Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 8 September 2025 – Tuesday, 16 September 2025
Monday, 12 January 2026 – Tuesday, 20 January 2026

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

Name of Registrant:	**Caroline Mary Hall**
NMC PIN:	76Y0739E
Part(s) of the register:	Registered Nurse - Adult (RN1) - 31 July 1979 Specialist Practitioner - District Nursing (SPDN) - 20 October 1989 Community Practitioner Nurse Prescriber (V100) - 27 June 1997 Specialist Practitioner – District Nursing (SPDN) – 20 October 1989 Specialist Practitioner - General Practice Nursing (SPGP) - 30 September 2003 Nurse Independent / Supplementary Prescriber (V300) - 24 June 2004
Relevant Location:	Leicester
Type of case:	Lack of competence
Panel members:	Derek Artis (Chair, Lay member) Karan Sheppard (Lay member) Catherine Devonport (Registrant member)
Legal Assessor:	John Donnelly (8 September 2025 – 16 September 2025)

	Elisabeth Acker (12 January 2026 – 20 January 2026)
Hearings Coordinator:	Ibe Amogbe (8 -11 September 2025, 15 -16 September 2025) Salima Begum (12 September 2025) Ifeoma Okere (12 January 2026 – 20 January 2026)
Nursing and Midwifery Council:	Represented by Ed Carey, Case Presenter
Miss Hall:	Present and represented by Aparna Rao, (instructed by the Royal College of Nursing)
Offer no evidence:	Charge 3b, Charge 4 Schedule 1 (7 March 2022 – **4.3**), Schedule 1 (26 April 2022 – **4.12**), Schedule 1 (Date Unknown – **4.14**), Charge 5 Schedule 2 (14 February 2022 – **5.5**) , Schedule 2 (15 February 2022 – **5.8**), and Schedule 2 (18 April 2022 – **5.15)**
Facts proved:	Charges 1a, 1b, 1c, 1d, 2b, 3a, 3c, 3d, 3e, Charge 4 Schedule 1 (7 March 2022 - **4.1**), Schedule 1 (7 March 2022 – **4.2**), Schedule 1 (18 April 2022 – **4.9**), Schedule 1 (18 April 2022 – **4.10**), Schedule 1 (26 April 2022 – **4.11**), Schedule 1 (26 April 2022 – **4.13**), Charge 5 Schedule 2 (1 February 2022 – **5.1**), Schedule 2 (1 February 2022 - **5.2**), Schedule 2 (10 February 2022 – **5.4**), Schedule 2 (14 February 2022 – **5.6**), Schedule 2 (14 February 2022 – **5.7**), Schedule 2 (15 February 2022 - **5.9**) ,

	Schedule 2 (24 February 2022 - **5.13**), Schedule 2 (24 February 2022 – **5.14**), 6a, 6b, 6c, and 6d
Facts not proved:	Charges 2a, 2c, 2d, 2e, Charge 4, Schedule 1 (18 April 2022 – Appointment 08:41- **4.4**), Schedule 1 (18 April 2022 – Appointment 09:05 - **4.5**) , Schedule 1 (18 April 2022 – Appointments 11:32 and 15:05 – **4.6**) , Schedule 1 (18 April 2022 – Appointment 12:19 – **4.7**), Schedule 1 (18 April 2022 – **4.8**) and Charge 5 Schedule 2 (1 February 2022 – **5.3**), Schedule 2 (21 February 2022 – **5.10**), Schedule 2 (21 February 2022 – **5.11**), Schedule 2 (21 February 2022 – **5.12**)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months) with review**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Carey to amend the wording of the heading of the charges.

The proposed amendment is a follows:

> *'That you, a Registered Nurse between October 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse ~~an Advanced Nurse Practitioner~~ without supervision, in that:*
>
> 1. *On 14 February 2022, in relation to Patient A, you:*
>   a. *Failed to identify symptoms of sepsis.*
>   b. *Failed to identify that urgent treatment was required.*
>   c. *Advised them to attend their GP.*
>   d. *Failed to make a direct referral to hospital.*
>
> 2. *On 21 February 2022, in relation to Patient B, you:*
>   a. *Failed to identify the severity of a large infected abscess.*
>   b. *Failed to recognise symptoms of osteomyelitis.*
>   c. *Failed to identify that urgent treatment was required.*
>   d. *Advised them to attend A&E.*
>   e. *Failed to make a direct referral to hospital.*
>
> 3. *On 15 February 2022, in relation to Patient C, you:*
>   a. *Failed to identify the risk of ketoacidosis in a diabetic patient.*
>   b. *Failed to identify and document symptoms of pancreatitis.*
>   c. *Failed to identify that urgent treatment was required.*
>   d. *Told them to make an appointment with their GP for further assessment.*
>   e. *Failed to make a direct referral to hospital or refer to A&E.*

4. *Failed to record information in patient medical notes as set out in **Schedule 1**.*

5. *Between 1 and 24 February 2022, inappropriately prescribed medication, as set out in **Schedule 2.***

6. *Failed to carry out adequate patient assessments on one or more occasions in that you:-*

    a. *failed to check past medical history;*
    b. *failed to check NICE or LMSG guidelines;*
    c. *failed to ask sufficiently probing questions;*
    d. *failed to conduct physical examination to an appropriate standard*

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

Mr Carey provided the panel with written submissions. He submitted:

'…

Submissions

1. *The NMC's application to amend the allegation is made primarily to reflect the evidence. At present, the Schedule of Charge is fundamentally flawed, as it implies that the Registrant worked as an ANP. This amendment is therefore necessary for the case to continue.*
2. *It is submitted that the amendments can be made without injustice to the Registrant:*
    a. *The Registrant has always known she was not working as an ACP/ANP;*
    b. *The amendment does not introduce new concerns but, rather, brings the focus to the more familiar standards of a Registered General Nurse; and*
    c. *The amendment does not increase the gravamen of the concerns.*

3. *The case of Holton v General Medical Council [2006] EWHC 2960 (Admin) is authority that performance is to be measured as against that expected of a reasonably competent practitioner of the same grade (nurse against nurse, surgeon against surgeon, specialist against specialist) in the job the registrant is actually doing. DHU Healthcare's Advanced Practitioner role is that role. The expectations of that role can be understood from the job description [CH/01] and live evidence.*

4. *It is submitted that, of the seven competency areas in the learning agreement [SH/02], all but one (prescribing) are competencies expected of all Registered General Nurses. Further, the Registrant was specifically accredited in prescribing, which is expressly identified in the job description, and the Registrant herself stated she was competent in this area in her self-assessment [SH/01].*

5. *There are strong public protection concerns in this case, where the Registrant is alleged to be deficient in her performance in several core nursing competency areas, and there is very limited insight shown from her. Considering the NMC's overriding objective, it is submitted that there is a risk the public would be inadequately protected, were the concerns to not be ruled upon.*

6. *The wider public interest is also engaged, as it's submitted a reasonable member of the public would be concerned and may lose confidence in the profession (and the NMC), were they to understand these concerns were not ruled upon purely on the basis that there was an error on the Schedule of Charge.*

Conclusion

7. *The Panel is invited to amend the Schedule of Charge in line with the proposed wording on the basis that the amendments are necessary, can be made without injustice and it would further the Overriding Objective.'*

Ms Rao adopted a neutral stance in relation to the application to amend the charges. She acknowledged the NMC's desire to clarify the role but submitted that the confusion now sought to be addressed should have been resolved earlier in the proceedings.

Ms Rao submitted that it is the NMC's responsibility to ensure that the charges are clear and well-defined from the outset. This includes articulating the nature of the allegations, your qualifications and the precise standards by which you are being assessed.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Nursing and Midwifery Rules 2004 (the Rules).

The panel was of the view that such amendments, as applied for, 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, as these clarify the charges. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charges (as amended)

That you, a Registered Nurse between October 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse without supervision, in that:

1. On 14 February 2022, in relation to Patient A, you:
    a. Failed to identify symptoms of sepsis.
    b. Failed to identify that urgent treatment was required.
    c. Advised them to attend their GP.
    d. Failed to make a direct referral to hospital.

2. On 21 February 2022, in relation to Patient B, you:
    a. Failed to identify the severity of a large infected abscess.
    b. Failed to recognise symptoms of osteomyelitis.
    c. Failed to identify that urgent treatment was required.
    d. Advised them to attend A&E.
    e. Failed to make a direct referral to hospital.

3. On 15 February 2022, in relation to Patient C, you:
    a. Failed to identify the risk of ketoacidosis in a diabetic patient.
    b. Failed to identify that urgent treatment was required.
    c. Told them to make an appointment with their GP for further assessment.
    d. Failed to make a direct referral to hospital or refer to A&E.

4. Failed to record information in patient medical notes as set out in **Schedule 1**.

5. Between 1 and 24 February 2022, inappropriately prescribed medication, as set out in **Schedule 2.**

6. Failed to carry out adequate patient assessments on one or more occasions in that you:
    a. failed to check past medical history;
    b. failed to check NICE or LMSG guidelines;
    c. failed to ask sufficiently probing questions;
    d. failed to conduct physical examination to an appropriate standard

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

Schedule 1

Date	**Concern Raised**
7 March 2022	Failed to note patient's medical history or consider symptom red flags.
7 March 2022	Failed to discuss a potential diabetic ketoacidosis patient with secondary care or consider further tests.
7 March 2022	Failed to follow guidelines to assess a potential DVT and note patient's medical history.
18 April 2022	Appointment 08.41 Failed to reference safeguarding concerns

18 April 2022	Appointment 09.05 Failed to ask patient about allergies, pregnancy and pre-medical history without prompting before completing a prescription.
18 April 2022	Appointment 11.32 and 15.05 (same patient) Failed to reference safeguarding concerns
18 April 2022	Appointment 12.19 Failed to reference safeguarding concerns
18 April 2022	Failed to document patient had upper abdominal pain
18 April 2022	Failed to take a full patient medical history relating to gastric reflux.
18 April 2022	Suggested prescribing terbinafine without escalating patient to a GP referral until prompted by supervisor.
26 April 2022	Failed to clean an infected finger wound.
26 April 2022	Failed to discharge a pregnant patient without senior input
26 April 2022	Diagnosed patient with gastroenteritis. Failed to consider red flags and NICE Guidelines for appendicitis. Failed to refer patient to A&E.
Date unknown	Failed to identify red flags associated with cauda equina syndrome and refer patient to Emergency department

Schedule 2

Date	**Prescription Audit**
1 February 2022	Inappropriately prescribed Amlodipine 5mg tablets
1 February 2022	Inappropriately prescribed Amoxicillin 250mg/5ml oral suspension
1 February 2022	Inappropriately prescribed Amoxicillin 500mg capsules. Unsuccessfully tried to cancel prescription. Failed to contact pharmacy to reject prescription.
10 February 2022	Inappropriately prescribed Phenoxymethylpenicillin 250mg tablets.

14 February 2022	Inappropriately prescribed Amoxicillin 500mg capsules.
14 February 2022	Incorrectly prescribed Nitrofurantoin 100mg modified-release capsules.
14 February 2022	Incorrectly prescribed Trimethoprim 50mg/5ml oral suspension
15 February 2022	Nitrofurantoin incorrect prescription.
15 February 2022	Incorrectly prescribed Sitagliptin 100mg tablets.
21 February 2022	Inappropriately issued Flucloxacillin 500mg capsules
21 February 2022	Appropriate need for antibiotic medication Flucloxacillin 500mg capsules. Incorrectly prescribed 3.5 days treatment
21 February 2022	Inappropriately prescribed for 3.5 days of Flucloxacillin 500mg capsules.
24 February 2022	Inappropriately issued Flucloxacillin 500mg capsules
24 February 2022	Inappropriately prescribed Phenoxymethylpenicillin 250mg/5ml oral solution.

Background

The charges arise from your employment as a registered nurse with DHU Healthcare, based at Oadby Urgent Care Centre from 1 November 2021.

