Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 19 January 2026 – Thursday, 29 January 2026

Virtual Hearing

Name of Registrant:	Marcus James Lynch
NMC PIN:	16E1514E
Part(s) of the register:	Registered Adult Nurse (2016)
Relevant Location:	Staffordshire
Type of case:	Misconduct/Lack of competence
Panel members:	Konrad Chrzanowski (Chair, Lay member) Lesley Foulkes (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mr Lynch:	Present and not represented on 19 – 21 January 2026 Not present and not represented on 22 – 23 January 2026 Present and not represented on 26 - 29 January 2026
Facts proved by way of admission:	1, 2, 3, 5(a), 5(b), 7(a), 7(b)(i), 7(b)(ii), 8(a), 9(a), 9(b), 10(c), 13(a), 13(b), 14(a), 14(b), 14(c), 15(a), 15(b), 15(c), 20(a), 20(b) and 20(c)
Facts proved:	4(a), 10(a), 10(b), 11(b), 16(a), 16(b), 17(a), 18(a), 18(b)(i) and 18(b)(ii)
Facts not proved:	4(b), 6(a), 6(b), 8(b), 11(a), 12, 17(b) and 19
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (18 months)**

Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge

That you, a registered nurse, failed to demonstrate the standards of knowledge, skills and judgment required to practice as a Band 5 nurse without supervision in that you:

1. On various unknown dates, failed to correctly administer immunisations;

2. On various unknown dates, failed to correctly administer and/or record travel vaccinations;

3. Failed to adequately record Yellow Fever vaccinations on the dates set out in Schedule 1;

4. On 17 January 2023, in respect of Patient A:
    a. Failed to take average blood pressure readings;
    b. Due to your actions at Charge ~~1(4)(a)~~ **4(a)** failed to increase medication.

5. On 7 February 2023:
    a. Provided Patient H with a prescription only medication (E45 Cream) without a prescription;
    b. Your actions at charge 5(a) were against the advice of the pharmacy technician.

6. Between January 2021 and February 2023 ~~undertook~~ **attempted to undertake** smoking cessation clinics:
    a. Without having completed the necessary training;
    b. Without the necessary supervision.

7. In November 2022
    a. in respect of Patient B, failed to submit blood pressure readings;
    b. In respect of Patient C:
        i. Failed to document a raised blood pressure reading;
        ii. Failed to organise for a follow-up appointment in the light of raised blood pressure.

8. On 16 January 2023, in respect of Patient J:
    a. Misdiagnosed Patient J's foot pain as being 'plantar fasciitis';
    b. Failed to refer Patient J to be reviewed by a doctor.

9. On 18 January 2023, in respect of Patient D:
    a. Failed to check cholesterol at a blood pressure/cholesterol check;
    b. Carried out a blood test, which was not indicated.

10 On 2 February 2023 in respect of Patient I:
    a. Mis-diagnosed thrush;
    b. Your actions at charge 10 (a) were undertaken despite you not having been trained in sexually transmitted infections;
    c. Failed to refer them to be seen by a doctor;

11 On 7 February 2023, in respect of Patient K:
    a. On one or more occasions, failed to escalate them to a doctor due to complaint of chest pains;
    b. On one or more occasions, discharged them without arranging for them to be seen by a doctor.

12 On an unknown date in relation to Patient L, failed to gain consent from them to complete a full blood-test (to include HIV test).

13 On 17 January 2023 in respect of Patient F:
    a. Failed to adequately record the reasoning as to why certain types of anti-malarial medications/vaccinations could not be administered to Patient F.
    b. Failed to complete a further risk assessment for travel.

14 On various unknown dates:
    a. Mismanaged and mis-documented blood samples;
    b. Failed to upload information concerning blood sampled onto the electronic records;
    c. Missed numerous patients' blood tests.

15 On 2 February 2023 in respect of Patient G, performed an ear irrigation when you;
    a. Were not supervised to undertake the procedure;
    b. had not undertaken the necessary training to perform the procedure alone;
    c. had been told by Colleague A not to perform the procedure.

16 In November 2022, during a feedback session with Colleague A, made inappropriate and/or threatening comments in relation to Patient C, including:
    a. That Patient C's breath smelled of coffee;

b. '*I hope we meet again in a dark alley'* or *'he should look out for me if we ever meet in a dark alley'* or words to that effect.

17 Did not respond professionally when receiving feedback from Colleague A, in that you:
   a. Paced around the room;
   b. Said to Colleague A "it's you, it's your tone" or words to that effect.

18 On 14 July 2022 demonstrated aggressive behaviour towards colleagues in that:
   a. Shouted in the presence of Colleague B;
   b. Shouted at Colleague C:
      i. In person
      ii. On the phone

19 On 18 July 2022 you aggressively accused Colleague C of unreasonably pointing out concerns in respect of your practice.

20 Sent Colleague D unprofessional messages, stating:
   a. "You are now part of the service complaint";
   b. "You're just like them";
   c. That Colleague D was part of the toxic work environment.

AND in light of the above, in respect of charges 1 -15 your fitness to practise is impaired by reason of your lack of competence and or misconduct, and in respect of charges 16-**20** ~~21~~ your fitness to practise is impaired by reason of your misconduct.

Schedule 1:

- 9 January 2023
- 10 January 2023
- 16 January 2023
- 20 January 2023
- 24 January 2023
- 27 January 2023
- 1 February 2023
- 2 February 2023

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Radley, on behalf of the NMC, to amend the conclusion of the charges. He stated that the charges run up to 20, and invited the panel to amend the wording so that it refers to charge 20 instead of charge 21. He said this was an administrative slip.

> *AND in light of the above, in respect of charges 1 -15 your fitness to practise is impaired by reason of your lack of competence and or misconduct, and in respect of charges 16- ~~21~~ **20** your fitness to practise is impaired by reason of your misconduct.*

Mr Radley also applied to amend charge 4(b) to correct the wording, so that it reads:

> 4. *On 17 January 2023, in respect of Patient A:*
>   a. *…;*
>   b. *Due to your actions at Charge ~~1(4)(a)~~ **4(a)**failed to increase medication.*

You did not oppose the application

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

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

Decision and reasons on application to admit written statement and exhibits of Colleague C

The panel heard an application made by Mr Radley under Rule 31 to allow the written statement of Colleague C into evidence. He referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Mr Radley submitted that Colleague C is the only witness giving evidence in relation to charges 6(a), 6(b) and 12. Her evidence in respect of those charges is not supported by other witness

evidence. He explained that she also gives evidence in relation to a number of other charges, but those charges have been admitted by you. He submitted that this may weigh in the balance when considering the charges where you have accepted her evidence.

Mr Radley further submitted that you have challenged the evidence and are able to give evidence yourself. He said there is no suggestion that Colleague C has any reason to fabricate her allegations.

