Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Thursday, 29 January 2026

Virtual Hearing

Name of Registrant:	Nadine Wilson
NMC PIN:	97Y0127O
Part(s) of the register:	Midwives Part of the Register: RM: Midwife (19 March 2001) Nurses Part of the Register Sub Part 1: RN1: Adult nurse, level 1 (14 August 1997)
Relevant Location:	London
Type of case:	Lack of competence
Panel members:	Isabelle Parasram (Chair, lay member) Michelle Wells-Braithwaite (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Audrey Chikosha
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Ms Wilson:	Present and represented by Gemma Mills instructed by ERRAS Consulting.
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (6 months) to come into effect on 18 April 2026 in accordance with Article 30 (1).**

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

[PRIVATE]

An application under Rule 19 of the Nursing and Midwifery Fitness to Practise Rules Order of Council 2004 ('the Rules') to hear some of the matters in private was accepted.

Decision and reasons on review of the substantive order

The panel decided to extend the current suspension order.

This order will come into effect at the expiry of the current order, namely at the end of 17 April 2026 in accordance with 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is an early review of the substantive order originally imposed on 18 October 2024 and extended by six months commencing 18 October 2025. This review is being held because you informed the NMC that you have new evidence to present to the panel.

This is the second review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 18 October 2024. This was reviewed on 15 September 2025 when that order was extended for 6 months.

The current order is due to expire at the end of 17 April 2026.

The panel is reviewing the order pursuant to Article 30(2) of the Order as this is an early review.

The charges found proved by way of admission which resulted in the imposition of the substantive order were as follows:

'First set of charges (2019)

That you a registered nurse and/or registered midwife:

1) On 5 March 2019 in relation to the preparation of an intra venous (I/V) Syntocinon, infusion for Patient A:

a) Failed to read the prescription chart;

b) Failed to prepare 10 international unts (iu) per 500 ml of sodium chloride;

c) Prepared 40 iu per 500 ml of sodium chloride;

d) Prepared a label with 40 iu per 500 ml of sodium chloride.

2) On 5 March 2019 in relation to Patient A failed to demonstrate knowledge of the correct dosage of Syntocinon to be administered to a patient who was in labour.

3) On 5 March 2019 in relation to Patient A failed to carry out the required:

a) Observations every hour;

b) Blood sugar/glucose tests;

c) Vital signs;

d) Amniotic fluid checks;

e) Foetal Heart monitoring.

…

5) Having been subject to undertakings as varied on 13 October 2022 failed to complete the undertakings within 6 months

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

<u>Second set of charges (2023)</u>

That you, a registered nurse and/or registered midwife, between 18 December 2022 and 19 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in the following:

1) On or around 19 December 2022, in relation to patient 2:

a) Administered intravenous medication.

b) In relation to charge 1(a) was acting outside her level of competency.

2) On 3 January 2023 failed to escalate Patient 3's condition, namely that they were hypothermic.

3) On 9 January 2023 in relation to Patient 4:

a) Failed to support the patient's perineum effectively;
b) Failed to ensure the CTG was correctly; recording during the third stage of labour;
c) Did not recognise the correct order of the labour procedure, namely:
i. The administration of Syntocinon:
ii. Delivery of the placenta;
iii. Suturing.

4) On 18 January 2023 in relation to Patient 5:
a) Did not make a record in a timely manner; namely within 30 minutes;
b) Did not recognise a Post-Partum Haemorrhage ("PPH").

5) On 19 January 2023, in relation to Patient 6:
a) The management and administration of medication, namely:
i. Oramorph;
ii. Syntocinon.
b) Incorrect labelling of a blood sample;
c) Delayed Patient 6 receiving an epidural.

6) On 25 January 2023 in relation to Patient X:
a) In regard to the timings of listening to the foetal heart rate in the first stage of labour, namely every 15 minutes;
b) In regard to Cardiotocography (CTG) physiology.