On 7 March 2022, a clinical audit of your patient records from 4 December 2021, 4 January, and 4 February 2022 was undertaken. It is alleged the audit identified concerns including failure to confirm patient identification, medical history, and allergies. It also allegedly noted that you frequently did not identify or explore red flag differentials, your clinical notes were unstructured, and your practice did not align with evidence-based or local/NICE prescribing guidelines. Additionally, your safety netting advice often failed to address red flag symptoms appropriately.

A prescribing audit was subsequently carried out by the Prescribing and Medicines Safety Lead, reviewing 59 prescribing decisions made by you in February 2022. Of these, 25 were appropriate, 11 could not be assessed due to insufficient documentation, and 20

were considered inappropriate. Three incidents were of significant concern and recorded on the organisation's incident reporting system (Datix).

As a result, you were removed from independent practice on 21 March 2022 and your probation period was extended. On 24 March 2022, you were allegedly placed on a structured training plan, with a learning agreement developed in conjunction with HR and the clinical trainer. You were allegedly allocated mentors and given supervised practice. Further concerns were allegedly raised regarding your progress. At an assessment on 26 April 2022, you were found to have met only one of seven training objectives.

At a final probationary review meeting on 5 May 2022, it was determined that there had been no significant improvement. You were deemed to have failed probation and your employment was terminated.

The concerns were referred to the NMC on 13 May 2022.

Decision and reasons on the application to find no evidence

The panel heard an application made by Mr Carey to offer no evidence pursuant to Rule 24(7) of the Rules. The application related to Charge 3b and the following concerns raised in the schedules:

Schedule 1:

- 7 March 2022 - Failed to follow guidelines to assess a potential DVT and note patient's medical history.
- 26 April 2022 - Failed to discharge a pregnant patient without senior input
- Date unknown - Failed to identify red flags associated with cauda equina syndrome and refer patient to Emergency department

Schedule 2:

- 14 February 2022 - Inappropriately prescribed Amoxicillin 500mg capsules.

- 15 February 2022 - Nitrofurantoin incorrect prescription.

Having heard all the evidence at the close of the NMC's case, Mr Carey submitted that the evidence available could not establish, on the balance of probabilities, whether you had failed in relation to these matters.

This application was agreed by Ms Rao.

The panel accepted the advice of the legal assessor.

The panel determined that it was appropriate to grant the application. It was satisfied that, in the circumstances, it would not be fair or proportionate to pursue Charge 3b and the associated items in Schedules 1 and 2. The panel therefore determined that no evidence would be offered in relation to this charge, and there will be no findings made by the panel in relation to this charge when the panel considered its decision on facts.

Interim order

As the hearing did not conclude within the allocated dates, the hearing will adjourn until a further date, provisionally, 12 – 20 January 2026.

The panel invited counsel to make submission on an interim order.

Mr Carey submitted that he does not intend to make an application for an interim order.

Ms Rao submitted that she does not intend to make an application for an interim order.

The panel therefore did not consider imposing an interim order for the period of adjournment.

Resumption of the hearing on Monday 12 January 2026

The panel resumed consideration of the fact stage of the Fitness to practise hearing on Monday 12 January 2026. The panel noted that the case had previously been adjourned on Tuesday 16 September 2025 and that the hearing on 12 January 2026 was convened for the purpose of concluding the facts stage.

At this resumed hearing, the panel heard closing submissions from the NMC Case Presenter, Mr Carey, and from your representative, Ms Rao. The panel also took cognisance of the attendance of a new Legal Assessor, Mrs Acker, and a new Hearings Coordinator, Miss Okere, both of whom were present for the resumed hearing.

Following the conclusion of closing submissions, and having taken legal advice from the Legal Assessor in the presence of the parties, the panel retired to deliberate and make findings of fact in respect of the charges.

Decision and reasons on facts

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 Carey on behalf
of the NMC and by Ms Rao 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: Registered Nurse at the Centre;

- Witness 2: Registered Paramedic at the Centre at the time of the incidents;
- Witness 3: Registered Nurse at the Centre;
- Witness 4: Registered Paramedic at the Centre;
- Witness 5: Registered Pharmacist at the Centre.

The panel also heard evidence from you under affirmation.

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 Mr Carey and Ms Rao

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

Background to the facts

The panel considered this case following a referral to the Fitness to Practise Committee concerning a series of clinical encounters and prescribing decisions that occurred in early 2022 while you were practising in an urgent care setting.

The panel noted from the evidence and the hearing transcript that the allegations arise from a period during which you were working as a Registered General Nurse in an urgent care environment. However, per the amended charge and as agreed between the Mr Carey and Ms Rao, the standard we applied throughout was that of a Registered General Nurse, and not the higher standard applicable to an Advanced Nurse Practitioner. The panel recognised that urgent care settings can be characterised as challenging work environments.

The panel noted that concerns were identified following an internal audit of clinical consultations and prescribing activity. The audit reviewed a number of patient encounters over a defined period and highlighted potential issues relating to clinical reasoning, escalation, record-keeping, and prescribing practice. The panel noted that the audit material formed a significant part of the documentary evidence relied upon by the NMC and was explored in detail during the hearing.

The panel further noted that the allegations were particularised by reference to individual patients, identified in the charges as Patients A, B and C, and by reference to specific dates and consultation episodes. In addition, the panel noted that separate allegations related to record-keeping and prescribing practices were set out in Schedules appended to the charges.

The panel recorded that, during the course of the hearing, the scope of the allegations was refined. Certain matters were withdrawn or not proceeded with by consent, and the panel was expressly directed to consider only those allegations that remained live. In particular, the panel noted that some Schedule items were struck through on the evidence matrix and were not the subject of findings. The panel was careful to ensure that it did not make findings on any matters that had been withdrawn or were no longer pursued.

The panel were mindful that the charges had been amended to remove Charge 3b, the third 7 March 2022 entry in schedule 1, the second 26 April 2022 entry in schedule 1, the date unknown entry in schedule 1, the first 14 February 2022 entry in schedule 1, and the first 15 February 2022 entry in schedule 1 as matters that were no longer pursued by the NMC. For the avoidance of doubt, the panel put these now dormant charges from their mind during deliberation.

Therefore, Charge 3b (failed to identify and document symptoms of pancreatitis) was not considered as it was no longer in the charges. Original charge lettering 3(a),(c),(d), and (e) were considered. In their discussions and in this written determination, these charges were and are referred to by their original lettering to avoid confusion when cross referencing the evidence heard.

Following the withdrawal of Charge 3(b), the panel confirmed that it was required to determine the remaining elements of Charge 3 only. Accordingly, the panel proceeded to make findings in respect of Charges 3(a), 3(c), 3(d), and 3(e).

The panel made no findings in relation to Charge 3(b), and its consideration of Charge 3 was confined to the sub-charges identified above.

The panel heard oral evidence from witnesses called by the NMC, including evidence relating to audit findings, prescribing standards, safeguarding expectations, and record-keeping practice. The panel also heard your oral evidence and had regard to your explanations of the clinical context, your decision-making at the time of the consultations, and the systems and constraints within which you were working.

The panel noted that, throughout the hearing, the parties emphasised that the panel must not assess the case with the benefit of hindsight. The panel therefore reminded itself that its task was to assess the allegations by reference to what was known, or ought reasonably to have been known, at the time of each consultation, and to determine whether the NMC had discharged the burden of proving the allegations on the balance of probabilities.

The panel further reminded itself that not every error, omission, or instance of suboptimal practice amounts to a failure to demonstrate the standards of knowledge, skills and judgment required to practice as a Registered General Nurse. The panel also took into account the clinical environment, the scope of urgent care practice, and the distinction between differences in opinion, not complying with work policies and/or best practices on the one hand, and failing to demonstrate the standards of knowledge, skills and judgment required to practice as a Registered General Nurse. The panel approached the evidence with care, distinguishing between matters of clinical judgment, documentation quality, and allegations that asserted failures of competence or unsafe practice.

The panel approached the charges with particular care. It identified that the issues raised by the charges required careful separation of: (i) what you recognised at the time, (ii) what

was recorded in the consultation notes, and (iii) whether any identified shortcomings evidenced a failure of competence as alleged.

Against this background, the panel proceeded to consider the allegations set out in Charges 1 to 6, applying the relevant standard of proof and making findings on each element of the charges in turn.

Charge 1a

> "That you, a Registered Nurse between December 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse without supervision, in that:
>
> 1. On 14 February 2022, in relation to Patient A, you:
>
>   a. Failed to identify symptoms of sepsis."

This charge is found proved.

In reaching this decision, the panel first considered whether Patient A's presentation required active consideration of sepsis as a potential diagnosis.

The panel noted from the contemporaneous records that Patient A presented with symptoms consistent with infection. The panel accepted that not every infection will amount to sepsis and that sepsis can present in a non-specific manner. The panel was mindful of the evidence of Witness 5 heard during the hearing that diagnosing sepsis can be challenging, particularly in urgent care settings where clinicians are working under time pressure.

The panel placed weight on the evidence of Witness 5, whose audit identified that the combination of symptoms present at the consultation should have prompted consideration

of sepsis as a differential diagnosis. The panel were aware Witness 5 was not an expert witness; he was not put forward as one by the NMC. The panel found his evidence to be careful, measured, and focused on recognised clinical expectations relating to risk identification rather than retrospective diagnosis.

The panel considered your oral evidence that you did not believe Patient A was septic at the time. The panel accepted that this was your assessment at the time. The panel noted that the patient did not go on to suffer sepsis. However, the panel agreed that the absence of an adverse outcome did not demonstrate that you had adequately considered symptoms of sepsis at the time of the consultation.

The panel attached particular significance to the contemporaneous consultation notes. It noted that there was no documented consideration of sepsis, no recorded reasoning demonstrating that sepsis had been ruled out, and no safety-netting consistent with a potential risk of deterioration. The panel agreed that where a serious condition is foreseeable but not suspected, the clinical records would nonetheless be expected to demonstrate that it had at least been considered and excluded.

The panel therefore concluded that, on the balance of probabilities, you failed to identify symptoms of sepsis in Patient A.

Charge 1b

> "That you, a Registered Nurse between December 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse without supervision, in that:
>
> 1. On 14 February 2022, in relation to Patient A, you:
>
> b. Failed to identify that urgent treatment was required."

This charge is found proved.

The panel next considered whether you identified that Patient A required urgent treatment.

Having found Charge 1(a) proved, the panel considered that suspected sepsis is a condition which requires urgent escalation. The panel examined the management plan you put in place and noted that it did not include urgent referral, escalation to emergency services, or direct hospital assessment.

The panel acknowledged your evidence that you did not consider Patient A's condition to require urgent treatment. The panel determined that this assessment flowed directly from the failure to identify sepsis as a potential diagnosis.

The panel accepted the evidence heard during the hearing that where sepsis is within the differential diagnosis, the appropriate clinical response is to treat the situation as time-critical. The panel concluded that your actions did not demonstrate recognition of that urgency.

Accordingly, the panel found that you failed to identify that urgent treatment was required.

Charge 1c

> "That you, a Registered Nurse between December 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse without supervision, in that:
>
> 1. On 14 February 2022, in relation to Patient A, you:
>
> c. Advised them to attend their GP."

This charge is found proved.

The panel noted that it was not disputed that you advised Patient A to attend their GP.

The panel considered whether that advice was appropriate in the circumstances. The panel accepted that advising GP attendance can, in some circumstances, be an appropriate step. However, the panel determined that in the context of a presentation where sepsis should have been considered, GP attendance did not amount to appropriate escalation.

The panel rejected the suggestion that GP attendance could reasonably be characterised as urgent treatment in this scenario. The panel considered that such advice carried a risk of delay in assessment and intervention.

The panel therefore found that this element of the charge was proved.

Charge 1d

> "That you, a Registered Nurse between December 2021 and April 2022, failed to demonstrate the standards of knowledge, skills and judgement required to practise as a Registered General Nurse without supervision, in that:
>
> 1. On 14 February 2022, in relation to Patient A, you:
>
> d. Failed to make a direct referral to hospital."

