Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 15 December 2025 – Friday, 19 December 2025
Monday, 22 December 2025
Wednesday, 15 July- Friday, 17 July 2026

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

Name of Registrant:	Diana Linda Griffiths
NMC PIN:	99C1125E
Part(s) of the register:	Registered Nurse – Adult (RNA) 20 March 2002
Relevant Location:	Staffordshire
Type of case:	Misconduct
Panel members:	Mark Gower (Chair, Lay member) Penelope Howard (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Peter Jennings (15- 22 December 2025) Robin Hay (15- 17 July 2026)
Hearings Coordinator:	Emily Mae Christie (15 and 16 December 2025) Ekaette Uwa (16 and 17 December 2025) Samara Baboolal (18 December 2025) Hanifah Choudhury (19 and 22 December 2025 15-17 July 2026)
Nursing and Midwifery Council:	Represented by Rachel Hughes, Case Presenter (15- 22 December 2025) Represented by Matt Kewley, Case Presenter (15-17 July 2026)
Ms Griffiths:	Present and represented by Laura Herbert, Counsel instructed by the Royal College of Nursing (RCN)

Facts proved by way of admission:	Charge 2 (in relation to Patient B on 15 March 2023), 3, 6a and 6b
Facts proved:	Charge 2 (in relation to Patient A and to Patient B on 13 March 2023), 5a and 5b
Facts not proved:	Charge 1a, 1b and 4
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (six months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Hughes, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 1b, 4 and 5.

The proposed amendments were to change the date in charge 1b to 15 March 2023 instead of 16 March 2023, in charge 4 to change the phrase *'working hours'* to *'workload'*, and in charge 5 to change the date to *'on or around 13 March 2023.'* It was submitted by Ms Hughes that the proposed amendments would more accurately reflect the evidence.

The proposed amendments to the charges are as follows:

'That you, a Registered Nurse:

1)…

1b) Patient B on 13 and ~~16~~ ***15*** *March 2023*

…

4) Your actions in charge 1 were dishonest in that you sought to reduce your own ~~working hours~~ ***workload****.*

5) On ***or around*** *13 March 2023 failed to escalate the HbA1C results in relation to:*

a) Patient C

b) Patient D'

Ms Herbert, on your behalf, did not object to the application and submitted that it would only be fair to amend charge 4 as this was the wording which the parties had initially expected, and to amend charge 1b) and charge 5 in order to reflect the evidence.

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

legal assessor also reminded the panel that its duty of due inquiry required it to consider whether the charges properly reflected the mischief alleged.

The panel took into account the submissions, the advice of the legal assessor, and the papers before it. The panel agreed to change the dates and wording in charges 1b and 5.

With regards to charge 4, the panel was of the view that the terms *'workload'* and *'working hours'* are inextricably linked. It noted that the earlier documents referred to workload, but the Notice of Hearing referred to *'working hours'*. The panel was not persuaded that removing those words would properly reflect the behaviour alleged. Therefore, the panel determined to amend the charge to read *'…working hours and/or workload.'* It was of the view that such an amendment 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 that amendment. It was therefore appropriate to make the amendment to better reflect the evidence in your case.

The panel invited submissions as to whether the wording of charge 5 should be changed to include reference to not following the HbA1c protocol.

Ms Hughes submitted that, while the evidence included a failure to comply with the protocol, the substance of the allegation was that you failed to escalate the results and the relevance of the protocol was as part of the evidence. It should not therefore be referred to expressly in the charge. Ms Herbert opposed the suggestion on similar grounds.

The panel was of the view that an amendment to reflect the specific failure alleged, in that you did not follow the HbA1c protocol, would add clarity and context to the charge. The panel determined to amend the wording of charge 5 to the following:

5) *On or around 13 March 2023 failed to escalate**, and/or failed to follow the Practice's HbA1c protocol in respect of,** the HbA1c results in relation to:*
   a) *Patient C*

b) Patient D

The panel was of the view that such an amendment 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 this amendment. It was therefore appropriate to make the amendment, to better reflect the evidence in your case.

Details of charge (as amended)

That you, a Registered Nurse:

1) Cancelled and/or rebooked patient appointments without clinical and/or administrative justification in relation to:
    a) Patient A on 8 March 2023
    b) Patient B on 13 and 15 March 2023

2) Failed to communicate to Patient A and or B that their appointments had been cancelled and or rescheduled.

3) Failed to make any patient records, or any adequate entries in relation to the communication to Patient A and or B in relation to their cancelled and or rescheduled appointments.

4) Your actions in charge 1 were dishonest in that you sought to reduce your own working hours and/or workload.

5) On or around 13 March 2023 failed to escalate, and/or failed to follow the Practice's HbA1c protocol in respect of, the HbA1c results in relation to:
    a) Patient C
    b) Patient D

6) Failed to keep adequate and or sufficient records of consultations with:
    a) Patient A, on one or more of the dates set out in Schedule 1.
    b) Patient B, on one or more of the dates set out in Schedule 2.

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

Schedule 1

21 October 2022

14 December 2022

14 March 2023

Schedule 2

10 March 2023

13 March 2023

Background

On 11 May 2023, the NMC received a complaint from Vicki Brown, the Nurse manager and an Advanced nurse practitioner (ANP) at Balance Street Practice (the Practice), in relation to you, a registered nurse. You had worked as a practice nurse at the Practice since 2018.

Ms Brown's referral raised concerns that you had cancelled and rescheduled patient appointments without clinical justification. It also raised a concern that you had allegedly failed to follow the HbA1c protocol for blood sugar testing on patients with diabetes, in that some patients you assessed had elevated blood sugar levels and were not escalated and booked in to see a nurse with higher levels of expertise in diabetics management.

Following this, Ms Brown conducted an audit of your appointments and found that the documentation and actions did not adhere to the HbA1c protocol. Your documentation was poor both in the patient medical records and blood test records, and it was unclear what had been discussed with the patient during the consultation, and it did not outline the advised next steps or any medication changes. You were suspended from the Practice on 15 March 2023, and an investigation was conducted by Ms Brown. The recommendation was to proceed to a disciplinary hearing, which took place on 21 April 2023.

