of residence, so they were not in hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed codeine phosphate for Patient F without clinical justification because diazepam was not prescribed to them and they were no longer in hospital when you dispensed this medication from the Omnicell on 20 December 2020.

Charge 1d)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    d) *On 22 December 2020, for Patient H:*
        i. *Lorazepam*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*At 19:58 on the same day Miss McLaughlan dispensed 1 x Lorazepam tablet from AECU for patient H who was not prescribed the medication...*'

The panel took into account the Omnicell report which indicated that one tablet of lorazepam had been dispensed from the Omnicell under your username for Patient H on 22 December 2020 at 19:58. The panel was therefore satisfied that you had, in fact, dispensed lorazepam from the Omnicell on that occasion, and that it was purported to be for Patient H.

The panel had regard to Patient H's emergency department attendance summary, which did not indicate that lorazepam had been prescribed for Patient H.

The panel therefore found that you had dispensed lorazepam for Patient H without clinical justification because lorazepam was not prescribed to them when you dispensed this medication from the Omnicell on 22 December 2020.

Charge 1d)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    d) *On 22 December 2020, for Patient H:*
        ii. Diazepam

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '...*At the same time, Miss McLaughlan accessed Diazepam 5mg for patient I, but no stock was recorded as having been removed. Patient I did not attend the hospital on this day and was not prescribed Diazepam or Lorazepam.*'

The panel noted that Witness 1's evidence in respect of diazepam on 22 December 2020, was clearly in reference to Patient I.

The panel had regard to the Omnicell report which listed diazepam on 22 December 2020 at 19:58, but did not indicate that a quantity had been dispensed from the Omnicell on that occasion. It noted the handwritten annotation which stated '*no stock removed*'. In addition, both Witness 1's evidence and the Omnicell report indicated that this entry related to a '*Patient I*', rather than '*Patient H*' as set out in the charge.

On this basis, the panel determined that there was no evidence to suggest that you dispensed diazepam for Patient H on 22 December 2020, and that the NMC had not discharged its burden of proof. It therefore found charge 1d)ii not proved.

Charge 1e

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    e) On 28 December 2020, Lorazepam for Patient K

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day at 18:14 Miss McLaughlan dispensed 1 x Lorazepam 1mg for patient K from AAU who had not been prescribed the medication. The patient was in the Emergency Department at the time.*'

The panel took into account the Omnicell report which indicated that one tablet of lorazepam had been dispensed from the Omnicell under your username for Patient K on 28 December 2020 at 18:14. The panel was therefore satisfied that you had, in fact, dispensed lorazepam from the Omnicell on that occasion, and that it was purported to be for Patient K.

The panel had regard to Patient K's adult prescription and administration chart, which did not indicate that lorazepam had been prescribed for Patient K. Further, despite Witness 1's evidence that the patient was in the Emergency Department at the time, the adult prescription and administration chart indicated that on 19 December 2020, Patient K was discharged from the hospital, so they were not in hospital at the time the medication was

dispensed from Omnicell using their details. The panel did not consider this to be a material error from Witness 1 in the light of the documentary evidence before the panel.

The panel therefore found that you had dispensed lorazepam for Patient K without clinical justification because lorazepam was not prescribed to them and they were no longer in hospital when you dispensed this medication from the Omnicell on 28 December 2020.

Charge 1f)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   f) On 10 January 2021:
      i. Diazepam for Patient L

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 10 January 2021 at 15:41 Miss McLaughlan dispensed 1 x Diazepam 5mg tablet from AAU for patient L that was not prescribed the medication and was not in the hospital on the day the medication was dispensed.*.'

The panel took into account the Omnicell report which indicated that one tablet of diazepam had been dispensed from the Omnicell under your username for Patient L on 10 January 2021 at 15:41. The panel was therefore satisfied that you had, in fact, dispensed diazepam from the Omnicell on that occasion, and that it was purported to be for Patient L.

The panel had regard to Patient L's adult prescription and administration chart, which did not indicate that diazepam had been prescribed for Patient L.

The panel therefore found that you had dispensed diazepam for Patient L without clinical justification because diazepam was not prescribed to them when you dispensed this medication from the Omnicell on 10 January 2021.

Charge 1f)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   f) On 10 January 2021:
      ii. Diazepam for Patient M

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day at 15.39 Miss McLaughlan dispensed 1 x Diazepam 5mg AM from the AECU cabinet for patient M that had not been prescribed the medication and was not in the hospital when the medication was dispensed.*'

The panel took into account the Omnicell report which indicated that one tablet of diazepam had been dispensed from the Omnicell under your username for Patient M on 10 January 2021 at 15:39. The panel was therefore satisfied that you had, in fact, dispensed diazepam from the Omnicell on that occasion, and that it was purported to be for Patient M.

The panel had regard to Patient M's emergency department attendance summary, which did not indicate that diazepam had been prescribed for Patient M. Further, it noted that at 19:15 on 9 January 2021, Patient M was discharged from the hospital to their usual place of residence, so they were not in hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed diazepam for Patient M without clinical justification because diazepam was not prescribed to them and they were no longer in hospital when you dispensed this medication from the Omnicell on 10 January 2021.

Charge 1g)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   g) On 16 January 2021:
      i. Co-codamol for Patient N

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 16 January 2021 at 09.58 Miss McLaughlan was working on the Medical Short Stay Unit ("MSSU") and dispensed 1 x Co-Codamol 30/500mg tablet from MSSU for patient N who had not been prescribed the medication. Miss McLaughlan correctly administered the medications that the patients had been prescribed*.'

The panel took into account the Omnicell report which indicated that one tablet of co-codamol had been dispensed from the Omnicell under your username for Patient N on 16 January 2021 at 09:58. The panel was therefore satisfied that you had, in fact, dispensed co-codamol from the Omnicell on that occasion, and that it was purported to be for Patient N.

The panel had regard to Patient N's adult prescription and administration chart, which did not indicate that co-codamol had been prescribed for Patient N.

The panel therefore found that you had dispensed co-codamol for Patient N without clinical justification because co-codamol was not prescribed to them when you dispensed this medication from the Omnicell on 16 January 2021.

Charge 1g)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   g) On 16 January 2021:
      ii. Co-codamol/ Lorazepam for Patient O

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day at 18:13 and 18:14 Miss McLaughlan dispensed 1 x Co-Codamol and 1 x Lorazepam 1mg tablet from MSSU under patient O who had not been prescribed the medication. Patient O was in the hospital at the time the medication had been dispensed.*'

The panel took into account the Omnicell report which indicated that one tablet of co-codamol and one tablet of lorazepam had been dispensed from the Omnicell under your username for Patient O on 16 January 2021 at 18:13 and 18:14, respectively. It noted that this was in addition to paracetamol and codeine phosphate, which you had also dispensed for Patient O. The panel was therefore satisfied that you had, in fact, dispensed co-codamol and lorazepam from the Omnicell on that occasion, and that it was purported to be for Patient O.

The panel had regard to Patient O's adult prescription and administration chart, which did not indicate that co-codamol and lorazepam had been prescribed for Patient O. However,

it noted that paracetamol and codeine phosphate were prescribed for this patient, and that you had dispensed and administered these medications and recorded it on the chart.

The panel therefore found that you had dispensed co-codamol and lorazepam for Patient O without clinical justification because neither of these medications were prescribed to them when you dispensed them from the Omnicell on 16 January 2021.