Mr Radley submitted that the charges to which this application relates are those effectively aligned with lack of competence, as opposed to the last five charges, which relate specifically to misconduct. He said that, as a consequence, these charges fall at the lower end of the range of charges you face. They remain serious, but are within the lower range of seriousness.

Referring the panel to the hearsay bundle, Mr Radley said that Colleague C is not attending these proceedings due to her medical condition which is supported by documentary evidence. He said this is not a situation where it appears that Colleague C is avoiding giving evidence or resiling from her statement. He submitted that her non-attendance is purely for medical reasons.

Mr Radley explained that there has been correspondence between the NMC and Colleague C to explore other options for her to give evidence, but in the circumstances it appears there are none. He submitted that it would be wrong to press too firmly for her attendance, particularly in light of clear health issues.

Mr Radley acknowledged that you did not have early notice that the witness statement of Colleague C was to be read and a hearsay bundle was not provided to you before you joined the hearing today. As a result, the time afforded to you to consider Colleague C's statement has been limited. However, he submitted that you are a professional person and have the support of the legal assessor if there are matters you do not understand, and that any impact of the short notice on your ability to respond is limited.

You said that you would prefer Colleague C to give evidence in person so that you could question her, but you indicated that you would not stand in the way of the application.

The panel accepted the advice of the legal assessor.

The panel accepted that Colleague C is the sole evidence in relation to charge 12. In relation to charges 6(a), 6(b), 18(a), 18(b)(i) and 18(b)(ii), there is other evidence from Colleague A and the panel has also been directed to the evidence of Colleague D.

The panel noted that you may choose to give evidence and that you have the opportunity to provide evidence to the contrary in relation to the charges.

The panel noted that there was some tension between you and Colleague C. However, it could not identify any reason why she would fabricate the allegations. Her evidence relates to clinical events, as well as your tone and manner. Some of it reflects her interpretation of your behaviour, but there is also factual material.

The NMC has indicated that the charges to which this evidence relates are competency-based. The panel noted that charge 18 is not competency-based. As an allegation of misconduct, it is potentially more serious.

The panel determined that there was good reason for the non-attendance of Colleague C. It had sight of the hearsay bundle, including correspondence between the NMC and her doctor.

The panel noted that you did not have substantial prior notice of the application, but you did not strongly object and responded reasonably. The statement was only received on 20 January 2025. The panel does not believe that you would be seriously disadvantaged by its admission.

The panel decided to accept the statement as hearsay evidence, but not the second bullet point of paragraph 27 in relation to charge 12, as there is no other independent evidence to support that part of the charge. While the panel admits the statement in relation to charge 12, that specific element is double hearsay.

22 - 23 January 2025

On 22 January 2025, you decided not to attend during the remainder of the NMC witness evidence. You were content for the panel to proceed in your absence and you were fully

appraised of your position. You said you would provide either direct evidence yourself, or reference statements, the following week from 26 January 2026.

Amendment to charge 6

Of its own motion, the panel decided to amend charge 6 so that it reads: "*Between January 2021 and February 2023 ~~undertook~~* ***attempted to undertake*** *smoking cessation clinics".*

The panel considered that this amendment fairly reflects the evidence presented. It found that no injustice or unfairness to you would result from the amendment.

The panel accepted the advice of the legal assessor.

Neither you nor Mr Radley opposed the amendment.

The panel therefore amended charge 6 accordingly.

Background

The NMC received a referral on 8 April 2024 from the Ministry of Defence raising concerns in relation to your nursing practice whilst working at the Whittington Barracks Medical Centre between 2021 – 2023. From the referral, the NMC identified the following regulatory concerns:

1. Acting outside of scope of competence/practice
2. Bullying and aggressive behaviour
3. Poor medications practice
4. Failure to treat patients with kindness and compassion
5. Failure in patient assessment
6. Poor record keeping
7. Failure to maintain professional boundaries

Decision and reasons on facts

At the outset of the hearing, you made full admissions to charges 1, 2, 3, 5(a), 5(b), 7(a), 7(b)(i), 7(b)(ii), 8(a), 9(a), 9(b), 10(c), 13(a), 13(b), 14(a), 14(b), 14(c), 15(a), 15(b), 15(c), 20(a), 20(b) and 20(c). The panel therefore finds these charges proved, by way of your own admissions.

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

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:

- Colleague A: Band 7 Senior Practice Nurse and Nurse Manager at the time
- Colleague B: Band 5 Civilian Nurse at the time
- Colleague D: Practice Manager at the time
- Colleague E: Senior Medical Officer at the time
- Witness 1: General Practitioner at the time
- Witness 2: Band 6 Practice Nurse providing ad hoc cover at the time

The panel also considered the hearsay evidence of Colleague C who was a Band 6 Nurse at the time.

The panel also heard live evidence from the following character witnesses called on your behalf:

- Ms 1: Senior Nurse
- Ms 2: Wing Commander (Retired)
- Mr 3: Squadron Leader

The panel also heard evidence from you under oath.

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

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

Charges 4(a) and 4(b)

4. On 17 January 2023, in respect of Patient A:

    a. Failed to take average blood pressure readings;
    b. Due to your actions at Charge **4(a)** failed to increase medication.

The panel found charge 4(a) proved.
Not proved in relation charge 4(b).

In reaching its decision, the panel took into account the following evidence:

The panel noted Colleague A's witness statement, which states:

> *"On 17 January 2023, Marcus took blood on a patient on antihypertension medication. The patient brought a week's worth of home readings with him. Marcus noted that they had been returned, but did not average them or note what range they were in. He did note that the patient had a follow up doctor's appointment. The doctor saw the patient on 20 January 2023, but referred the patient to a rapid access TIA clinic due to concerns. The BP was not averaged by the dcotor* [sic] *at that time (it had already been scanned). The patient's medication was not changed until June 2023, a significant delay to treatment."*

In oral evidence, Colleague A described this as a small omission. The panel noted that the blood pressure was not averaged by the doctor either, and that the patient was referred to a TIA clinic by the doctor.

The panel also had sight of the Copy of Audit undertaken of your clinical documentation and took the following considerations into account when relying on this material. This audit is attached to an email sent by Colleague A on 17 February 2023. While this document was produced near the time of the events, it is not a fully contemporaneous document but an investigatory one. The document is a review of the clinical notes with extracts of your clinical notes and the author's commentary but not the full original notes themselves. The notes contain various points which are not direct lifts from the medical records but are instead an expression of someone's opinion. At the end of the email dated 17 February 2023, Colleague A added a considerable amount of

her own opinion. The panel was therefore mindful that this may not be a completely unbiased document.