7) On 3 February 2023 in relation to patient 7:
a) Administered intravenous antibiotics on the incorrect occasion;

b) *Did not make a proper record in regard to the administration of the intravenous antibiotics.*

8) *On 4 February 2023 in relation to patient 8:*
   a) *Did not provide the correct information during labour, namely the direction in which to push;*
   b) *In regard to the battery on the Cardiotocography equipment:*
      i. *Allowed the battery to cease to function;*
      ii. *Failed to have a backup battery.*
   c) *Did not stimulate Patient 8's baby without prompting;*
   d) *Did not provide third stage labour medication without prompting.*

9) *On 5 February 2023 in relation to an unknown patient:*
   a) *Did not complete records in a timely manner;*
   b) *Failed to stimulate the baby of the patient.*

10) *On 10 February 2023 in relation to an unknown patient required prompting to:*
   a) *Check the patient's blood pressure;*
   b) *Escalate the patient's condition;*
   c) *Administer fluids.*

11) *On 11 February 2023 in relation to Patient 9:*
   a) *Did not escalate Patient 9's condition to:*
      i. *A midwife in charge*
      ii. *An anaesthetist*
   b) *Provided incorrect information to:*
      i. *Colleague Y regarding Patient 9's heart rate;*
      ii. *To Patient 9, namely the reasons for the administration of Terbutaline.*

12) *On 12 February 2023 in relation to Patient 10 in labour:*
   a) *Delayed the care of Patient 10;*

b) *Did not or did not adequately, communicate with Patient 9 during delivery of Patient 10's baby;*
c) *Delayed the stimulating and/or covering of Patient 10's baby.*

13) *On or around 13 February 2023 failed to store a placenta correctly.*

14) *On 16 February 2023 in relation to Patient 11, failed to:*
a) *Recognise low sodium levels;*
b) *Carry out one or more tests/checks on sodium levels;*
…
d) *Escalate Patient 11's condition regarding sodium levels to:*
i. *A senior colleague;*
ii. *A doctor.*

15) *On 17 February 2023 in relation to Patient 11, failed to:*
a) *Recognise or take appropriate action when Patient 11 suffered a post-partum haemorrhage;*
b) *Record Patient's 11 blood loss in a timely manner.*
c) *To keep proper and/or accurate records.*

16) *Did not effectively communicate with colleagues during handovers on:*

a) *9 January 2023*
b) *18 January 2023*
c) *19 January 2023*
d) *25 January 2023*
e) *4 February 2023*
f) *11 February 2023*
g) *12 February 2023*

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

The first reviewing panel determined the following with regard to impairment:

‘The panel considered whether your fitness to practise remains impaired.

The panel noted that the previous panel found that you had insufficient insight. At this hearing, the panel considered that you were genuinely remorseful and that you have demonstrated an improvement into your insight.

However, the panel found that you have not yet demonstrated fully developed insight. Specifically, the panel found that you have not yet demonstrated an understanding of how your conduct was dangerous to patients. The panel found that there were points in your written reflections where you deflect blame onto other members of staff instead of accepting full responsibility for your conduct. Further, the panel found that while you indicate throughout your reflections that you will act more professionally in the future, you do not indicate specifically how your conduct will change, or why your previous conduct was insufficient in the circumstances. Therefore, the panel found that you have obtained some insight into your practice but have not fully developed insight.

The panel also considered whether you have strengthened your practice. The panel considered that you have taken a number of courses and that you have made an effort to strengthen your practice by attending and engaging in learning. The panel also considered the positive remarks made from your line manager. However, the panel had regard to the fact that most of these courses were completed on 9 September 2025, six days prior to this hearing. Further, the panel was not satisfied that you have demonstrated a direct understanding of how to apply what you have learned to your practice. Specifically, the panel found that you have not demonstrated an understanding of the clinical risk and harm that your conduct could and did cause, nor have you demonstrated how you will act differently in the future.