This charge is found proved.

In reaching its decision, the panel considered whether you failed to make a direct referral to hospital.

The panel noted that no direct referral to hospital or emergency services was made. The panel accepted that there may be circumstances in which advising a patient to seek further care is sufficient. However, for the reasons already set out, the panel determined that this was not such a case.

The panel accepted Witness 5's evidence that where sepsis is a potential diagnosis, direct referral to hospital is the appropriate and expected course of action. The panel concluded that the absence of such a referral amounted to a failure to escalate appropriately.

Charge 2a

"2. On 21 February 2022, in relation to Patient B, you:

a. Failed to identify the severity of a large infected abscess."

This charge is NOT proved.

In reaching this decision, the panel first considered whether you failed to identify the severity of Patient B's large infected abscess.

The panel examined the consultation records and noted that you identified the presence of an abscess and recognised infection. The panel accepted that the contemporaneous documentation demonstrated that you engaged clinically with the presenting complaint and did not treat it as a minor condition. Your notes of the consultation indicate that you identified evidence of a large abscess which required transfer to A&E or secondary care.

The panel considered the evidence of Witness 5, who raised concerns about aspects of the overall management. However, the panel was careful to distinguish between criticism of management decisions and proof of the specific allegation that you failed to recognise severity. The panel determined that the allegation, as framed, required the NMC to prove that you did not appreciate the seriousness of what you were dealing with, rather than to prove that the management could have been better.

The panel assessed whether the documentary record, taken together with the oral evidence, demonstrated that you failed to recognise the severity. The panel concluded that it did not. The panel accepted that there may have been features of the case which should have prompted more comprehensive assessment and more clearly documented clinical reasoning. However, the panel was not satisfied that those concerns established that you failed to recognise the severity of the abscess itself.

The panel therefore concluded that the NMC had not discharged the burden of proof in respect of Charge 2(a).

Charge 2b

"2. On 21 February 2022, in relation to Patient B, you:

b. Failed to recognise symptoms of osteomyelitis.

This charge is found proved.

The panel next considered whether you failed to recognise symptoms of osteomyelitis.

The panel noted that Patient B had a relevant clinical history of osteomyelitis. The panel determined that this history was a material risk factor which altered the clinical context of the presentation. The panel considered that, where a patient presents with an infected lesion or abscess and has a known history of osteomyelitis, it is a foreseeable and clinically significant risk that osteomyelitis may recur or be relevant to the presentation, and that this risk should be actively considered.

The panel considered the evidence of Witness 5, who stated that, given the size and nature of the infected abscess and the patient's history, osteomyelitis should have been considered as part of the differential diagnosis and risk assessment. The panel did not treat Witness 5 as determinative on diagnosis. However, the panel found his evidence to be measured and directed to risk recognition and safe clinical reasoning, rather than retrospective diagnostic certainty.

The panel then examined the contemporaneous consultation notes. The panel noted that there was no documented indication that osteomyelitis was considered, explored, or ruled out. The panel also noted the absence of any recorded reasoning demonstrating why osteomyelitis was not thought relevant, despite the recorded history. The panel emphasised that the issue was not whether osteomyelitis ought to have been diagnosed in urgent care, but whether the risk created by the patient's history was recognised and addressed as part of safe clinical reasoning.

The panel considered your oral evidence and your position that you managed the presentation in line with what you considered clinically appropriate at the time. The panel accepted that this was your evidence. However, the panel determined that, on the balance of probabilities, the lack of any documented consideration of osteomyelitis, in the context of a patient with a known relevant history, demonstrated a failure to recognise osteomyelitis as a potential concern requiring further consideration.

The panel therefore concluded that Charge 2(b) was proved.

Charge 2c

"2. On 21 February 2022, in relation to Patient B, you:

c. Failed to identify that urgent treatment was required."

This charge is NOT proved.

The panel next considered whether you failed to identify that urgent treatment was required.

The panel reviewed the contemporaneous records and noted that you advised Patient B to attend A&E. The panel considered what this advice demonstrated about your appreciation of urgency. The panel determined that advising attendance at A&E is, in ordinary terms, an instruction to seek urgent assessment and treatment in an emergency setting.

The panel considered the submission that advising A&E attendance might not necessarily demonstrate that a clinician has identified urgency, particularly where other clinical reasoning is not well documented. However, the panel concluded that the act of directing the patient to A&E was, in itself, a recognition that urgent treatment and urgent assessment were required.

The panel was clear that it was not making a finding that the overall management was optimal. The panel also noted that it had found proved the discrete risk-recognition failing in Charge 2(b). Nevertheless, the panel concluded that the specific allegation in Charge 2(c) was not established, because the contemporaneous record of A&E advice contradicted the suggestion that you failed to identify urgency.

The panel therefore found that the NMC had not discharged the burden of proof in respect of Charge 2(c).

Charge 2d

"2. On 21 February 2022, in relation to Patient B, you:

d. Advised them to attend A&E."

This charge is not proved.

In reaching its decision, the panel then considered Charge 2(d), which alleged that you advised Patient B to attend A&E.

The panel noted that the contemporaneous records clearly documented that such advice was given. The panel determined that, because the allegation asserted that you advised A&E attendance, and because the records confirmed that you did so, the allegation as framed was not made out as a failing.

The panel therefore found Charge 2(d) not proved.

Charge 2e

"2. On 21 February 2022, in relation to Patient B, you:

e. Failed to make a direct referral to hospital."

This charge is found NOT proved.

In reaching this decision, the panel took into account whether you failed to make a direct referral to hospital.

The panel considered the distinction between: (i) advising a patient to attend A&E, and (ii) making a direct referral to hospital. The panel accepted that a direct referral was not made. The panel then considered whether, in the circumstances of this case, the absence of a direct referral, in addition to the A&E advice, amounted to the failing alleged.

The panel determined that where a patient is advised to attend A&E, the absence of a direct referral does not, of itself, demonstrate a failure to demonstrate the standards of knowledge, skills and judgment required to practice as a Registered General Nurse. The panel considered that the NMC would need to establish that a direct referral was required in addition to the A&E advice, and that failing to make such a referral amounted to a departure from acceptable standards. The panel concluded that the evidence did not establish this.

The panel therefore found that the NMC had not discharged the burden of proof in relation to Charge 2(e).

Charge 3a

"3. On 15 February 2022, in relation to Patient C, you:

a. Failed to identify the risk of ketoacidosis in a diabetic patient.

This charge is found proved.

In reaching its decision, the panel noted that Patient C was a known diabetic. The panel considered that this was a material risk factor which required heightened clinical vigilance, because a diabetic patient presenting with symptoms which could indicate a metabolic decompensation would require urgent assessment and escalation even where a definitive diagnosis cannot be reached in urgent care.

In considering whether diabetic ketoacidosis should have been identified as a risk, the panel placed weight on the oral evidence of Witness 5, who explained during the hearing that the combination of symptoms should have prompted consideration of ketoacidosis as a potential diagnosis. During questioning, it was put to you that the audit finding stated:

"you failed to discuss a potential diabetic ketoacidosis patient with secondary care or consider further tests."

The panel noted your oral evidence and the submissions provided by Ms Rao, in which she highlighted your position that type 2 diabetes rarely develop ketoacidosis and ketones can be present in a person's urine if they are dehydrated, a position the with which Witness 5 agreed.

The panel carefully considered this evidence. The panel determined that the issue was not whether you were required to make a definitive diagnosis or perform a particular test, but whether the risk of diabetic ketoacidosis was identified and addressed as part of safe clinical reasoning. The panel examined the contemporaneous consultation notes and noted that there was no documented consideration of ketoacidosis, no documented reasoning for discounting it, and no recorded escalation or safety-netting consistent with a serious metabolic risk.

Thee panel noted that where a patient is known to be diabetic and presents with symptoms capable of indicating a serious metabolic complication, the consultation record would be expected to reflect that such a risk had been considered, explored, and either acted upon or appropriately excluded. The panel determined that your assertion as to the absence of ketoacidosis was not supported by any contemporaneous documentation demonstrating clinical reasoning to that effect.

The panel therefore concluded that, on the balance of probabilities, you failed to identify the risk of diabetic ketoacidosis.

Charge 3c

"3. On 15 February 2022, in relation to Patient C, you:

c. Failed to identify that urgent treatment was required."

This charge is found proved.

The panel next considered whether you failed to identify that urgent treatment was required.

Having found Charge 3(a) proved, the panel considered that suspected diabetic ketoacidosis is a medical emergency requiring urgent assessment and intervention. The panel examined your management plan and noted that it did not involve urgent escalation to emergency or secondary care.

The panel accepted that you did not regard the presentation as urgent at the time. The panel concluded that this conclusion flowed directly from the failure to identify diabetic ketoacidosis as a potential risk requiring consideration. The panel further determined that, in the absence of escalation, referral, or safety-netting consistent with urgency, your actions did not demonstrate recognition of the need for urgent treatment.

Charge 3d

"3. On 15 February 2022, in relation to Patient C, you:

d. Told them to make an appointment with their GP for further assessment."

This charge is found proved.

The panel noted that you advised Patient C to make an appointment with their GP.

The panel considered whether this advice constituted appropriate escalation in the circumstances. The panel concluded that GP follow-up did not amount to appropriate escalation where urgent assessment was required and that such advice carried a risk of delay in diagnosis and treatment. The panel determined that the advice given was inconsistent with the level of urgency required where diabetic ketoacidosis should have been considered.

Charge 3e

"3. On 15 February 2022, in relation to Patient C, you:

e. Failed to make a direct referral to hospital or refer to A&E."

This charge is found proved.

In reaching this decision, the panel noted that no direct referral to hospital or A&E was made.

The panel considered whether such a referral was required. For the reasons already set out in relation to Charges 3(a) and 3(c), the panel determined that escalation to emergency or secondary care was required. The panel concluded that the failure to make such a referral amounted to a failure to escalate appropriately.

Charge 4

"4. Failed to record information in patient medical notes as set out in:

Schedule 1 (7 March 2022 - Failed to note patient's medical history or consider symptom red flags)."

The charge is found proved.

In reaching its decision, the panel considered the audit evidence and the contemporaneous consultation records relating to this consultation.

The panel accepted the evidence of Witness 3 that the consultation notes did not record key elements of the patient's medical history and did not demonstrate consideration of red-flag symptoms. Witness 3 also explained that where red flags are not documented, it is not possible for a reviewing clinician to determine whether those risks were considered and appropriately excluded.

The panel emphasised that this was not a criticism of the style or length of the notes, but of their substance. The panel considered that red-flag assessment is a core element of safe clinical reasoning and that the absence of any documented engagement with red-flag symptoms undermined confidence in the safety of the assessment.

The panel concluded that, on the balance of probabilities, the consultation record failed to demonstrate adequate consideration of the patient's medical history and symptom red flags.

"4. Failed to record information in patient medical notes as set out in:

Schedule 1 (7 March 2022 - Failed to discuss a potential diabetic ketoacidosis patient with secondary care or consider further tests)."

The charge is found proved.

The panel considered this allegation in light of the contemporaneous consultation notes and the audit findings. The panel reviewed the audit material and patient record.

The panel noted that the records did not demonstrate any discussion with secondary care or consideration of further investigations where diabetic ketoacidosis was identified as a potential concern in the audit.

During cross-examination, you addressed this issue directly, stating:

“I would agree that a different method of testing… is more accurate… Despite what I’ve just said, yes… I was under no obligation to do a blood sugar.”

The panel carefully considered this evidence. The panel determined that the issue was not whether you were under a strict obligation to carry out a specific test, but whether the records demonstrated that the risk of diabetic ketoacidosis had been considered and that options for escalation or further testing had been actively evaluated.