Decision and reasons on application to admit hearsay evidence

The panel heard an application from Ms Hughes to allow the hearsay evidence in an email from Patient B, which comes from their initial complaint to the Practice. Ms Hughes submitted that this evidence pertains to the underlying facts of charge 1, specifically regarding the rearrangement and cancellation of appointments. Having heard your admissions and reasons for denying charge 1, Ms Hughes submitted that this evidence is not significantly in dispute, and it is not the sole or decisive evidence of the charges, as it

is supported by other contemporaneous evidence of bookings and appointments. She submitted that this evidence is relevant and that there would be no unfairness to you if it were to be admitted.

Furthermore, Ms Hughes submitted that the NMC does not intend to call Patient B as a witness due to the passage of time since the alleged incident and the limited scope of the facts to which their evidence pertains.

Ms Herbert did not oppose the application to admit this evidence as hearsay.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel determined that the evidence of Patient B was relevant and was not the sole or decisive evidence in support of Charge 1. It noted that, although you may not have had prior notice that the NMC would be making this application, you do not object to its admission as evidence. The panel determined that whilst you would be unable to challenge this evidence, you can compare it with other contemporaneous evidence to test its credibility.

The panel went on to consider that the NMC does not usually require patients to give oral evidence, unless their evidence is substantial to the facts of the charge. Therefore, the panel was of the view that the NMC's decision not to call Patient B to give oral evidence was reasonable. The panel found no evidence to suggest that Patient B had fabricated this evidence. The panel was of the view that the charges are serious, and the non-attendance of Patient B should not lead to the exclusion of this evidence.

In all the circumstances, the panel considered it fair and relevant to accept Patient B's email as hearsay evidence. The panel would give it what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Decision and reasons on application of no case to answer in respect of the words 'working hours' in charge 4

The panel considered an application from Ms Herbert that there is no case to answer in respect of the words 'working hours' as stated in charge 4. This application was made under Rule 24(7) of the Rules.

Ms Herbert submitted that there is no evidence from the witnesses or within the case bundles to support this aspect of the charge. She submitted that, even if some evidence existed, it was so tenuous that any finding would require the panel to draw improper references to conclude that you had sought dishonestly to reduce your work hours in respect of Patient A and Patient B. Ms Herbert submitted that there is no evidence to indicate that you did not work the hours you were contracted to and therefore, no evidence on the balance of probabilities that you sought to reduce your working hours as alleged.

Ms Hughes submitted that the NMC was neutral in relation to this application and does not oppose it.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor concerning the provisions of Rule 24(7) and the principles which it should have in mind.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you have a case to answer in relation to the words *'working hours.'*

The panel accepted that whilst the words 'working hours' and 'workload' were somewhat related, the evidence before it supporting your dishonesty in this respect was weak.

The panel noted that some evidence related to this charge was redacted from the case bundles and that it would be within its powers to request that both this evidence and evidence of the sign-in records be produced. It bore in mind the practical difficulties of obtaining records from three years ago and considered that seeking further material at this stage would be undesirable. In any event, the panel concluded that it is unlikely that any such evidence would make a material difference to its decision on the present application.

Accordingly, the panel was of the view that the evidence on this matter was tenuous. It determined that the evidence did not support the allegation that you sought to reduce your working hours in respect of Patient A and Patient B, sufficiently for a panel to be able properly to find this matter proved on the balance of probabilities. The application was therefore upheld.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Herbert, who informed the panel that you made full admissions to charges 3, 6a, and 6b. She also informed the panel that you accepted charge 2, but only in relation to Patient B on 15 March 2023.

Ms Herbert also told the panel that you deny charge 1, on the basis that you accept that the appointments were cancelled and booked as alleged but that you do not accept that you acted without clinical and/or administrative justification.

The panel therefore finds charges 3, 6a, and 6b proved in their entirety, and charge 2 in relation to Patient B on 15 March 2023, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence, provided by both parties in this case, together with the submissions made by Ms Hughes and by Ms Herbert.

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:

- Vicki Brown: ANP and Nurse manager at the Practice at the material time;
- Tonya Davis: Lead Nurse at the Practice at the material time;
- Tim Hames: Practice Pharmacist and Medicines Management Team Leader.
- Finn Whelan: Receptionist at the Practice.

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who advised it as to the legal principles to which it should have regard. The panel took into account that you have not been the subject of any previous regulatory findings, as relevant to both your credibility and also to whether you are likely to have committed the failings alleged.

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

Charge 1a)

That you, a Registered Nurse:

1) Cancelled and/or rebooked patient appointments without clinical and/or administrative justification in relation to:
a) Patient A on 8 March 2023

This charge is found NOT proved.

In reaching this decision, the panel accepted your admission that Patient A's appointment was rebooked and was subsequently cancelled by Mr Whelan at your instigation. Accordingly, the factual issue for the panel was not whether the appointment was cancelled and rebooked, but whether this was done without clinical and/or administrative justification.

The panel's understanding of the substance of the charge is that you acted without either clinical or administrative justification. Accordingly, if the panel were of the view that there was clinical justification the charge would not be proved and it would be unnecessary to consider whether or not there was also an administrative justification.

The panel also considered that charge 1 alleged that your reasons for cancelling and re-booking appointments were not clinical ones. It did not regard the charge as requiring a medical analysis of whether your clinical judgement was objectively correct. Ms Hughes and Ms Herbert agreed with that approach.

The panel heard oral evidence from Mr Whelan and considered his contemporaneous written statement, dated 22 March 2023, which said:

‘He checked in on the screens, and then the patient notified me that Diana had given him a call right before the appointment to let the patient know he will need to see Colleague G instead as she is the diabetic nurse. She then proceeded whilst on call to book him an appointment two days later for the 10th of March.