Charge 1h

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   h) *On 24 January 2021, Diazepam/Zopiclone for Patient P*

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 24 January 2021 at 12.51 Miss McLaughlan dispensed 1 x Diazepam 5mg tablet and 1 x Zopiclone 3.75mg from MADU for patient P who had not been prescribed the medication and was an inpatient on another ward when the medications were removed.*'

The panel had regard to the Omnicell report which indicated that one tablet of diazepam and one tablet of zopiclone had been dispensed from the Omnicell under your username for a patient/patients on 24 January 2021 at 12:51 and 17:12, respectively. However, the patient name for each of these entries had been redacted and the panel did not have enough information to make the inference that both of these entries related to a '*Patient P*'. There was no reference to Patient P in the Omnicell report or the patient records before the panel.

On this basis, the panel was not satisfied that the NMC had discharged its burden of proof in respect of charge 1h. It therefore found this charge not proved.

Charge 1i)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    i) *On 6 February 2021, for Patient Q:*
        i. *Amoxicillin/Lansoprazole that had been stopped on 4 February 2021*
        ii. *Paracetamol, that had not been administered to Patient Q since 30 January 2021*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 6 February 2021 at 12.03 Miss McLaughlan dispensed 1 x Amoxicillin, 1 x Paracetamol and 1 x Lansoprazole from AECU for patient Q that was on another ward who had been prescribed the medications however two (2) of the medications had been stopped on 4 February 2021 and paracetamol had not been administered since 30 January 2021, and this was not Miss McLaughlan's patient*.'

<u>Amoxicillin and Lansoprazole</u>

The panel took into account the Omnicell report which indicated that one capsule of amoxicillin and one capsule of lansoprazole had been dispensed from the Omnicell under your username for Patient Q on 6 February 2021 at 12:02 and 12:03, respectively. The panel was therefore satisfied that you had, in fact, dispensed amoxicillin and lansoprazole from the Omnicell on that occasion, and that it was purported to be for Patient Q.

The panel had regard to Patient Q's adult prescription and administration chart, which indicated that:

- Lansoprazole was prescribed, but had not been administered to the patient since 3 February 2021, and it had been discontinued from 4 February 2021.
- Amoxicillin was prescribed, but had not been given to the patient since 4 February, and it had been discontinued from the afternoon of 4 February 2021.

The panel therefore found that you had dispensed lansoprazole and amoxicillin for Patient Q without clinical justification because these medications had been stopped and were no longer prescribed to them when you dispensed them from the Omnicell on 6 February 2021.

Paracetamol

The panel took into account the Omnicell report which indicated that one capsule of paracetamol had been dispensed from the Omnicell under your username for Patient Q on 6 February 2021 at 12:03. The panel was therefore satisfied that you had, in fact, dispensed paracetamol from the Omnicell on that occasion, and that it was purported to be for Patient Q.

The panel had regard to Patient Q's adult prescription and administration chart, which indicated that paracetamol was last administered to the patient on 30 January 2021. It noted that this medication was prescribed to Patient Q as PRN (or as needed). However, there was no entry on the records to show that it had been administered or signed as being administered to Patient Q as PRN on 6 February 2021.

As such, the panel determined that you had dispensed paracetamol for Patient Q without clinical justification because there was no evidence that you had administered it to the patient after you dispensed it from the Omnicell on 6 February 2021.

The panel therefore found charge 1i proved in its entirety.

Charge 1j)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   j) On 13 February 2021:
      i. Co-codamol for Patient R

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 13 February 2021 at 09.10 Miss McLaughlan dispensed 1 x Co-codamol from AECU for patient R who had not been at the hospital since 2020 and was not in the hospital that day when the medications were removed.*'

The panel took into account the Omnicell report which indicated that one tablet of co-codamol had been dispensed from the Omnicell under your username on 13 February 2021 at 09:10, for a patient whose name had not been redacted nor anonymised as '*Patient R*'. The panel was therefore satisfied that you had, in fact, dispensed co-codamol from the Omnicell on that occasion for the patient named in the report.

The panel had regard to '*Patient R*''s emergency department attendance summary, which showed that they arrived at the Hospital on 23 March 2021, almost five weeks after the entry on the Omnicell report. The panel considered that the documentary evidence in respect of '*Patient R*' did not appear to correlate with the entry Omnicell report, or clearly identify who '*Patient R*' was. There were no other patient records before the panel that related to the relevant Omnicell report entry on 13 February 2021.

On this basis, whilst the panel had found that you dispensed co-codamol for a patient on 13 February 2021, it did not have sufficient information to determine whether or not the patient named in the Omnicell report had a prescription for co-codamol. It therefore could not make a finding in respect of clinical justification, and so found charge 1j)i not proved.

Charge 1j)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    j) On 13 February 2021:
        ii. Naproxen for Patient S

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day, at 14.46 Miss McLaughlan dispensed 1 x Naproxen 500mg tablet from ACEU for patient S that had not been prescribed the medication and was not in the hospital on the day the medication was removed.*'

The panel took into account the Omnicell report which indicated that one tablet of naproxen had been dispensed from the Omnicell under your username for Patient S on 13 February 2021 at 14:46. The panel was therefore satisfied that you had, in fact, dispensed naproxen from the Omnicell on that occasion, and that it was purported to be for Patient S.

The panel had regard to Patient S' adult prescription and administration chart, which did not indicate that naproxen had been prescribed for Patient S.

The panel therefore found that you had dispensed naproxen for Patient S without clinical justification because naproxen was not prescribed to them when you dispensed this medication from the Omnicell on 13 February 2021.

Charge 1k

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   k) On 15 February 2021 Lansoprazole/Naproxen for Patient T

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 15 February 2021 at 13.05 Miss McLaughlan dispensed 1 x Lansoprazole 30mg tablet and 1 x Naproxen 500mg tablet from AECU for patient T that had not been prescribed the medication and was not in the hospital the day the medication was removed.*'

The panel took into account the Omnicell report which indicated that one tablet of lansoprazole and one tablet of naproxen had been dispensed from the Omnicell under your username for Patient T on 15 February 2021 at 13:05. The panel was therefore satisfied that you had, in fact, dispensed lansoprazole and naproxen from the Omnicell on that occasion, and that it was purported to be for Patient T.

The panel had regard to Patient T's emergency department attendance summary, which did not indicate that lansoprazole and naproxen had been prescribed for Patient T. Further, it noted that Patient T attended the hospital at 16:42 on 13 February 2021 and was discharged at 19:23 that same day back to the care of the GP, and that there was no

medication prescribed for Patient T on that record at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed lansoprazole and naproxen for Patient T without clinical justification because neither of these medications were prescribed to them and they were no longer in hospital when you dispensed them from the Omnicell on 15 February 2021.

Charge 1l

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   l) On 18 February 2021 Lansoprazole/Naproxen for Patient U

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 18 February 2021 at 18:43 and 18:44 Miss McLaughlan dispensed 1 x Lansoprazole tablet and 1 x Naproxen 250mg tablet from AECU for patient U that had not been prescribed the medication and was not in the hospital the day the medication was removed*.'

The panel took into account the Omnicell report which indicated that one capsule of lansoprazole and one tablet of naproxen had been dispensed from the Omnicell under your username for Patient U on 18 February 2021 at 18:43 and 18:44, respectively. The panel was therefore satisfied that you had, in fact, dispensed lansoprazole and naproxen from the Omnicell on that occasion, and that it was purported to be for Patient U.