In relation to charge 4(b), the copy of audit states:

> "*Patient handed in home BP readings. These were not averaged, but MO appt made. Not been averaged, but has been referred to TIA clinic. PT SAFETY CONCERN – I have previously discussed the importance of BP readings, in Dec when x2 raised were missed"*

In Colleague A's exhibit, "answers to the NMC", it states:

> *"ML saw a patient on 17th Jan 2023 who had returned 4 days of home readings for his BP management, was on Ramipril 5mg. BP readings put for scanning, but not averaged by ML, who noted that he had returned a week of readings. No note of where bloods were taken from. Pt had a follow up appointment with an MO on 20th Jan. MO did not average the readings either. (Av was 141/91) which indicates poor control on Ramipril 5mg and would have initiated an increase in dose of Ramipril. Referred to TIA clinic on 20th Jan due to ongoing migraines and episode of slurred speech. Next time BP measured in clinic in June 2023, raised, and medication increased to 7.5mg Ramipril in June 2023."*

In your oral evidence, you said you did not recall the incident, and that you "*have always taken blood pressure readings and was taking them everyday of my life when I was in secondary care."* You further stated: "*I've never increased medication one way or the other for somebody with blood pressure. That'd be something a doctor would need to do*." You said: "*I've never been accused of failing to take average blood pressure readings before, and as for recording them, they had this weird situation where you would write them down on a card. you would drop it into a tray and would notify the doctor...I was treated as if I was, as if I'd never nursed a day in my life…"*

The panel noted that this account was supported by the copy of audit carried out near the time of events showing that there was concern at the time and that the average blood pressure readings were not taken. On the balance of probabilities, the panel found charge 4(a) proved.

In relation to charge 4(b), the panel noted that it was not your responsibility to increase the medication, as you were not qualified as an independent prescriber and therefore had no

authority to do so. The panel concluded that there was no duty on you to increase the medication. The panel considered that a failure to increase would only arise where there was an obligation to increase. The panel therefore found charge 4(b) not proved.

Charges 6(a) and 6(b)

6. Between January 2021 and February 2023 ~~undertook~~ **attempted to undertake** smoking cessation clinics:

    a. Without having completed the necessary training;
    b. Without the necessary supervision.

This charge is found NOT proved.

In reaching its decision, the panel took into account the following evidence:

In relation to 6(b), the panel noted Colleague A's witness statement, which states:

> *"Marcus had not been trained to carry out smoking cessation consultations. He had attended a few consultations that either [Colleague C] or I had conducted in order to observe. This was a part of his broadening post. We never gave him a smoking cessation consultation to run on his own, and so if there had been a patient who wanted to book in for smoking cessation appointment, it would either be done by [Colleague C] or me with Marcus as an observer. This was done for patient protection, so they received the correct advice and treatment.*
>
> *At this point, Marcus had apparently been a qualified nurse for 5 years (However, I never did receive any formal background information, despite asking). Marcus had been based in a hospital and was not trained in primary care. However, Marcus appeared to have the mentality that if he had watched any specialist consultation, that he was trained on it, and could therefore run one himself. He called a patient in for a smoking cessation appointment without asking for support. [Colleague C] had noticed this happen and flagged it with me, and I therefore had to run in behind the patient to ensure the appointment was supervised, as I did not have the confidence in Marcus that he would have requested someone to attend and supervise.*

Marcus was offered smoking cessation online training. However, it was not completed. He was provided with the links and passwords to access the training and offered protected time to complete it."

In her oral evidence, Colleague A was asked whether you saw patients unsupervised, and her answer was no. She stated that although you did call a patient without support, this was merely calling the patient in for an appointment.

The panel also considered Colleague C's witness statement, which states:

"• I cannot recall the precise date; however, I recall being present for an incident in around January 2023: whereby I walked in on Marcus conducting a smoking cessation clinic despite the fact that he had not had the training and therefore did not have the knowledge required to conduct these clinics. Marcus was aware of this fact, and to my knowledge Marcus was aware that further training in this area was in the process of being booked in on his behalf by the Practices' receptionists. Upon discovering this, I verbally informed [Colleague A]."

In your oral evidence, you said that you did not complete the training, but you also said that you did not attempt to undertake the consultation: "*…I opened my computer, started a consultation, and in popped Colleague A or Colleague C. It wasn't that I was continuing on and wanted to do it on my own. I knew one of them would be coming in. They both had access. They knew exactly what patients. I would have had in my office. And if they hadn't come in by the end of the consultation, I would have went out to get them…"*

The panel noted that the booking process was not specific to the skill set of practitioners, and that patients were allocated to the available practitioner at the time. There is no evidence to suggest that you sought out patients for smoking cessation.

The panel determined that there is no evidence to show that your actions were anything more than preparatory steps for the consultation. The panel therefore found charge 6(b) not proved.

In light of the finding on charge 6(b), the panel determined that charge 6(a) falls away.

Charge 8(b)

8. On 16 January 2023, in respect of Patient J:
    b. Failed to refer Patient J to be reviewed by a doctor.

This charge is found NOT proved.

The panel took into account Colleague A's witness statement, which states:

> *"On 16 January 2023 Marcus had triaged a patient who was complaining of foot pain. When he entered in the notes from the triage, Marcus had noted it down as plantar fasciitis. Based on the symptoms the patient had reported, it was unclear as to why Marcus had put it down as being plantar fasciitis. If this had been the potential diagnosis, then the appropriate course of action would have been to refer the patient on to a doctor for a further assessment. If a diagnosis of plantar fasciitis was then confirmed, then a further referral on for physiotherapy should have been made. He did book the patient in for a review with himself, which the patient later cancelled as his foot pain had resolved*."

The panel noted the '*Copy of Audit undertaken for Marcus's clinical documentation for patients*', which states: "*(Not a big thing) Saw a pt with foot pain, and put that it was plantar fasciitis, but no clear Hx noted to indicate that."* The panel is of the view that this is not a direct replication of the original clinical notes, but rather part notes and part comment by the author of the document and that it does not mention the need to refer the patient to a doctor or review.

In your oral evidence, you said that it is normal practice to refer such cases to physiotherapist. You said you may refer a case to the GP, or you may refer it to physiotherapist. You could not recall this particular occasion. However, you were of the belief that you would have done one or the other.

The panel noted that it must be satisfied that you had an obligation or duty. It determined that there is no supporting evidence. The only evidence it has that the patient should have been referred to a doctor is Colleague A's opinion as expressed in her statement to the NMC. The copy of audit document does not extend to a requirement that the case be reviewed by a doctor. Therefore, in the absence of supporting evidence, the panel found charge 8(b) not proved.

Charges 10(a) and 10(b)

10 On 2 February 2023 in respect of Patient I:

a. Mis-diagnosed thrush;
b. Your actions at charge 10 (a) were undertaken despite you not having been trained in sexually transmitted infections;

These charges are found proved.