However, she did not cancel the appointment for the patient and because the patient still came down for the appointment I am assuming she didn't let him know to not come to the appointment.

Because of this information I apologised on behalf of Diana for the appointment not being cancelled and said that it was down to human error that the appointment was not cancelled. I then said that the appointment on Friday the 10th will stay and that will be for the diabetic review.

The patient was visibly irritated and then left and after he left I cancelled the appointment he was supposed to have at the same time on the 8th of March.’

The panel noted that the appointment had been logged on the Practice’s system at 16:22 on 8 March 2023, recorded as a *“Diabetic discussion”* and booked into the diary of Colleague G for 10 March 2023. The panel accepted that the appointment was cancelled after Patient A arrived at the Practice.

The panel considered the clinical justification for the cancellation and rebooking. It noted that the entry for the appointment booking on the system recorded the reason for the appointment as a “Diabetic discussion”. The panel took into account Ms Brown’s notes completed during the investigation in which you stated that there may have been a need for a prescription and that Patient A’s needs may have been too complex for you to manage, particularly as you believed they may have been on insulin.

In your oral evidence, you accepted that you may have been mistaken as to whether Patient A was on insulin and you accepted that you should have seen Patient A when he arrived and acknowledged the missed opportunity to answer questions, give advice and provide an action plan, and that you recognised that you did not check Patient A's notes for his medical history. The panel noted that you had undertaken diabetic care training in 2006, although this had not been updated since then. The panel had sight of your training certificate, and you confirmed this in your oral evidence. The panel also accepted that Colleague G had greater relevant expertise.

The panel further noted evidence that there was a recognised process within the Practice whereby patients could be referred to colleagues with greater specialisation in diabetes. The panel accepted that it is a normal and appropriate professional practice to defer or refer a patient to a colleague with more specialist expertise where a clinician considers a matter to be more suitable for another clinician.

Although Ms Brown gave evidence that the area of concern in relation to Patient A was within your competence and responsibility, the panel accepted that at the material time you believed that you were clinically justified in rebooking Patient A with a nurse with more experience in this field.

Taking all of the evidence into account, the panel found that although the cancellation and rebooking of Patient A's appointment occurred, it was done as a matter of clinical judgement. The panel was therefore not satisfied that the cancellation and rebooking were without clinical and/or administrative justification. Accordingly, Charge 1a is found not proved.

Charge 1b

That you, a Registered Nurse:

1) Cancelled and/or rebooked patient appointments without clinical and/or administrative justification in relation to:

b) Patient B on 13 and 15 March 2023

This charge is found NOT proved.

In reaching this decision, the panel took into consideration your acceptance that Patient B's appointments were booked, cancelled and rebooked during this period. The panel therefore focused on whether those actions were taken without clinical and/or administrative justification.

The panel noted that at 08:30 on 13 March 2023 you created a telephone appointment for Patient B with Ms Davis. Later that day, at 16:17, that appointment was cancelled. On 15 March 2023 at 10:44 you created a further appointment for Patient B with yourself.

The panel considered the contemporaneous records of Patient B's appointment history, which showed that during this period you were seeking advice from Ms Davis regarding the management of Patient B's respiratory condition, specifically in relation to inhaler guidance. The panel noted that respiratory care had been identified as an area for your professional development, a matter you accepted in your evidence. You explained that although you had undertaken training, you were still developing your skills and confidence in this area.

The panel noted that you had emailed Ms Davis regarding Patient B's respiratory condition and created an appointment for Patient B with Ms Davis before being aware of her response. The panel accepted that once you became aware of Ms Davis' response, you contacted Mr Hames, the pharmacist, to generate the relevant prescription and created a follow-up appointment for Patient B with yourself for 17 March 2023, cancelling the appointment with Ms Davis.

The panel heard evidence from Ms Brown, who accepted that the clinical process you followed was rational and appropriately focused on seeking guidance and ensuring safe patient care. Ms Brown described the process as being "followed well", save for the

changes to appointments. She acknowledged that the issue arose from your administrative handling, including booking into Ms Davis' blocked diary and unblocking that diary without consultation, which was not accepted practice and contrary to guidance you had received in 2021. You accepted that you should have consulted or communicated with Ms Davis the appointment change in these circumstances.

However, the panel was of the view that Ms Brown's evidence was in substance that the actions you took were clinically justified and arose from you recognising that the respiratory issue was outside your current expertise and confidence, prompting you to seek advice from a colleague more experienced in respiratory care.

The panel further noted that, after obtaining advice from Ms Davis, you appropriately contacted Mr Hames to arrange the necessary prescription and arranged a follow-up appointment with yourself for Patient B to review the effectiveness of the new inhaler. The panel accepted that arranging a follow-up appointment in these circumstances amounted to good clinical practice.

The panel acknowledged that there was cancelling and booking of appointments, which was undesirable and did not follow the surgery's practice. However, it accepted that these changes were driven by your evolving understanding of the clinical situation, the advice received, and the practical requirements of prescribing and follow-up, rather than an absence of justification.

Taking all of the evidence into account, the panel was satisfied that the booking, cancellation and rebooking of Patient B's appointments were undertaken for clinical reasons and in the context of seeking appropriate guidance and ensuring safe care. The panel was therefore not satisfied that the actions were taken without clinical and/or administrative justification.

Accordingly, Charge 1b is found not proved.

Charge 2

That you, a Registered Nurse:

2) Failed to communicate to Patient A and or B that their appointments had been cancelled and or rescheduled.

This charge is found proved in relation to Patient A and to Patient B on 13 March 2023. It was admitted in relation to Patient B on 15 March 2023.

In reaching this decision, the panel carefully considered all the documentary evidence, the oral evidence of witnesses, and your own witness statement and oral evidence.

Patient A

The panel noted that Patient A attended the Practice believing they had a scheduled appointment. The evidence before the panel showed that Patient A was visibly irritated on arrival, having not been informed that their appointment had been cancelled or rescheduled. The panel accepted the evidence contained within Mr Whelan's local statement which confirmed that Patient A turned up at the clinic because they had not been notified of a cancellation.