Regarding the risk that you will repeat your past misconduct, the original hearing panel determined that you were liable to repeat matters of the kind found proved. Today’s panel considered your written and oral submissions and had particular regard to your written statements. Upon reviewing your evidence, the panel was not satisfied that you have demonstrated an understanding of how and why your

conduct raised a clinical risk of harm to your patients, or how you would act differently in the future. In other words, while you have provided evidence of understanding that your prior conduct was wrong, you have not provided any indication of how you will act differently in the future. Therefore, the panel concluded that a risk of repetition exists in this case.

In light of this, this panel determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance.

The panel determined that, given the seriousness of the original charges that were found proved, a finding of continuing impairment on public interest grounds is also required in order to protect the public's confidence in the profession and to uphold the standards of conduct and performance.

For these reasons, the panel finds that your fitness to practise remains impaired.'

The first reviewing panel determined the following with regard to sanction:

'Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 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 bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. Given the breadth of the charges, the panel was not able to formulate conditions of practice that would be workable or that would adequately address the concerns relating to your lack of competence.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to deeply reflect on your previous lack of competence. The panel concluded that a further six month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice and demonstrate how you will act differently in the future. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 17 October 2025 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- *Evidence of deeper insight of the clinical risk around the scenarios which led to the original charges, and how you would apply your increased insight and learning to your practice in the future.*
- *Evidence of professional development, including evidence of how your transferable skills and knowledge learned as a health care assistant, particularly around communication, record keeping, escalation, and recognising the deteriorating patient are being applied to your practice.*
- *Evidence of feedback where possible from your course facilitators about your participation in the courses you have attended or are attending in the next 6 months.*
- *A testimonial from a registered nurse or midwife which you have recently worked closely with which demonstrates how your further learning has been applied to your practice.*

This panel has indicated that an emphasis on the future evidence should be focussed on the quality of further reflections and evidence, rather than quantity'

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the midwife's ability to practise safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle and two On-Table bundles submitted by you containing a detailed chronology of your

efforts at remediation, training certificates, testimonials and reflections. It has taken account of the submissions made by Mr Kabasinskas on behalf of the NMC and Ms Mills on your behalf.

Mr Kabasinskas referred the panel to NMC Guidance on Early Reviews (REV-2b), Standard Reviews of Substantive Orders before they Expire (REV-2a) and Lack of Competence (FTP-2b).

Mr Kabasinskas submitted that the concerns in this case are numerous and wide-ranging. He acknowledged that you have submitted evidence of training courses, reflections and testimonials. However, Mr Kabasinskas submitted that there is no evidence that you have strengthened your practice as a midwife. He referred the panel to NMC Guidance (FTP-15B) titled '*Has the concern been addressed.'* Mr Kabasinskas submitted that the panel must look at the concerns, assess the seriousness and determine whether the remediation is sufficient to reduce the risk.

Mr Kabasinskas submitted that once the panel has undertaken the task of assessing each concern and the present risk it, may make a decision on whether your fitness to practise remains impaired on the ground of public protection. He submitted that given this is a case regarding lack of competence, public safety is a primary consideration, and should the panel deem there to be matters that still need to be addressed, it should determine that your fitness to practise is impaired.

Regarding public interest, Mr Kabasinskas submitted that should the panel find that there is no longer a public safety concern, given you have been suspended for a significant period of time, the public interest ground may not arise.

Mr Kabasinskas submitted that the panel has two available sanctions to it today: conditions of practice or suspension. He submitted that allowing the order to lapse with impairment is not appropriate given your indication you wish to continue practising. A striking-off order is also not applicable at this time given this is a lack of competence case and you have not been suspended for a period of more than two years. Mr Kabasinskas submitted that should the panel find that some areas of concern have been remediated but some risk of repetition remains then it may formulate conditions. However, should the

panel find that no conditions can be formulated then it must impose a further suspension order.

Ms Mills reminded the panel that the charges found proved in this case were found proved by way of admission. She submitted that this admission was evidence of your engagement in the process and insight into the seriousness of the concerns.

Ms Mills took the panel through the recommendations from the previous panel and submitted that you have fully engaged and complied with them and have provided evidence in the areas outlined. She also submitted that at the previous hearings you have provided the panel with evidence of your learning, remediation and strengthened practice.