The panel had regard to Patient U's surgical ambulatory emergency care letter which indicated that the patient attended ambulatory care on 17 June 2019, where they were seen and discharged that day. It also had regard to Patient U's adult prescription and administration chart which showed that medication had been prescribed to them on 11 February 2021, but given on 11 March 2021.

The panel considered that the documentary evidence in respect of Patient U appeared to be incomplete and did not appear to relate to the entry in the Omnicell report. The panel had no other patient records before it in respect of Patient U.

On this basis, whilst the panel had found that you dispensed lansoprazole and naproxen for Patient U on 18 February 2021, it did not have sufficient information to determine whether or not Patient U had a prescription for those medications when you dispensed them from the Omnicell on that date. It therefore could not make a finding in respect of clinical justification, and so found charge 1l not proved.

Charge 1m

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   m) On 27 February 2021, Diazepam for Patient W

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 27 February 2021 at 11.06 Miss McLaughlan dispensed 1 x Diazepam 2mg tablet from AECU for patient W that had been discharged transferred to a mental health hospital on 26 February 2021.*'

The panel took into account the Omnicell report which indicated that one tablet of diazepam had been dispensed from the Omnicell under your username for a patient whose name had been redacted on 27 February 2021 at 11:06. The panel considered that this was the only entry from the Omnicell report that corresponded with Witness 1's witness statement in relation to the date, time, and dose of diazepam. The panel determined, from the documentary evidence before it, that despite this redaction, the entry corresponded with the patient records attributed to '*Patient W*'.

The panel was therefore satisfied that you had, in fact, dispensed diazepam from the Omnicell on that occasion, and that it related to a '*Patient W*', even though the patient's name had been redacted.

The panel had regard to Patient W's emergency department attendance summary, which did not indicate that diazepam had been prescribed for Patient W. Further, it noted that at 18:07 on 26 February 2021, Patient W was discharged from the hospital to a medium secure hospital, so they were not at the Hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed diazepam for Patient W without clinical justification because diazepam was not prescribed to them and they were no longer at the Hospital when you dispensed this medication from the Omnicell on 27 February 2021.

Charge 1n)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   n) *On 1 March 2021:*
      i. *Co-codamol/Naproxen for Patient DD*

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 1 March 2021 at 18:59 Miss McLaughlan dispensed 1 x Co-Codamol tablet and 1 x Naproxen tablet from AECU for a patient who was not in the hospital on the day the medications were removed.*'

The panel noted that Witness 1's evidence in respect of co-codamol and naproxen on 1 March 2021, made no reference to a '*Patient DD*'.

The panel had regard to the Omnicell report which indicated that one tablet of co-codamol and one tablet of naproxen had been dispensed from the Omnicell under your username for a patient/patients on 1 March 2021 at 18:59. However, the patient name for each of these entries had been redacted and the panel did not have enough information to make the inference that both of these entries related to a '*Patient DD*'. There was no reference to Patient DD in the Omnicell report or the patient records before the panel.

On this basis, the panel was not satisfied that the NMC had discharged its burden of proof in respect of charge 1n)i. It therefore found this charge not proved.

Charge 1n)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   n) *On 1 March 2021:*
      ii. *Co-codamol for Patient X*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

'*On the same day at 19:27 Miss McLaughlan dispensed 1 x Co-Codamol tablet and at 19:28 2 x Paracetamol table from AAU. Patient X was prescribed Paracetamol, which was correctly dispensed, however the patient was not prescribed Co-Codamol which is also an analgesic, and not medication you would give at the same time if giving Paracetamol. Patient X was not in the hospital on the day the medication was removed.*'

The panel took into account the Omnicell report which indicated that one tablet of co-codamol had been dispensed from the Omnicell under your username for Patient X on 1 March 2021 at 19:27. It noted that this was in addition to paracetamol, which you had also dispensed for Patient X. The panel was therefore satisfied that you had, in fact, dispensed co-codamol from the Omnicell on that occasion, and that it was purported to be for Patient X.

The panel had regard to Patient X's adult prescription and administration chart, which did not indicate that co-codamol had been prescribed for Patient X. However, it noted that paracetamol was prescribed for this patient, and that you had dispensed and administered this medication and recorded it on the chart.

The panel therefore found that you had dispensed co-codamol for Patient X without clinical justification because co-codamol was not prescribed to them when you dispensed this medication from the Omnicell on 1 March 2021.

Charge 1o)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
    - *o) On 12 March 2021:*
        - *i. Diazepam for Patient Y*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 12 March 2021 at 18:46 Miss McLaughlan dispensed 1 x Diazepam 5mg tablet from AECU to patient Y who had not been prescribed the medication and was not on the AECU ward when the medication was removed.*'

The panel took into account the Omnicell report which indicated that one tablet of diazepam had been dispensed from the Omnicell under your username for Patient Y on 12 March 2021 at 18:46. The panel was therefore satisfied that you had, in fact, dispensed diazepam from the Omnicell on that occasion, and that it was purported to be for Patient Y.

The panel had regard to Patient Y's emergency department attendance summary, which did not indicate that diazepam had been prescribed for Patient Y.

The panel therefore found that you had dispensed diazepam for Patient Y without clinical justification because diazepam was not prescribed to them when you dispensed this medication from the Omnicell on 12 March 2021.

Charge 1o)ii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   - o) *On 12 March 2021:*
     - ii. *Paracetamol, to Patient Z at 18.47 hours*

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day at 18:47 Miss McLaughlan dispensed 1 x Paracetamol 500mg tablets and 2 x Naproxen 500mg tablets from AECU for patient Z on the AECU ward who was discharged at 18:19. The patient had been prescribed Paracetamol but was not prescribed Naproxen.*'

The panel took into account the Omnicell report which indicated that two caplets of paracetamol had been dispensed from the Omnicell under your username for Patient Z on 12 March 2021 at 18:46. The panel was satisfied that the time set out in the charge (18:47) and the time set out in the Omnicell report (18:46) reflected a minor error in the charge, rather than within the evidence before it. It determined that this was not a material difference that would affect its consideration of the charge.

Further, the panel noted that Witness 1's statement made reference to '*1 x Paracetamol 500mg tablets and 2 x Naproxen 500mg tablets*', rather than '2 *x Paracetamol 500mg caplets and 1 x Naproxen 500mg tablets'*. The panel was satisfied that this was also a minor error that would not materially alter its findings in the light of the documentary evidence before it.

The panel was therefore satisfied that you had, in fact, dispensed paracetamol from the Omnicell on that occasion, and that it was purported to be for Patient Z.

The panel had regard to Patient Z's emergency department attendance summary, which indicated that paracetamol had been prescribed for Patient Z, and that you had dispensed, administered and recorded this in the record. The panel also noted that you were recorded as the prescriber of this paracetamol.

The panel therefore found that you had dispensed paracetamol for Patient Z with clinical justification because paracetamol was prescribed to them when you dispensed it from the Omnicell on 12 March 2021, and you had administered it to them.

Charge 1o)iii

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   o) *On 12 March 2021:*
      iii. *Naproxen, to Patient Z at 18.47 hours*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On the same day at 18:47 Miss McLaughlan dispensed 1 x Paracetamol 500mg tablets and 2 x Naproxen 500mg tablets from AECU for patient Z on the AECU ward who was discharged at 18:19. The patient had been prescribed Paracetamol but was not prescribed Naproxen.*'

The panel took into account the Omnicell report which indicated that one tablet of naproxen had been dispensed from the Omnicell under your username for Patient Z on 12 March 2021 at 18:47. The panel was therefore satisfied that you had, in fact, dispensed naproxen from the Omnicell on that occasion, and that it was purported to be for Patient Z.