The panel noted that you made a change to Patient A's appointment approximately 15 minutes before it was due to take place. You then telephoned Patient A at that time when he was already on the way to the clinic. The panel considered that this constituted very late notice and it noted that the appointment was actually cancelled, with your approval, at a time when Patient A had already attended the clinic.

The panel noted that there was no record of any conversation between you and Patient A, and you were unable to recall what, if anything, was said. The panel further noted the absence of any patient record documenting that you had cancelled the appointment,

contacted Patient A, or explained the reasons for the cancellation. The only record present was that the appointment had been cancelled on the Practice's system.

The panel found that you informed Patient A of an appointment with Colleague G. You failed, during the telephone conversation, to inform him that this was scheduled for a different date, and that your own appointment would be cancelled. Your evidence was that you informed Patient A that the appointment would be with another colleague, without explaining when that appointment would take place. As a result, Patient A attended the clinic expecting to be seen.

When questioned about your communication with Patient A, you accepted that your communication *"was not good enough."* The panel accepted this admission and concluded that any attempt to communicate with Patient A was made at the very last minute, immediately prior to the scheduled appointment, and was inadequate. It did not convey to Patient A that the appointment was to be cancelled and had been fixed for a new date. Also, until that late stage, you failed to communicate any information at all to Patient A.

The panel therefore found that you failed to communicate to Patient A that their appointment had been cancelled and/or rescheduled.

Patient B

In relation to Patient B's appointment on 13 March 2023, the panel considered the evidence in full.

The panel took into account that on 13 March 2023, you booked an appointment into Ms Davis' diary for a respiratory telephone consultation with Patient B. The panel understand that the booking system would have normally generated an automated text message notification. However, the panel noted that you did not contact Patient B yourself and that there was no patient record or contemporaneous note in evidence indicating any communication with Patient B by you.

The panel found that the appointment was booked at approximately 08:30 and later confirmed.

The panel took into consideration that you had unblocked Ms Davis' diary in order to book the appointment, despite not having authorisation to do so, and without seeking their consent. The panel considered that there was a clear expectation that you should have contacted Patient B directly to inform them of the appointment with a colleague who had greater experience in respiratory care review.

There was no evidence that you cancelled the appointment in a way that ensured Patient B was informed, and no evidence to suggest that Patient B was otherwise made aware of any change. In your oral evidence, you accepted that you did not speak to Patient B before booking the appointment and acknowledged that you should have done so.

The panel found that this amounted to a communication failure encompassing events on both 13 and 15 March 2023. The panel noted that Ms Davis' diary was unblocked without consultation, and there was no communication with them regarding the appointment.

Patient B was not contacted by you to inform them of the cancellation of that booking, despite Patient B expecting contact from Ms Davis. The panel noted that the appointment was cancelled on 13 March 2023 at 16:17 but Patient B was not informed of this cancellation. The panel concluded that responsibility lay with you to ensure that Patient B was contacted. While you stated in evidence that you attempted to contact Patient B, the panel took into consideration that you did not reach them or speak to them. Consequently, Patient B was not informed that their appointment had been cancelled or rescheduled.

The panel further noted that Patient B understood they were due to be seen by Ms Davis and expected a call on 15 March 2023, which did not occur.

For the reasons set out above, the panel found that you failed to communicate to Patient A and Patient B that their appointments had been cancelled and/or rescheduled.

Accordingly, charge 2 is found proved in full.

Charge 4

That you, a Registered Nurse:

4) Your actions in charge 1 were dishonest in that you sought to reduce your own workload.

This charge is found NOT proved.

The panel considered Charge 4 in light of its finding that Charge 1 was not proved. In those circumstances, Charge 4 could not be made out. The panel was however of the view that the allegation of dishonesty was not proved in any event.

The panel was not satisfied that your actions were dishonest or that you were seeking to reduce your own workload. The panel accepted that deferring an appointment in order to refer a patient to a colleague with greater specialist expertise is a normal and appropriate professional practice.

The panel noted that you saw another patient at 18:05 on 8 March 2023, an appointment that took place after the cancelled appointment with Patient A. This was inconsistent with an intention to reduce your workload. The panel also noted that you arranged a follow-up appointment for Patient B, which increased rather than reduced your workload and demonstrated appropriate patient management.

The panel also took account of your oral evidence in relation to Patient C and Patient D, that following the HbA1c protocol would have saved you time. The panel accepted this

evidence and found it undermined the allegation that your actions were motivated by a desire to reduce your workload.

Whilst the panel accepted that aspects of your actions may not have been carried out as efficiently as they could have been, it concluded that this amounted, at most, to poor professional practice. The evidence fell well short of establishing dishonesty. Indeed, there was some evidence that indicated that your actions may have created additional work for you.

Accordingly, even if Charge 1 had been proved, the Panel would not have found that your actions were dishonest. The panel therefore determined that Charge 4 is found not proved.

Charges 5a) and 5b)

That you, a Registered Nurse:

5) On or around 13 March 2023 failed to escalate, and/or failed to follow the Practice's HbA1c protocol in respect of, the HbA1c results in relation to:
   a) Patient C
   b) Patient D

These charges are found proved.

In reaching this decision, the panel first considered whether you were aware, or should have been aware, of the Practice's HbA1c protocol. The panel accepted the evidence of Ms Brown and Ms Davis that the protocol was displayed in all clinical rooms, had been implemented in August 2022, and a meeting took place on 2 December 2022.

The panel also accepted Ms Brown's evidence that you attended the meeting on 2 December 2022.