Ms Mills referred the panel to your reflective statement dated 4 December 2025 and submitted it is very detailed and goes into depth concerning each of the charges found proved. She then referred the panel to a chronology which outlines the steps you have taken in order to remediate and develop fuller insight into the concerns raised. Ms Mills submitted that you have undertaken a sustained programme of education in specific areas which relate to the charges found proved including a course which you commenced prior to the substantive hearing in 2024.

Ms Mills submitted that in addition to the further training, you have also completed your annual compliance and competency training as well as the mandatory training for midwives despite being presently suspended from practice. Ms Mills submitted that you have completed intensive, hands-on and practical training which has strengthened your practice. She submitted that your training has been consistent and relevant to the concerns raised in this case.

Ms Mills then addressed the panel on the recommendation to provide testimonial evidence. She submitted that the panel has before it, a testimonial from a Ward Manager at [PRIVATE] ("the Hospital") where you have been working as a Healthcare Assistant (HCA) since June 2024, dated 7 August 2025 which reads:

> *'…During her time on* [PRIVATE]*, Nadine has consistently demonstrated a compassionate and patient-centred approach, particularly in caring for vulnerable*

patients recovering from surgery. She shows genuine empathy and kindness, which has made a positive impact on both patients and their families.

Nadine communicates clearly and effectively with patients, their families, and colleagues, fostering a supportive and collaborative environment. She works seamlessly as part of the multidisciplinary team, showing reliability and professionalism in all aspects of her role...'

Ms Mills submitted that despite the suspension, you have made attempts within your current practice to implement the training that you have undertaken. She submitted that the details of the training courses alongside your reflective accounts show that you have been able to remediate in numerous areas and reduced the risk of repetition to such that it is now negligible.

Ms Mills then referred the panel to a testimonial by one of your training course instructors who has also known you in a professional capacity for over a decade, dated 28 January 2026 which reads:

'…Nadine demonstrated excellent practical skills hands -on vaginal breech delivery, shoulder dystocia, resuscitation of the newborn and maternal resuscitation assessments (among other maternity issues)

They were all interactive sessions and Nadine contributed effectively in all issues that affect midwifery practice.

In clarity this is an evidence in her fitness to continue caring for women without concerns or supervision .

I strongly believe that Nadine is one of the experienced midwives the midwifery profession needs…'

Ms Mills submitted that you demonstrated genuine and fully developed insight into the nature and seriousness of the original concerns. She referred the panel to your reflective

accounts and submitted that they are extensive. Ms Mills submitted that you have engaged with your mentor and have provided a testimonial from her.

Ms Mills submitted that you have taken proactive steps to remediate the concerns identified by the previous panel and have undertaken targeted training. She submitted that in light of the evidence before the panel today, your fitness to practise is no longer impaired such that a continued suspension order would not be proportionate to satisfy the public protection and public interest concerns. Ms Mills submitted that should the panel find that you have shown full insight and addressed the areas of concern then it should revoke the suspension order.

Ms Mills submitted that given you have not been in practice for a significant period of time, the panel may find there to be an ongoing public interest concern. She submitted that in this case, the panel should impose a conditions of practice order on the ground of public interest alone. Ms Mills submitted that this would allow you to continue to strengthen your practice under supervision in order to ensure the risk of repetition has been eradicated.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel bore in mind the recommendations provided by the previous panel which read:

‘*Any future panel reviewing this case would be assisted by:*

- *Evidence of deeper insight of the clinical risk around the scenarios which led to the original charges, and how you would apply your increased insight and learning to your practice in the future.*
- *Evidence of professional development, including evidence of how your transferable skills and knowledge learned as a health care*

assistant, particularly around communication, record keeping, escalation, and recognising the deteriorating patient are being applied to your practice.