In reaching its decision, the panel took into account the following evidence:

The panel noted Colleague A's witness statement, which states:

"Marcus had confirmed to the patient it was thrush and reviewed him 3 days later when the patient reported his symptoms were improved. Off the back of this, without any further assessment, or request for further input, Marcus discharged the patient. Marcus has had no training in sexually transmitted infections, and I am unaware of any training he has had to examine a patient's genitals.

I therefore called the patient back and explained that I had reviewed the notes from his appointment and that I had some follow-up questions for him. I firstly asked why he thought he did have thrush at the time, and the patient explained that he had searched his symptoms online, and the search results suggested he was suffering with thrush. The patient had therefore bought thrush cream at a chemist to treat his symptoms, (it had not been dispensed by the MTF). Following on from this response, I then asked if he was in a sexual relationship with a female partner (as male thrush is very uncommon unless contracted from a female partner or if the male is possibly immune compromised), and he confirmed he was with a female partner. I then asked if his partner had thrush, which he confirmed that she did not, and he had no indications of immune suppression. I then asked if he had suffered with a tight foreskin before, to which the patient explained that he had, and that pre-enlistment, his GP had offered him surgery. He confirmed that his symptoms were ongoing and bothering him and were worsened by the cold weather. I did not examine him. Following this I decided that it would be appropriate for the patient to be seen by a doctor and booked him in for a further appointment. "

The panel took into account the *'Copy of Audit undertaken for Marcus's clinical documentation for patients'*, which states:

"*Assessed patient with sore penis as having thrush. (Diagnosed?) Pt reported he had canestan cream, but it wasn't issued by MOD. Not sexual health trained, no appropriate*

history taken, no notes made about how he may have got it, sexual history etc. No other screening offered. 'Netting advice given' – not detailed. What advice was given considering he has no SH training? Did book review appt on 6th Feb, and reassured patient who said he'd had some stomach and chest pain over the weekend. Worth a review???"

In oral evidence, Colleague A said she was not sure why you diagnosed thrush, as you had noted no indication of infection, but the patient had been prescribed thrush cream.

You admitted that you had carried out the examination and that you had not been trained in sexually transmitted infections (STIs).

On the balance of probabilities, the panel found that there was a misdiagnosis of thrush. You had made the initial diagnosis on the basis of the patient's self-report, but you also suspected tight foreskin. You called the patient back three days later; the patient reported that their symptoms had subsided, and you discharged them. [PRIVATE]. The patient was subsequently reviewed by Colleague A, who made a diagnosis of tight foreskin.

In relation to charge 10(b), you carried out an examination for a potentially sexually transmitted infection and admitted in oral evidence that you had not completed any training in this field. The panel found charges 10(a) and 10(b) proved.

Charges 11(a) and 11(b)

11 On 7 February 2023, in respect of Patient K:

a. On one or more occasions, failed to escalate them to a doctor due to complaint of chest pains;
b. On one or more occasions, discharged them without arranging for them to be seen by a doctor.

The panel found charge 11(b) proved and found charge 11(a) not proved.

In relation to 11(a), the panel took into account Colleague A, which states:

"*Marcus then showed the ECG to [doctor] later on in the morning around 11:00. Based on the findings the doctor had asked Marcus repeat the ECG. At this point, Marcus failed to*

explain that the patient had left the practice. As the doctor wanted a repeat ECG, this meant that Marcus had to call the patient and ask them to come back to the MTF for a repeat ECG at 14:00."

In light of this paragraph, in which Colleague A clearly records that the ECG results were escalated to the doctor at around 11:00 that morning, the panel finds that you did escalate the ECG, albeit later than Colleague A's expectation that you should have escalated them immediately as soon as the doctor arrived at the clinic in the morning.

The panel took into account the '*Copy of Audit undertaken for Marcus's clinical documentation for patients'*– entry dated 7/2/2023: "*Later that morning, ECG shown to [doctor] who verbally commented that she would like the ECG repeated as there were high voltage complexes.*"

In your oral evidence, you accepted that you recognised the need to show the ECG to the doctor and that you did so later that morning.

Based on this evidence, the panel found charge 11(a) not proved.

Regarding charge 11(b), you stated that you assessed a patient with chest pain, carried out a full examination, recorded all observations and performed an ECG, which you considered to be normal, and that you then allowed the patient to leave. You said you undertook ECGs multiple times a day, every day in your previous role in a secondary healthcare clinical setting.

In summary, your evidence was that there was no doctor present when you first saw the patient in the morning. You carried out a full history and examination, including clarifying the nature and location of the chest pain, completing a full set of observations and performing an ECG, which you recall as normal. The patient's symptoms lessened, and he reported feeling better. You told him he could wait in the waiting area until the doctors arrived, or return later that day for the doctors to review his ECG. You advised him to return immediately if his symptoms worsened or if he developed central chest pain. You explained that, as this was a small camp, you had his telephone number, could easily contact him, and could arrange for him to return promptly if required. In your oral evidence you accepted that, with hindsight, you might have asked him to remain until the doctor arrived, but maintained that the case was escalated to the doctor, albeit in the doctor's absence at that time.

The panel's view is that, in a clinical context, 'discharge' would ordinarily mean that no further follow-up is required. However, in this case, the panel understands the charge to allege that you allowed the patient to leave the medical centre on more than one occasion without being seen by a doctor.

It noted the witness statement of Colleague A, which states:

> "*On 7 February 2023 soon after 08:00, so quite early in the morning, a patient had come to the MTF, complaining of chest pains. Marcus had checked the patient over and did an ECG. The ECG automated printout suggested that there was nothing wrong, so Marcus assumed that the issues were musculoskeletal in nature rather than anything cardiac, and as such discharged the patient. At this point in time the doctor had not yet come in, and Marcus did not retain the patient, or flag anything to the doctor or any other team member.*"

You said that the patient was allowed to leave because he remained on the camp, you had his telephone number, and he was only 5 minutes away from the surgery, so could be easily recalled if needed. However, the panel also heard from Colleague E that it would be reasonable to expect that the patient wait the arrival of the doctor as it was only a short period of time.

Colleague A's written statement records that you showed the ECG to the doctor at around 11:00. The doctor requested a repeat ECG; you therefore called the patient back and performed a second ECG, but again allowed him to leave without being seen by the doctor. The doctor then requested blood tests, requiring the patient to be called back a second time. The copy of audit shows that you queried the doctor's decision to order blood tests, as you considered the presentation to be clearly musculoskeletal rather than something more serious.

The essence of charge 11(b) is that you allowed the patient to leave the medical centre without arranging for them to be seen by a doctor on one or more occasions. The evidence outlined above supports this allegation. The panel therefore found charge 11(b) proved.