Although the panel acknowledged that the protocol was informal in presentation, not dated and not clearly headed, it nevertheless set out clear instructions, including your role and responsibilities in the management of patients with diabetes:

> *'HbA1c (over 48 for the first time) – Book face-to-face appointment with Diana to discuss Type 2 diabetes and discuss starting medication. Ask GP or Pharmacist to prescribe.*
>
> *HbA1c (48–50 known and stable diabetes) – check when last review was. Telephone call with Diana for review annually.'*

The panel was satisfied on the evidence that you either were or should have been aware of the current protocol in place. The panel further noted that, while you stated you could not attend one-to-one *'lab training'* with Colleague A on 16 September 2022 due to a diary conflict, it was incumbent upon you to follow up concerning the meeting and to familiarise yourself with relevant policies, particularly where you were specifically referenced within them.

The panel took into account that on 13 March 2023 you reviewed the HbA1c results for both Patient C and Patient D and recorded those results as *"discussed with patient"* and filed them accordingly. The panel was satisfied that, in respect of both patients, there was no reliable evidence that such discussions in fact took place. In the case of Patient C, the panel accepted evidence that they had to contact the practice approximately one week later to chase their blood results. In respect of Patient D, although a telephone appointment was recorded as having been booked, it was unclear whether that appointment occurred or whether the results were discussed.

The panel noted that Patient C's HbA1c result was 76 and Patient D's was 51.9. The panel found that both results required escalation for further clinical review and intervention. Further action was required in respect of both results. The panel further

accepted the evidence of Ms Brown that the documentation for Patient C and Patient D were either poor or absent.

The panel found that you were actively reviewing the blood results yourself, rather than relying on GP review under the previous procedure of the Practice. Accordingly, you were not acting correctly under either the current protocol or the previous procedure. By undertaking that role, you assumed responsibility for ensuring that abnormal results were escalated appropriately. The panel accepted the evidence of Ms Davis that no further action was taken in relation to either patient.

The panel further noted that under the Practice's HbA1c protocol, results at these levels required escalation to colleagues with more diabetics expertise, experienced in managing patients with higher HbA1c levels. There was no documentary evidence that you escalated either result or referred either patient, whether in accordance with the protocol or at all.

In your oral evidence, you stated that it was the GP who reviewed the results. However, the panel found this inconsistent with your own clinical entries recording the results as *"discussed with patient"* and referring to follow-up arrangements. The panel further noted that in your written response you did not suggest the existence of any additional contemporaneous notes and relied instead on your assertion that the GP would have followed up the results. However, the panel noted that it was only because the Practice reviewed your records as part of its investigation that these matters came to light. As you had filed the results with the entry *'discussed with patient'* and made no further appointment, there was apparently no reason for the GP to be aware of the need for follow ups.

In your oral evidence, you accepted that you did not review the HbA1c trends, and relied solely on the last previous numerical value. The panel found that this fell below the standard expected of a nurse in your role. The panel further concluded that, even in the

absence of a specific protocol, a nurse of your experience and role should reasonably have recognised that both results required escalation for further consultation.

For these reasons, the panel found that on or around 13 March 2023 you failed to escalate and failed to follow the Practice's HbA1c protocol in respect of the HbA1c results relating to both Patient C and Patient D. Accordingly, Charge 5a) and Charge 5b) are found proved.

Interim order

Following the determination of facts, after careful and considered reflection, the panel adjourned this hearing due to a lack of time to conclude the remaining stages of these proceedings.

On the basis that the hearing has adjourned, 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 is in your own interests.

Submissions on interim order

Ms Hughes submitted that that the NMC would not be applying for an interim order at this stage given that there has been no material change in circumstances. She submitted that whilst the matters found proved are serious, they do not reach the threshold in determining that an interim order is necessary to protect the public or meet the public interest.

Ms Herbert submitted that it is neither necessary nor proportionate to impose an interim order at this stage. She submitted that you have been working in your current role since August 2023 and have provided references and testimonials which have confirmed there have been no issues with your practice.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor who advised it as to the provisions of Article 31(2) of the Nursing and Midwifery Order (2001) and the principles which should guide its approach.

Taking into account the submissions made and the legal advice, the panel was not satisfied that an interim order is necessary for the protection of the public or that it is otherwise in the public interest or in your interest.

Specifically, the panel was not satisfied that there is a real risk to patients, colleagues or other members of the public if an interim order were not made. In reaching this decision, the panel noted that you have been working since 2023 without concern. The panel had sight of references from your current employer who attest to your good clinical practice and to a number of training courses which you have completed.

The panel also did not consider that an interim order was in the public interest, especially given the high threshold required for such an order. The panel also did not consider that an interim order was needed in your interests. In reaching this decision, the panel bore in mind the need for proportionality: the panel was satisfied that this decision properly balanced the interests of the public and your interests.

Accordingly, the panel made no order.

The hearing resumed on 15 July 2026.

Fitness to practise

Having reached its determination on the facts of this case, the panel next considered whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct

Mr Kewley provided the panel with written submissions and supplemented this with oral submissions.

Mr Kewley identified the specific, relevant standards in 'The Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code)' where the NMC alleges that your actions amounted to misconduct.

Mr Kewley submitted that the concerns relating to escalation and record keeping are of greater seriousness than those relating to communication failures. He submitted that the panel may consider that the failures to escalate created a risk of harm to patients.

Ms Herbert submitted that the allegations found proved, whether considered individually or cumulatively, do not amount to serious misconduct. She referred the panel to the principles in *Schodlok v GMC* [2015] EWCA Civ 769, submitting that whilst it is possible for a series of individually non-serious allegations to amount to serious misconduct when taken together, such findings should be confined to exceptional circumstances. She submitted that this is not such a case as the allegations do not involve dishonesty, personal gain, or conduct such as cancelling work for your own benefit. Rather, the findings demonstrate poor professional practice falling short of the required standards, but not serious misconduct.

Ms Herbert submitted that the context of the case is significant. She submitted that the matters now found proved present a materially different picture from that which initially informed the NMC's decision to investigate, and that, had the remaining allegations arisen in isolation, they would ordinarily have been addressed by your employer through local management processes rather than referral to the NMC.