The panel concluded that, while escalation or further testing may not be required in every case, where a serious metabolic risk is foreseeable and possible, the records would be expected to demonstrate that those options were considered and, if not pursued, why they were discounted. The absence of any such documentation amounted to a failure of record-keeping.

> “4. Failed to record information in patient medical notes as set out in:
>
> Schedule 1(18 April 2022 – Appointment 08:41
> Failed to reference safeguarding concerns)”

The charge is found NOT proved

The panel considered the contemporaneous consultation record. The panel was not made aware of any actual safeguarding concerns in relation to this charge.

During cross-examination, you accepted that safeguarding was not recorded, stating:

"No, I haven't… I haven't written in the records 'safeguarding considered'."

The panel was satisfied that reference to consideration of safeguarding was not included in the records. It therefore went on to consider whether such an admission amounted to a failure as required by the stem of the charge in this case.

The panel accepted the evidence of Witness 1, who explained that best practice is to record that safeguarding has been considered, even where no concerns are identified and particularly where features of the consultation make safeguarding a relevant consideration.

The panel noted that it had not been provided with any written policy or guidance requiring clinicians to document "no safeguarding concerns". The panel discussed whether not reaching the level of best practice (in the circumstances of no policy outlining or requiring that best practice) amounted to a failure to demonstrate the standards of knowledge, skills and judgment required of a Registered General Nurse. The panel considered that what happened was not best practice but it was not such a failure.

> "4. Failed to record information in patient medical notes as set out in:
>
> Schedule 1(18 April 2022 – Appointment 09:05)
> Failed to ask patient about allergies, pregnancy, and pre-medical history before completing a prescription"

This charge is found NOT proved.

The panel carefully examined the evidence of Witness 1, consultation notes and the transcript evidence. The panel also distinguished between suboptimal documentation and the specific allegation that you failed to ask these questions at all.

The panel noted that there was evidence that some of these matters were addressed during the consultation, albeit prompted and not recorded in a structured or comprehensive manner. Witness 1 accepted during cross examination that potentially she had intervened and prompted before you had the opportunity to ask the questions.

The panel concluded that therefore the charge is not proved.

"4. Failed to record information in patient medical notes as set out in:

Schedule 1(18 April 2022 – Appointments 11:32 and 15:05 (same patient))
Failed to reference safeguarding concerns"

This charge is found NOT proved.

The panel considered the records for both appointments. The panel was not made aware of any actual safeguarding concerns in relation to this charge.

The panel noted that the evidence was inconsistent as to whether safeguarding considerations were applicable to these consultations and whether any safeguarding issues arose that required documentation. The panel also noted the absence of clear evidence demonstrating that safeguarding should necessarily have been addressed in these encounters.

Applying the burden of proof, the panel was not satisfied that the NMC had established this allegation.

"4. Failed to record information in patient medical notes as set out in:

Schedule 1(18 April 2022 – Appointment 12:19)

Failed to reference safeguarding concerns”

This charge is found NOT proved.

The panel was not made aware of any actual safeguarding concerns in relation to this charge. The panel reviewed the consultation record. In your oral evidence, you stated:

“No… if I had safeguarding concerns, I would have explored that with the patient and written it down.”

The panel noted that it had not been provided with any written policy or guidance requiring clinicians to document “no safeguarding concerns” in every consultation. The panel discussed whether a failure to document safeguarding on every occasion amounted to unacceptably low performance and concluded that, in the absence of a policy, it did not.

Applying the burden of proof, the panel concluded that this allegation was not proved.

“4. Failed to record information in patient medical notes as set out in:

Schedule 1(18 April 2022)
Failed to document patient had upper abdominal pain”

This charge is found NOT proved.

In reaching its decision, the panel reviewed the contemporaneous consultation notes.

The panel noted that the records included reference to soreness around the upper abdominal area and ribs associated with coughing. The panel considered this entry and determined that the symptom was recorded, albeit not in ideal terms.

The panel therefore concluded that the allegation that upper abdominal pain was not documented was not made out.

"4. Failed to record information in patient medical notes as set out in:

Schedule 1(18 April 2022)
Failed to take a full patient medical history relating to gastric reflux"

This charge is found proved.

The panel considered the consultation notes and noted that they did not demonstrate a full medical history relating to gastric reflux. The panel also took into account that in your live evidence, you stated that you felt that the patient's condition was something her own GP needed to follow up on. You also said you were satisfied that you got the amount of information you needed to safety net the patient and let her go. However, Witness 1 gave evidence and stated that this was a clear example of you not correctly probing a patient's history whilst conducting your assessment.

The panel determined that without clear documentation, it was not possible to understand the clinical reasoning that underpinned the management plan. The panel concluded that this omission went beyond poor style and amounted to a substantive failure of record-keeping.

"4. Failed to record information in patient medical notes as set out in:

Schedule 1(18 April 2022)
Suggested prescribing terbinafine without escalating patient to a GP referral until prompted by supervisor"

This charge is found proved.

The panel took into account your oral evidence that you did intend to refer the patient to the GP but you were interrupted by Witness 1 before you could do that.

The panel considered the evidence of Witness 1, who explained the risks associated with prescribing terbinafine and the importance of appropriate escalation and monitoring.
The panel accepted her evidence that the initial suggestion to prescribe terbinafine was not documented alongside any evidence of escalation and that escalation occurred only after prompting by a supervisor. the panel concluded that the records did not demonstrate appropriate clinical reasoning or timely escalation at the point the prescribing decision was first contemplated.

> “4. Failed to record information in patient medical notes as set out in:
>
> Schedule 1(26 April 2022)
> Failed to clean an infected finger wound”

This charge is found proved.

The panel examined the consultation notes and accepted the evidence that the records did not document cleaning of the wound. In your evidence , you admitted not cleaning the wound and you admitted you saw a sign of infection. Witness 2 said this should have been cleaned as you had identified infection and prescribed antibiotics.

The panel determined that, in the absence of documentation, it could not be satisfied that this essential step had been undertaken. The panel concluded that this amounted to a failure of record-keeping.

> “4. Failed to record information in patient medical notes as set out in:
>
> Schedule 1(26 April 2022)
> Diagnosed patient with gastroenteritis; failed to consider red flags and NICE guidance for appendicitis; failed to refer patient to A&E”

This charge is found proved.

The panel considered the Schedule 1 allegation that on 26 April 2022 you diagnosed a patient with gastroenteritis, failed to consider red flags associated with appendicitis, failed to engage with relevant NICE guidance, and failed to refer the patient to A&E.

In determining this allegation, the panel considered the contemporaneous consultation record, the audit evidence relied upon by the NMC, the oral evidence of Witness 1 and Witness 5, your oral evidence, and the hearing transcript.

The panel noted from the contemporaneous records that the patient presented with abdominal symptoms which were capable of indicating a serious underlying condition. The panel accepted that gastroenteritis can be an appropriate working diagnosis in some cases. However, during deliberations, the panel emphasised that abdominal presentations require careful consideration of red flags, including those associated with appendicitis, and that NICE guidance exists precisely to assist clinicians in identifying when escalation is required.

The panel attached weight to the evidence of Witness 5, who explained that the consultation notes did not demonstrate any engagement with appendicitis red flags or NICE guidance. In the hearing, this concern was articulated clearly, and it was emphasised that the absence of such documentation meant that a reviewing clinician could not determine whether appendicitis had been considered and excluded as part of the clinical reasoning process.

The panel noted that there was no recorded abdominal examination sufficient to exclude appendicitis, no documented reasoning addressing why appendicitis was not considered, and no reference to NICE guidance relevant to acute abdominal pain. The panel further noted that there was no documented safety-netting or escalation plan consistent with the risk profile of the presentation.

In your oral evidence, you explained your reasoning for diagnosing gastroenteritis and did not accept that escalation was required at the time. The panel accepted that this was your

genuinely held view. However, during deliberations, the panel determined that the issue was not whether gastroenteritis could have been a possible diagnosis, but whether the records demonstrated safe clinical reasoning in excluding more serious causes of abdominal pain.

The panel concluded that the failure to document consideration of appendicitis red flags, the absence of any recorded engagement with NICE guidance, and the lack of referral to A&E meant that the consultation record did not demonstrate a safe or defensible clinical decision-making process.

The panel further concluded that this was not a matter of stylistic documentation, but a substantive failure to record essential elements of assessment and escalation in a presentation where serious pathology required active consideration.

Accordingly, the panel determined that, on the balance of probabilities, you failed to consider red flags and NICE guidance for appendicitis and failed to refer the patient to A&E.

Charge 5

> "5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> Schedule 2 (1 February 2022
> Inappropriately prescribed Amlodipine 5mg tablets) "

The charge is found proved.

The panel first considered the allegation that you inappropriately prescribed amlodipine 5mg tablets. The panel considered the consultation record, the prescribing entry, the audit materials, and the oral evidence given about what

would be expected before initiating long-term antihypertensive therapy in an urgent care context.

The panel attached weight to the oral evidence addressing the basis for the criticism of this prescription, which was the presence of only a single documented blood pressure reading. The panel noted the explanation given that a single reading may reflect transient elevation (including “white coat” hypertension), and that, under normal circumstances, at least a second reading is expected, followed by home monitoring where appropriate, before commencing treatment. In the transcript, the pharmacist witness explained (in substance) that the concern was “only one blood pressure reading” and that the appropriate approach would ordinarily be to take at least two readings and then advise home monitoring to obtain a reliable picture.

The panel also considered your oral evidence (as captured within the transcript passages addressing this item), including your acknowledgement that time constraints in a short appointment can affect the ability to take multiple readings “properly”. The panel noted the recorded exchange in which it was put to you that you accepted you did not always do blood pressure readings properly within 15-minute appointment times, and you responded:

“That’s correct, yes, because really, if you’re going to take several blood pressures, they should really be done correctly if you’re leaving five minutes between them.”

The panel then considered the relevance of documentation. The panel noted that the evidential focus for this allegation was not whether there might have been additional readings taken, but whether the record demonstrated the basis for initiating amlodipine. In deliberations, the panel considered that if a clinician relies on additional readings, those readings (or the reasoning derived from them) must be recorded so that another clinician can understand why a long-term antihypertensive was started and to ensure continuity and safety of care. The panel therefore determined that the documented record did not demonstrate an adequate basis for initiating amlodipine and that the prescription fell below acceptable prescribing standards.

"5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;

1 February 2022
Inappropriately prescribed Amoxicillin 250mg/5ml oral suspension"

The charge is found proved.

The panel next considered the allegation that you inappropriately prescribed amoxicillin 250mg/5ml oral suspension. The panel considered the consultation record and the prescribing entry alongside the audit critique, and it also considered the narrative within the transcript which explored the context of prescribing antibiotics for a child and the question of whether the clinical picture supported bacterial infection requiring antibiotic therapy.

The panel noted that in your evidence you stated that you prescribed Amoxicillin due to the high temperature of the child and pressure from the child's parents.

The panel noted that the case was explored in evidence by reference to the consultation notes (including the documented examination findings) and the wider principles of antimicrobial stewardship. The panel took into account the concerns recorded in the audit materials (as reflected in the draft you provided) that the prescription did not align with local antimicrobial guidance and that the clinical indication for antibiotic prescribing was not clearly documented. The panel considered that where the documented assessment points towards a viral presentation, prescribing an antibiotic requires clear justification, and the absence of such justification undermines safe prescribing.

The panel also considered the evidence about process and governance: that where the documented clinical picture does not meet guidance-based thresholds, a prescriber should either follow guidance (including non-antibiotic management and safety netting) or document a clearly reasoned basis for deviation. The panel determined that the record did

not contain sufficient justification for antibiotic prescribing in this instance, and it concluded that the prescription was inappropriate.

> "5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 1 February 2022
> Inappropriately prescribed Amoxicillin 500mg capsules; unsuccessfully tried to cancel prescription; failed to contact pharmacy"

The charge is found NOT proved.

The panel then considered the allegation relating to amoxicillin 500mg capsules, which included both (a) the initial issuing of an incorrect formulation, and (b) the steps taken (or not taken) to cancel and prevent dispensing.