Further, the panel noted that Witness 1's statement made reference to '*1 x Paracetamol 500mg tablets and 2 x Naproxen 500mg tablets*', rather than '2 *x Paracetamol 500mg caplets and 1 x Naproxen 500mg tablets'*. As above, the panel was satisfied that this was also a minor error that would not materially alter its findings, in the light of the documentary evidence before it.

The panel had regard to Patient Z's emergency department attendance summary, which did not indicate that naproxen had been prescribed for Patient Z.

The panel therefore found that you had dispensed naproxen for Patient Z without clinical justification because naproxen was not prescribed to them when you dispensed this medication from the Omnicell on 12 March 2021.

Charge 1p

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   p) *On 14 March 2021 Lansoprazole for Patient AA*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 14 March 2021 at 17.59 Miss McLaughlan dispensed 1 x Lansoprazole 30mg tablet from AECU for patient AA and was not in the hospital on the day the medication was removed*.'

The panel took into account the Omnicell report which indicated that one tablet of lansoprazole had been dispensed from the Omnicell under your username for Patient AA on 14 March 2021 at 17:59. The panel was therefore satisfied that you had, in fact, dispensed lansoprazole from the Omnicell on that occasion, and that it was purported to be for Patient AA.

The panel had regard to Patient AA's adult prescription and administration chart, which did not indicate that lansoprazole had been prescribed for Patient AA. Further, it noted that

Patient AA appeared to be a day case on 9 March 2021 and there was no record of them being an in-patient at the Hospital at the time the medication was dispensed from Omnicell using their details on 14 March 2021.

The panel therefore found that you had dispensed lansoprazole for Patient AA without clinical justification because lansoprazole was not prescribed to them when you dispensed this medication from the Omnicell on 14 March 2021.

Charge 1q

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   q) On 21 March 2021 Co-Codamol for Patient BB

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 21 March 2021 at 12:59 Miss McLaughlan dispensed 1 x Co-Codamol 30/500mg tablet, from AECU for patient BB that had not been prescribed the medication and was not in the hospital on the day the medication was removed.*'

The panel took into account the Omnicell report which indicated that one tablet of co-codamol had been dispensed from the Omnicell under your username for Patient BB on 21 March 2021 at 12:59. The panel was therefore satisfied that you had, in fact, dispensed co-codamol from the Omnicell on that occasion, and that it was purported to be for Patient BB.

The panel had regard to Patient BB's emergency department attendance summary, which did not indicate that co-codamol had been prescribed for Patient BB.

The panel therefore found that you had dispensed co-codamol for Patient BB without clinical justification because co-codamol was not prescribed to them when you dispensed this medication from the Omnicell on 21 March 2021.

Charge 1r

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   r) On 3 April 2021, Naproxen for Patient CC

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 3 April 2021 at 12.09 Miss McLaughlan dispensed 1 x Naproxen 500mg tablet from AECU for patient CC that was not in the hospital that day when the medication was removed*'

The panel took into account the Omnicell report which indicated that one tablet of naproxen had been dispensed from the Omnicell under your username for Patient CC on 3 April 2021 at 12:09. The panel was therefore satisfied that you had, in fact, dispensed naproxen from the Omnicell on that occasion, and that it was purported to be for Patient CC.

The panel had regard to Patient CC's emergency department attendance summary, which did not indicate that naproxen had been prescribed for Patient CC. Further, it noted that at 00:41 on 24 March 2021, Patient CC was discharged from the hospital to their usual place of residence, so they were not in hospital at the time the medication was dispensed from Omnicell using their details.

The panel therefore found that you had dispensed naproxen for Patient CC without clinical justification because naproxen was not prescribed to them and they were no longer in hospital when you dispensed this medication from the Omnicell on 3 April 2021.

Charge 1s)i

That you, a registered nurse:

1. *Dispensed the following medication from the Omnicell without clinical justification:*
   s) *On 5 April 2021:*
      i. *A quantity of Pregabalin to Patient A*

This charge is found proved.

In reaching this decision, the panel considered Witness 1's witness statement dated 7 July 2023, which stated:

> '*On 6 April 2021, when I arrived at work between 8:30am and 9am, I was approached by Matron [Witness 2] who informed me that the night staff had come across a discrepancy with a controlled drug count where twenty-eight (28) Pregabalin tablets were missing. Pregabalin comes in a box of twenty-eight (28) tablets and is a schedule three (3) controlled medication.*
> *...*
> *I asked [Witness 2] to investigate; to check the area and speak to staff before they left work and then speak to the pharmacy to see if there was any dispensing or stock errors. I asked her to check the cupboards incase [sic] the medication had been stored in the wrong place by mistake and to check the Controlled Drugs Book ("CDB") which was normal procedure when medications go missing.*
>
> *[Witness 2] came back to me later and said they looked and that they couldn't find the missing tablets and the CDB correlated that on 5 April 2021 the medication*

count for Pregabalin was incorrect and there was missing medication. Pregabalin is a strong pain killer and needs to be recorded in the CDB and is not a medication a nurse can self-prescribe to a patient because a prescription is needed.

[Witness 2] asked the pharmacy to run an Omnicell report for Pregabalin and do an audit check to see who had been into the cabinet for that medication and at what time.

...

The report run under the medication Pregabalin found that the stock had been checked on 3 April 2021 and on 4 April 2021 showing a total of fifty-four (54) tablets which correlated with the CDB however on 5 April 2021 at 23:21 the Omnicell and CDB medication count was incorrect.

It was discovered that the only nurse who had been in the drawer for Pregabalin on the shift was Miss McLaughlan having logged into the Omnicell system.

A report was then run on the individual user Miss McLaughlan, and it was found that a minute after she had taken out one (1) Pregabalin tablet at 15:11 she had taken out another patient's medications, which, when cross referenced, had been properly administered and recorded. This meant she would have had to close the drawer to get the next medications after having the Pregabalin dispensed. This also meant that no one had logged on the system after she took out the Pregabalin tablet because she hadn't logged out.

...

There were four (4) trained nurses working on 5 April 2021, 7am to 7pm, and individual user reports were run on all the nurses. The reports were cross referenced with the medications and their patients MAR charts, and all come up correct except for Ms McLaughlan's.

...

[Witness 2] and I looked at patient A's notes and found the patient was located on an orthopaedic ward at the time the medication was removed and not on the MADU where Ms McLaughlan was working a banked shift.

We double checked the patient's prescriptions and the patient had not been prescribed Pregabalin. [Witness 2] checked the patients MAR Chart and confirmed no Pregabalin had been prescribed or administered.'

The panel had sight of the incident report dated 7 April 2021, which was completed by Witness 1 and provided a near contemporaneous account of the discrepancy of 28 capsules of pregabalin that had gone missing.

The panel took into account the Omnicell report which indicated that one capsule of pregabalin had been dispensed from the Omnicell under your username for Patient A on 5 April 2021 at 15:10.

The panel had regard to Patient A's adult prescription and administration chart, which did not indicate that pregabalin had been prescribed for Patient A.

