Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 17 November – Thursday, 27 November 2025
Tuesday, 27 January – Wednesday, 28 January 2026

Virtual Hearing

Name of Registrant:	**Feba Daniel**
NMC PIN:	19K0517O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 18 November 2019
Relevant Location:	Armagh City, Banbridge and Craigavon
Type of case:	Misconduct/Lack of Competence
Panel members:	Paul O'Connor (Chair, Lay Member) Vickie Glass (Registrant Member) Norah Christie (Lay Member)
Legal Assessor:	Gareth Jones KC Ian Ashford-Thom (28 January 2026)
Hearings Coordinator:	Petra Bernard Angela Nkansa-Dwamena (27 – 28 January 2026)
Nursing and Midwifery Council:	Represented by Jamie Perriam, Case Presenter Represented by Debbie Churaman, Case Presenter (27 – 28 January 2026)
Mrs Daniel:	Present and represented by James Wilkinson, (UNISON)
Facts proved by admission:	**2, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19a**
Facts proved:	**1, 3, 4, 6, 7, 19b and 20**

Facts not proved:	**None**
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 (Day 1)

Mr Wilkinson, on your behalf, made an application that the hearing be held partly in private on the basis that your case makes reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Perriam, on behalf of the Nursing and Midwifery Council (NMC), submitted that the NMC's position is neutral on this point however, could see no reason for there to be any opposition to Mr Wilkinson's application.

The legal assessor reminded the panel that 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.

Having heard there will be reference to [PRIVATE], the panel determined to go into private as and when such issues are raised in order to protect your privacy.

Decision and reasons on application to amended charges (Day one)

Mr Perriam made an application under Rule 28 of the Rules to make the following proposed amendments to charges 2, 8, 9, 10 (Schedule 1), 11, 13, 14 (Schedule 7) and 17. He submitted that these minor amendments would correct grammatical errors where appropriate and more accurately reflect the evidence to support the charges.

<u>Original charges</u>

2. On 17 April 2023, in relation to an unknown patient, did not conduct regular vaginal blood loss checks, as required.

8. Failed to undertake patient assessments competently and / or at all on the occasions set out in **Schedule 1**.

9. Failed to maintain accurate and / or adequate patient records on the occasions set out in **Schedule 2**.

10. Between 27 January 2020 and 25 March 2023 you incorrectly administered and / or attempted to administer medication on the occasions set out in **Schedule 3**.

11. Between September 2022 and 24 March 2022, you failed to escalate a deteriorating patient's condition on the occasions set out in **Schedule 4**.

13. Between January 2020 and 7 June 2023, you failed to adhere to infection prevention control measures on the occasions set out in **Schedule 6**.

14. Between 28 September 2022 and 11 June 2023, you failed to accurately complete and or interpret fluid balance charts on the occasions set out in **Schedule 7**.

16. Between 9 January 2023 and 1 May 2023 you failed to develop and / or maintain sufficient knowledge in relation to the Diabetic Protocol on the occasions set out in **Schedule 9.**

17. Between 28 September 2022 and 10 October 2022 engaged in sub-standard patient handovers on the occasions set out in **Schedule 10**.

Schedule 1 on 07.06.23 and Schedule 7 on 14.04.23 and 07.06.23 includes:

Schedule 1	**Concern**
07.06.23	Failed to attach facemask line to the oxygen port

Schedule 7	**Concern**
14.04.23	Incorrectly recorded urine output in fluid output chart
07.06.23	Failed to record hourly input and output

Proposed amendments

2. On 17 April 2023, in relation to ~~an~~ **Patient A** ~~unknown patient~~, did not conduct regular vaginal blood loss checks, as required.

8. **You** failed to undertake patient assessments competently and / or at all on the occasions set out in **Schedule 1**.

9. **You** failed to maintain accurate and / or adequate patient records on the occasions set out in **Schedule 2**.

10. Between ~~27 January 2020 and 25 March 2023~~ **28 September 2022 and 22 May 2023** you incorrectly administered and / or attempted to administer medication on the occasions set out in **Schedule 3**.

11. Between September 2022 and 24 March 202~~2~~**3**, **and on an unknown date you** failed to escalate a deteriorating patient's condition on the occasions set out in **Schedule 4**.

13. Between January 2020 and ~~7 June 2023~~, **19 June 2023** you failed to adhere to infection prevention control measures on the occasions set out in **Schedule 6**.

14. Between 28 September 2022 and 11 June 2023, **and on an unknown date**, you failed to accurately complete and or interpret fluid balance charts on the occasions set out in **Schedule 7**.

16. Between 9 January 2023 and 1 May 2023, **you** failed to develop and / or maintain sufficient knowledge in relation to the Diabetic Protocol on the occasions set out in **Schedule 9.**

17. Between 28 September 2022 and ~~10 October 2022~~ **14 April 2023, you** engaged in sub-standard patient handovers on the occasions set out in **Schedule 10**.

Schedule 1 on 07.06.23 and **Schedule 7** on 14.04.23 and 07.06.23 proposed amendments are as follows:

Schedule 1	**Concern**
07.06.23	Failed to ~~attach facemask line to the oxygen port~~ **turn on the oxygen in a facemask line**

Schedule 7	**Concern**
14.04.23	~~Incorrectly~~ Recorded **on an incorrect date** urine output in fluid output chart
07.06.23	Failed **accurately** to record hourly input and output

Mr Wilkinson indicated that, having had the opportunity to discuss the proposed amendments in advance of the application with Mr Perriam, he was content with the proposed amendments as applied for.

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

The panel decided to accept the proposed amendments to the charges as applied for.

The panel was satisfied that no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments as applied for, to reflect the evidence and ensure clarity and accuracy.

Details of charge (as read) (Day 1)

That you, a registered nurse,

1. On 23 March 2023, in relation to an unknown patient, did not conduct 15-minute checks on vaginal blood loss, as required.

2. On 17 April 2023, in relation to Patient A did not conduct regular vaginal blood loss checks, as required.

3. On 18 May 2023:
    a. Documented patient observations on an anaesthetic chart;
    b. Had not carried out the observations referred to in charge 3a.

4. On 11 June 2023:
    a. Documented entries “TA” and “MA” relating to neurovascular observations in a patient’s record;
    b. Had not carried out the observations referred to in charge 4a.

5. On 14 June 2023:
    a. Documented that you had checked a patient’s epidural catheter site;
    b. Had not checked the site before making the record referred to in charge 5a.

6. Your actions at charges 3 and 4 were dishonest in that you knew you had not carried out the observations and intended to mislead your colleagues to believe that you had.

7. Your actions at charge 5 were dishonest in that you knew you had not checked the epidural catheter site and intended to mislead your colleagues to believe that you had.

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

That you, a Registered Nurse, between December 2019 and October 2023, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Band 5 Nurse without supervision in that:

8. You failed to undertake patient assessments competently and / or at all on the occasions set out in **Schedule 1**.

9. You failed to maintain accurate and / or adequate patient records on the occasions set out in **Schedule 2**.

10. Between 28 September 2022 and 22 May 2023 you incorrectly administered and / or attempted to administer medication on the occasions set out in **Schedule 3**.

11. Between September 2022 and 24 March 2023, and on an unknown date you failed to escalate a deteriorating patient's condition on the occasions set out in **Schedule 4**.

12. Between 28 September 2022 and 3 May 2023, you failed to apply Aseptic Non Touch Technique (ANTT) principles on the occasions set out in **Schedule 5**.

13. Between January 2020 and 19 June 2023 you failed to adhere to infection prevention control measures on the occasions set out in **Schedule 6**.