The panel first addressed the factual question of how the error occurred and what steps were taken. The panel noted the evidence in the transcript that the incorrect selection occurred through the electronic prescribing system, where multiple options appear and an incorrect item can be selected inadvertently. In the transcript, you explained:

"Well, it happens to us all from time to time because when you go into your electronic prescribing system, you pick from several lists of – you put in amoxicillin and several options will come up and I must have just pressed the wrong one."

You further explained:

"Then realised it immediately and cancelled it and then prescribed the correct dose."

The panel then considered the cancellation mechanism and whether contacting the pharmacy was required. The panel noted the transcript evidence that the cancellation could be carried out within the electronic system itself. The panel particularly noted the exchange where it was put to you (by reference to the evidence of the pharmacist witness) that cancellation on the system cancels the prescription, and you agreed:

“Yes. I think I cancelled it on the system, yes.” It was then put to you that you do not need to contact anyone because the system cancels it, and you answered:

“No, I didn’t think that I had to contact anybody, no.”

The panel noted that it was also recorded that the pharmacist witness did not take issue with the fact of the mistake being cancelled, and that the concern was focused on the appropriateness of antibiotic prescribing itself.

The panel also noted the contemporaneous reference in the transcript to the issuing and destruction of a token: *“Token destroyed, not sent to a chemist”.* The panel considered that this supported your position that you took steps consistent with preventing the incorrect prescription being dispensed.

In deliberations, the panel distinguished between (i) an error in selection within an electronic system, promptly identified and cancelled, and (ii) a failure to take reasonable steps to prevent dispensing once an error is recognised. The panel determined that the evidence did not establish, on the balance of probabilities, that you failed to take reasonable steps to cancel or that you were required to contact the pharmacy over and above system cancellation in the circumstances of this case.

> “5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 10 February 2022
> Inappropriately prescribed Phenoxymethylpenicillin 250mg tablets”

The charge found proved.

The panel considered the allegation that you inappropriately prescribed phenoxymethylpenicillin 250mg tablets. The panel had regard to the prescribing record

and the evidence addressing the relevant guidance framework (including the use of a scoring system to guide antibiotic prescribing and the circumstances in which a delayed prescription might be appropriate).

The panel noted that, within the deliberations material, there was specific reference to your oral evidence about your mindset when prescribing in sore throat cases, including the statement that you had a fear of missing the strep throat.

The panel considered that this was relevant because it tended to show an anxiety-driven prescribing rationale which must still be anchored to guidance and clinical indicators, rather than fear of missing a diagnosis.

The panel also noted the discussion recorded in the deliberations material about the scoring approach: that where the score is low (for example, a score of 1), guidance would not support immediate antibiotics, and the rationale for antibiotics (including delayed antibiotics) must be clearly justified. The panel considered that the core question was whether the prescription met the guidance threshold, or whether there was documented clinical reasoning to support deviation.

Taking the evidence as a whole, the panel determined that the prescription did not meet the criteria set out in local guidance and that there was no documented clinical rationale for deviation. The panel concluded that the prescription was inappropriate.

> “5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 14 February 2022
> Incorrectly prescribed Nitrofurantoin 100mg modified-release capsules”

The charge is found proved.

The panel considered the allegation that on 14 February 2022 you incorrectly prescribed Nitrofurantoin 100mg modified-release capsules.

In determining this allegation, the panel considered the contemporaneous consultation record, the prescribing entry, the prescribing audit evidence of Witness 5, your oral evidence, and the hearing transcript.

The panel noted that the prescribing audit identified this prescription as not compliant with local antimicrobial guidance. During the hearing, Witness 5 explained that the concern related not merely to the act of prescribing Nitrofurantoin, but to the formulation and regimen selected, which did not accord with the applicable guidance for the clinical presentation.

During oral evidence, the issue was put squarely to you. You accepted that the prescription was for modified-release Nitrofurantoin and that this was the formulation selected at the time. The panel noted that you did not dispute that local guidance specified a different formulation and/or regimen in these circumstances.

The panel attached weight to the explanation given by Witness 5 in the transcript, where he stated that adherence to local antimicrobial guidance is essential to safe prescribing, particularly in the context of urinary tract infections, and that errors in formulation or regimen can undermine treatment effectiveness and contribute to antimicrobial resistance. In evidence, he explained that modified-release Nitrofurantoin is not interchangeable with other formulations and must be prescribed strictly in accordance with guidance.

The panel noted that the transcript reflected a clear distinction being drawn between an understandable clinical error and a prescribing decision that falls outside accepted standards. The panel recorded that Witness 5 did not suggest that the error was deliberate, but that it nonetheless constituted incorrect prescribing. The panel considered that the purpose of the allegation was not to attribute motive, but to assess whether the prescribing met accepted standards.

The panel then considered your oral evidence in response to this allegation. You did not suggest that the prescription complied with guidance, nor did you identify any documented clinical reasoning explaining a justified deviation from guidance. The panel noted that no such justification was recorded in the contemporaneous notes.

During deliberations, the panel emphasised that Nitrofurantoin prescribing requires careful attention to formulation, dose, and regimen, and that where guidance is not followed, the records must demonstrate why. The panel determined that, in the absence of any documented reasoning supporting the prescription as issued, it could not be satisfied that the prescribing decision met accepted professional standards.

The panel concluded that the evidence established that the Nitrofurantoin 100mg modified-release capsules were incorrectly prescribed on 14 February 2022.

> “5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 14 February 2022
> Incorrectly prescribed Trimethoprim 50mg/5ml oral suspension”

This charge is found proved.

The panel took into account the contemporaneous consultation record.

In determining this allegation, the panel considered the contemporaneous consultation notes, the prescribing entry, the prescribing audit evidence of Witness 5, your oral evidence, and the hearing transcript.

The panel noted that the prescribing decision was tested in evidence by reference to local antimicrobial guidance and the principles of antimicrobial stewardship. The panel attached weight to the evidence of Witness 5, who explained that the choice of antibiotic and the

duration prescribed did not align with local guidance for the treatment of urinary tract infection in a child, and that first-line treatment in that locality was different.

During the hearing, Witness 5 explained the importance of resistance patterns in determining appropriate antibiotic choice and cautioned against reliance on past effectiveness. In the transcript, he stated:

“Just because trimethoprim worked in the past, under no circumstances does it mean it will work now, especially given the resistance patterns to it.”

He further explained that local antimicrobial guidance is driven by regional resistance patterns and that, for this age group and presentation, trimethoprim would not ordinarily be first-line treatment.

The panel then considered your oral evidence explaining why trimethoprim was prescribed in this instance. The panel noted your account that the prescribing decision was influenced by the child’s history, including allergies and previous tolerability issues described by the parent. The panel noted the transcript passage in which you stated:

“The reason why I gave this child trimethoprim was definitely on the history.”

The panel accepted that a patient’s history, including previous antibiotic intolerance, is a relevant clinical consideration. However, during deliberations, the panel assessed whether this explanation amounted to a properly reasoned and documented justification for departing from clear local first-line guidance in a child, particularly in the context of known resistance patterns.

The panel determined that antimicrobial stewardship requires more than reliance on historical antibiotic use or prior effectiveness. Where local guidance is clear and is informed by resistance data, and where deviation from that guidance is contemplated, the panel considered that the contemporaneous record would be expected to demonstrate:

- the specific reason for deviation,
- the alternative treatments considered,
- an assessment of the risks and benefits, including resistance considerations, and
- a clear plan for review or follow-up.

The panel noted that the consultation record did not contain sufficiently clear documentation addressing these matters. The panel concluded that, taken as a whole, the evidence established that the choice of trimethoprim and/or the duration prescribed fell outside the expectations of local antimicrobial guidance for this presentation and age group and was not supported by adequately documented clinical reasoning.

Accordingly, the panel determined that this prescribing decision did not meet accepted prescribing standards.

> "5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 15 February 2022
> Incorrectly prescribed Sitagliptin 100mg tablets"

The charge is found proved.

The panel considered the allegation that on 15 February 2022 you incorrectly prescribed Sitagliptin 100mg tablets.

In determining this allegation, the panel considered the contemporaneous consultation record, the prescribing entry, the audit evidence of Witness 5, your oral evidence, the submissions made on your behalf, and the hearing transcript.

The panel noted that the clinical context for this prescribing decision involved a diabetic patient presenting with features that raised concern for diabetic ketoacidosis. The panel

was mindful that the allegation did not assert that Sitagliptin was inherently unsafe in all circumstances, but that its prescription in this clinical context was inappropriate.

The panel attached particular weight to the oral evidence of Witness 5, who explained that Sitagliptin is a slow-acting medication which does not reduce blood glucose in the short term and therefore has no role in the acute management of a patient at risk of ketoacidosis. In the transcript, Witness 5 stated:

“Sitagliptin will do nothing to reduce a high blood glucose level in the short term. It can take anything up to 24 weeks before it actually affects long-term blood sugar, and it’s certainly not a drug we would use to quickly reduce blood sugar.”

The panel carefully considered your oral evidence and the submissions advanced on your behalf, in which it was suggested that Witness 5 had accepted that continuing Sitagliptin would not cause harm or interfere with hospital treatment. The panel examined that evidence in its full context and noted that, when pressed on this point, Witness 5 did not retract his criticism. When asked whether he wished to revise his view, he responded:

“No, I wouldn’t, because we’re ignoring the fact that we’ve got plus three ketones and plus four glucose in the urine.”

During deliberations, the panel determined that the absence of immediate harm was not determinative. The panel concluded that prescribing must be assessed by reference to appropriateness and clinical utility in the circumstances. The panel found that prescribing a medication which could not address the acute metabolic risk, and which NICE guidance indicates is contraindicated in the context of suspected ketoacidosis, fell below accepted prescribing standards.

The panel concluded that, on the balance of probabilities, Sitagliptin was incorrectly prescribed in these circumstances.

"5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;

21 February 2022
Inappropriately issued Flucloxacillin 500mg capsules"

The charge is found NOT proved.

The panel considered the allegation that on 21 February 2022 you inappropriately issued Flucloxacillin 500mg capsules.

The panel examined the contemporaneous records, the prescribing audit, and the transcript evidence relating to this prescription. The panel noted that the patient had a complex clinical background, including infection concerns and previous medical history.

The panel attached weight to the evidence of Witness 5, who accepted during oral evidence that the use of antibiotics in this case was not outside antimicrobial guidance. The panel noted that the primary concern raised by Witness 5 was not the issuing of Flucloxacillin itself, but the wider clinical risk that a patient might delay attending secondary care if they believed antibiotics alone were sufficient.

During deliberations, the panel carefully distinguished between concerns about optimal practice and allegations of inappropriate prescribing. The panel determined that while issuing antibiotics in this context may have carried risks and required careful safety-netting, the evidence did not establish that the prescription itself fell outside accepted guidance.

The panel concluded that the NMC had not discharged the burden of proving that the Flucloxacillin was inappropriately issued.

"5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;

21 February 2022
Appropriate need for antibiotic medication – Flucloxacillin 500mg capsules, incorrectly prescribed 3.5 days' treatment"

The charge is found NOT proved.

The panel next considered the allegation that, although there was an appropriate need for antibiotics, Flucloxacillin 500mg capsules were incorrectly prescribed for a duration of 3.5 days.

The panel noted that this allegation was explored in the hearing as a discrete issue relating to prescription duration rather than antibiotic choice. The panel attached weight to the oral evidence of Witness 5, who accepted that this represented a prescribing error rather than a substantive failure of clinical judgment. In the transcript, when asked whether this amounted to a serious failing, Witness 5 agreed that it was *"just an error"* and accepted that *"errors happen"*.

The panel further noted that the prescription instructions themselves were otherwise correct and that there was no evidence that the shortened duration caused harm or materially increased risk to the patient.

