Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 17 July 2026

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

Virtual Meeting

Monday, 20 July 2026 – Wednesday, 22 July 2026

Name of Registrant:	**Gail Johnson**
NMC PIN:	13B0714E
Part(s) of the register:	Registered Nurse RNA: Adult Nurse L1 (February 2015)
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, Lay member) Jason Flannigan-Salmon (Registrant member) Graham Woodham (Lay member)
Legal Assessor:	Justin Gau (Friday, 17 July 2026 and Monday, 20 July 2026) Gerard Coll (Tuesday, 21 July 2026 – Wednesday, 22 July 2026)
Hearings Coordinator:	Elizabeth Fagbo
Facts proved:	Charges 1a, 1b, 2a, 2b, 3, 4a, 4b, 4c, 4d, 5 and 6
Facts not proved:	Charges 4e, 4f, and 4g
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Johnson's registered email address by secure email on 11 June 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, date and venue of the meeting.

In the light of all of the information available, the panel was satisfied that Miss Johnson has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse:

1) On 2 April 2022:

a) administered Oxycodone, a controlled drug to Patient A, in the absence of a second nurse to witness and sign as a second checker;

b) asked Colleague 1 to sign Patient A's MAR chart and/or the Controlled Drugs Book retrospectively;

2) Following the medication error at Charge 1(a), failed to:

a) complete a DATIX/Incident Form;

b) escalate and/or report the error to the Nurse in charge;

3) Your conduct at charge 1(b) was dishonest as you sought to mislead others into believing that a second checker was present when the medication was administered when you knew that they were not;

4) On 20 November 2021:

a) administered Morphine, a controlled drug to Patient B instead of Oxycodone;

b) did so in the absence of a second nurse to witness and sign as a second checker;

c) asked Colleague 2 to sign Patient B's MAR chart and/or the Controlled Drugs Book retrospectively;

d) did not inform Patient B of the error at 4(a);

e) did not undertake adequately, or at all, observations for Patient B following administration of the wrong medication, or in the alternative, did not document observations in Patient B's record;

f) failed to report the medication administration error;

g) failed to escalate and/or seek advice from a doctor and/or medical team;

5) Your conduct at charge 4(c) was dishonest as you sought to mislead others into believing that a second checker was present when the medication was administered when you knew that they were not;

6) Your conduct at charge 4(d) was in breach of the duty of candour in that you failed to inform Patient B of the medication error;

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

Background

The NMC received a referral in relation to Miss Johnson on 15 September 2022 from the Head of Nursing at East Surrey Hospital ("the Hospital"), which is part of the Surrey and Sussex Healthcare NHS Trust ("the Trust").

At the time of the concerns raised in the referral, Miss Johnson was employed by the Trust as a Band 5 Nurse on Brook Ward ("the Ward") of the Hospital. Miss Johnson had been employed by the Trust from 2008 when she was a Nursing Assistant. She subsequently joined the Trust as a Band 5 Nurse in February 2015.

The regulatory concerns relate to two incidents that occurred when Miss Johnson was employed as a Band 5 Nurse at the Hospital:

On 2 April 2022, it is alleged that Miss Johnson administered a controlled drug, oxycodone, to Patient A in the absence of a second nurse to witness and sign as second checker. It is also alleged that after the incident, Miss Johnson asked the second nurse on duty with her to retrospectively sign for the controlled drug once the nurse returned from her break. However, the second nurse refused to sign for the controlled drug as she did not witness them being removed from the controlled drug cupboard or them being administered to the patient. This nurse reported the incident via the Datix incident system and to her supervisor.

On 20 November 2021, it is alleged that Miss Johnson administered a controlled drug, morphine sulphate, to Patient B who was no longer prescribed the medication, and in the absence of a second nurse present to witness and act as a second checker for the medication. Patient B had previously been prescribed morphine sulphate but had requested a different medication because they believed that the morphine caused them to have seizures. As a result, morphine was crossed out of Patient B's medication chart, meaning it was no longer prescribed for Patient B to receive this medication.

It is further alleged that following this error, Miss Johnson asked the second nurse on duty, who was newly qualified, to sign the documentation retrospectively to say that the nurse

was present when the medication had been administered. In addition, having become aware that the medication was no longer prescribed to Patient B, Miss Johnson did not inform Patient B of the medication error and did not continue with any observations. Following this incident, Miss Johnson reported the matter to her senior and completed an incident report.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.
It noted that it appeared that Miss Johnson admitted to both incidents at local level and the evidence is that after the incident in November 2021, she was remorseful and apologetic. Further, the panel noted that Miss Johnson's engagement with the NMC has been limited and she has not responded to the allegations but has said that she is no longer practising and has expressed a wish to be removed from the NMC's register. However, to date, it does not appear that Miss Johnson has submitted the appropriate application for voluntary removal.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Lucy Weeks: Chief Nursing Information Officer at the Trust
- Sandhya Blakey: Patient Safety Lead Surgical Division at the Trust
- Charmain Ang: Staff Nurse at the Trust

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The legal assessor advised the panel that the test for dishonesty was as set out in paragraph 74 of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords)* [2017] UKSC 67. It considered the documentary evidence provided by the NMC.