14. Between 28 September 2022 and 11 June 2023, and on an unknown date, you failed to accurately complete and or interpret fluid balance charts on the occasions set out in **Schedule 7**.

15. Between October 2022 and 3 January 2023, you received patient handovers following surgery when not qualified to do so on the occasions set out in **Schedule 8**.

16. Between 9 January 2023 and 1 May 2023 you failed to develop and / or maintain sufficient knowledge in relation to the Diabetic Protocol on the occasions set out in **Schedule 9.**

17. Between 28 September 2022 and 14 April 2023, you engaged in sub-standard patient handovers on the occasions set out in **Schedule 10**.

18. On 5 April 2023 you failed to escalate a NEWS score of 6.

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

Schedule 1	**Concern**
September 2022	Failed to prime intravenous giving set before administration
October 2022	Failed to monitor a patient for haematuria
31.10.22	Failed to assess and wean oxygen levels
03.11.22	Incorrectly recorded IV Fluids
03.11.22	Failed to follow up post operative care observations
07.11.22	Failed to act on a patient's low oxygen saturation levels
07.12.22	Failed to check patient's blood pressure
09.01.23	Failed to check if patient was insulin dependant
19.01.23	Failed to follow up patient observations
03.02.23	Failed to carry out repeat observations in a timely manner
03.02.23	Failed to measure oxygen saturations correctly
24.03.23	Failed to follow neurovascular observations time guidelines
24.03.23	Failed to obtain patient consent
06.04.23	Failed to check a patient's blood sugar level
14.04.23	Failed to take accurate oxygen saturation reading
14.04.23	Failed to arrange chest physiotherapy post-surgery
14.04.23	Incorrectly went to remove patient drain instead of clamp
17.04.23	Failed to carry out checks post surgery
18.04.23	Failed to note left sided facial droop
18.04.23	Failed to note patient nil by mouth
03.05.23	Missed patient observations
03.05.23	Incorrect setting used for patient respirations

11.05.23	Failed to carry out patient observations
12.05.23	Failed to flush cannula before administering intravenous infusions
23.05.23	Failed to carry out ECG
07.06.23	Recorded incorrect drain output readings
07.06.23	Failed to turn on the oxygen in a facemask line
11.06.23	Failed to assess low oxygen saturation levels
07.12.22	Failed to check patient's blood pressure
Unknown date	Failed to assess patient wound

Schedule 2	**Concern**
January 2020	Failed to comply with AFFP Guidelines
03.01.22	Failed to record time of assessment / care provided
18.10.22	Recorded incorrect procedure
18.10.22	Recorded wound was checked incorrectly
18/19.10.22	Failed to document pain medication
31.10.22	Failed to document two wound checks
31.10.22	Failed to complete NEWS chart correctly
01.11.22	Failed to complete NEWS chart correctly
01.11.22	Falsified rectus sheath infusion observations
03.11.22	Failed to sign next to input / output readings
03.11.22	Failed to complete Anaesthetic chart observations
03.11.22	Failed to correctly complete the Controlled Drug Register
07.11.22	Failed to document removing arterial line
07.11.22	Failed to document a spinal opioid
08.11.22	Failed to complete nursing intervention plan of care
19.01.23	Incorrectly documented intravenous fluids
19.01.23	Incorrectly recorded urine output
24.03.23	Failed to complete patient records

05.04.23	Incorrectly recorded oxygen increase level
06.04.23	Incorrectly recorded a blood sugar reading
14.04.23	Insufficient details regarding patient's atrial fibrillation
16.04.23	Failed to document a penicillin allergy
18.04.23	Failed to record ECG showing Bundle Branch Block
18.04.23	Failed to monitor clinical observations
25.04.23	Failed to document a patient passed urine after a urology procedure
29.04.23	Incorrectly recorded reason for patient admission
01.05.23	Failed to sign for intravenous fluids
01.05.23	Recorded incorrect time in patient record
03.05.23	Failed to replace identity armband
03.05.23	Incorrectly used a chart label as patient identity armband
05.04.23	Incorrectly recorded a NEWS score of 4
12.05.23	Incorrectly documented volume infusion of pain relief as zero
18.05.23	Incorrectly documented spinal observation.
18.05.23	Failed to update NEWS score in time
14.06.23	Incorrect epidural infusion observations.
14.06.23	Incorrect motor block reading
14.06.23	Incorrectly documented glucose administered
11.06.23	Recorded incorrect insulin infusion
Unknown date	Failed to complete PCA monitoring chart
Unknown date	Failed to initial patient assessments

Schedule 3	**Concern**
28.09.22-10.10.22	Administered IV paracetamol through a cannula knowing the patient was in pain.
October 2022	Tried to administer IV paracetamol without checking the ward Kardex

13.10.22	Failed to prime the IV giving set
31.10.22	Failed to connect oxygen tubing to oxygen port
11.12.22	Failed IV Pump competencies
11.12.22	Set IV paracetamol infusion for 500mls instead of 50mls
28.12.22	Positioned a tap incorrectly after taking an Arterial Blood Gas reading resulting in blood loss from patient
31.12.22	Wanted to prescribe ephedrine instead of naloxone
21.03.23	Selected incorrect intravenous fluids
23.03.23	Failed to carry out observations post surgery
23.03.23	Failed to carry out neurovascular observations
23.03.23	Incorrectly programmed IV syringe pump
23.03.23	Incorrectly calculated medication dose
23.03.23	Provided incorrect medication information on handover
24.03.23	Inappropriately administered medication via intravenous cannula
05.04.23	Incorrectly calculated an intravenous magnesium infusion
14.04.23	Incorrectly administered STAT of Hartmanns
11.05.23	Prescribed incorrect dose of fentanyl
22.05.23	Incorrectly said to increase oxygen levels

Schedule 4	**Concern**
Unknown date	Failed to escalate low blood pressure
September 2022	Failed to escalate out of range clinical observations
24.03.23	Failed to act on / escalate low oxygen saturation levels

Schedule 5	**Concern**
28.09.22-10.10.22	Prepared an IV morphine injection and left top of the syringe uncovered resulting in contamination
13.10.22	Failed to follow ANTT practise by not protecting the point of connection between the IV cannula and giving set

01.02.23	Failed all aspects of ANTT assessment
03.05.23	Failed to protect key part for arterial blood gas sample

Schedule 6	**Concern**
January 2020	Poor aseptic technique opening spinal packs
14.01.20	Failed to wear PPE
20.01.20	Failure to maintain sterility
28.09.22 – 10.10.22	Failed to wear PPE
12.12.22	Failed to follow the World Health Organisation 5 moments of hand hygiene
December 2022	Failed to wear PPE
December 2022	Failed to identify IV line needed cleaning
December 2022	Breached IPC protocol
21.03.23	Failed to follow infection prevention and control precautions with PPE
24.03.23	Failed to adhere to infection prevention and control practices when opening and closing curtains with contaminated gloves
05.04.23	Failed to clean a dirty trolley before patient use
17.04.23	Failed to follow correct procedure disposing of PPE
19.06.23	Failed to assemble aseptic field
07.06.23	Failed to adhere to infection prevention control practices when emptying urine from urometer

Schedule 7	**Concern**
28.09.22-10.10.22	Incorrect input and output on charts
18.10.22	Unable to calculate fluid balance charts
31.10.22	Failed to document wound drain output
03.11.22	Failed to correctly record input and output readings