During deliberations, the panel considered the legal advice and asked itself whether this amounted to a failure to demonstrate the standard of knowledge, skills and judgment as a Registered General Nurse without supervision. The panel considered that a simple prescribing error, without more, did not amount to such a failure.

The panel concluded that the NMC had not discharged the burden of proof in respect of this allegation.

"5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;

21 February 2022
Inappropriately prescribed for 3.5 days of Flucloxacillin 500mg capsules"

The charge is found NOT proved.

The panel considered this allegation alongside the previous entry, noting that it arose from the same factual matrix and concerned the same prescription.

For the reasons already set out, the panel concluded that while the duration of treatment was not ideal, the evidence demonstrated a human prescribing error rather than inappropriate prescribing.

The panel therefore reached the same conclusion in respect of this allegation.

"5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;

24 February 2022
Inappropriately issued Flucloxacillin 500mg capsules"

The charge is found proved.

The panel considered the allegation that on 24 February 2022 you inappropriately issued Flucloxacillin 500mg capsules.

The panel reviewed the contemporaneous notes and the prescribing audit, which described the clinical presentation as involving minor, localised skin lesions. The panel attached weight to the oral evidence of Witness 5, who explained that the notes did not demonstrate signs of bacterial infection warranting systemic antibiotics.

In the transcript, Witness 5 stated:

“At the very most, perhaps a topical antimicrobial. You would not normally treat pimples or small spots with systemic antibiotics; they will clear themselves.”

The panel noted that your oral evidence relied on factors such as diabetes, delayed healing, and precautionary prescribing. During deliberations, the panel determined that these factors were not, without documented evidence of infection, sufficient to justify systemic antibiotic use.

The panel concluded that the prescribing decision fell outside accepted antimicrobial stewardship principles.

> “5. Between 1 February 2022 and April 2022, inappropriately prescribed medication, as set out in;
>
> 24 February 2022
> Inappropriately prescribed Phenoxymethylpenicillin 250mg/5ml oral solution”

The charge is found proved.

The panel considered the allegation relating to the prescription of Phenoxymethylpenicillin oral solution on 24 February 2022.

The panel considered the consultation notes, audit evidence, and transcript material relating to fever-pain scoring and NICE guidance. The panel attached significant weight to the evidence of Witness 5, who explained that the documented features supported a fever-pain score of one, or at most two, which would not justify immediate antibiotic prescribing.

The panel noted the transcript passage in which you stated:

“I afforded the child a fever-pain score of three, because I know that’s what DHU will be looking at in order for me to prescribe anything.”

During deliberations, the panel regarded this evidence as highly significant. The panel determined that prescribing antibiotics to meet a perceived threshold, rather than as a result of an objective clinical assessment supported by the notes, undermined safe prescribing practice.

The panel concluded that the prescription did not accord with NICE guidance and was not supported by defensible clinical reasoning.

Charge 6a

> “6. Between December 2021 to April 2022, failed to carry out adequate patient assessments on one or more occasions in that you:-
>
> a. failed to check past medical history”

The charge is found proved.

The panel considered whether, on one or more occasions, you failed to check patients’ past medical history.

In determining this allegation, the panel relied specifically on its findings under Charge 4, Schedule 1, and reminded itself that Charge 6(a) is not a standalone allegation but a factual aggregation drawn from the Schedule 1 record-keeping failures already found proved. The panel therefore confined its consideration to those Schedule 1 matters where the absence of past medical history was expressly identified.

The panel noted that, under Charge 4, Schedule 1, it had found proved that on 7 March 2022 you failed to note the patient's medical history. The panel had determined that the consultation notes did not record key elements of the patient's past medical history and did not demonstrate that relevant background conditions had been identified or considered. The panel further determined that this omission prevented a reviewing clinician from understanding whether known risks had been identified or excluded as part of the assessment process. The panel emphasised that this was not a matter of documentation style, but of failing to record an essential component of clinical assessment.

In addition, the panel relied on its findings under Charge 4, Schedule 1 that on 18 April 2022 you failed to take a full patient medical history relating to gastric reflux. The panel had determined that the consultation notes did not demonstrate that a relevant and focused medical history had been obtained and that, in the absence of such documentation, the clinical reasoning behind the management plan could not be understood.

The panel considered these Schedule 1 findings together. The panel concluded that they demonstrated more than an isolated omission and instead evidenced occasions where past medical history was not adequately checked and recorded as part of the patient assessment.

The panel carefully considered your oral evidence that you may have taken medical histories but not recorded them fully. The panel accepted that this was your account. However, the panel reiterated that where the contemporaneous record does not demonstrate that past medical history was checked, and where the Schedule 1 findings expressly identify that omission, it cannot safely conclude that an adequate assessment took place.

Accordingly, the panel concluded that the facts found proved under Charge 4, Schedule 1 establish, on the balance of probabilities, that on one or more occasions you failed to check patients' past medical history.

Charge 6b

> "6. Between December 2021 to April 2022, failed to carry out adequate patient assessments on one or more occasions in that you:-
>
> b. failed to check NICE or LMSG guidelines"

The charge is found proved.

The panel considered whether, on one or more occasions, you failed to check relevant NICE or Local Medicines and Safety Group (LMSG) guidelines.

In determining this allegation, the panel relied on specific factual findings already made, rather than undertaking a general review of prescribing practice. The panel reminded itself that Charge 6(b) must be grounded in the findings already reached and not extended beyond those matters.

The panel noted that, under Charge 4, Schedule 1, it had found proved that on 26 April 2022 you diagnosed a patient with gastroenteritis and failed to consider red flags or engage with NICE guidance relating to appendicitis. The panel also took into account its previous findings in relation to Schedule 2:

- 1 February 2022 Inappropriately prescribed Amlodipine 5mg tablets,
- 1 February 2022 Inappropriately prescribed Amoxicillin 250mg/5ml oral suspension
- 14 February 2022 Incorrectly prescribed Trimethoprim 50mg/5ml oral suspension,
- 24 February 2022 Inappropriately issued Flucloxacillin 500mg capsules,
- 24 February 2022 Inappropriately prescribed Phenoxymethylpenicillin 250mg/5ml oral solution.

The panel had determined that NICE guidance exists to support clinicians in identifying when abdominal presentations require escalation and that the consultation record did not demonstrate any engagement with that guidance.

The panel further noted that this Schedule 1 finding was expressly relied upon during deliberations as an example of failure to check or apply relevant guidance in circumstances where such guidance was clearly applicable.

The panel considered whether any other Schedule 1 or Schedule 2 matters were relied upon to support this allegation. The panel noted that other Schedule 1 items involving guideline references had not been found proved and that those items could not therefore be relied upon. The panel confined its reasoning accordingly.

Taking the proved Schedule 1 finding of 26 April 2022 together with the absence of any recorded engagement with NICE guidance in that consultation, the panel concluded that the facts found proved establish, on the balance of probabilities, that on one or more occasions you failed to check relevant NICE or LMSG guidelines. The panel also took into account findings in relation to Schedule 2.

Charge 6c

> "6. Between December 2021 to April 2022, failed to carry out adequate patient assessments on one or more occasions in that you:-
>
> c. failed to ask sufficiently probing questions"

The charge is found proved.

The panel considered whether, on one or more occasions, you failed to ask sufficiently probing questions as part of patient assessments.

In determining this allegation, the panel relied primarily and expressly on its findings under Charge 4, Schedule 1, and confined itself to those Schedule 1 matters that were found proved and which related directly to the adequacy of enquiry.

The panel noted that, under Charge 4, Schedule 1, it had found proved that on 26 April 2022 you diagnosed a patient with gastroenteritis and failed to consider appendicitis red flags. The panel had determined that the consultation record did not demonstrate enquiry directed at identifying or excluding serious abdominal pathology, nor did it demonstrate questioning consistent with NICE guidance for acute abdominal pain.

The panel noted that it had expressly considered whether other Schedule 1 items supported this allegation. The panel recorded that Schedule 1 items relating to 18 April 2022 at 09:05 and other safeguarding-related entries were not proved and could not be relied upon to support Charge 6(c).

The panel therefore confined its conclusion to the 26 April 2022 consultation, where the absence of documented red-flag enquiry was found proved and where the panel had already determined that the record did not demonstrate sufficient questioning to support a safe assessment.

The panel carefully considered your oral evidence that questions may have been asked but not recorded. The panel accepted that this was your account. However, the panel reiterated that, where probing questions are central to excluding serious pathology, their absence from the contemporaneous record supports the conclusion that they were not asked to a sufficient extent.

Accordingly, the panel concluded that the facts found proved under Charge 4, Schedule 1 (26 April 2022) establish, on the balance of probabilities, that on one or more occasions you failed to ask sufficiently probing questions.

Charge 6d

"6. Between December 2021 to April 2022, failed to carry out adequate patient assessments on one or more occasions in that you:-

d. failed to conduct physical examination to an appropriate standard"

This charge is found proved.

In reaching this decision, The panel considered whether, on one or more occasions, you failed to conduct physical examination to an appropriate standard.

In determining this allegation, the panel was careful to rely only on findings already made and not to infer failures beyond those findings. The panel noted that certain Schedule 1 items that referred to examination or safeguarding had been found not proved and could not be relied upon.

The panel relied specifically on its findings under Charge 3(a). The panel had found proved that, on 15 February 2022, you failed to identify the risk of diabetic ketoacidosis in a known diabetic patient. In making that finding, the panel had determined that the consultation record did not demonstrate assessment steps sufficient to identify or exclude a serious metabolic condition.

The panel considered that assessment of diabetic ketoacidosis necessarily involves clinical assessment directed at identifying systemic illness. The panel noted that its finding under Charge 3(a) was concerned with the process of assessment, not merely diagnostic outcome.

The panel also considered whether any Schedule 1 items supported this allegation. The panel noted that certain Schedule 1 items referring to examination had been found not proved and could not be relied upon. The panel therefore did not base its conclusion on those items.

Taking the proved finding under Charge 3(a), and the absence of evidence of assessment and examination steps sufficient to identify or exclude diabetic ketoacidosis, the panel concluded that the facts found proved establish, on the balance of probabilities, that on one or more occasions you failed to conduct physical examination to an appropriate standard.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence 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 suitability to remain on the register unrestricted

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 a lack of competence (it considered whether it had a fair sample and whether by the standard of a Band 7 Registered Nurse and prescriber, you fell unacceptably low). Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

‘A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.’

Mr Carey invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of ‘The Code: Professional standards of practice and behaviour for nurses and midwives (2015)’ (“the Code”) in making its decision. He submitted that the panel had already found multiple, serious departures from the standards expected of a registered nurse, and that these were not isolated lapses but demonstrated an unacceptably low standard of professional performance.

Mr Carey submitted that the facts found proved spanned a period of several months, approximately from December 2021 to April 2022, and included two distinct schedules: one relating to general clinical activity and the other to prescribing practice.

Mr Carey emphasised that the findings were supported by a variety of evidence, including contemporaneous clinical records, prescribing audits, and the oral and written evidence of multiple witnesses, including clinical leads. He submitted that this amounted to a fair sample of your work.

Mr Carey identified a number of recurring themes arising from the panel’s findings, including failures in assessment and history-taking, failures to recognise and identify serious medical conditions and red flags, failures to make appropriate and timely urgent referrals or to escalate care, deficiencies in documentation, and inappropriate prescribing.

Mr Carey referred the panel to the evidence of Witness 5, including his audit findings, and highlighted that a number of prescribing decisions were assessed as inappropriate or of concern. He submitted that this evidence demonstrated weaknesses in clinical judgment and record-keeping.

Mr Carey accepted that you were working in a challenging environment and under pressure. However, he submitted that this did not absolve you of your professional responsibility to practise safely, to recognise your limits, and to adhere to evidence-based

guidance. He submitted that the failures identified went beyond what could reasonably be attributed to workload pressures alone.

Mr Carey submitted that, taken together, the facts found proved demonstrated performance reflected a lack of competence.