Witness 2's local statement dated 20 April 2021, described when she first arrived at work on 6 April 2021 and was made aware, that 28 tablets of pregabalin were missing when a stock check was conducted. Witness 2's evidence was that she checked the controlled drugs book and looked at the transaction history for Omnicell, and that Patient A had never been in MADU or looked after by the team. She stated she had attempted to call you twice that morning and left a message for you to call her back. Witness 2 stated that when you returned her call, you sounded shocked and confused and could not immediately account for how the medication had gone missing. The panel noted that Witness 2 also went on to describe that the Omnicell transactions were checked by the pharmacist, and all of the nurses on duty were audited, but it was only you that had dispensed the pregabalin during that 12-hour shift. The panel was satisfied that Witness

2's local statement was written close to the time and so was likely to be a reliable account of what she did and observed.

The panel then considered the local statement of Witness 4 dated 7 April 2021, which set out that there was a discrepancy of 28 capsules of pregabalin and that Patient A was not on the MADU at the time that the pregabalin was dispensed from Omnicell using their details. The panel noted that this was a near contemporaneous account and was likely to be reliable.

In addition, the panel considered the undated local statement of Witness 3, which described her account of when she was told by the matron, Witness 2, that the stock levels of pregabalin did not tally in the controlled drug book on the night check, which was consistent with her oral evidence to the panel. She went on to describe the further checks she had conducted with colleagues.

The panel had regard to Witness 6's undated local statement which set out her account of being involved in the checking of pregabalin with the nurse in charge, Witness 7, on April 5 2021. It also considered Witness 7's undated local statement which set out her description of noticing a '*big discrepancy on Pregabalin 25mg capsules*' and checking the controlled drugs book.

The panel had sight of the controlled drugs night check record, which included the entry '*checked but incorrect*' on 5 April 2021 at 23:50. Further, the copy of the controlled drugs record for pregabalin 25mg included the entry '*actual count on Omnicell*' on 5 April 2021 at 23:50.

The panel considered that the evidence before it clearly set out that there was a deficit in the quantity of pregabalin in the Omnicell that came to light from the audit.

The panel then noted your acceptance in written and oral evidence that you had dispensed pregabalin on 5 April 2021 in the name of Patient A, but that you had done so

only to access Omnicell for the information leaflet to learn about the drug interactions and side effects of pregabalin. Your evidence was that the drawers of the Omnicell stuck together and as a result you caught your hand on the drawer. You told the panel that you kept the medication in your hand whilst you looked for the information leaflet. You gave evidence that there was no information leaflet and you proceeded to look on your phone for drug interactions of citalopram and pregabalin. You said that the Omnicell then timed out and you left the medication on the side but you could not be certain of where you left it because you were feeling unwell.

The panel was mindful that at the time, you would have had available to you other sources of information about the drug interactions and side effects of pregabalin, both from other members of staff and electronically. In addition, it had heard that whilst the drawers of the Omnicell did, on occasion, stick together, you would have had to close the drawer to dispense the next medication after having dispensed the pregabalin. The evidence before the panel was that you had, in fact, dispensed and administered medication to another patient one minute after dispensing the pregabalin.

The panel considered your evidence that although you knew the pregabalin needed to be returned to the Omnicell, you did not know how to do it. The panel was of the view that you did have the opportunity to ask other staff for help in doing this.

The panel preferred the accounts given by the NMC witnesses as they provided consistent, credible and reliable evidence, which were provided closer in time to the discovery and supported by the Omnicell reports and controlled drugs book entries.

In light of the evidence, the panel was satisfied that you had dispensed a quantity of pregabalin from the Omnicell on 5 April 2021, and that it was purported to be for Patient A.

The panel therefore found, on the balance of probabilities, that you had dispensed a quantity of pregabalin for Patient A without clinical justification because pregabalin was not prescribed to them when you dispensed this medication from the Omnicell on 5 April 2021.

Charge 2

That you, a registered nurse:

2. *By your actions at charge 1 you took the medication for a use other than for which it was intended*

This charge is found proved.

In reaching this decision, the panel had regard to its decisions and reasons in respect of charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii, which had been found proved.

In each of these charges, the panel had found that you had dispensed medication from Omnicell in the name of patients who did not have prescriptions for those medications, and so they were not taken for the purpose of being administered to those named patients.

You gave evidence that you dispensed medications always on the basis of a prescription, but not necessarily for the patient name that you selected from the display on the Omnicell screen. You also gave evidence that it was "*common practice because it was so busy*" to select the name of any patient on Omnicell, and dispense the medication to administer to the correct patient who required it and whose prescription you had checked.

You said that you did not feel adequately trained to use the Omnicell, but gave evidence that you had been shown how to use it by your manager, before being issued with your fingerprint login. You confirmed on questioning that you did not raise how you felt with anyone or ask for further training. The panel heard evidence that whilst there may have been no formal training in the sense of it requiring sign-off, every nurse was shown how to use it and there was a user guide attached to the machine.

The panel also noted your evidence that you were not always provided a legal prescription for patients, and that post it notes were occasionally passed to you from other members of staff to dispense drugs. However, the panel considered from the evidence before it, that it was the responsibility of the nurse to ensure that prescriptions were correctly recorded on the correct patient records following any dispensing of medication not prescribed on a legal prescription. There was also no evidence before the panel of this occurrence.

The panel considered that by accessing Omnicell and dispensing medication for anyone other than the named patient, you took the medication for a use other than for which it was intended. It therefore found charge 2 proved.

Charge 3

In considering charges 3a, 3b and 3c, the panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel also had regard to the NMC guidance on making decisions on dishonesty charges and the professional duty of candour (reference: DMA-8).

Charge 3a and 3b

That you, a registered nurse:

3. *Your actions at charges 1 and/or 2 were dishonest in that:*
   a) *you knew the medication was the property of Frimley Health NHS Foundation Trust*
   b) *you knew you had permission only to dispense it for the use of patients*

This charge is found proved.

In reaching this decision, the panel had regard to its decisions and reasons in respect of charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii and 2, which had been found proved.

The panel first considered your state of mind as to the facts, i.e. whether you knew the medication was the property of the Trust and that you had permission only to dispense it for the use of patients. These facts were not in dispute as you had acknowledged and accepted in cross-examination that the medication was the property of the Trust and that you knew that you had permission only to dispense it for the use of patients. You therefore knew that the correct patient details should have been selected on the Omnicell screen, in order to dispense the correct medication for the correct patient.

The panel next considered whether, in the context of what you knew, your conduct was dishonest by the standards of ordinary decent people. The panel was satisfied that by the objective standards of ordinary decent people, your actions at the charges that had been found proved were dishonest. An ordinary decent person would expect a registered nurse to dispense medication for the correct patient in line with a legal prescription.

The panel therefore determined that your actions at charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii and 2

were dishonest, in that you knew the medication was the property of the Trust and that you had permission only to dispense it for the use of patients.

Charge 3c

That you, a registered nurse:

3. *Your actions at charges 1 and/or 2 were dishonest in that:*
    c) *you knew that when you dispensed it you were taking it for a different purpose*

This charge is found proved.

In reaching this decision, the panel had regard to its decisions and reasons in respect of charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii and 2, which had been found proved.

The panel first considered your state of mind as to the facts, i.e. whether you knew that when you dispensed the medications, you were taking it for a different purpose. It had regard to your positive testimonials and your denial of any dishonesty. The panel noted all of the evidence you gave regarding your actions. It concluded that whilst you were working on a busy ward during the COVID-19 pandemic, none of the other NMC witnesses had given evidence that the wards were chaotic enough to explain the practice you claimed to have used, as well as claiming everyone else was doing it, in selecting any patient name on Omnicell to dispense medication for other patients.