31.12.22	Incorrect drug calculation
03.01.23	Incorrect calculation of fluid.
19.01.23	Failed to accurately record input and output on fluid balance sheet
21.03.23	Failed to record abdominal drain on fluid balance chart
23.03.23	Incorrectly recorded wrong medication amount on fluid balance chart
24.03.23	Incorrectly documented medication on fluid balance chart
14.04.23	Recorded on an incorrect chart urine output in fluid output chart
18.04.23	Incorrectly documented fluid input administered
24.04.23	Incorrect calculation to total up IV fluid input
25.04.23	Incorrectly recorded fluid output
29.04.23	Failed to read prescription correctly on fluid balance chart
01.05.23	Incorrectly completed the overall output
11.05.23	Incorrectly recorded amount of intravenous fluids
23.05.23	Incorrect fluid balance totalling
07.06.23	Failed accurately to record hourly input and output
11.06.23	Failed to document fluid output
Unknown date	Failed to accurately complete fluid balance charts

Schedule 8	**Concern**
October 2022	Tried to remove a laryngeal mask when the patient was not able to maintain their own airway
31.10.22	Took anaesthetic handover without another nurse present
07.12.22	Accepted post surgery patient without senior nurse
03.01.23	Received handover from anaesthetist without senior nurse

Schedule 9	**Concern**

09.01.23	Lack of knowledge of intravenous insulin and intravenous fluid prescriptions
01.05.23	Unable to explain Diabetic Protocol

Schedule 10	**Concern**
28.09.22-10.10.22	Poor patient handover post surgical procedure, failed to highlight treatment for atrial fibrillation
24.03.23	Failed to communicate vital information relating to patient's past medical history and medications administered
24.03.23	Failed to provide key patient information relating to a patient's blood pressure and post surgery blood loss
24.03.23	Handed over incorrect care details
14.04.23	Insufficient detail contained in written handover

Decision and reasons on application to amended charges (Day 6)

Mr Perriam made an application under Rule 28 to make the following proposed amendments to charges:

3. On ~~18~~ **16 or 17** May 2023:
    a. Documented patient observations on an anaesthetic chart;
    b. Had not carried out the observations referred to in charge 3a.

Schedule 3

~~22.05.23~~ **19.05. 23**	Incorrectly said to increase oxygen levels

Mr Perriam also made an application to amend the charge to include two additional factual allegations, as follows:

That you, a registered nurse,

19. On 23 March 2023:

a) **Documented "nil Per Vaginal (PV) blood loss" in a patient's records.**
b) **Had not attended upon the patient before making the record referred to in charge 19a.**

20. Your actions at charge 19 were dishonest in that you knew you had not attended upon the patient and intended to mislead your colleagues to believe that you had.

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

Mr Perriam referred the panel to NMC Guidance: PRE-2c 'How a charge becomes final' and DMA-5 'Directing further investigation during a hearing'. He also referred the panel to the relevant legal principles set out in the case of *PSA v NMC & Jozi* [2015] EWHC 764 (Admin) at paragraphs 23 and 24.

Mr Perriam first addressed the panel on its competency to allow such an application and referred it to the relevant parts of Rule 28 of the Rules. Referring to the case of *Jozi* he reminded the panel that it has a responsibility to ensure that a case is properly presented and that the factual allegations considered adequately reflect the real mischief of the case.

In relation to the amendment to Charge 3 he submitted that it was due to a simple error that had occurred in the drafting of the original charge.

In relation to the additional new Charges 19 and 20 to the schedule of charge, he submitted that these charges follow on from evidence the panel heard from both Witnesses 3 and 5.

Mr Wilkinson submitted that the application to amend Charge 3, including the dates at and the entry in Schedule 3, is unopposed as it more accurately reflects the evidence before the panel.

In relation to the additional charges, namely Charges 19a, 19b and 20, Mr Wilkinson indicated no opposition to the proposed amendments in the event he was given an opportunity to take instructions and that relevant witnesses could be recalled to allow him to ask further questions, including you, if appropriate.

Mr Perriam made a further application to amend Charge 19a, as follows:

19. On 23 March 2023:

a) Documented "~~nil~~ **slight** Per Vaginal (PV) blood loss" in a patient's records.

Mr Wilkinson raised no objection to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules and to the cases of *PSA v HCPC and Doree* [2015] EWHC 822 (Admin) and ***Jozi.***

The panel was of the view that the proposed amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. The panel was of the view that there is an evidential basis to allow for the amendments and having noted Mr Wilkinson's submission that any potential prejudice to you could be cured by his ability to cross-examine the recalled witnesses and to take further instruction from you.

Having undertaken a balancing exercise, the panel decided to grant the application in full under Rule 28 and by reference to the case law authorities referred to.

Background

The allegations which led to the charges arose whilst you were employed by [PRIVATE] (the Trust) as a Band 5 nurse. The NMC received a referral on 1 November 2023 from the Head of Employee Relations of the Trust, raising concerns alleging your misconduct and lack of competence, in that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse.

You commenced a Band 5 nursing post at the Trust in November 2019. During your probation, concerns were raised about your competency while working in theatres. You had periods [PRIVATE] which interrupted the normal process for probation review.

In August 2022, you were redeployed to the Recovery Ward (the Ward) on the advice of [PRIVATE] and a new period of supernumerary practice and induction commenced. Further concerns were then raised regarding your lack of progress in this area. Action plans were subsequently put in place and in October 2022, and informal capability was commenced.

In February 2023, you were placed on a formal capability action plan, however, this did not commence until March 2023 following a period [PRIVATE]. An early formal review took place in June 2023 where you were informed that your performance remained of concern. Following this, [PRIVATE]. You then submitted your resignation in October 2023 prior to a scheduled capability (Stage 2) hearing.

You have engaged with the NMC investigation providing context and reflective accounts, testimonies, training record, training diary and training certificates, those most relevant to the regulatory concerns include medicines management/awareness; diabetes awareness; and infection control.

You put forward some context including *'unavoidable life events'* such as [PRIVATE]. You stated that you experienced *'constant nitpicking'* for your mistakes and that this '*undue scrutiny'* created a stressful work environment and that your request for a change of department was refused which further negatively impacted on you.

Decision and reasons on facts

At the outset of the hearing, your representative, Mr Wilkinson, informed the panel that you make full admissions to Charges 2, 5, 8, 9, 10 (date 22 May 2023 in Schedule 3 not admitted),11, 12, 13, 14, 15, 16, 17 and 18. Following agreed amendments to charges, Mr Wilkinson informed the panel that you admit to Charge 10 in full and Charge 19a.

The panel therefore finds Charges 2, 5, 8, 9, 10,11, 12, 13, 14, 15, 16, 17, 18 and 19a proved by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Perriam and those by Mr Wilkinson.

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 evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Band 7 Ward Manager at the Trust, at the material time
- Witness 2: Band 6 Clinical Sister at the Trust, at the material time
- Witness 3: Band 5 Nurse on the Ward at the Trust, at the material time
- Witness 4: Band 6 Clinical Sister on the Ward at the Trust, at the material time
- Witness 5: Clinical Sister on the Ward at the Trust, at the material time
- Witness 6: Theatre Manager at the Trust, at the material time

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and considered all the witness and documentary evidence, submissions of both representatives, and the advice of the legal assessor who referred to the legal test for dishonesty, as set out in the case of *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 and the NMC guidance DMA-8.

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

Charge 1

1. On 23 March 2023, in relation to an unknown patient, did not conduct 15-minute checks on vaginal blood loss, as required.

This charge is found proved

In reaching this decision, the panel took account of Witness 5's witness statement dated 21 August 2024, notably paragraphs 19 and 20, which state that the required checks were not done and you had to be prompted to do so. The panel had sight of an email dated 23 March 2023 from Witness 5 to Witness 1, Witness 2 and copied to Witness 3, which included an update on your Capability Plan outlining the areas for improvement after having worked with you on that day. It included reference to *'continuous prompting required'.* The panel was of the view that this was a contemporaneous record of events which occurred.