Charges 12

12 On an unknown date in relation to Patient L, failed to gain consent from them to complete a full blood-test (to include HIV test).

This charge is found NOT proved.

The panel noted that the NMC has indicated that no evidence is being called or relied upon in relation to charge 12. The panel therefore determined that the evidential burden of providing this charge has not been discharged, and accordingly there is no evidence before it in respect of charge 12.

Charges 16(a) and 16(b)

16 In November 2022, during a feedback session with Colleague A, made inappropriate and/or threatening comments in relation to Patient C, including:

a. That Patient C's breath smelled of coffee;
b. '*I hope we meet again in a dark alley'* or *'he should look out for me if we ever meet in a dark alley'* or words to that effect.

These charges are found proved.

In relation to 16(a), the panel took into account Colleague A's witness statement, which states:

"In November 2022, when giving feedback about appointment and raised BP that Marcus had missed, Marcus had commented that he did not like Patient C and that Patient C's breath smelled of coffee during the medical, so he had wanted to finish the medical as soon as possible. There was no clinical link in Marcus' responses, (he did not comment for example that maybe the recent coffees had contributed to his raised BP, it was just a personal comment to emphasise why Marcus didn't like him) and again was an entirely inappropriate personal comment to have made about a patient.

On this same occasion in November 2022, Marcus had also said to me that he hoped to see Patient C in the street before Patient C left the RAF and say to him "I hope we meet again in a dark alley". I asked him why he would want to say that, to which Marcus had said that he wanted to make Patient C uncomfortable, and that he would feel the need to look over his shoulder. I pointed out to Marcus that what he had just said was a threat to a patient. He then said that it was not a threat, and that he used to be a policeman, and he knew what a threat was. I reminded him that he was no longer a policeman, that he was a nurse, and that he was talking about threatening a patient."

In relation to charge 16(b), the panel took into account the '*Copy of Audit undertaken for Marcus's clinical documentation for patients'*, which states:

> "*inappropriate comments about patients (I don't like him, I would like to meet him a dark alley, I know what a threat is because I used to be a policeman)"*

Colleague A reiterated that evidence in her oral evidence, which was consistent with her witness statement.

When questioned on this matter, you stated that you may have made the comments, but not in a derogatory or threatening manner. You also explained that there had been an incident involving your respective pets outside the clinical setting, and that you were quite exercised by the patient's refusal to report that incident to the Service Police or the civilian police.

On the balance of probabilities, the panel determined that you did make the comments outlined in charge 16. The panel therefore found charges 16(a) and 16(b) proved.

Charges 17(a) and 17(b)

17 Did not respond professionally when receiving feedback from Colleague A, in that you:

a. Paced around the room;
b. Said to Colleague A "it's you, it's your tone" or words to that effect.

This charge is found proved in relation to 17(a)
Not proved in relation to 17(b).

The panel took into account Colleague A's witness statement, which states:

> "*As I gave Marcus this feedback about BP incidents, he became angry and began pacing around the room. I kept my tone level, and did not raise my voice, but I was speaking in a grave tone, to express to Marcus the severity of what had happened. Marcus then walked towards the door and said to me that he needed to go. I said to him that I understood and that receiving this type of feedback off the back of a complaint is difficult. Marcus had then said to me that "it's not that [Colleague A], it's you, it's your tone." I was quite taken aback by this, as I did not know what he meant."*

The panel took into account the record of interview with Colleague A dated 28 March 2024, which states:

> *29. [Colleague A] detailed that about a week after Cpl Lynch had conducted the Release Medical, she provided feedback to Cpl Lynch regarding the highlighted errors (24 hour blood pressure and recording of raised blood pressure at medical) alone in her treatment room, adding that she was careful in how she delivered further critique. [Colleague A] stated that due to Cpl Lynch's errors in undertaking and managing blood pressure readings in the context of patient safety, she did deliver her feedback in a "serious" tone. [Colleague A] further stated that whilst she was sat at her desk, Cpl Lynch began to "pace the room", and said he needed to leave, to which she replied that he could but that they would have to continue the feedback when he was calmer and better able to discuss. [Colleague A] recalled that Cpl Lynch replied that it was nothing to do with the blood pressure reading feedback or the patient 'complaint', "it's you [Colleague A], it's your tone", which she replied that they should talk later.*

In Colleague D's witness statement, she states:

> "*I therefore wanted to empower [Colleague A] to be able to manage Marcus herself. I therefore offered her suggestions and advice about different ways of providing feedback, teaching and training Marcus which may be more suitable to him. It is noted that [Colleague A] has a particular teaching style, which is perfectly fine but does not necessarily suit all individuals. I also made [Colleague A] aware that if she should want me to commence the formal disciplinary process, then I would. What I was really trying to do was to push the nursing team together and try to get them to build a functional working relationship."*

Colleague A said she was sitting at the computer in a large room. You were pacing and irritated, but not near her, and she did not feel threatened. She said that you stated, *"It's not about you, [Colleague A]. It is your tone."*

You said in your oral evidence that you probably did pace around the room, but that it was not unprofessional. You said: "*it's a big huge room. I just remembered walking around and just being probably upset…But sometimes the tone could be over the top. I don't know if any of your witnesses have said that to you before. Like it could move from professional criticism to*

downright nitpicking and the school teacher kind of stuff…. It wouldn't be a one-to-one professional conversation."

In light of the above, the panel determined that pacing around the room in an agitated state in a feedback meeting is not professional. The panel therefore found charge 17(a) proved.

In relation to charge 17(b), whilst the panel accepted that the words were said in a professional feedback session, you were asked to explain yourself and it is not unprofessional to comment on the way the feedback had been given to you. The panel found charge 17(b) not proved.

Charges 18(a) and 18(b)

18. On 14 July 2022 demonstrated aggressive behaviour towards colleagues in that:

    a. Shouted in the presence of Colleague B;
    b. Shouted at Colleague C:
        i. In person
        ii. On the phone

This charge is found proved in its entirety.

In relation to charge 18(a), the panel took into account the evidence of Colleague B. In her witness statement, she states:

> *"It was an incredibly difficult meeting as Marcus was very angry and upset, [Colleague C] was very upset, and I was felt distressed. However, I believe that Marcus and [Colleague C] finally discussed what had happened. Following this, they were able to work together until [Colleague C] left Whittington in or around November/December 2022"*

In Colleague B's oral evidence, she said there was shouting and that it was a difficult meeting. She said she was always between senior nurses and you. She said you had reached the end of your tether and were upset. When asked whether there were comments directed to specific individuals, Colleague B said you had a raised voice, were frustrated and agitated, and that comments were directed towards Colleague C as you were turned towards her. The comments were defensive in tone and not meant to be disrespectful. She said the meeting was not well managed by Colleague D and that it became very personal and unprofessional. She confirmed that your behaviour was aggressive.