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

Charge 1a and 1b)

"That you, a registered nurse:

1) On 2 April 2022:

a) administered Oxycodone, a controlled drug to Patient A, in the absence of a second nurse to witness and sign as a second checker
b) asked Colleague 1 to sign Patient A's MAR chart and/or the Controlled Drugs Book retrospectively"

This charge is found proved.

In reaching this decision, the panel took into account the following from the local Investigation Meeting Notes with Miss Johnson dated 3 May 2022:

'SB …I would like to show you a document (drug chart for patient given Oramorph on 02/04/2022). SB explains the drug chart regarding the allegation.

Can you confirm that the first signature under oramorph is yours?

GJ Yes

SB But there is no second signature, can you confirm this?

GJ Yes

SB Where [sic] there any other options, to get second signature? Was the other staff nurse on break?

GJ Yes, should have called someone to witness and sign. I think she might have been but I can't remember.

SB Did you do ask someone to witness?

GJ No…'

The panel took into account Patient A's MAR chart dated 7 March – 2 April 2022. It noted that there should be two sets of initials in the box to indicate that the medication had been administered to the patient. Two sets of initials are required as the medication being administered was a controlled drug. Further, it noted that on 2 April 2022 at 03:40 the MAR chart identifies that the medication is given to the patient. However, the chart was only signed for with Miss Johnson's initials and there is a gap next to her initials which should have been filled in with a second nurses initials.

The panel took into account Miss Johnson's admissions in the witness statement of Charmain Ang:

'… On 2 April 2022, I was working a night shift on Brook Ward alongside Miss Johnson. There are two (2) nurses allocated to the ward.

I recall I went on an allocated break and when I returned Miss Johnson approached me and asked me to sign the Controlled Drug Book and a patient's chart as the second checker/witness for the controlled drug Oxycodone which Miss Johnson said she had administered to the patient.

I asked Miss Johnson why she didn't wait for me to come back from my break or call someone from another ward to come and witness the

controlled drug medication administration, and she didn't answer and didn't say anything at all. I told her I would not sign for the medication that I did not witness…'

It also took into account the following from the local Disciplinary Investigation Report dated 30 June 2022:

'…Gail was working a night shift on Brook ward on 2nd April 2022. During this shift, she administered a controlled drug to a patient at 0340 hours (Appendix 6), without following the correct process set out by the Controlled Drugs [Supervision of management and use] Regulation 2013 (Appendix 9) and the gold standard NICE accreditation (Appendix 8).

During her investigation meeting when Gail was asked why she had not followed the correct procedure and she stated that there was nothing that she could say, "it was stupid not getting a second signature", that she was annoyed with herself and understood the concerns; "patients are vulnerable and we cannot get it wrong for them or make mistakes" (Appendix 3).

When she was asked if she was aware of the correct procedure for administering Controlled Drugs, she responded that she should not administer these by herself and that "2 people need to witness this". Furthermore, stated that it was about "keeping the patient safe, giving the right drug, at the right time, to the right patient, the right dose", she did not follow this procedure and she knew this" (Appendix 3)…'

Further, it took into account the following from the Trust's Medicines Management Policy:

'…3.6.7 Single person administration A registered nurse, medical practitioner or other authorised practitioner may undertake single-person administration of medicines with the following exceptions in the

hospital settings. A second authorised person must be involved in all stages of the checking process for controlled drugs…'

The panel was satisfied that Miss Johnson had administered Oxycodone to Patient A in the absence of a second nurse to witness and sign as a second checker, and that she had asked Colleague 1 to sign Patient A's MAR chart retrospectively, which Colleague 1 rightfully refused to do.

For these reasons, the panel found charge 1a and 1b proved.

Charge 2a and 2b)

"That you, a registered nurse:

2) Following the medication error at Charge 1(a), failed to:

a) complete a DATIX/Incident Form;
b) escalate and/or report the error to the Nurse in charge"

This charge is found proved.

The panel took into account the following from the Witness statement of Sandhya Blakey:

'…When Registered Nurse Charmain Ang ("Ms Ang") came off her break at 04:00 Miss Johnson informed her she had administered the controlled drug and asked her to sign the Controlled Drugs Book and patient A's MAR Chart however Ms Ang refused to do so. Ms Ang checked on the patient and confirmed with the patient that she had received pain relief which was confirmed. No harm was caused to the patient due to Miss Johnson's procedural error.

At the handover, Miss Johnson did not raise her error to the day shift NIC. Miss Johnson had a duty of candour – exhibit SB/06 - to be honest about her mistake and to report it however she did not do this.