The panel found Witness 5 to be a credible and reliable witness whose written and oral evidence were consistent when called upon to give more clarity on this point. The panel considered your oral evidence that *'I would not record something I did not do...'* however, you then went on to say that if you had made mistakes, it was due to pressure or stress. The panel found your evidence to be confusing and inconsistent. The panel therefore preferred Witness 5 's evidence to yours.

Whilst you said that you felt over-scrutinised, in the panel's view scrutiny and observations by your supervisors was justified due to the identified competency concerns and to ensure patient safety.

The panel therefore finds on the balance of probabilities that this charge is proved.

Charge 3

3. On 16 or 17 May 2023:
    a. Documented patient observations on an anaesthetic chart;
    b. Had not carried out the observations referred to in charge 3a.

This charge is found proved in its entirety.

In reaching this decision, the panel took account of the witness statement of Witness 2 dated 27 April 2024. It also had sight of the email dated 18 May 2023 from Witness 2 to Witness 1, with an update of your Capability Plan.

Witness 2 state:

> *'On the same day, Mrs Daniel documenting the patient's observations on a local anaesthetic chart. Mrs Daniel documented at 14:35 that the site was clear and dry with a tick...I challenged Mrs Daniel on the timing of her documentation. I stated that I checked the site along with the wound at 13:55 when the patient came into recovery and I did not notice her checking since as I was with the patient the whole time. I informed her that she cannot document for something that she did not do at the time she stated she made the observation. Mrs Daniel did not disagree with what I said.'*

The panel assessed Witness 2 to be a reliable and credible witness. Her statement was cogent and her timeline easily understood with references to her contemporaneous reflections of her concerns about you. The panel noted that she addressed these concerns

with you on the day in question on the Ward. In oral evidence you said you checked visually from a distance and had not done the check in the way it should have been done. The panel was satisfied that you did not do the check you recorded that you had done.

The panel noted your oral evidence that you were unable to recall this event and in the details of your written statement, you state:

> *'This experience has taught me that maintaining the absolute integrity of every patient record is non-negotiable and is a core, fundamental duty of a registered nurse.'*

In contrast to the credible and reliable evidence of Witness 2, the panel was of the view that your evidence was vague and confusing and did not answer what is alleged in the charge.

The panel therefore finds this charge proved in its entirety.

Charge 4

4. On 11 June 2023:
    a. Documented entries "TA" and "MA" relating to neurovascular observations in a patient's record;
    b. Had not carried out the observations referred to in charge 4a.

This charge is found proved in its entirety.

In reaching this decision, the panel took account of Witness 4 and Witness 5's respective witness statements.

Witness 4's witness statement includes:

'Falsified documentation for neurovascular observations without actually completing the check. Mrs Daniel copied the previous entry that a student nurse had carried out on the patient. Mrs Daniel did not check that the student had correctly carried out these observations or if they were recorded correctly. The student had recorded TA for touch absent and MA for movement absent when the patient had, in fact, full movement and touch which had been recorded for the previous half hour observations...If Mrs Daniel had completed the neurovascular checks she would have found the student's entry to be incorrect.'

Witness 5's witness statement includes:

'The trauma patient also required neurovascular observations. These should be recorded every 30 minutes...I wrote the neurovascular observations down myself after 30 minutes and they were stable so there was no harm to the patient. It was about an hour and Ms Daniels had still not carried them out before I had to remind her to. I do not recall that she gave me much of a response, so I do not know if she took in the concern with not checking neurovascular observations in a timely manner.

...

Another concern with Ms Daniel's documentation was that she had recorded her observations on the wrong side for where the patient had been operated...the expected practice is that on the patient's chart we document observations on the correct side for where the patient had been operated on and we score out the other side.'

The panel noted that there were two separate occasions that you referenced you had accurately recorded what you had observed, and you stood by the records of *'touch absent'* and *'movement absent'*. Later on, you said that you had recorded them in error. The panel found there to be inconsistencies in your statement about the recordings. The panel agreed with Witness 4's evidence that you copied a genuine mistake of a student nurse without making the observations yourself.

The panel was satisfied that the NMC's evidence was clear and determined your evidence to be vague by comparison. The panel therefore determined that this charge is found proved in its entirety.

Charge 19b

19. On 23 March 2023:

b) Had not attended upon the patient before making the record referred to in charge 19a.

This charge is found proved.

In reaching this decision, the panel took into account the respective witness statements and evidence of Witness 3 and Witness 5. Both said in evidence that there were two gynaecological patients on the ward on this day. It was established that Witness 3 was the nurse supervising you with the patient whose record is shown in the Postoperative instructions / monitoring chart' dated 23 March 2023. In her evidence Witness 3 made reference to the chart and stated that in relation to the entry timed at '*10:40*', you had made that entry despite not actually checking the patient.

In your oral evidence you said you did not create the entry at *'10:40'* and highlighted that this entry was not signed by you. You also state that someone else must have recorded this entry however you accepted doing checks either side of this entry. You also later said that you had done the *'10:40'* check in question with partially closed curtains. The panel was of the view that your evidence was inconsistent and confusing. The panel also considered your evidence of having conducted a highly personal patient check in this way, if true, is indicative of the concerns raised in that it shows limited insight into the need to protect the privacy and dignity of a vulnerable patient.

The panel also had sight of 'Record of Staff Conversations' dated 23 March 2023, which was signed by both you and Witness 2, where Witness 2 recorded '*REITERATED – do not document what you do not do'.* and *'Previous conversation *Disciplinary*'.* The panel considered this document supported Witness 2's testimony.

The panel's view on the balance of probabilities you were the most likely person to have documented the record at *'10:40'*.

Charges 6, 7 and 20

The panel considered charges 6, 7 and 20 separately. In reaching a decision on the charges, the panel bore in mind the test for dishonesty as set out in the case of *Ivey* v *Genting*. The panel reminded itself that there is a two-stage test to be applied. Firstly, to consider what your actual state of knowledge or belief as to the facts was at the relevant time and secondly, whether your actions found proved were dishonest according to the standards of ordinary decent people. The panel also recognised that it is required to consider any alternative explanation for your actions, falling short of dishonesty.

Charge 6

6. Your actions at charges 3 and 4 were dishonest in that you knew you had not carried out the observations and intended to mislead your colleagues to believe that you had.

The charge is found proved.

For the reasons previously outlined, the panel found both Charges 3 and 4 proved. In considering the reasons for your actions, whilst the panel accepted that you were stressed, overwhelmed and worried about your performance at the time you documented patient observations on an anaesthetic chart (Charge 3) and documented entries *"TA"* and *"MA"* relating to neurovascular observations in a patient's records (Charge 4) despite not having carried out these checks / observations. The panel noted that you are an experienced Band 5 nurse, and you must have been fully aware of what you were doing and of the importance of only documenting checks / observations that you had carried out.

The panel determined that by the standards of ordinary decent people your actions, as set out in Charges 3 and 4 were not only dishonest but had the potential to place vulnerable patients at risk of harm. The panel could find no other alternative, innocent explanation for your actions and was satisfied instead that you intended to mislead your colleagues that you had carried out the observations when you knew you had not.

The panel therefore finds this charge proved on the balance of probabilities.

Charge 7

7. Your actions at charge 5 were dishonest in that you knew you had not checked the epidural catheter site and intended to mislead your colleagues to believe that you had.

This charge is found proved.

The panel noted that you admitted Charge 5 at the outset of proceedings. You therefore accept on 14 June 2023 you a) documented that you had checked a patient's epidural catheter site and b) had not checked the site before making the record referred to in Charge 5a.