The panel noted that it was your evidence that the majority of the medication discrepancies were the result of either medications not being in the drawer or someone else using the Omnicell after you or using your log in details.

The panel considered that there appeared to be a pattern in the type of medications that you had dispensed, in particular benzodiazepines and painkillers. It also took into account Witness 1's witness statement dated 7 July 2023, which stated that the medications you

had dispensed from the Omnicell were not medications they would normally have used on the Ambulatory Emergency Care Unit (ACEU). There was also no evidence before the panel to support your account that your colleagues might have dispensed medication from the Omnicell using your log in, particularly in light of the fact that each nurse had their own log in details.

The panel took into account your evidence that the medications you dispensed from the Omnicell were administered to the correct patients. However, no evidence had been adduced to show that you had actually done so.

In addition, the panel decided that there had been some disparity in your evidence, in relation to whether there was anyone in the room with you, whether there was one box or two strips of pregabalin, and whether you were rushing off to do intravenous medication or patient observations straight after the Omnicell locked you out and you put the medication aside. The disparity in your evidence was mainly noted between your local statement in 2021 and your most recent evidence in these proceedings, and in the panel's view undermined the credibility of some of your evidence.

The panel took into account the evidence you gave regarding dispensing a quantity of pregabalin on 5 April 2021, as set out at charge 1s)i. The panel decided that your account that you had accessed Omnicell on that occasion only to read the information leaflet to learn about the drug interactions and side effects of pregabalin, was implausible and not credible. The panel was aware that you had access to the British National Formulary (BNF), Medusa and Google; and that you could have spoken to your colleagues, GP or pharmacist in relation to the information you sought.

You told the panel that you left the pregabalin you had dispensed from the Omnicell on the side, after it logged you out. You went on to tell the panel that you did not know how to return the pregabalin to the Omnicell machine. The panel considered that if the pregabalin had been left on the side, it was likely to have been seen by a member of staff given the very busy nature of the treatment room where the Omnicell machine was housed, and

about which the panel heard evidence from a number of witnesses. The panel also decided that you could have sought advice on how to return the pregabalin back to the Omnicell.

The panel also had sight of evidence from Witness 1 and an Omnicell report that confirmed that another medication was dispensed and administered by you one minute after you dispensed the pregabalin on 5 April 2021. The panel understood from this evidence that the Omnicell drawer would have to be closed and your login details re-entered to dispense that medication.

The panel acknowledged that you were a relatively newly qualified nurse at the time of the incidents, and that you said you did not feel you were properly trained to use Omnicell. Witness 5 had given oral evidence that there was no formal training on Omnicell. on questioning, Witness 5 acknowledged that not all training for equipment takes a formal route and that being shown how to use equipment by a manager was common practice even though in this instance, Witness 5 believed there should have been a more formal package of training. Witness 5 also gave evidence that they found it a relatively simple piece of equipment to use, but acknowledged that not all nurses may find it to be so. You gave evidence that you had been shown how to use the Omnicell by your manager, so you had received some training related to its use and had been using the system for at least six months. The panel was not satisfied that your lack of formal training could account for the number of irregularities found in the Omnicell audit.

The panel considered that you knew the required procedure for a registered nurse dispensing medication, you knew that Omnicell was equivalent to an electronic drug cupboard, and you knew the expectation on you as a registered nurse to check that the correct prescriptions or patient records were being used to dispense the correct medications to be given to the correct patient.

The panel had regard to the positive testimonials which commented on your character. However, having considered all of the evidence before it and the context and

circumstances, the panel drew an inference that you were taking the medication for your own use. The panel also found that the reasons and explanations you provided for your actions lacked plausibility and it did not find you to be a reliable witness.

In determining whether your conduct was dishonest by the standards of ordinary decent people, the panel took account of its finding that you had dispensed medication, intended for patients, for your own use. The panel was satisfied that by the objective standards of ordinary decent people, dispensing medication for your own use would be considered dishonest. It determined that an ordinary decent person would expect a registered nurse to dispense medication for the correct purpose.

The panel therefore determined that your actions at charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii and 2 were dishonest, in that you knew that when you dispensed the medications, you were taking it for a different purpose.

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

Ms Jones submitted that the facts found proved amount to misconduct. She submitted that your actions fell significantly short of the standards expected of a registered nurse.

Ms Jones referred to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and submitted that you had breached parts 20.1 and 20.8 of the Code. She submitted that whilst breaches of the Code do not automatically result in a finding of misconduct, on the basis of the facts the panel has found proved, it may determine that your actions fell short of the standards expected of a registered nurse and therefore amounted to misconduct.

Ms Lambert, on your behalf, asked the panel to consider the historical nature of these events going back four and a half years, your previous good conduct, and your current good conduct. She submitted that in addressing whether your misconduct is remediable, whilst the finding of dishonesty will always be problematic for a registrant, there was no previous history of dishonesty and that post-referral, you worked as a "*RGN*" (registered nurse) from June 2021 to May 2022. Ms Lambert referred to the character reference from your employer at the time, which confirmed your high level of professionalism, integrity and reliability.

Ms Lambert submitted that from June 2022 to date, you have been employed as cabin crew and are now a cabin manager. She submitted that in those positions, you have demonstrated integrity and honesty, which are key parts of the role. Ms Lambert submitted that you have also adhered to the interim conditions of practise order imposed in May 2021.

Ms Lambert submitted that there was no evidence of repetition since these incidents. She highlighted your most recent work as an "*RGN*", where you had access to medication and had no problems.

Submissions on impairment

Ms Jones moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Jones submitted that as a result of your misconduct, your fitness to practise is currently impaired. She referred to your witness statement dated June 2025 and your reflective piece, and submitted that you have sought to place the blame on others and have not taken any accountability for your own actions.

Ms Jones submitted that some of the facts found proved concerned matters relating to dishonesty, which is serious. She submitted that this was not one occasion of dishonesty or dishonest actions, but several, demonstrating a pattern. Ms Jones submitted that your behaviour is attitudinal and on that basis, is harder to remediate. She submitted that there did not appear to be any evidence to demonstrate that you have done anything to remediate the way you think in terms of your actions in relation to the charges found proved.

Ms Jones submitted that whilst you were perfectly entitled to deny the allegations, you have not shown any meaningful remorse or recognition of how your actions could cause potential harm to others. She submitted that there has been no appropriate action or any demonstration of how you may act differently in the future to prevent the same situations from happening again.

Ms Jones highlighted that nurses occupy a position of trust in society and are expected at all times to be professional whilst discharging their duties in an efficient and safe manner. In addition, patients are entitled to place their trust in nurses to do the job that they are engaged to do. She also reminded the panel of 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.

Ms Jones submitted that there is a real risk of repetition of the matters found proved in this case. She submitted that a member of the public would be concerned if a nurse in the circumstances of this case were permitted to remain in practice without restriction.

Ms Lambert referred the panel to the character references in support of your case. She reminded the panel of the factors relevant to its consideration of current impairment and highlighted the cases of *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Lusinga v Nursing and Midwifery Council* [2017] EWHC 1458 (Admin).

In relation to whether you pose an ongoing risk to patients, Ms Lambert submitted that you had provided a reference from an employer, which attested to your high level of professionalism, integrity and reliability. She highlighted that you quickly became a trusted member of the team and were regularly requested by clients due to your calm and reassuring bedside manner, outstanding interpersonal skills and friendly yet professional personality. In addition, your reference stated that your ability to put individuals at ease, often in high pressure environments, was a testament to both your clinical competence and your emotional intelligence; and that you are honest, trustworthy, and take pride in the quality of your work.