In Colleague D's witness statement, he states:

> *"The meeting became heated and both Marcus and [Colleague C] were speaking over each other. I also noticed that Marcus' voice became more aggressive in tone and that he puffed his chest out (I had witnessed this type of behaviour from him a few occasions during his time within the Practice). There were points where [Colleague C] was not really listening to what Marcus had to say either. My impression was that neither Marcus or [Colleague C] got what they wanted out of the discussion, and they both lost control a bit."*

In his oral evidence, when questioned about whether he would have classed your behaviour as aggressive towards colleagues, he said yes. He also recalled that you raised your voice towards Colleague C.

The panel also considered the witness statement of Colleague C, which states:

> "…*Marcus berated me, stating that I had 'no right' to intervene in this event and provide further clinical assessment to the patient in this way….*
>
> *….*
>
> *Throughout the meeting, Marcus was 'back-peddling' in my opinion. I recall that [Colleague B] cried during the meeting and afterwards advised [Colleague D] and I that Marcus's behaviour made her nervous. To my knowledge, no notes or transcript was taken during this meeting."*

In your oral evidence, you said Colleague B was very upset as there was tension in the room, that she burst out crying, and that there was an unrelated issue between Colleague B and Colleague D as acknowledged by Colleague B in her own evidence. You said you did not shout in person or on the phone. Your voice might have been raised, but everybody's voice was raised. You said you were coming to the end of your tether in that place, and that you were upset and hyper alert. You denied demonstrating aggressive behaviour and denied shouting in the presence of Colleague B. You said there were raised voices, but there was no aggressive intent. You were just upset, but everybody else was in there and there were tears all over the place.

The panel noted that there was aggression and shouting. Colleague B and Colleague D confirmed in their oral evidence that it was aggressive. It is clear from the oral and written evidence that there was shouting and raised voices in the meeting and that you shouted in the presence of Colleague B. The oral evidence of Colleague B is that you directed that shouting to

Colleague C. Both Colleague B and Colleague D outlined that they considered the behaviour to be aggressive. The panel therefore finds charges 18(a) and 18(b)(i) proved. However, the panel noted that it was a badly managed meeting, that there were high emotions on all sides, and that there were other reasons people were upset aside from your behaviour.

In relation to 18(b)(ii), the panel took into account Colleague B's witness statement, which states:

> *"…On this day, [Colleague C] had raised concerns with me regarding Marcus's use of an ECG and asked me to oversee him conducting this, as she was not happy with how Marcus had used this the day before. I recall [Colleague C] advising that Marcus had previously used a 12-lead which was incorrect.*
>
> *Following this, I approached Marcus to inform him that I would be overseeing his use of an ECG and explained that [Colleague C] had asked me to do this as she had witnessed that he had incorrectly used the ECG previously. Immediately after informing Marcus of this, he asked why [Colleague C] had asked me to watch him. I repeated that she was unhappy with his use of the ECG previously. However, Marcus was not happy with this reason. He responded that felt competent performing ECGs and told me that he had completed numerous ECGs whilst working in his previous employment at the Hospital. I responded to advise that he should speak with [Colleague C] further regarding this. Marcus then stepped outside the centre to call [Colleague C] regarding his use of the ECG. I was not present for this call and cannot comment further on the call.*
>
> *Shortly after the call had taken place, [Colleague C] arrived at the medical centre. I recall that upon arrival she was upset and in tears, wearing her civilian clothing. Following [Colleague C's] arrival, the Practice Manager [Colleague D] gathered all nursing staff members present on shift into the coffee room within Whittington for an emergency staff meeting. I recall the reason for this meeting was that [Colleague D] was concerned about the tense relations between staff within the nursing department."*

In her oral evidence, Colleague B said that she could hear the tone as heated and frustrated, that it did not sound happy, but that she could not hear what was said.

The panel considered Colleague C's witness statement, which states:

"Following this incident, on 14 July 2022, I was working from home due to personal commitments. As a result of this I had spoken with Colleague B to ask if she would work closely, in partnership with Marcus. This was because Marcus had made previous errors, and therefore required supervision. However, later that day, whilst I was working from home, I received a call from Marcus querying why I had 'spoken about him behind his back?'. During this call Marcus was very angry, and I found his behaviour and tone be quite threatening."

You said that your voice was possibly raised, and when asked whether there were expletives, you said no. You said you did not remember the details, you did not get angry, but were frustrated. You admitted that on the call to Colleague C you were upset and frustrated.

On the balance of probabilities, the panel attached weight to Colleague B's evidence that she heard raised voices through the frosted glass window and, given the overall context of that meeting, the panel found that it is more likely than not that you were aggressive in that you shouted at Colleague C on the phone. The panel therefore found charge 18(b)(ii) proved.

Charge 19

19 On 18 July 2022 you aggressively accused Colleague C of unreasonably pointing out concerns in respect of your practice.

This charge is found NOT proved.

The panel found no independent or corroborating evidence to support this charge, and as a result, the NMC has not met the required evidential standards to prove the matter. The panel therefore found charge 19 not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to lack of competence and/or misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to

practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to lack of competence and/or misconduct. Secondly, only if the facts found proved amount to lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Submissions on misconduct/lack of competence and impairment

Mr Radley took the panel through his written submissions which included references to the NMC Guidance and relevant case law.

You said that you had been suspended for two and a half years, having already spent a year off [PRIVATE]. You accepted that you had overstepped professional boundaries, particularly in carrying out ear irrigation when you should have declined as you were not trained to undertake this procedure independently and therefore should have rearranged the appointment, and in supplying E45 cream without prescription as per PGD policy and having been told not to. You said you have been under significant stress at the time, but accepted responsibility, expressed remorse and stated that you would not repeat such behaviour.

Since your suspension, you said you have engaged in further training, including aesthetics and CPR courses, and worked part-time in aesthetics, both independently and in a clinic. [PRIVATE]. [PRIVATE].

You said that you loved nursing, wanted to return, and aspired to lead the HCPT charity nursing team on a voluntary basis while also working a few shifts a week in a paid nursing role. You acknowledged that your actions could have impacted patients and that there was "a bit of luck" no one was harmed. You said you had previously made minor medication errors, as you

believed most nurses had, but had always admitted them and learned from them. You said you have not faced any formal disciplinary processes previously. You said you had never administered anything dangerous and that systems of checks and balances, particularly in vaccination clinics, reduced the risk of harm.