In the panel's view you provided no credible explanation for your actions as set out in Charge 5. You stated instead in your adopted witness statement that you do not recall this incident happening on 14 June 2023 before then stating the following:

> *'Falsely documenting a check on a critical intervention like an epidural is a direct act of professional misconduct that instantly destroys public trust and exposes the patient to potentially fatal harm, severely damaging the reputation of both the profession and my colleagues. Moving forward, I commit to treating every documentation entry as a legal and clinical affirmation that the physical check was performed, prioritizing these safety tasks using checklists and strict time management. I have fundamentally learned that honest, accurate, and timely*

documentation is not optional, but rather the cornerstone of responsible nursing practice and patient safety.'

The panel was satisfied that on your own evidence, you recognise that your actions set out in Charge 5 were dishonest. In any event, the panel was of the view that ordinary decent people would reach that conclusion.

The panel therefore finds this charge proved on the balance of probabilities.

Charge 20

20. Your actions at charge 19 were dishonest in that you knew you had not attended upon the patient and intended to mislead your colleagues to believe that you had.

This charge is found proved.

For the reasons previously outlined, the panel found Charge 19 proved. It noted again that you were a Band 5 nurse who must have been fully aware of what you were doing and the importance of only documenting checks / observations that you had carried out. The panel therefore determined that by the standards of ordinary decent people your actions as set out in Charge 19 were dishonest and had the potential to place a vulnerable patient at risk of harm.

The panel rejected your evidence for the reasons given, that you were not responsible for the '*10:40'* entry and therefore found no credible alternative explanation for why you made the entry in question other than to mislead your colleagues.

The panel therefore finds this charge proved on the balance of probabilities.

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 in respect of Charges 1, 2, 3, 4, 5, 6, 7, 19a, 19b and 20 amount to misconduct and whether the charges found proved in respect of Charges 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18 amount to a lack of competence, and, if so, whether your fitness to practise is currently impaired by reason of misconduct and / or a lack of competence. 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 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 a misconduct / lack of competence. Secondly, only if the facts found proved amount to misconduct / lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct / lack of competence.

Witness evidence

Mr 1 gave evidence under oath on your behalf. He has been your line manager since January 2025 at a 40-bed dementia nursing home where you are currently employed as a Healthcare Assistant (HCA). Mr 1 provided the panel with details of your current role, your good character and how aspects of your current role in his view relate to nursing practice. Mr 1 told the panel that he had no concerns whatsoever in relation to your work as an HCA.

Submissions on misconduct

Mr Perriam referred the panel to the NMC guidance on Misconduct (*reference FTP-2a*) and drew the panel's attention to the relevant parts in the guidance. He submitted that where behaviour suggests deep-seated attitudinal issues of this kind, it is less likely that the nurse will be able to remediate and take steps to address the underlying concerns.

Mr Perriam submitted that the facts found proved relate to repeated failures to conduct, critical checks on vulnerable post-operative patients and include a repeated falsification of records over several months, despite being warned not to do so by your mentors and supervisors. He submitted this represents serious and repeated breaches of the fundamental standards expected of a professional registered nurse in the course of your clinical practice.

Mr Perriam invited the panel to take the view that the facts found proved amount to misconduct as your actions fell below the standards expected of a registered nurse. He directed the panel to the following specific sections within *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code) and identified where, in the NMC's view, your actions amounted to misconduct: 1.2, 1.4, 3.1, 8.2, 8.3, 8.5, 8.6, 10.1, 10.2, 10.3, 10.4, 13.1, 13.3, 20.1, 20.2 and 20.8.

Mr Wilkinson referred the panel to relevant parts in the following cases: *Nandi v General Medical Council [2004]* EWHC 2317 (Admin); *Meadows v GMC* [2006] EWCA Civ 1390; *R v Applied Language Solutions Ltd* [2013] EWCA Crim 326 [paragraph 12] and Roylance v GMC *(No. 2) [2000] 1 AC 311.*

Mr Wilkinson submitted that there are contextual factors to be taken into consideration to explain what occurred, not as any excuse, but as part of the whole picture. He submitted that you were under a level of pressure at the time, which on occasions was excessive. He submitted that you were split between multiple supervisors simultaneously and this made you feel overwhelmed and fearful and impacted your ability to focus on your job.

Mr Wilkinson submitted that mere negligence does not amount to misconduct and that the facts need to not merely fall below the standards expected but fall far below. He submitted that misconduct should not be viewed as anything less than serious professional

misconduct. He submitted that a breach of the NMC standards does not necessarily or automatically amount to misconduct, and that a finding should only be made where the panel consider serious misconduct has occurred.

Mr Wilkinson submitted that your actions, as determined by the panel, were not deliberate, but occurred as a result of the pressure you felt you were under at that time. He submitted that the panel may consider some of the allegations do not meet the threshold for serious misconduct as required.

Submissions on lack of competence

Mr Perriam invited the panel to take the view that the facts found proved in Charges 8 – 18 by your admission and the schedules relating to those charges, amount to a lack of competence. He referred to the Code and identified the following sections where, in the NMC's view, your actions amount to a lack of competence: 4.2, 6.1, 6.2, 14, 14.1, 18, 18.2, 18.4, 19, 19.1, 19.3, and 19.4.

Mr Perriam submitted that you demonstrated a lack of knowledge, skill and judgement to demonstrate you are capable of safe and effective practice. He submitted that it is plain that your actions demonstrate a clear lack of competence as a registered nurse. He referred the panel to the schedules attached to the Schedule of Charge which sets out over 140 clinical failings made by you between January 2020 and June 2023, with most having taken place from October 2022 onwards.

Mr Perriam set out the failings where you demonstrated a lack of competence in numerous areas including infection prevention and control, medication administration, record-keeping and providing safe care. He submitted that these failings took place over an extended period of time in two different hospital settings, both in theatres and for the main part in the recovery ward.

Mr Perriam highlighted sections of the Code which, in his submission, demonstrate a lack of competence: 4.2, 6.1, 6.2, 14.1, 18.2, 18.4, 19.1, 19.3 and 19.4.

He referred the panel to the NMC guidance entitled 'Lack of competence' (*reference FTP-2b*) and cited the section that state that a lack of competence 'usually involves an unacceptably low standard of professional performance, judged on a fair sample of the [the registrant's] work, which could put patients at risk.'

Mr Perriam submitted that while no actual harm was caused, your actions had the potential to put vulnerable patients at serious risk of harm, up to and including death, by being unable to provide them with safe care. He invited the panel to find that your conduct fell significantly short of the standards expected of a registered Band 5 nurse.

Mr Perriam invited the panel to conclude that the facts found proved amount to misconduct as well as a lack of competence.

Mr Wilkinson referred the panel to NMC guidance (*FTP-2b*). He submitted that the panel should consider context (as outlined in his earlier submissions on misconduct) when considering your practice at the time of the charges found proved.

Submissions on impairment

Mr Perriam moved on to the issue of impairment. He referred the panel to the NMC guidance entitled 'Impairment' (*reference: DMA-1*). He reminded the panel that the guidance sets out that a panel, when considering if a nurse is impaired, should start by considering *'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*. He submitted that the answer to this question in your case is no.

Mr Perriam referred the panel to NMC guidance (*reference FTP-15*) *'Insight and strengthened practice'*. He submitted that you have been unable to demonstrate strengthening of your nursing practice. He submitted that none of the references provided

to the panel speak to your fitness to practise as a nurse, rather as a care assistant. He submitted that you have had no opportunity to improve in the key areas of concern identified. Mr Perriam submitted that there is insufficient evidence before the panel today to show that you are currently able to practice safely as a nurse.