- *Evidence of feedback where possible from your course facilitators about your participation in the courses you have attended or are attending in the next 6 months.*
- *A testimonial from a registered nurse or midwife which you have recently worked closely with which demonstrates how your further learning has been applied to your practice.'*

The panel determined your insight has deepened since the last review; however, it was not satisfied that you have demonstrated how you would apply your increased insight and learning to your practice in the future as a midwife. The panel acknowledged that you admitted the charges at the original hearing. However, the panel was of the view that your insight is not yet sufficient to indicate that you are able to practise safely and effectively as a midwife. The panel noted that you have shown a significant level of remorse. It noted in your reflection dated 4 December 2025 you wrote:

'…My actions had the ability to cause serious harm to the women and babies in my care; its effect could be felt long after the actual events have transpired. apologise to the women who were in my care, their families, my colleagues, the members of my profession other members of the wider healthcare profession, as well as the public as a whole. In doing so I recognise that I did not uphold the standards of the professional code of practice of the Nursing and Midwifery Council. I understand the level of risk that I posed to the safety of the women and babies in my care, because of my poor competencies and decision making as a professional…'

With regards to the second point, the panel noted that while you outline in your reflection that you would escalate concerns to a midwife, you do not provide any detail on how you would do so, i.e. by explaining the techniques in your training. The panel was of the view that given the extent of the competency concerns in this case, your reflections do not sufficiently illustrate the learning from the training you have completed and how you would utilise those skills in practice.

The panel noted that you provided two testimonials from a registered midwife who has worked with you for over a decade and was also the course instructor for one of the training courses you completed. It noted that while these testimonials were positive, they are limited in providing an overall picture of your competency as a midwife. The panel noted that these testimonials referred to one course which is also annual mandatory training for midwives. The panel had no other information regarding your participation, engagement and ability to implement the learning into practice with the numerous other areas of practice relevant in this case.

The panel was of the view that at this time, it had insufficient evidence before it to demonstrate that you have been able to implement your further learning into practice. It noted that you are currently working as a HCA and thus are not able to carry out midwifery duties, however, it had no evidence before it of how you have transferred your training to your current role nor how you would do so if you were to return to midwifery practice.

The panel bore in mind the tests in Grant *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant* [2011] EWHC 927 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin) as well as the NMC Guidance (REV-2a).

The panel determined that the first three limbs of the *Shipman* test remain engaged when looking at the position today and going forward, namely that you are liable in the future to put patients at risk of harm, you are liable in the future to bring the profession into disrepute and are liable in the future to breach one of the fundamental tenets of the midwifery profession.

In light of the above, the panel determined that your fitness to practise remains impaired on the ground of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required given the serious public protection concerns that you are not yet competent to practise safely as a midwife.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risks identified and the wide-ranging nature of the concerns. 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 public protection issues identified, in particular the concerns around your ability to practise safely and effectively, an order that does not restrict your practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order 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 bore in mind the extent of the concerns regarding your competency and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest at this time. The panel was not satisfied that you have demonstrated a sufficient level of insight and remediation to be permitted to return to practice. The panel was not able to formulate conditions of practice that would adequately address the concerns without being overly onerous to the point where conditions would not be workable.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on your previous lack of

competence. It considered that you need to gain a full understanding of the competencies of a midwife and demonstrate how you would implement your training to strengthen your practice. The panel concluded that a further suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. It would also give you an opportunity to approach health professionals to attest to your strengthened practice and ability to demonstrate putting your learning and training in practice.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined that imposing a suspension order for a period of 6 months would provide you with an opportunity to demonstrate developed insight and strengthened practice, undertake continued training and reflect fully on how you can implement the training in practice to avoid repetition of the failings in this case. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 17 April 2026 in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of continued training in relevant areas of midwifery and fundamental midwifery competencies
- A detailed reflection including an understanding of how you would implement your learning and training in practice with examples to include the detailed steps you would now take to address the deficiencies which have been proved in the charges that you admitted.
- Testimonials from colleagues/ managers/ supervisor/ course instructors that detail your participation and engagement with training and learning and how you have demonstrated this in practice.

A future panel may be assisted, if you wish to do so or are so advised, to give evidence under oath or affirmation so a panel can directly question you in respect of your learning over the six months this order has been in place.

This will be confirmed to you in writing.

That concludes this determination.