Ms Herbert submitted that Charge 2, concerning the failure to communicate changes, amounted to poor practice rather than serious misconduct. There was an explanation for your actions, including that you had contacted the patient concerned, and that the allegation should be viewed in its proper context. When considered alongside the other findings, it does not elevate the case to one of serious misconduct.

Ms Herbert submitted that Charge 3 relates to deficiencies in record keeping. You accepted that accurate record keeping is a fundamental aspect of nursing practice and that your documentation fell below the expected standard. However, this was a limited example of poor record keeping which, whilst unacceptable and not reflective of good

professional practice, does not demonstrate attitudinal concerns or amount to serious misconduct.

Ms Herbert submitted that Charge 5 was the most serious of the allegations because of the potential risk of harm and your failure to follow the relevant protocol. You accepted that you should have known and complied with the applicable procedure and that your conduct fell below the standards expected of a registered nurse. However, the incident represented a clinical error arising from a gap in knowledge and competence, rather than deliberate or reckless conduct. Therefore, although it constituted poor practice, it did not cross the threshold into serious misconduct.

Ms Herbert submitted that Charge 6 also concerns deficiencies in record keeping. You accept that your record keeping was not of the standard expected and that this amounted to poor professional practice. However, this was not indicative of attitudinal concerns and did not amount to serious misconduct. Had this allegation arisen in isolation, it would have remained a matter for your employer to address rather than requiring regulatory action by the NMC.

Submissions on impairment

In regard to the issue of impairment, Mr Kewley referred to his written submissions and to the need to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Kewley submitted that, in the light of the panel's finding that dishonesty was not proved, the remaining concerns are capable of remediation. It is a matter for the panel to determine whether your fitness to practise is currently impaired, having regard to all the evidence before it.

Mr Kewley submitted that, in relation to the public interest, this is not a case that raises attitudinal concerns but rather concerns relating to clinical practice. When considering the training certificates you have provided, the panel may wish to assess the extent to which they are relevant, and address the clinical concerns identified.

Ms Herbert submitted that the concerns identified have been fully addressed and that the way you now practise no longer gives rise to concerns about patient safety. You have been practising without incident since 2023 and that your reflective account demonstrates genuine remorse, meaningful insight and a clear understanding of the impact of your actions. The panel can be reassured that you do not present a risk of harm to patients. This is not a case involving deliberate harm, personal gain or persistent misconduct over a prolonged period. Whilst accepting that there were breaches of the Code, they do not amount to breaches of fundamental tenets of the profession.

Ms Herbert submitted that there were a number of important contextual factors for the panel to take into account. The concerns arose in the context of an exceptionally busy practice, a heavy patient workload, changes in management and a prolonged absence of a lead nurse. At the time you did not fully understand how the systems operated and simply continued with your work when you should instead have sought advice and escalated your concerns. You now have profound insight into your failings, recognising that your failure to escalate concerns could have placed patients at risk of harm, accepting that your actions fell below the required standard, and demonstrating an honest appreciation of their impact on patients. You have undertaken relevant training to address the concerns, including training on record keeping, which has strengthened and embedded safe clinical practice.

Ms Herbert’s submission was that there is no current impairment of your fitness to practise. This is evidenced by your safe and unrestricted practice over the past three years, the positive testimonials from your current employers, and your consistent engagement throughout these proceedings. you have demonstrated a genuine commitment to maintaining safe practice and continuing your career as a capable nurse.

The previous risk of harm has been effectively addressed and that any future risk is now remote and that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which was also provided in writing.

Decision and reasons on misconduct

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

> ***'7 Communicate clearly***
> *To achieve this, you must:*
> ***7.1*** *use terms that people in your care, colleagues and the public can understand*
> ***7.4*** *check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.2*** *maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

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 appreciate that breaches of the Code do not automatically result in a finding of misconduct.

In relation to charge 2, the panel had in mind that effective communication is a fundamental aspect of nursing practice and an essential component of safe and effective patient care. The panel was satisfied that this failing amounted to poor practice rather than serious misconduct. Whilst your actions had the potential to place patients at risk of harm and caused them understandable distress, the panel did not find that they created a direct clinical risk of harm. It accepted that you cancelled the appointments because you did not

consider yourself sufficiently competent to undertake the clinical consultations and wanted the patients to be assessed by more experienced clinicians. The panel determined that your actions did not arise from an attitudinal issue but from a lack of competence. Nevertheless, the panel considered that you should have ensured that appropriate follow-up communication took place after the appointments were cancelled and rescheduled. The panel noted your acceptance that this should have occurred. Taking all of the circumstances into account, the panel concluded that your failings, whilst falling below the required standard, did not reach the threshold of serious misconduct.

In relation to charge 3, the panel noted your acceptance that your record keeping was below the standard expected. Accurate, contemporaneous and comprehensive clinical records are a fundamental requirement of nursing practice. Patient records provide an essential account of a patient's care, enable effective communication between healthcare professionals, and support the safe continuity of treatment. The panel found that your inadequate documentation created the potential for delays in patients receiving appropriate care and increased the risk of confusion for colleagues involved in their ongoing management. Whilst these failings had the potential to adversely affect patient care and experience, the panel was satisfied that they amounted to poor practice rather than serious misconduct.

In respect of charge 5, the panel noted that both Patients B and C had significantly elevated HbA1c results, requiring urgent and appropriate intervention. Whilst the protocol in place may have been informal in its presentation, the panel was satisfied that it was applicable to you as your name, role, and area of responsibility were expressly identified within it. The results for both patients, especially Patient C, were sufficiently elevated to cause concern in any nurse. Further, the panel had evidence that you attended the practice meeting in December 2022 during which all nursing staff were provided with a copy of the protocol, and it also noted that the protocol was displayed in every clinical room. The panel found that you were responsible for ensuring that significantly abnormal results were appropriately escalated and acted upon. In particular, there was no documentary evidence that you escalated or referred Patient C's abnormal results for

further review, or that you took appropriate action in relation to Patient D. With regard to Patient C specifically, the panel accepted that Patient C contacted the Practice to obtain their results. This is contrary to the record which states you discussed the results with Patient C when in fact you had not. The panel concluded that these omissions exposed both Patients C and D to a significant risk of harm, potential long-term consequences, and represented a serious departure from the standards expected of a registered nurse. In all the circumstances, the panel determined that this conduct was sufficiently serious to amount to misconduct.