Mr Perriam submitted that you have demonstrated little real acknowledgement of the gravity of the dishonesty and lack of competence, and as a result, insufficient understanding of the nature of the conduct found proved. He submitted that there is insufficient evidence to demonstrate that the root cause of your behaviour has been addressed.

Mr Perriam submitted that in the absence of effective insight and remediation there remains a real risk of repetition and a real risk of patient harm. He submitted that there is a real and present danger of future falsehoods and errors occurring with potentially very grave consequences.

Mr Perriam referred to the following factors in *DMA-1* in relation to the nature of the concern:

> *'Whether the professional has in the past acted and/or is liable in the future to act so as to put a person receiving care at unwarranted risk of harm'*
>
> *'Whether the professional has in the past breached and/or is liable in the future to breach a fundamental tenet of the profession'*
>
> *'Whether the professional has in the past acted and/or is liable in the future to act dishonestly'*

Mr Perriam submitted that all three factors are satisfied in this case.

Mr Perriam reminded the panel of its overarching primary duty to protect the public and the wider public interest, which includes the need to declare and maintain proper

standards and maintain public confidence in the profession and in the NMC as its regulatory body.

Mr Perriam submitted that members of the public would be disturbed were a finding of impairment not made in a case of this nature, involving dishonesty and falsification of critical care records, misleading colleagues as well as widespread lack of competence, putting patients at risk of serious harm.

Mr Perriam invited the panel to find your fitness to practice currently impaired by reason of your misconduct and lack of competence on both public protection and public interest grounds.

In relation to strengthening of practice, Mr Wilkinson referred the panel to the positive references you have received that attest to your excellent skills as a carer and transferable nursing skills, as well as to the additional extensive evidence from Mr 1 who provided you with positive feedback in your current role and spoke of your good character.

In relation to the public interest, Mr Wilkinson submitted that taking into account your current role, the references and training undertaken independently by you, a member of the public may not demand a finding of impairment, however, this remains entirely the panel's decision.

Mr Wilkinson submitted that you have gone above and beyond what would ordinarily be expected. He submitted that this shows you are a professional driven to improve your practice. Taken together with the feedback provided in evidence by Mr 1, he submitted that there is that there is little to no risk of repetition.

Mr Wilkinson submitted that there is no evidence before the panel to show that you would currently place any patients at unwarranted risk of harm now or in the future.
In relation to the dishonesty found, he asked the panel to take account of the contextual factors set out in your reflective statements.

Mr Wilkinson submitted that you understand the gravity and impact of your past conduct and would dispute the assertion that you have provided insufficient evidence to address the root cause of your behaviour. Rather, your evidence was clear that you understand what dishonesty is and set out why honesty is important in the profession. He submitted the panel can be satisfied that if faced with a similar set of circumstances you would not act dishonestly in the future.

In relation to public interest, Mr Wilkinson submitted that a member of the public fully informed of all the information before the panel today, not only the findings on facts but also the details of your current role, the references provided and the training certificates of the courses you have independently undertaken, may not demand a finding of impairment on public interest, however it remains a matter for the panel.

Decision and reasons on lack of competence and/or misconduct

The panel accepted the advice of the legal assessor which included reference to the cases of *Mallon v GMC* [2007] CSIH 17, *Roylance* and *Grant* as well as to NMC guidance reference FTP-2b entitled 'Lack of competence'.

The panel had regard to the terms of the Code when determining whether Charges 1, 2, 3, 4, 5, 6, 7, 19a, 19b and 20 found proved amount to misconduct, and whether the charges found proved in respect of Charges 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18 amount to a lack of competence.

Misconduct

The panel considered whether the conduct found proved in Charges 1 – 5, 19a and 19b were so serious as to constitute misconduct. The panel determined that these five charges involved the failure on your part to carry out checks and / or observations on vulnerable patients, thereby placing them at potential risk of serious harm.

In relation to Charges 3, 4, 5, 19a and 19b, the panel found that you deliberately falsified records to cover up the fact that these checks and observations had in fact not been

carried out to the potential detriment of patients. The panel determined that individually and cumulatively, Charges 1 – 5, 19a and 19b met the threshold of seriousness for a finding of misconduct. The panel found the same level of seriousness for Charges 6,7 and 20, which describe the dishonesty involved in these falsified records.

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

> *'**1.2** make sure you deliver the fundamentals of care effectively*
>
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***3.1** pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> ***8.2** maintain effective communication with colleagues*
>
> ***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> ***8.5** work with colleagues to preserve the safety of those receiving care*
>
> ***8.6** share information to identify and reduce risk*
>
> ***10.1** complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> ***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

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*

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

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

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

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

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

Lack of competence

The panel then moved on to consider whether the facts found proved amount to a lack of competence. The panel had regard to the Code and identified sections which in its view amounted to a breach. The panel bore in mind that there was no burden or standard of proof at this stage. The panel had to reach its decision on lack of competence having regard to its own professional judgement.

The panel considered that Charges 8 – 18 spanned a significant period of time and relate to repeated wide-ranging failures, for which the potential to put patients at serious risk of harm was also concerning. The panel considered that the charges individually and collectively demonstrate an unacceptably low standard of performance judged by a fair sample of your work so as to call into question your competence to practise as a Band 5

nurse at that time. The panel noted the detailed and comprehensive action plans that had been put in place by your employer and your failure to make significant progress to be assessed as competent. There were several fundamental areas of nursing practice that you had been unable to demonstrate competence in.

The panel determined that there had been departures from the Code. It determined that you did not:

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

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

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

***4.2** make sure that you get properly informed consent and document it before carrying out any action*

***6.1** make sure that any information or advice given is evidence-based including information relating to using any health and care products or services*

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

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

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

***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

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

***18.2** keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

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

***19.3** keep to and promote recommended practice in relation to controlling and preventing infection*

***19.4** take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

***25.1** identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

In all the circumstances, the panel determined the facts found proved demonstrated a lack of competence.

Decision and reasons on impairment

Having found misconduct in relation to Charges 1 – 7, 19a, 19b and 20 and lack of competence in relation to Charges 8-18, the panel went on to consider whether your fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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.'*

Having regard to the conduct found proved in relation to the charges, the panel was satisfied that all four limbs of the *Grant* test are engaged in your case. Specifically, the panel identified that you have breached fundamental tenets of the nursing profession, namely honesty and your responsibility to protect vulnerable patients in your care.

In relation to Charges 8 – 18 and lack of competence, the panel was of the view that the concerns raised are potentially remediable. However, the concerns resulting from Charges 1 – 7, 19a, 19b and 20, in the panel's view are more difficult to remediate, in particular the charges relating to dishonesty, which give rise to potential attitudinal concerns.

The panel considered the following factors set out in the case of *Cohen:*

- Is the behaviour easily remediable?

The panel determined that your behaviour is not easily remediable as there appears to be a lack of understanding on your part as to your responsibilities and the impact your actions may have had on patients. You have said that your current interim conditions of practice

order has made it difficult for you to find a role in an environment to build up your skills. The panel determined that the added factor of dishonesty in seeking to cover-up your misconduct is difficult to remediate as trust has been broken.

- Has it already been remedied?

In its consideration of this factor, the panel had regard to your expressions of remorse and the extent to which you have shown insight into your past conduct. The panel considered your reflective statements but was of the view that it had incomplete evidence before it to show that the concerns have been remedied.