You described your background in both military and civilian settings, noting pressures and tensions between military and NHS staff, but said you generally got on well with colleagues and remained in contact with some. You felt you had been a victim of the process and of your colleagues conduct, and that the RAF, military nursing services and the NMC had treated you poorly. Nonetheless, you said you had no bitterness, had lost faith in the NMC process but chose to participate in the NMC proceedings, and were prepared to undertake any training or remediation required to enable you to go back to nursing.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on lack of competence (Charges 1 – 15)

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:*
> ***1.2*** *make sure you deliver the fundamentals of care effectively*
> ***1.4*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2*** *Listen to people and respond to their preferences and concerns*
> *To achieve this, you must:*
> ***2.1*** *work in partnership with people to make sure you deliver care effectively*
>
> *4 Act in the best interests of people at all times*
> *To achieve this, you must:*

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

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*

8 *Work cooperatively*
To achieve this, you must:
8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
8.2 *maintain effective communication with colleagues*
8.6 *share information to identify and reduce risk*

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

10 *Keep clear and accurate records relevant to your practice*
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 *Recognise and work within the limits of your competence*
To achieve this, you must, as appropriate:
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*
13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
13.5 *complete the necessary training before carrying out a new role*

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, including repeat prescriptions (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 the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel considered each of the proved charges individually. It noted that there were a number of different clinical practices involved over a period of two months, and that these represented a significant range of concerning conduct. Despite being relatively new to a role in primary care, you were a nurse with over six years experience, the panel noted that nevertheless you made these basic clinical errors.

The panel was referred to the case of *Holton v GMC [2006] EWHC 2960 (Admin)* and took it into account when considering the charges found proved. It was aware that, during the timeframe covered by charges 1–15, you had been qualified for over six years and had been working in a broadening post, a development position which enabled you to transfer from secondary to primary healthcare and undertake the necessary training in primary healthcare. In light of the

Holton case, the panel considered that there was a wide range of examples of failings in your practice which fell below the standard that would reasonably be expected of an experienced nurse, even one in the second year of a broadening post.

The panel took full account of the challenging working conditions and the timeline of the exchange of complaints between you and Colleague A, and noted that there appeared to be an antagonistic or conflictual relationship between you both.

The panel was mindful of the broader context of the working environment, which it considered to be challenging. It noted the tensions between you and colleagues as well as between colleagues for reasons that did not have anything to do with you, and the difficult working relationships that existed. [PRIVATE]. While the panel took all of this into account, it concluded that a nurse of your experience should not have been making the basic errors identified in relation to these relatively straightforward clinical tasks.

The panel was satisfied that the matters found proved were not so serious as to amount to misconduct (except for charges 5 and 15, which the panel will address in detail below in its decision on misconduct). However, taking into account its reasons for the findings of fact, the panel concluded that your practice fell below the standard that would be expected of a registered nurse acting in your role. In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on misconduct (Charges 5(a), 5(b), 15(a), 15(b), 15(c), 16(a), 16(b), 17(a) 18(a), 18b(i), 18(b)(ii), 20(a), 20(b) and 20(c))

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Charges 16(a), 16(b)

The panel determined that the remarks were inappropriate but were not intended as a serious threat. Having considered the context in which they were made, the panel concluded that they were off-hand comments made in the course of a feedback conversation. There was no evidence that Patient C was aware of the remarks, nor that they had any impact on patient care or safety. In all the circumstances, the conduct, though unprofessional, did not represent a serious departure from the standards expected of a registered nurse and therefore did not amount to misconduct.

Charge 17(a)

The panel accepted that your conduct occurred in a large room during a feedback session that you found challenging and was borne out of frustration. While your response was not appropriate or professionally measured, the panel noted that the behaviour was momentary. The panel also noted that Colleague A stated in her oral evidence that she did not feel threatened. In light of these factors, the panel concluded that this represented a lapse in professionalism rather than a serious departure from the standards expected, and therefore did not amount to misconduct.

Charges 18(a), 18b(i)

The panel heard that the meeting on 14 July 2022 was highly emotive; all parties were upset, some were in tears, and there was raised volume and shouting from more than one individual. The evidence before the panel was limited and, apart from the fact that you raised your voice, there was no clear or reliable account of the specific words used by you. The panel considered that the situation was complex, involving several individuals and that responsibility for the tone and direction of the meeting could not be attributed to you alone. The panel heard evidence which suggested that parties to the meeting may also have been upset for reasons which were not related to you or your conduct.

Although your behaviour on that occasion was unacceptable and your manner towards Colleague C was perceived as aggressive, the panel considered it to have been an isolated incident arising in an unusually charged context, rather than reflective of your usual practice or character. There was no evidence that your conduct resulted in harm to patients. In all the

circumstances, the panel concluded that, while inappropriate, your behaviour did not fall so far below the standards expected of a registered nurse as to amount to misconduct.

Charge 18(b)(ii)

The panel accepted the evidence that you raised your voice and that the conversation, as overheard by Colleague B, sounded heated. However, there was no evidence of abusive language nor of any escalation beyond raised voices. The panel concluded that this behaviour did not amount to misconduct.

Charges 20(a), 20(b) and 20(c)

The panel accepted that aspects of the messages you sent could properly be described as unprofessional. However, the content, when viewed in full context, did not demonstrate malice nor did it compromise patient safety. The panel concluded that, while the communications were not professional, it did not amount to misconduct.

In relation to charges 5 and 15, the panel determined that these charges do amount to misconduct.

In respect of Charges 5(a) and 5(b), you were informed that you could not administer the medication under a PGD and that a prescription was required. Despite this advice from the pharmacy technician, you proceeded to take and issue the prescription-only medication, stating that you would obtain a prescription later, and you then failed to do so. You therefore acted in direct contravention of both the advice given and the applicable policy at the time, and without the authority to supply that item.

The panel noted the written representations provided on your behalf, which states:

> *"Initially Mr Lynch did not know he required a prescription for an over-the-counter cream but once it was brought to his attention by the Pharmacist that a prescription was required, he endeavoured to obtain one, he believes he asked [doctor] for the prescription. Given the nature of the medication in question namely an over-the-counter moisturiser Mr Lynch accepts that he did not fully appreciate the urgency with which he*

was expected to have obtained the prescription and as such he opted to prioritise his busy clinic and cannot now recall whether a prescription was ultimately obtained."

Notwithstanding this, the panel considered that proceeding in the face of advice to the contrary represented a serious departure from the standards of safe prescribing practice expected of a registered nurse.

In relation to charge 15, the panel found that you knowingly acted outside the scope of your training and competence by performing ear irrigation. You had been told by Colleague A not to carry out the procedure and you had yourself admitted that you did not have the necessary training to undertake it. The procedure carried a risk of harm and could have caused injury to the patient.

Taken together, the conduct in charges 5 and 15 fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

'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* in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) …..'*

When considering the above test, the panel determined that all limbs a, b and c are engaged in this case in that your actions potentially put patients at unwarranted risk of harm; you brought the nursing profession into disrepute; you breached fundamental tenets of the profession, namely to practise effectively, preserve safety, promote professionalism and trust and prioritise people.