In respect of charge 6, the panel was particularly concerned that there was a repeated pattern of failing to make adequate clinical records following consultations with patients over a period of six months involving two patients. The panel considered that registered nurses are expected to make an appropriate record of every patient consultation, including the purpose of the appointment, any assessment undertaken, outcome, and plan of care where appropriate. In this case, the panel found that, in some instances, no record had been made, whilst in others the entries were insufficient to reflect the consultation that had taken place. You accepted that your record keeping was not up to standard. The panel concluded that these failings amounted to unsafe practice as they created the potential for delays in patient care, prevented colleagues from fully understanding previous clinical interactions, and increased the risk that appropriate follow-up care would not be provided. In the panel's judgement, the repeated nature of these failings and the potential impact on patient safety elevated this conduct beyond poor practice and amounted to misconduct.

Decision and reasons on impairment

The panel next considered whether, as a result of the misconduct, your fitness to practise is currently impaired.

In reaching its decision, the panel had regard to the NMC Guidance on *‘Impairment’* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

‘Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.’

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) *...'*

The panel first considered whether any of the limbs of the Grant test were engaged in the past. It determined that your misconduct placed patients at potential risk of harm.

The panel determined that your misconduct constituted serious breaches of fundamental tenets of the nursing profession as you failed to uphold the standards and values of the nursing profession, thereby bringing the nursing profession into disrepute.

The panel therefore concluded that limbs a, b, and c of the Grant test were engaged in the past and, if repeated, would be engaged in the future.

With respect to future conduct, the panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), namely whether the conduct is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated. The panel had regard to your reflective piece and bundles of documents you had provided to the NMC.

The panel first considered whether your misconduct is capable of remediation. It was satisfied that the concerns are remediable as they relate to deficiencies in your clinical practice, namely communication, record keeping and the management and escalation of abnormal clinical results, rather than attitudinal concerns. The panel was satisfied that

these are areas of practice which can be addressed through reflection, training, experience and strengthened clinical practice.

The panel then considered whether the concerns have, in fact, been remedied.

The panel took into account the positive testimonials you provided from colleagues at your current employer, including those from a Consultant Manager and a Lead Nurse. The panel acknowledged that they speak positively about your professionalism, clinical practice and commitment to patient care. However, the panel noted that two of the testimonials were undated and that it was not clear whether the authors had supervised your practice directly or had sufficient oversight to comment on the specific areas of concern identified. Nor were the references up to date as they had been provided for the previous hearing in December 2025. Whilst these references provide some reassurance regarding your current practice, the panel considered that they were not sufficient, on their own, to demonstrate that all of the concerns had been fully remediated.

The panel also considered the screenshots of your clinical work records. Whilst these demonstrated examples of your documentation, the panel was unable to place significant weight on them as they appeared to comprise self-selected records rather than a representative sample of your clinical practice which has been independently tested and verified. The panel therefore considered that it could not properly assess the consistency or overall standard of your record keeping from those documents alone.

The panel took into account the training certificates you provided. The panel noted that you have undertaken a range of additional training relevant to the concerns in this case, including courses in diabetic care, respiratory care, duty of candour and record keeping. The panel considered that the training demonstrates a genuine commitment to maintaining and improving your professional knowledge and clinical practice and are appropriate to your role and responsibilities.

The panel also considered your reflective piece. It found your reflection to be comprehensive and detailed and was satisfied that you have demonstrated genuine remorse and some insight into your failings. The panel acknowledged that you have been open and candid in accepting responsibility for your actions and have demonstrated some understanding of the impact your omissions could have had on patients. However, the panel considered that your insight remains developing. In particular, it found that your reflection did not address the specifics of the concerns identified in charge 6 at all in relation to record keeping as detailed in your local investigation interview, nor did it adequately explore the impacts that booking and unbooking appointments could have on patients and the wider clinical team. Whilst your reflection included action plans, the panel considered that these were not sufficiently forward-looking to demonstrate how similar failings would consistently be avoided in the future.

Having considered all the evidence, the panel was not satisfied that the concerns have been fully remedied. Whilst it accepted that you have made meaningful progress through training, reflection and ongoing clinical practice, it could not be confident that it is highly unlikely for the conduct to be repeated. The panel remained concerned that greater evidence of consistency is required in relation to your communication and record keeping, both of which are fundamental to safe and effective nursing practice. Although the concerns do not arise from attitudinal issues, the panel concluded that there remains a risk of harm to patients should similar failings recur. The panel therefore determined that your fitness to practise is currently impaired on the grounds of public protection.

The panel also considered whether a finding of impairment is required in the wider public interest. It acknowledged that the misconduct in this case resulted in the potential, rather than actual, risk of harm. Nevertheless, the panel concluded that a finding of current impairment is necessary to uphold proper professional standards and maintain public confidence in the nursing profession and the regulatory process. This is particularly important when working in a pressurised environment when the fundamental requirements of professional practice are needed and tested. Accordingly, the panel determined that your fitness to practise is also currently impaired on public interest grounds.

Sanction

The panel has decided to make a conditions of practice order for a period of six 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

Mr Kewley identified the following aggravating features. The concerns were repeated in nature, particularly in relation to inadequate record keeping. The failings created a significant risk of harm to patients and that you had not yet demonstrated complete insight into the concerns identified.

In relation to sanction, Mr Kewley submitted that taking no action or imposing a caution order would not sufficiently address the substance and seriousness of the case.