The panel noted that you have completed some training, and you have reflected on what has been learnt however, much of this training covers the basic fundamentals of nursing which should already have been evident in your practice. The panel was of the view that your misconduct and lack of competence contradict this theoretical knowledge and the application of this theory and skills has not been sufficiently tested since your interim conditions of practice order was introduced. This was because you had been unable to find a prolonged period of work as a registered nurse under the conditions of practice order. The panel acknowledged that you are clearly a kind and caring HCA however, you do not demonstrate competence as a registered nurse. The panel was therefore not satisfied that the concerns have been remediated.

Although dishonesty is addressed through reflection in your bundle, your reflections on dishonesty do not demonstrate full and in-depth insight into the dishonesty charges. The implications of falsifying documentation do not appear to have been clearly understood, nor is there clear acceptance of your responsibility of this dishonesty.

- Is it highly unlikely to be repeated?

In considering these issues the panel had regard to your expressions of remorse and the extent to which you have shown insight into your past conduct. The panel found your

insight to be lacking and was of the view that you do not truly understand or appreciate the gravity of your conduct in this case.

In your bundle, you described feeling unsupported and feeling ‘a strong sense of discrimination’ during the time of employment that the charges relate to. However, there is no evidence to suggest that this was the case and the panel found that extensive support had been implemented through the use of supervision, one-to-one mentorship and action plans during the period of employment in question. Furthermore, by your own admissions in your evidence bundle, you stated that you felt supported during this time and this was recorded contemporaneously.

The panel took into account that you are working to good effect in your current role as a HCA, however, it noted that this role is significantly different from the role you were performing as a Band 5 nurse where these concerns arose. Your evidence was that you were struggling at the relevant time to cope with the pressures and demands of the role of a Band 5 nurse. The panel had no evidence of remediation and could not be satisfied that you are now capable of safe and effective practice as a Band 5 nurse. It could not therefore exclude the possibility of similar conduct being repeated in the future.

The panel was satisfied that your fitness to practice is currently impaired on the ground of public protection.

The panel also determined that a finding of current impairment was also in the public interest. Given the seriousness of the conduct found proved and the potential to put patients at risk of harm, the panel concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Nurses are in a position of power and authority and will come into contact with those vulnerable people in society who need care the most. The panel determined that these concerns are related to critical patient and public safety. The extent of your misconduct,

lack of competence and the repeated nature of your actions over a prolonged period of time raise significant issues around public protection.

The panel determined the public confidence in the NMC as regulator would be damaged if it allowed this level of incompetence and misconduct to remain without any action being taken.

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

Sanction

The panel considered this case very carefully and 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 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 Churaman, on behalf of the NMC, invited the panel to impose a striking-off order and submitted that this does not include its finding with respect to lack of competence. She reminded the panel that the overarching objective is the protection of the public. She referred to NMC guidance (*SAN-1*) and submitted that the aggravating features in this case are an abuse of a position of trust, lack of insight into failings, a pattern of misconduct and other conduct which put people receiving care at risk of suffering harm. She further submitted that there are no mitigating features in your case.

Ms Churaman also referred to *SAN-2* and outlined the forms of dishonesty that are likely to call into question whether a registrant should be allowed to remain on the register. Ms

Churaman went on to address the sanctions available to the panel, starting with the least restrictive.

Ms Churaman submitted that taking no further action is rare and considering the panel's finding that you are impaired on both public protection and public interest grounds, and that your conduct would undermine public trust in the nursing profession, this would not be an appropriate sanction.

With regards to a caution order, Ms Churaman submitted that the guidance states that this is only appropriate if the case is at the lower end of the spectrum of misconduct and there is no risk to the public. She submitted that in view of the panel's finding, this would also not be an appropriate sanction.

In terms of a conditions of practice order, Ms Churaman submitted that the guidance states that this sanction may be appropriate if there is no evidence of general incompetence, no evidence of harmful, deep-seated personality or attitudinal problems and a potential and willingness to respond positively to training. She submitted that in this case, these do not feature therefore, a conditions of practice order is not appropriate.

Ms Churaman submitted that a suspension order is again not an appropriate sanction. She submitted that the guidance states that this sanction is only appropriate if there is a single instance of misconduct, no evidence of harmful, deep-seated personality or attitudinal problems and a registrant has insight and does not pose a significant risk of repeating the behaviour. She submitted that in your case, there were several instances of misconduct and by virtue of the panel's finding of dishonesty and your lack of insight, you pose a significant risk of repeating your behaviour.

Ms Churaman then moved on to a striking-off order and submitted that this is the only sanction available to the panel in light of its findings. She referred to the guidance which encourages panels to consider whether the regulatory concerns raise fundamental questions about a registrant's professionalism, if public confidence can still be maintained

if they are not struck off the register and if this is the only sanction that can protect the public and maintain professional standards.

Ms Churaman submitted that honesty, trustworthiness and the ability to deliver safe care effectively, as set out in the Code, are seriously deficient in your practice. She submitted that in light of the panel's findings, public confidence cannot be maintained if you were to remain on the register.

Ms Churaman submitted that a striking-off order is the only sanction sufficient to protect the public in this matter. She referred the panel to the case of *Parkinson v NMC* [2010] EWHC 1898 (Admin), in which the courts affirmed that a striking-off is appropriate where a registrant has demonstrated a lack of probity, honesty, or trustworthiness, even where there are no concerns regarding clinical skills or risk of harm. She submitted that in your case, the concerns are significantly more serious. Not only are there issues relating to your honesty and integrity, but there are also concerns regarding your clinical competence and there is a risk of harm to the public. She further submitted that a nurse found to have acted dishonestly is always going to be at severe risk of having their name erased from the register.

Turning to lack of competence, Ms Churaman submitted that a striking-off order cannot be imposed solely on the basis of lack of competence. She submitted that if the panel is not minded to impose a striking-off for misconduct, the next appropriate sanction would be a suspension order as a conditions of practice order would not be suitable in this case, for the reasons previously outlined.

Mr Wilkinson invited the panel to consider imposing a conditions of practice order for a duration of the panel's discretion. He submitted that if the panel considers this to be insufficient, the most serious sanction it should consider is a suspension order, to be reviewed after six months.

Mr Wilkinson submitted that in determining whether any sanction is appropriate, the panel must consider whether your practice requires restriction to protect the public, whether it is in the public interest or your own interests. He submitted that the panel should impose no

more than is necessary in this case. He submitted that while it is accepted that the allegations in this case are wide-ranging, spanning multiple areas of practice, they are practice-related concerns and are capable of remediation.

In relation to the dishonesty findings, Mr Wilkinson referred the panel to the case of *Lusinga v NMC* [2017] EWHC (Admin) 1458, which makes clear that not all dishonesty should be treated the same. He submitted that, when determining sanction, the panel should have a detailed consideration of the facts and any mitigating circumstances. In light of this, Mr Wilkinson submitted that a striking-off order is disproportionate. Further, he drew the panel's attention to the recently published sanction banding guidance from the Medical Practitioners Tribunal Service (MPTS), which he submitted may assist with the panel's assessment.

Turning to the charges found proved, Mr Wilkinson submitted that you have demonstrated insight through your oral and written evidence, as well as through the training you have undertaken, and you have shown a clear understanding of how your actions could have impacted patients and the potential for harm. He submitted that it is appreciated that the panel considers that further work is necessary in relation to aspects of dishonesty. He further submitted it is also accepted that the role of an HCA differs from that of a registered nurse. However, you have been unable to demonstrate improvements in your nursing practice due to your inability to secure nursing employment while subject to an interim conditions of practice order, which the panel has recognised.