Looking at the test in *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), the panel was satisfied that your lack of competence and misconduct in this case are capable of being addressed. The panel therefore carefully considered all of the evidence before it in determining whether you have taken steps to strengthen your practice.

The panel noted that you provided written representations, admitted a number of the charges, and submitted character references, as well as calling three character witnesses. Their evidence indicated that you are a skilled professional who has others' best interests at heart and that you undertake a significant amount of work with a charity organisation. Whilst your character witnesses characterised you as a skilled professional, they had not worked with your previously and were not able to comment on your clinical practise. The panel also noted that you expressed some degree of remorse and accepted that, with hindsight, you would have acted differently.

Colleague E in his evidence stated that he had not observed any unacceptable behaviour in eight months of working with you. Colleague B described you as an *"incredible nurse with patients, kind and compassionate."*

The panel also noted that you gave an oral reflection and acknowledged that these events have had a significant impact on you personally. However, it considered that there was limited exploration of the impact of your actions on others, and therefore concluded that your reflection was only partial.

The panel took into account the attitudinal element of your behaviour. It recognised that you were working in a challenging environment and that you considered yourself to be more experienced than some colleagues in some areas of practice. However, it considered that you have not fully reflected on the incidents since they occurred and have, at times, appeared to solely attribute blame to others. Although your actions did not result in direct harm, the panel considered that you did not sufficiently acknowledge the potential wider impact of your conduct. It determined that these concerns are not deep-seated but that you require greater awareness and insight.

The panel noted that there was no evidence of you having undertaken relevant training or produced a developed written reflection. While it accepted that your suspension has limited the opportunities available to you, it considered that you could have done more to demonstrate

proactive remediation. The panel also noted that you described yourself as a victim and that there appeared to be an ongoing tendency to attribute blame to others. Although you admitted the charges, you often focused on how the situation has affected you, rather than on its impact more broadly. In these circumstances, the panel was not satisfied that you have demonstrated full remediation. It therefore concluded that a finding of impairment is necessary on the grounds of public protection.

In light of the above, the panel found that your fitness to practise is currently impaired, due to your limited insight and the relatively modest remediation undertaken in the two years since the incidents occurred. However, the panel considers that these matters are capable of being remedied with appropriate support, further reflection and your full engagement.

For these reasons, the panel concluded that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind 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 and 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.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Mr Radley provided written submissions. He invited the panel to impose a suspension order for a short period. He also suggested that a conditions of practice order may be an option. He said that you have been subject to a suspension order since July 2024.

You asked the panel to take into account the period of time you have not been in frontline nursing and to consider imposing a conditions of practice order. You said you would be committed to complying with such an order, rather than a further suspension, as you did not see the point of another suspension. You explained that you want to work full time in aesthetics. You have checked which of your aesthetics courses count towards your nursing Continuing Professional Development (CPD) and you have records of them. You said that you understand the seriousness of the charges that have been found proved.

In response to questions from the panel, you said you would carry out certain procedures in aesthetics, including injecting and Platelet-Rich Plasma (PRP), but that this would not be as comprehensive as it would be in a hospital setting. You said that you want to be able to obtain a job.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A pattern of conduct over a period of time
- Conduct that put patient receiving care at risk of suffering harm
- Failure to consistently follow instructions and fully demonstrate that you had learnt from feedback
- Lack of adequate insight into failings

The panel also took into account the following mitigating features:

- Early admissions to a number of charges
- Your level of experience and the limited support available to you at the time: you began a new role in primary healthcare when both senior nurses were off sick, and you were effectively placed in a challenging situation and what was considered to be a toxic environment
- Personal mitigation [PRIVATE]

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 and misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would 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:

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

In reaching its decision, the panel noted that the incidents occurred some time ago. While it noted attitudinal concerns, it did not find that it was deep-seated. It noted that you have shown some reflection and it accepted that you would be willing to comply with conditions of practice. The panel considered that a conditions of practice order would allow you to further develop and strengthen your professional practice and provide you with an opportunity that a suspension order would deny, whilst still ensuring the safety of the public.

The panel was satisfied that, with appropriate safeguards in place, it is in the public interest for you to return to nursing practice. Balancing all the relevant factors, the panel concluded that a conditions of practice order is the appropriate and proportionate sanction.

The panel, taking full account of the principles in the overarching objective of the NMC guidance in the SG and the principle of proportionality, concluded that a suspension order is not proportionate in this case and that a conditions of practice order would protect the public. Furthermore, 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 not be the sole nurse on shift

2. You must develop a Personal Development Plan (PDP) to address the concerns about your lack of competence and misconduct. It should focus on the following aspects:
    - Immunisation and vaccination practice
    - Clinical assessment and monitoring
    - Diagnosis and clinical judgement
    - Prescribing and medicines management
    - Referral, escalation and management
    - Scope of practice, supervision and compliance with instructions

You must meet with your manager or supervisor monthly to discuss your progress against the areas of concern identified above. These meetings must be recorded.

3. You must send your NMC case officer a report from either your manager or supervisor every six months. This report must show your progress towards achieving aims set out in your PDP.

4. You must keep a personal reflective practice profile recording written reflections on a monthly basis. The profile must include actions you have undertaken to address learning and practice related to:
    - Immunisation and vaccination practice
    - Clinical assessment and monitoring
    - Diagnosis and clinical judgement

- Prescribing and medicines management
- Referral, escalation and management
- Scope of practice, supervision and compliance with instructions

5. You must undertake additional learning and training, with a particular focus on the areas of concern identified above.

6. Prior to any NMC review, you must provide a report from your manager or supervisor commenting on your clinical performance, conduct and progress against the areas of concern identified above.

7. You must raise any challenging situations you have encountered within the workplace with your manager or supervisor as soon as practicable.

8. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

9. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

11. You must tell your NMC case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

12. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

While not a condition, the panel considers that the support of a professional mentor would be beneficial to your practice and enable you to reflect on your work with someone outside of your workplace.

The period of this order is for eighteen months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at a future hearing
- Evidence of monthly reviews (see condition 2)
- A report from your manager or supervisor prior to a review (see condition 6)
- Copies of your reflections (see condition 4)

- Testimonials and feedback about your practice including from your professional mentor
- Evidence of CPD training (see condition 5)
- Details of courses and/or training you have undertaken

Interim order

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

Submissions on interim order

Mr Radley invited the panel to impose an interim conditions of practice order for a period of eighteen months to provide for the gap between the making of any substantive order and closure of the statutory appeal window or any actual appeal. He submitted that, given the panel's findings, an interim conditions of practice order would be appropriate

You did not oppose the application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the

interim order will be the same as those detailed in the substantive order for a period of eighteen months to allow for the possibility of an appeal to be made and determined.

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.

This will be confirmed to you in writing.