Mr Kewley submitted that a conditions of practice order may be an appropriate and proportionate outcome, although he acknowledged that this was ultimately a matter for the panel. Any conditions should be specific, measurable and capable of addressing the identified concerns. He provided the panel with suggested conditions including that you should be required to work with a supervisor or manager to develop a Personal Development Plan (PDP) addressing communication, record keeping and the escalation of abnormal results, that the PDP should be shared with the NMC, that you should meet regularly with your manager or supervisor to discuss your performance in those areas, and that a report from your manager or supervisor commenting on your progress should be provided to the NMC before any review hearing.

Mr Kewley made no specific submissions as to the appropriate length of any conditions of practice order. He submitted that any period imposed should be realistic and sufficient to enable you to address the outstanding concerns and demonstrate meaningful progress.

Ms Herbert submitted that, although there was a pattern of errors, these had to be considered in the context of your approximately 20-year history of good and competent nursing practice. This was not a particularly aggravating feature. A lack of insight should not be treated as an aggravating feature as the panel had already found that you had demonstrated some insight. This was not a case in which you had deliberately or recklessly placed patients at risk of harm.

Ms Herbert submitted that there were a number of significant mitigating features. You made early admissions to charges 3 and 6, had apologised both orally and in writing to those affected, and had made significant efforts to remedy the concerns through training, reflection and practice. There was evidence that you had worked safely and professionally in a similar role since the concerns arose without restriction and without any further concerns being raised. You had fulfilled all of the mitigating features identified by the NMC and that contextual factors at the Practice should also be taken into account.

Ms Herbert provided an updated reference from the GP Assistant, Kelly Mansell, and submitted that this demonstrates continued good practice, including responsibility for quality assurance and patient care, with no concerns identified regarding record keeping, communication or the escalation of abnormal results. The references can satisfy the panel that the concerns in your practice had been fully remediated.

Ms Herbert submitted that the panel had not considered an interim order necessary when the hearing was part-heard in December 2025 because there were no public protection concerns and you had continued to practise unrestricted. This position had only strengthened following a further six months of safe practice. As a nurse with over 20 years'

experience and only one referral you had demonstrated genuine remorse and sufficient insight to make repetition highly unlikely.

Ms Herbert submitted that the panel should take no further action, relying on all of the evidence before it, including the new reference. Publication of the panel's determination would, of itself, mark your behaviour and satisfy the public interest. In the alternative, a caution order for one year would be sufficient and proportionate to mark the seriousness of the case. A conditions of practice order was unnecessary, given your unrestricted and safe practice over the past three years, but if the panel considered conditions necessary, they should be limited to six months and should not require supervision. A suspension order would be wholly disproportionate.

The panel accepted the advice of the legal assessor.

Having taken into account Ms Herbert's submissions and the updated reference provided, the panel gave a further opportunity to you to provide additional information before it reached its decision on sanction. An email was sent at 15:16 on 16 July 2026 inviting you to submit the following information by 12:00 on 17 July 2026:

- *'at least the last two appraisals from Diana's current employer*
- *an authoritative reference from someone who currently has managerial responsibility over Diana and can attest to her record keeping, communication and escalation practice. This must be dated, show the author's role and the length of time they have worked with Diana.*
- *an updated reflection from Diana that addresses the gaps in her reflection in relation to charge 6 (record keeping)'*

The panel received the following information from you:

- a short reference from the former practice manager
- one self appraisal dated 28 May 2025

- an updated reflection on charge 6

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel considered what sanction, if any, it should impose. 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 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 misconduct over a period of time.
- Conduct which recklessly put patients at risk of harm.

The panel also took into account the following mitigating features:

- You made early admissions to some of the charges.
- You have shown genuine remorse for your actions.
- You have completed training relevant to the concerns identified.
- Your reflective piece demonstrates a strengthening of practice.

In the light of Ms Herbert's robust submissions and the late addition of a current reference, the panel, as set out above, provided a further opportunity for you to reassure it regarding your future clinical performance. The panel took into account the further documentation provided but it was not sufficiently reassured. The brief reference was from a previous manager, and there was only one appraisal which was a self appraisal from May 2025 without any managerial assessment. The panel acknowledged the updated reflection on charge 6.

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 considered Ms Herbert's submissions but was not persuaded that taking no further action would be a proportionate response. The panel concluded that, as you continue to present a risk of harm, it would be neither appropriate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that, although your actions were at the lower end of the spectrum, it found that there is still a risk to patient and public safety. Whilst you have shown developing insight, this did not mitigate the remaining risk of harm to the public. The panel therefore determined that a sanction that does not restrict your practice would not protect the public. The panel also determined 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 appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*

- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel was satisfied that your failings are capable of being addressed through workable, measurable and realistic conditions. The panel determined that a conditions of practice order would appropriately address the risk of repetition, protect the public and uphold the wider public interest. The panel considered that appropriately drafted conditions would be proportionate and would reflect its findings in this case.
It therefore determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case.

The panel determined that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response as the concerns are remediable, you have demonstrated developing insight and remediation, and you have continued to practise safely and without restriction for a significant period without any further concerns. The panel was satisfied that the public could be adequately protected by a conditions of practice order and that a more restrictive sanction was therefore unnecessary.

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

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

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must create a Professional Development Plan (PDP) with your line manager within one month of this order. Your PDP must address concerns about:
    - Record keeping
    - Communication
    - Escalating clinical concerns

2. You must engage with your line manager on a frequent basis to ensure that you are making progress towards aims set in your PDP, which include:
    • Meeting with your line manager at least every six weeks to discuss your progress towards achieving the aims set out in your PDP.

3. 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.

4. 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.

5. 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.

6. You must tell your 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.

7. You must allow your 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

The period of this order is for six 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 the review hearing.
- Your completed PDP.
- A report from your line manager on your progress in the matters set out above.
- Updated reflections.
- Evidence of any relevant training completed.

Interim order

As the 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

In the light of the conditions of practice order directed by the panel, Mr Kewley submitted that the NMC was neutral on the imposition of an interim order to cover any period of appeal.

Ms Herbert submitted that an interim order would not be necessary and proportionate given the panel's findings.

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 18 months.

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.