Ms Rao submitted that the facts found proved did not amount to a lack of competence. She emphasised that lack of competence is a serious statutory threshold and does not automatically follow from findings that care fell below the expected standard on individual occasions.

Ms Rao reminded the panel that lack of competence requires an assessment of whether there is an unacceptably low standard of performance demonstrated by a fair sample of work, rather than an aggregation of isolated errors. She submitted that the period relied upon by the NMC was limited and did not represent a fair or balanced sample of your overall practice, particularly in the context of your long professional career without previous regulatory criticism.

Ms Rao emphasised that the panel must distinguish between errors arising from systemic pressures, deficiencies in induction and supervision, and true professional incompetence. She submitted that the evidence showed you were working in a challenging environment characterised by workload pressure, professional isolation, and unclear managerial support.

Ms Rao further submitted that a substantial proportion of the findings related to documentation rather than substantive clinical decision-making. She submitted that deficiencies in record-keeping do not of themselves demonstrate a lack of knowledge, skill, or judgment sufficient to amount to a lack of competence. Ms Rao further submitted that there was no evidence that patients suffered actual harm.

Ms Rao submitted that differences in clinical judgment, including the application of guidelines, should not be conflated with incompetence. She reminded the panel that guidelines are not inflexible rules.

Overall, Ms Rao invited the panel to conclude that, while the findings identified areas of concern, they did not demonstrate performance that was so unacceptably low as to meet the definition of lack of competence.

Submissions on impairment

Mr Carey moved on to the issue of impairment and invited the panel to find that, if the facts found proved amounted to a lack of competence, your fitness to practise is currently impaired.

In addressing impairment, Mr Carey referred the panel to the principles set out in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Carey submitted that the panel had found repeated failings across core areas of nursing practice and that these raised concerns about insight, remediation, and the risk of repetition. He relied on aspects of your evidence, including your approach to documentation and the application of guidelines, as relevant to insight.

Mr Carey accepted that you were practising in a challenging environment but submitted that this did not fully explain the seriousness and breadth of the concerns found proved.

Mr Carey submitted that there was no evidence of remediation, including no reflective statement or independent evidence of strengthened practice. He submitted that, in the absence of such evidence, the panel could not be satisfied that the risk of repetition had been addressed.

Mr Carey further submitted that the findings found proved continued to engage, and remained inconsistent with, the standards set out in *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)***.** He submitted that the NMC relied on the following provisions of the Code as engaged by the facts found proved and relevant to the panel's assessment of current impairment: **1.4, 4.1, 6.1, 6.2, 7.1–7.4, 8.5, 8.6, 10.110.3, 13.1–13.3, 15.2, 18.1 and 18.3**. He submitted that, in the absence of evidence

of remediation or strengthened practice, the panel could not be satisfied that these professional standards were currently being met consistently.

Mr Carey invited the panel to find that your fitness to practise is currently impaired on public protection and public interest grounds.

Ms Rao submitted that, even if the panel were to find that the facts found proved amounted to a lack of competence, your fitness to practise is not currently impaired. She reminded the panel that impairment must be assessed as at the date of the hearing and is not an automatic consequence of past findings.

Ms Rao submitted that there was no evidence of current risk to patients and that the panel should not conflate historic concerns with present-day risk. She emphasised that there was no evidence of concerns arising after April 2022**.**

Ms Rao addressed the issue of insight and submitted that the absence of admissions or a reflective statement should not be equated with a lack of insight. She emphasised that you were entitled to defend the allegations.

Ms Rao submitted that the panel should take account of the significant shortcomings in the DHU training and supervision process, including the inadequacy of the training plan relied upon, and submitted that these systemic failures materially contributed to the concerns identified.

Ms Rao further submitted that you have now retired and do not intend to return to clinical practice. She submitted that this was a relevant consideration when assessing current risk, although she accepted it was not determinative.

Ms Rao submitted that the public interest did not require a finding of impairment and that a well-reasoned determination would be sufficient to maintain public confidence.

Ms Rao addressed the principles derived from *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)

and submitted that, properly applied, those principles did not point towards a finding of current impairment.

In conclusion, Ms Rao invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor, which included reference to the principles set out in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin),* concerning the assessment of current impairment.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 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.

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand.

8 Work co-operatively

To achieve this, you must:

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

8.6 share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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.

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly.

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:

18.1 prescribe, advise on, or provide medicines or treatment (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs.

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel bore in mind, when reaching its decision, that you should be judged by the standards of a Band 7 Registered Nurse and prescriber**,** and not by any higher or more demanding standard. The panel accepted that you were practising in a fast-paced, pressured and operationally challenging environment, and took this into account when assessing whether your performance was unacceptably low by those standards.

The panel also bore in mind that a finding of lack of competence is a serious matter. It reminded itself that such a finding is not established by isolated errors or a single lapse, but requires evidence of an unacceptably low standard of performance, demonstrated by a fair sample of work.

The panel concluded that there was a fair sample of work and it demonstrated an unacceptably low standard of practise during this period.

In this case, the panel was satisfied that the facts found proved spanned a number of months and arose across two distinct schedules of clinical and prescribing practice. The panel identified repeated and consistent failings across fundamental areas of nursing practice, including assessment, recognition of serious conditions and red flags, escalation, documentation, and prescribing.

The panel concluded that these were not isolated lapses, but demonstrated a pattern of deficient performance. The panel was satisfied that this conclusion remained justified even when the pressures of the working environment were taken into account.

The panel had in mind the evidence it had heard including, Witness 5's evidence that :

“ I do not often see cases which cause me the level of concern that Ms Hall’s cases caused”

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, 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. 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 [2011] EWHC 927 (Admin)* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

d) *...’*

The panel found that patients were put at risk of harm as a result of your lack of competence. While the panel did not find evidence that patients suffered actual physical harm, it considered that the deficiencies identified exposed patients to the risk of avoidable harm, particularly in relation to assessment, escalation, documentation, and prescribing.

The panel concluded that your lack of competence breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that public confidence in the nursing profession would be undermined if such failings were not marked by a finding of impairment.

Regarding insight, the panel carefully considered your evidence. The panel acknowledged that you were entitled to defend the allegations and reminded itself that the absence of admissions does not, of itself, demonstrate a lack of insight. However, the panel noted that there was limited evidence demonstrating an appreciation of the seriousness of the concerns found proved, including an understanding of how those failings placed patients at risk and how similar issues would be avoided in the future. The panel took into account your engagement with the regulatory process.

In considering whether you had taken steps to strengthen your practice, the panel noted that there was no reflective statement before it and no independent evidence of remediation, such as targeted training, supervision, or learning addressing the specific deficiencies identified. The panel also noted that there was no evidence of any relevant training, supervision, or professional development undertaken since 2022.

The panel concluded that there remains a risk of repetition, given the seriousness and breadth of the deficiencies found proved, the limited evidence of insight, and the absence of remediation.

The panel attached particular weight to the absence of evidence demonstrating that these deficiencies had been addressed. It considered that, without such evidence, it could not be satisfied that you had developed the necessary insight into the seriousness of the failings or taken steps to prevent their recurrence.

The panel also considered your oral evidence and noted that, while you acknowledged the challenging and pressured working environment in which you were practising, there was limited evidence of reflection on how your own practice could or should have been

adapted to ensure patient safety notwithstanding those pressures. The panel was concerned that aspects of your evidence suggested a continued reliance on personal clinical judgment in circumstances where adherence to guidance, escalation pathways, and documentation standards was required. The panel considered that this increased the risk that similar concerns could arise again.

The panel took into account the challenging working conditions at the relevant time. However, it concluded that these factors did not remove your professional responsibility to practise safely, recognise the limits of your competence, and escalate concerns appropriately. In the absence of evidence demonstrating strengthened practice, the panel was not satisfied that the risk of repetition had been sufficiently mitigated.

For these reasons, the panel determined that a finding of impairment is necessary on public protection grounds, in order to protect patients from the risk of harm.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered that the lack of competence found proved was serious and wide-ranging, involving repeated deficiencies across fundamental aspects of nursing practice, including assessment, recognition of serious conditions and red flags, escalation, documentation, and prescribing. The panel determined that these matters went to the heart of what the public is entitled to expect from a Registered Nurse and prescriber.

The panel concluded that, quite apart from the risk of repetition identified, a finding of impairment was required in order to maintain public confidence in the nursing profession and in the regulatory process, and to declare and uphold proper professional standards. The panel considered that an informed member of the public would be concerned if a

nurse found to have demonstrated such deficiencies were permitted to remain on the register unrestricted without a finding of impairment.

For these reasons, the panel determined that, in this case, a finding of impairment was required on public interest grounds.

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

Sanction

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

Submissions on sanction

Mr Carey informed the panel that, following its findings on lack of competence and current impairment, the NMC invited the panel to impose a conditions of practice order for a period of 12 months.

Mr Carey reminded the panel that the purpose of sanction is not punitive, but to protect the public, to promote and maintain public confidence in the profession, and to declare and uphold proper professional standards. He invited the panel to have regard to the NMC Sanctions Guidance and to impose the least restrictive sanction necessary to achieve those aims.

Mr Carey submitted that the panel had found a serious and wide-ranging lack of competence, extending across core areas of nursing practice, including assessment, recognition of serious conditions and red flags, escalation, documentation, and

prescribing. He acknowledged that the concerns identified were capable of remediation and did not involve dishonesty, attitudinal failings, or deliberate misconduct.

Mr Carey submitted that there were a number of aggravating features which the panel should take into account when determining sanction. He submitted that the concerns were not confined to a single isolated lapse but arose across different domains of practice. Mr Carey further submitted that the panel had identified a risk of repetition, together with limited evidence of insight and reflection to date and an absence of remediation. He submitted that these matters were relevant to the assessment of ongoing risk and to whether a caution or no action would be sufficient to protect the public.

Mr Carey acknowledged the presence of mitigating features. He accepted that the findings related to a lack of competence rather than misconduct and did not involve dishonesty, attitudinal failings, abuse of trust, or deliberate disregard for patient safety. He submitted that the concerns identified were capable of remediation through appropriate supervision, training, reflection, and review. Mr Carey further acknowledged that the panel had heard evidence regarding the context in which the concerns arose, including issues relating to support and supervision in the workplace, and accepted that the panel had not found behaviour fundamentally incompatible with continued registration.

Mr Carey addressed the available sanctions in ascending order of seriousness. He submitted that taking no further action or imposing a caution Order would be insufficient in light of the panel's findings. He submitted that the panel had identified a risk of repetition, limited evidence of insight and reflection to date, and an absence of remediation, and that a caution would not provide meaningful protection to the public or adequately address the deficiencies found proved.

Mr Carey then addressed a conditions of practice order, which he submitted was the most appropriate and proportionate sanction. He submitted that such an order would allow you to practise safely under appropriate supervision and would directly address the specific areas of concern identified by the panel. He submitted that the proposed conditions could

be tailored to require supervision, training, reflection, and review over a 12-month period, thereby protecting the public while providing you with the opportunity to demonstrate remediation and insight.

Mr Carey submitted that a conditions of practice order was particularly suitable given that the concerns related to clinical competence rather than misconduct or attitudinal issues. He submitted that conditions would adequately protect the public and would be sufficient to maintain public confidence in the profession and the regulatory process.

Mr Carey addressed the sanction of suspension and submitted that the NMC did not invite the panel to impose a suspension order. He submitted that suspension would be a more restrictive sanction than necessary, given the absence of findings of dishonesty, attitudinal concerns, or deliberate disregard for patient safety, and noting that the concerns identified were capable of remediation.

Mr Carey further submitted that a striking-off order would be wholly disproportionate and was neither sought nor available, given the nature of the findings and the absence of behaviour fundamentally incompatible with continued registration.

Accordingly, Mr Carey invited the panel to impose a 12-month conditions of practice order, with conditions carefully framed to address the specific deficiencies identified in the panel's findings, which he submitted would be necessary, proportionate, and sufficient to meet the overarching objectives of the NMC.