Mr Wilkinson referred the panel to the case of *NMC v Persand* [2023] EWHC 3356 (Admin), which highlighted the 'double bind' faced by registrants who are subject to restrictive conditions that hinder their ability to obtain employment, thereby limiting their opportunity to demonstrate strengthened practice. He submitted that while the facts are not identical, you have made repeated efforts to secure substantive nursing work but have been unsuccessful, therefore you have undertaken extensive training and remediation and have secured work in a role with significant clinical crossover. He submitted that as an HCA, you have remained committed to working in healthcare.

Mr Wilkinson submitted that given the seriousness of the case, it is expected that the panel will find that no sanction or a caution order would be insufficient to protect the public

or satisfy the public interest. He submitted that in relation to a conditions of practice order, you have been subject to an interim conditions of practice since 20 November 2023, and those conditions have remained in place, with amendments to reflect training completed, and there has never been any suggestion of a breach. He submitted that while concerns regarding dishonesty remain, they fall at the lower end of the spectrum and do not reflect your true character.

Mr Wilkinson submitted that there is no evidence to suggest that you would act dishonestly in the future or fail to comply with a conditions of practice order. He submitted that you have been forthcoming with prospective employers about your interim conditions of practice order over the past two years. Mr Wilkinson suggested that a conditions of practice order mirroring the current interim conditions, which he outlined for the panel, could be imposed to address the identified areas of concern.

However, Mr Wilkinson submitted that if the panel considers that a conditions of practice order is not appropriate and that a suspension order is more suitable to protect the public or uphold the public interest, he reminded the panel that the maximum duration is 12 months, and that 12 months is not the standard. He submitted that to suspend your PIN would completely remove your ability to remediate and demonstrate development. He stated that even a six-month suspension would have significant implications for your career and would affect how you are perceived professionally.

Mr Wilkinson submitted that while the panel has the ability to impose a striking-off order, this would be disproportionate and unnecessarily archaic. He submitted that a striking-off order should only be considered in the most serious cases, such as those involving criminal convictions. He submitted that whilst cases involving dishonesty and clinical concerns may reach this level, where sufficiently serious, and a registrant has shown no insight or remorse, your case is not one of those cases.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be

punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put particularly vulnerable patients at risk of suffering harm.
- Wide ranging clinical concerns
- Dishonesty

The panel also took into account the following mitigating features:

- Early admissions to some of the facts
- Been forthright with prospective employers about interim conditions of practice order
- Undertaken training and provided written reflective accounts, albeit limited

The panel had regard to NMC guidance (*SAN-2*) which outlines types of dishonesty and how they can be categorised in terms of seriousness. The panel was of the view that your dishonesty was a direct risk to people receiving care and that you had deliberately breached the professional duty of candour by claiming to have completed observations which had not taken place, which places your dishonesty at the higher end of the spectrum.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection 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 considered that the clinical concerns in this case are wide-ranging and relate to both a pattern of dishonesty and extensive deficits in fundamental nursing skills. Although, there are identifiable areas of practice that could, in principle, be addressed through conditions, the panel noted that you have already been subject to an interim conditions of practice order for the past two years. The panel took account of the submissions of Mr Wilkinson that the interim order had limited your ability to work and therefore strengthen your practice. However, the panel also noted that prior to the interim order being imposed, you did not benefit from the retraining opportunities offered to you by your employer, as despite extensive mentorship and supervision, no discernible improvement was made. The panel identified attitudinal concerns, including a reluctance to accept responsibility for your actions and a pattern of dishonesty. Given the breadth of the competence concerns, the panel concluded that patients would remain at risk even if conditions were imposed. The panel was not satisfied that workable conditions could be formulated that would adequately protect the public. The panel decided that a conditions of practice order would not be sufficient or appropriate in light of the seriousness of the concerns, the limited insight demonstrated, and the risk of repetition.

The panel noted that the schedules of concerns refer to over 140 instances of lack of competence across a wide range of essential nursing skills. It noted that you had already received significant support through supervision and mentoring, yet the panel was not provided with any evidence of discernible or sustained improvement. The panel considered the scale and persistence of your failings indicate deeply embedded

competence issues that have not responded to intervention. The panel considered whether a condition in relation to working in a different nursing environment could be formulated. However, it noted that the competence concerns relate to fundamental areas of practice including documentation, medication administration, and infection control, which could arise in any clinical setting.

The panel was also particularly concerned about the attitudinal issues in this case, including a repeated pattern of dishonesty. Dishonesty is a serious departure from the standards expected of a registered nurse and undermines trust in the profession. The panel determined that there were no workable conditions to address the dishonesty.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered that your case involves serious misconduct, including dishonesty and significant lack of competence. The panel was of the view that there were multiple instances of misconduct and there was evidence of attitudinal problems, including a pattern of dishonesty. The panel noted that your insight remains limited, and the factors leading to misconduct and lack of competence are numerous and extensive. In addition, despite considerable support from your employer, there was no marked improvement in your clinical practice.

The panel concluded that there remains a risk of repetition and although there has been no repetition of the specific incidents, you have been subject to an interim conditions of practice order and you have only worked as a registered nurse for a brief period of time. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to mark the serious and persistent nature of your misconduct.

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel considered that 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 concluded that your actions raise fundamental questions about your professionalism and ability to practise safely and in accordance with the Code. The panel considered that you neglected your duty of candour and were found to have been dishonest on several occasions. Your dishonesty had the potential to mislead colleagues and adversely affect patient care.

The panel was of the view that public confidence in the nursing profession and in the NMC as its regulator, would be undermined if you were permitted to remain on the register. A reasonable member of the public would be seriously concerned by the wide-ranging nature of the charges, including dishonesty and falsifying observations that had not been carried out. The panel considered that the number and seriousness of the breaches of the Code, combined with the risk of harm arising from your misconduct and limited insight,

mean that no lesser sanction would adequately protect the public or uphold professional standards.

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 recognised that lack of competence in itself could not be a ground for making a striking-off order, as you have not been subject to a substantive conditions of practice order or a suspension order for a period of at least two years. However, the panel was satisfied that the misconduct in your case was in itself so serious that no sanction other than a striking-off order could be justified.

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 conduct 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 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 Churaman. She invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and otherwise in the public interest. She submitted that as the striking-off order will not take effect until after a 28-day appeal period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

Mr Wilkinson submitted that the panel's decision on sanction has been noted, but he invited the panel to consider imposing an interim conditions of practice order similar to the one that you are already subject to. He submitted that given your current situation and in light of the panel's determination, it is extremely unlikely that you will be working as a registered nurse therefore, to move from your current interim conditions of practice order to an interim suspension order would have little to no impact on the risk factors.

Mr Wilkinson also submitted that your current role as a HCA requires a Northern Ireland Social Care Council (NISCC) registration, and up until this time, you have been able to work in this role with your NMC PIN. He submitted that if an interim suspension order were to be imposed, you would not be able to return to work as a HCA pending an application to NISCC.

Mr Wilkinson submitted that it is conceded that the findings in this case are serious and the panel may consider imposing an interim suspension order. However, he invited the panel to take account of his submissions and the wider implications of an interim suspension order preventing you from not only working as a nurse, but in general.

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 sanction it has

imposed; namely a striking-off order and the reasons for that, and its findings and reasons on the facts, misconduct, lack of competence and impairment.

The panel took into account Mr Wilkinson's submissions. However, the panel determined that in view of its findings and reasons overall, only an interim suspension order would be consistent with its determination. This would be a proportionate response in the view of this panel. The panel determined that, in imposing an interim suspension order, the public would have the continuity of protection from harm, and the public interest would continue to be upheld. In the panel's judgement, these outweigh your own interests during the potential appeal period or the 28-day notice period.

The panel has therefore determined to impose an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.