Ms Lambert submitted that there had been no previous regulatory concerns, no previous acts of dishonesty, nor any post-referral acts of dishonesty.

Ms Lambert submitted that the positive references were not given lightly. She submitted that the people providing them were aware of the allegations put to you, but they were still content to provide these. She submitted that your refusal to admit to the charges could not, in itself mean that you had no remorse. Ms Lambert submitted that you have provided a reflective practice piece where you have identified the steps you would take to ensure that you would adhere to the appropriate policies and procedures in the future. She submitted that you have spent four years developing your skill set. Ms Lambert submitted that you have secured an alternative profession, although your love for nursing remains and it has always been your intention to return to practice. She therefore invited the panel not to make a finding of current impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Cohen v General Medical Council* and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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:

'10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.:

To achieve this, you must:

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 keep to appropriate guidelines when ... recording the ... dispensing or administration of controlled drugs.

18.4 take all steps to keep medicines stored securely

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, ...

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.'

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

Charge 1

The panel considered whether the charges amounted to misconduct, first individually and then cumulatively within the area of concern.

The panel had regard to its findings that on multiple occasions, you dispensed medication for patients who were not prescribed them and, on some occasions, the patients were not present at the Hospital, and in doing so, you acted without clinical justification. It was of the view that the manner in which you dispensed the medications, with no regard for whether they were for the correct patients was unacceptable for a nurse. The panel found that you had circumvented the correct procedures put in place to ensure that the process of medication dispensing and administration were carried out properly at the Hospital.

Further, in relation to charges 1s)i and 1s)ii, the panel considered that your actions that resulted in two strips or 28 tablets of pregabalin being inappropriately dispensed, were serious. The panel heard evidence from the NMC's witnesses that the discrepancy in relation to pregabalin was sufficiently serious for an incident report to be completed, and an internal investigation commenced.

The panel determined that your actions at charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i and 1s)ii would be regarded as deplorable by fellow practitioners. It therefore concluded that your actions at these charges fell seriously short of the conduct and standards expected of a registered nurse, and amounted to misconduct.

Charge 2

In relation to its finding that by your actions at charge 1, you took the medication for a use other than for which it was intended, the panel considered that nurses are entrusted with the power to access medication for a particular purpose, that is to dispense the correct medication for the correctly named patient in accordance with a legal prescription, and not for any other purpose. It considered that nurses are expected to do this professionally and honestly, and so by not doing so, your actions were serious.

The panel found that your actions at the charge 2 would be regarded as deplorable by fellow practitioners. It therefore determined that your actions at this charge fell seriously short of the conduct and standards expected of a nurse, and amounted to misconduct.

Charge 3

The panel noted its finding that you acted dishonestly in that you knew the medication was the property of the Trust, you knew you had permission only to dispense it for the use of patients, and you knew that when you dispensed it you were taking it for a different purpose. The panel has determined that you took the medications for your own use and it noted that over a prolonged period of time, you acted dishonestly in respect of the medication you were dispensing without clinical justification.

The panel considered that you had a duty as a registered nurse to be open and honest, and act with integrity, but you did not do so. It was the view that your dishonesty in respect of charge 3 brought your integrity into question, would be regarded as a deplorable by fellow practitioners and the public, and was a significant departure from the conduct and standards expected of a registered nurse. The panel was therefore satisfied that your dishonesty amounted to misconduct.

In all the circumstances, the panel concluded that your actions at charges 1a)i, 1a)ii, 1b)i, 1b)ii, 1c, 1d)i, 1e, 1f)i, 1f)ii, 1g)i, 1g)ii, 1i)i, 1i)ii, 1j)ii, 1k, 1m, 1n)ii, 1o)i, 1o)iii, 1p, 1q, 1r, 1s)i, 1s)ii, 2, 3a, 3b and 3c amounted to misconduct, both individually and cumulatively.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, 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, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

The panel determined that limbs a), b), c) and d) are engaged in this case. The panel found that patients were put at risk of harm as a result of your misconduct because you increased the risk of patients being administered the wrong medication or of patients not receiving the medication they were prescribed. The panel was satisfied that your misconduct had breached the fundamental tenets of the nursing profession, including promoting professionalism and trust and practising effectively, and therefore brought its reputation into disrepute. Further, it determined that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel had regard to the case of *Cohen v General Medical Council* and considered the following factors:

- whether the misconduct is capable of being addressed;
- whether it has been addressed; and
- whether the misconduct is highly unlikely to be repeated.

The panel considered that the misconduct at charges 1, 2 and 3 were so interlinked that it would be difficult to separate the dispensing of the medications from the dishonesty facts that had been found proved. It determined that your misconduct raised attitudinal concerns which are very difficult to address.

In relation to whether your misconduct has been addressed, the panel noted that between June 2021 and May 2022, you worked as on a temporary basis as a registered nurse, primarily supporting COVID-19 testing for high-profile clients with a private company. It had regard to the reference from your employer in that role dated 7 July 2025, but noted that this role was not within a clinical setting at an NHS organisation and did not appear to involve any medication management. The panel therefore did not place significant weight on this as evidence of strengthened practice.

The panel also had sight of the undated positive reference from a Consultant Physician at the Trust when you worked there, as well as a number of other positive character references from a former colleague and friend. The panel noted that there was no reference or testimonial from your current employer.

Regarding insight, the panel determined that you had made some attempt in your reflective piece to discuss the impact of your actions on colleagues and the wider public and acknowledge that any act of dishonesty is viewed as undermining the profession as a whole. However, your insight focussed largely on your own position and avoiding responsibility for the incidents. The panel found that you have not demonstrated a full understanding of how your actions put patients at a risk of harm, why what you did was wrong and how this impacted negatively on the reputation of the nursing profession, and how you would handle the situation differently in the future.

The panel carefully considered the evidence of any steps you have taken to strengthen your practice. It had not been provided with any evidence of any relevant training. It therefore had no evidence that you have undertaken any learning and applied that

learning in practice to demonstrate that the concerns have been addressed, and that you can practise effectively.

The panel considered that each charge found proved took place over a sustained period between November 2020 and April 2021, and they formed a pattern of misconduct. It noted Ms Lambert's submission that you have not repeated the misconduct, either within your previous role as a nurse supporting COVID-19 testing or your current role as a cabin manager, but the panel had no evidence before it about any medication practice during the time since you have left the Trust.

As such, the panel could not be satisfied that it is highly unlikely that your misconduct would be repeated in the future. It therefore found that there is a high risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required to mark the unacceptability of your misconduct and to uphold proper professional standards. The panel considered that a well-informed member of the public would be concerned if a finding of impairment were not made in the specific circumstances of this case.

In addition, 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 found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was not satisfied that at this stage, you can practise safely and professionally. It therefore determined that your fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

Ms Kyriacou, on behalf of the NMC, informed the panel that in the Notice of Hearing, dated 29 May 2025, 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.

She suggested the following aggravating factors in this case:

- A pattern of misconduct over a period of time
- Lack of evidence of insight or reflection
- Dispensing medication for personal use

Ms Kyriacou referred the panel to SAN-2. She submitted that that making no order or imposing a caution order would be inappropriate given the seriousness of the case and that there is a real risk of significant harm to the public, therefore engaging public protection. She submitted that imposing a conditions of practice order would be inappropriate and insufficient given the nature of the conduct and the finding of the panel

that you had demonstrated attitudinal issues and there are no identifiable clinical areas in need of training as the conduct does not concern clinical matters. Therefore, no relevant conditions could be formulated that would address the identified concerns.