The panel also bore in mind Ms Rao's submissions on sanction. She invited the panel to approach sanction by starting at the lowest available outcome and working upwards, stopping at the point where the regulatory objectives were met. She reminded the panel that the purpose of sanction is protective rather than punitive, and that it must impose no greater restriction than was necessary.

Ms Rao submitted that the panel's findings related to a lack of competence, rather than misconduct. She emphasised that the panel had made no findings of dishonesty,

attitudinal failings, abuse of trust, or deliberate disregard for patient safety, and that there were no concerns fundamentally incompatible with continued registration.

Ms Rao submitted that the concerns arose within a specific context. She reminded the panel that the issues occurred over a relatively limited period towards the end of a long career, in an unfamiliar urgent care setting, and in circumstances where there were difficulties around support and line management. She submitted that these contextual factors were relevant to the panel's assessment of proportionality at the sanction stage.

Ms Rao referred the panel to evidence of mitigation, including your lengthy career without prior complaint, testimonials and references, and evidence of some improvement identified towards the end of the audit process. She submitted that these matters were properly part of the overall picture the panel was entitled to take into account.

Ms Rao addressed the available sanctions in ascending order. She submitted that the panel had the full range of options open to it up to, but not including, a striking-off order, which was not available at this stage.

Ms Rao referred the panel to a written undertaking provided on your behalf, confirming that you do not intend to return to nursing practice. She accepted that the undertaking was not, of itself, an enforceable regulatory mechanism. However, she submitted that it was a significant factor when assessing risk and proportionality, as it demonstrated that there was no realistic prospect of you practising again.

Ms Rao submitted that, in light of your clear intention not to return to practice, a conditions of practice order would be inappropriate and unworkable. She submitted that conditions are designed to regulate future practice, and where a registrant is not practising and does not intend to do so, such conditions could not realistically be complied with and would serve no meaningful regulatory purpose.

Ms Rao submitted that it would be wrong in principle to move to a more restrictive sanction, such as suspension, solely on the basis that conditions were unworkable. She submitted that a more restrictive sanction should not be imposed where a lesser sanction

would otherwise be proportionate but was impractical for reasons unrelated to risk or unwillingness to comply.

Ms Rao submitted that suspension would be disproportionate in the circumstances of this case, particularly given that the concerns were remediable, related to competence, and did not involve dishonesty or misconduct. She submitted that suspension is generally reserved for cases where concerns are not capable of remediation or where public confidence could not be maintained by a lesser outcome.

Ms Rao submitted that public protection had already been achieved in practice, as you had not worked as a nurse for a significant period of time and had no intention of returning to practice. She submitted that public confidence could be maintained by a proportionate outcome which reflected the findings, the context in which they arose, and the reality of your position.

In conclusion, Ms Rao invited the panel to conclude that no further regulatory intervention was required. Alternatively, she submitted that, if the panel considered some form of regulatory response necessary, it should adopt the least restrictive option available, bearing in mind that you do not intend to return to nursing practice. She submitted that a warning coupled with what she described as a formal undertaking would suffice. Ms Rao provided a signed copy of your proposed undertaking but in doing so, she accepted that it was not enforceable other than potentially by further disciplinary action.

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:

- The panel found a serious and wide-ranging lack of competence, extending across a number of core areas of nursing practice, including clinical assessment, recognition of serious conditions and red flags, escalation, documentation, and prescribing.

- The concerns were not confined to a single lapse but arose across a fair sample of practice over a period of several months.

- The panel identified a risk of repetition, particularly in light of the limited evidence of insight and reflection to date.

- The panel was satisfied that the failings identified had the potential to place patients at risk of harm, even though no actual harm was found.

The panel also took into account the following mitigating features:

- The concerns related to lack of competence rather than misconduct. The panel made no findings of dishonesty, abuse of trust, attitudinal failings, or deliberate disregard for patient safety.

- The panel accepted that the concerns identified were capable of remediation.

- The panel had regard to the context in which the concerns arose, including your recent move into an unfamiliar urgent care setting and difficulties relating to support and line management.

- The panel noted that, aside from the matters found proved, you had a lengthy career without previous regulatory findings.

- The panel took limited account of the testimonials provided, noting their age and general nature, but accepted that they formed part of the overall picture.

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 lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would 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 is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- There was no evidence of harmful deep-seated personality or attitudinal problems**.**

- There were clearly identifiable areas of practice requiring retraining and supervision.

- The panel did not find evidence of general incompetence.

- The concerns were remediable through supervision, retraining, reflection, and review.

- Conditions could be formulated that would protect patients, could be monitored and assessed, and would allow any future employer to understand the restrictions in place.

The panel carefully considered submissions made on your behalf regarding your stated intention not to return to nursing practice and the signed written undertaking you proposed and provided. The panel considered that the undertaking was not enforceable other than by potentially further disciplinary action, a position which was accepted by Mr Carey and Ms Rao. In these circumstances, while the panel considered your offer to make such a promise, well intentioned, the undertakings' unenforceability meant that it did not of itself provide public protection. The panel determined that an unenforceable undertaking would not discharge its regulatory responsibility to protect the public where a risk in you practising unrestricted has been identified.

The panel considered whether conditions would be workable given your current intention not to practise. The panel concluded that workability must be assessed objectively, on the basis of whether the conditions could operate should you choose to return to practice. The panel was satisfied that the proposed conditions were workable for a registrant taking up employment in an appropriate setting and would adequately manage the risk identified.

The panel was satisfied that the conditions of practice are workable in principle and could be facilitated by an appropriate workplace. The panel noted that, should you apply for employment in the future, an employer would be able to consider your application and implement the restrictions imposed. The panel acknowledged your stated intention not to return to nursing practice at present. However, the panel did not consider that you are someone who should be prevented from working by way of sanction. The panel determined that a suspension order would be inappropriate and disproportionate.

The panel concluded that the public interest requires that your practice be restricted, rather than prohibited, in order to protect the public should you choose to return to practice.

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

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because the concerns were remediable, did not involve misconduct or dishonesty, and were not fundamentally incompatible with continued registration. The panel determined that public protection and public confidence could be adequately maintained by a conditions of practice order.

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

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

> ‘For the purposes of these conditions , ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must keep the NMC informed about anywhere you are working by telling your case officer within seven days of accepting or leaving any employment, and by providing your employer’s contact details.

2. You must immediately give a copy of these conditions to any organisation or person you work for in a nursing capacity, any nursing agency you apply to or are registered with, and any employer you apply to (for nursing work) at the time of application.

3. You must tell your case officer, within seven days of becoming aware of any clinical incident you are involved in, any investigation started against you, or any disciplinary proceedings taken against you.

4. You must allow your case officer to share, as necessary, details about your performance and compliance with these conditions with any current or future employer and any person(s) involved in your retraining and/or supervision.

5. You must work only in a role that provides direct line management by, and access during shifts to, a registered nurse of Band 6 or above, or equivalent seniority in the setting.

6. You must ensure that you are supervised at all times when working by a registered nurse of Band 6 or above, or equivalent. This supervision must consist of working at all times on the same shift as, but not always being directly observed by, a registered nurse of Band 6 or above.

7. You must not work in unsupervised autonomous urgent care or advanced clinical practitioner roles, and you must not undertake triage or same-day urgent care assessments without the availability of your supervisor for advice and escalation.

8. You must not undertake independent prescribing unless directly supervised by your line manager, mentor or a registered prescriber.

This supervision must include review of each prescription issued and monthly prescribing audits.

9. You must complete, and send to your case officer evidence of successful completion of, assessed training courses in each of the following: clinical assessment and escalation of acutely unwell adults; record-recordkeeping and clinical reasoning; antimicrobial stewardship and local/NICE guidance application; safe primary care/urgent care prescribing. Evidence must be provided by 20 July 2026.

10. You must work with your supervisor to create a Personal Development Plan addressing assessment and escalation, record-keeping, and prescribing. You must send a copy of your PDP to your case officer by 20 April 2026 and provide supervisor reports on progress every three (3) months.

11. You must keep a reflective practice profile detailing cases where you undertake assessment, escalation decisions, or prescribing. This must be signed by your supervisor with feedback and sent to your case officer every three (3) months.

12. You must send to NMC a report seven days before the next review hearing from your line manager or supervisor addressing your compliance with, and progress under, these conditions .

The period of this order is for up to 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any

condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- evidence of completion of the required training;
- supervisor or line manager reports addressing compliance and progress;
- evidence of reflective practice; and
- evidence of engagement with the Personal Development Plan.

This will be confirmed to you in writing.

Interim order

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

The panel accepted the advice of the legal assessor that an interim order should only be imposed if it is necessary to protect the public or is otherwise in the public interest (it is not suggested that it will be in your interest), and that the panel must impose the least restrictive interim measure capable of addressing the identified risk.

Submissions on interim order

The panel took account of the submissions made by Mr Carey. He addressed the panel on the issue of an interim order. He reminded the panel that, where a substantive order is made, there is a period of 28 days before that order takes effect, and that period may be

extended if an appeal is lodged. He submitted that, during that period, there would otherwise be no restriction in place.

Mr Carey submitted that the panel was required to consider whether an interim order was necessary to protect members of the public or was otherwise in the public interest. He reminded the panel that, if it concluded that protection of the public or the public interest required ongoing restriction during the appeal period, it was appropriate to impose an interim order to bridge that gap.

Mr Carey submitted that, if the panel decided to impose an interim order, it should mirror the level of restriction imposed at the substantive stage. He submitted that the interim order should be no more restrictive than necessary and should reflect the panel's findings and conclusions on sanction.

The panel also took into account the submissions of Ms Rao. She submitted that the panel should consider whether an interim order was in fact necessary in the circumstances of this case.

Ms Rao submitted that you had not practised as a nurse for a significant period of time and had given a clear undertaking that you did not intend to return to nursing practice. She submitted that there had been no interim restriction in place for several years, and that no new risk had arisen which would justify the imposition of an interim order at this stage.

Ms Rao submitted that, if the panel were to impose a substantive outcome which did not involve conditions or suspension, there would be no basis for imposing an interim order. She submitted that an interim order should not be imposed as a matter of routine, but only where it was necessary to address a real and identified risk.

Ms Rao further submitted that, if the panel were minded to impose a Conditions of practice order at the substantive stage, there was no need to impose an interim order, given that you were not practising and did not intend to do so. She submitted that

imposing interim conditions in circumstances where there was no realistic prospect of practice would serve no meaningful protective purpose.

Ms Rao submitted that an interim suspension order would be disproportionate and unnecessary. She submitted that there was no evidence of immediate risk to the public, no allegations of dishonesty or misconduct, and no public interest justification for imposing an interim order, particularly given the length of time during which you had already been unrestricted without incident.

Ms Rao invited the panel to conclude that an interim order was not necessary in the circumstances. Alternatively, if the panel considered that an interim order was required, she submitted that it should be no more restrictive than the substantive outcome and should be imposed only for the minimum period necessary.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of an interim conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The interim conditions of practice order will be the same as those detailed in the substantive order.

In determining the duration of the interim order, the panel accepted the advice of the legal assessor that it must be no longer than is necessary to address the identified risk and must take account of the potential length of the appeal process. The panel noted that, if an appeal were lodged, the interim order would need to remain in place until that process concluded, the duration of which could not be predicted with certainty.

Having regard to the seriousness of the concerns found proved and the risk identified in its substantive decision, the panel concluded that a shorter interim order of six or twelve months may be insufficient to provide continuous public protection. The panel therefore determined that an interim conditions of practice order for a period of 18 months was necessary and proportionate.

The panel was satisfied that interim conditions would adequately address the identified risk during the appeal period and would be proportionate, noting that a more restrictive interim order, such as suspension, would not be justified. The panel therefore determined that the interim conditions of practice order should mirror the substantive order, as this represented the least restrictive measure necessary to meet the regulatory objectives.

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

That concludes this determination.