Ms Kyriacou stated that the NMC guidance on suspension sets out that a suspension order will be appropriate where the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional. She submitted that the NMC's overarching objectives include public protection and your conduct is fundamentally incompatible with remaining on the register. She submitted that a less severe outcome than a striking-off order would not satisfy the overriding objective of public protection. Ms Kyriacou submitted that the misconduct took place over a sustained period of time, from November 2020 to April 2021 forming a pattern of conduct. She submitted that your conduct raised serious deep seated attitudinal concerns and you failed to adhere to the fundamental character traits required of a nurse, to act with honesty and integrity.

Ms Kyriacou submitted that you have not provided any evidence or reflections before the panel today to demonstrate your insight into the impact or potential impact of your misconduct despite the finding of the panel of the misconduct being found proved approximately six months ago (July 2025). Therefore, your insight remains limited, there is a high risk of repetition, and the public remains at a significant risk of harm.

Ms Kyriacou submitted that you have had sufficient time to attempt to remediate the misconduct, to show insight, and to demonstrate strengthened practice. However, you have not done so, and therefore, the misconduct has not been remedied. She submitted that the public's confidence in the profession would be undermined if the panel did not remove you from the register.

Ms Kyriacou submitted that the conduct found proved falls far short of that expected of a registered professional in taking medication intended for patients which you had been trusted to have access to but took for your own personal use. For these reasons, she invited the panel to impose a striking-off order.

The panel also bore in mind Ms Lambert's submissions on your behalf that you have fully complied with all NMC proceedings, and you have given evidence under oath. She submitted that you are currently employed in work away from the nursing field, in a role of responsibility that demands honesty and integrity. There have been no concerns raised in your current role and prior to this you worked as a registered nurse without any regulatory concerns. Also, you are of good character and have not had any convictions.

Ms Lambert referred the panel to the character references all provided with knowledge of the charges and which confirm your good character. She also referred the panel to your reflective piece, completed prior to the commencement of the hearing in July, which the panel had recognised as providing some level of insight.

Ms Lambert submitted that a striking-off order preventing you from working as a nurse would be devastating for you. She told the panel that you came to the profession as a mature student and qualified with a first-class honours degree and have practised without concern for two years. She submitted that a removal order may also impact your current employment. For these reasons, Ms Lambert submitted that a suspension order would be the appropriate sanction in order to allow you the opportunity to reflect on your actions, undertake further training, and demonstrate remediation and insight, ensuring that the concerns are remediated.

Attendance of Miss McLaughlan

On day 10 of the hearing, after hearing submissions on the sanction stage, Ms Lambert informed the panel that Miss McLaughlan would no longer be present, and she is instructed to continue in her absence.

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 discussed and considered any potential biases in its decision and was satisfied that there were no biases held that impacted its decision making.

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Very limited insight into failings
- Risk of harm to patients
- A pattern of misconduct over a period of 5 months, where there were numerous incidents found proved as detailed in the charges
- Undermining of medication systems designed to protect patients
- Deep seated attitudinal issues

The panel also took into account the following mitigating features:

- [PRIVATE]
- Your admission to charge 1s)ii

The panel acknowledged your continued engagement with these proceedings. In the view of the panel this fell short of providing mitigation, but the panel accepted that you had engaged with the NMC throughout. The panel was of the view that the aggravating factors outweighed the mitigating factors in your case.

It took into account the following guidance – SAN-4 (last updated on 28 January 2026):

> *'…Honesty is of central importance to a professional's practice because of the large degree of trust placed in them. Therefore, allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy; because of this a professional who has acted dishonestly will always be at risk of strike-off. However, in every case the Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious.[1] Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):*
>
> - *…*
> - *…*
> - *personal … gain from a breach of trust*
> - *direct risk to people receiving care*
> - *premeditated, systematic or longstanding deception.*
>
> *Dishonest conduct will generally be less serious in cases of:*
>
> - *one-off incidents*
> - *spontaneous conduct*
> - *no direct personal gain*
> - *incidents outside professional practice.*
>
> *This is not an exhaustive list.*
>
> *Professionals who have behaved dishonestly can engage with the Committee to:*
>
> - *show that they feel remorse*

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

The panel noted that your misconduct involved a repeated deception and an element of personal gain. In particular, it had regard to the absence of any remorse, recognition of the dishonesty or how you would prevent this happening in the future. The panel also noted that the dishonesty in your case was towards the more serious end of the scale.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. A sanction was necessary to secure public safety, uphold public confidence and maintain professional standards.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, which involves dishonesty, and the public protection and public interest issues identified, 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 seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel took into account the SG, including SAN-2c and SAN-3 (last updated on 28 January 2026), in particular it noted the following matters which assist in determining whether conditions might be appropriate:

- *'…no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or*

retraining

- *…*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *…*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed…'*

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct found proved which related to your professional practice rather than your clinical competence. The misconduct identified in this case involved a pattern of dishonesty, which evidenced deep-seated attitudinal concerns that cannot be easily addressed through retraining. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case or the attitudinal concerns. It was also of the view that conditions would not adequately protect the public or satisfy the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where:

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

The panel also considered the following matters from the guidance in SAN-2d:

- *'…whether the risk posed to the public, or to people receiving care, can only be managed by temporary removal from the Register?*
- *will suspension be sufficient to protect people using services, public confidence in the profession, or professional standards?*
- *is it realistic that the professional could return to unrestricted practice in the future, even if it is not appropriate for them to do so now?*
- *What would the registrant need to do in order to be fit to practise in the future? Is it realistic that they will be able to do this?...'*

The panel noted that this was not a single incident of misconduct but represented a pattern of conduct repeated over a 5-month period of time. The panel determined that your dishonesty reflected deep seated attitudinal concerns. The panel also took into account that it had very limited evidence of meaningful insight, and no remorse or remediation demonstrated with regard to the misconduct; it therefore determined there was a high risk of repetition.

Furthermore, the charges found proved are at the more serious end of the spectrum and call into question your suitability to continue practising as a registered nurse. They also involved a risk to patient safety. In the view of the panel, your misconduct is so serious that public confidence in the profession and professional standards could not be maintained if you were to continue practising.

The panel noted that you have not practised as a registered nurse for three years. It noted that your last reflective piece was dated June 2025 and it was of the view that the reflections did not acknowledge the risk of harm to patients, colleagues or members of the public. Since the finding of impairment made in July 2025, the panel have received a reference on your behalf, however, there was nothing to suggest that the author of the reference had been made aware of these proceedings. The panel had no evidence before

it to suggest any increase in insight or strengthening of practice and nothing to suggest a period of suspension would mitigate the identified risks.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions were fundamentally incompatible with remaining on the register.

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

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG at SAN-2e:

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

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the misconduct in this particular case demonstrates that your actions

raised fundamental questions about your professionalism and your willingness to uphold the standard and values of the Code, and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel further noted the lack of insight. It was not satisfied that after any period of suspension you would gain sufficient insight. In any event, it noted the guidance in SAN-3 that *'…where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight…'*

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

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

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

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the

striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Kyriacou. She submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive sanction order takes effect.

Ms Kyriacou submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

Ms Lambert did not oppose this.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and the wider public interest. Also, to cover the 28-day appeal period and the duration of any appeal should you decide to appeal against the panel's decision.

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

That concludes this determination.