Ms Ang, who stayed behind after her shift had ended, informed Ward Manager … ("…") of Miss Johnson's error and that she did not countersign for the administered Oxycodone. [the Ward Manager] *knowing of Miss Johnson's previous controlled drug error occurring on 20 November 2021, immediately escalated the concern to Surgical Matron for Brook ward Lucy Weeks ("Mrs Weeks").*

Miss Johnson failed to immediately escalate her error and did not submit a Datix Incident Report as she was supposed to do. RN Ms Ang submitted a Datix Incident report on 3 April 2022…'

The panel took into account a Datix Incident Review Form dated 3 April 2022, submitted at 19:15 by Charmaine Ang. It noted that Miss Johnson had not completed a Datix Incident Review Form.

It also took into account the following from the Trust's Medicines Management Policy:

*'…**Medication incidents***
Any incident that occurs which falls outside the guidelines and regulations set out within this policy, must be reported immediately to the appropriate line manager using Datix.

Such incidents will include administration errors, prescription errors, failure to administer prescribed medications and those situations in which medications are given in extra ordinary circumstances (as outlined within the policy).

All incidents relating to the prescribing, supply, transport, storage, preparation, administration, disposal or recording of Controlled Drugs must be reported by the risk management team to the Trust Accountable Officer for Controlled Drugs...'

The panel was satisfied that based on the evidence identified above, following the medication error at Charge 1a, that Miss Johnson had failed to complete a DATIX/Incident Form and escalate and/or report the error to the Nurse in charge.

For these reasons, the panel found charge 2a and 2b proved.

Charge 3)

"That you, a registered nurse:

3) Your conduct at charge 1(b) was dishonest as you sought to mislead others into believing that a second checker was present when the medication was administered when you knew that they were not"

This charge is found proved.

The panel applied the *'Ivey'* test in accordance with the legal assessor's advice:

'*(a) what was the defendant's actual state of knowledge or belief as to the facts and*

(b) was his conduct dishonest by the standards of ordinary decent people?'

In reaching this decision, the panel took into account the Investigation Meeting Notes with Miss Johnson dated 3 May 2022, Patient A's MAR chart dated 7 March – 2 April 2022, Miss Johnson's admissions in the witness statement of Charmain Ang, the Datix Incident Review Form dated 3 April 2022, submitted at 19:15 by Charmaine Ang, the Disciplinary Investigation Report and the Trust's Medicines Management Policy. All as outlined in charge 1a, 1b, 2a and 2b.

The panel also took into account the Controlled Drug Book for Oxycodone entry for 2 April 2022 timed 03:40.

The panel accepted all of the evidence in its entirety in relation to charges 1 and 2. Having considered the evidence and in particular the medication records, the panel concluded that Miss Johnson deliberately sought to mislead others into believing that a second checker was present when the medication was administered when she knew that they were not. The panel noted that Charmaine Ang then challenged Miss Johnson about this in a meeting where it was confirmed that Miss Johnson had administered medication without a second checker and had attempted to obtain a second signature afterwards in an effort to conceal her actions.

It was therefore clear to the panel that Miss Johnson knew that this was not the correct procedure to follow when administering medication, and her conduct in charge 1(b) was dishonest by the standards of ordinary people.

For these reasons, the panel found charge found 3 proved.

Charge 4a)

" That you, a registered nurse:

4) On 20 November 2021:

a) administered Morphine, a controlled drug to Patient B instead of Oxycodone"

This charge is found proved.

In reaching this decision, the panel took into account Patient B's MAR chart dated 20 November 2021, which showed that Miss Johnson had administered morphine to Patient B on this date and signed the MAR chart.

The panel took into account the Datix Incident Review Form dated 20 November 2021, submitted at 08:03 by Gail Johnson which stated the following:

'… Drug error, I gave subcut morphine 2mg when I should have given subcut oxycodone 2mg…

… I observed the patient. He had previously been on morphine subcut and it was prescribed in his drug chart but had been crossed out…'

The panel also noted the following from the Datix Incident Review Form dated 20 November 2021, under the heading of Incident Triage and Outcome:

'…After the morning handover, the nurse concerned informed me that she had made a drug error overnight which involved controlled medication. The nurse had administered a subcutaneous medication to a patient on the ward and she did not follow the procedures in place for checking. The nurse concerned got a controlled medication out of the cupboard independently and gave the patient s/c morphine instead of oxycodone. Both drugs were prescribed on the drug chart but the morphine had been stopped. At the time, the other trained nurse was on her break. The nurse realised her mistake and monitored the patient but she did not report the mistake to anybody overnight. I asked the nurse to completed a Datix and complete a statement. I also asked her to inform the medical team caring for the patient about the error. I informed senior nurses of the mistake. At this point, the patient is not aware and has had no ill effects following the incident…'

The panel was satisfied that based on Miss Johnsons' signature on Patient B's MAR chart and the admissions in the Datix report submitted by her, that on 20 November 2021 Miss Johson had indeed administered Morphine, a controlled drug to Patient B instead of Oxycodone.

Therefore, the panel found charge 4a proved.

Charge 4b and 4c)

"That you, a registered nurse:

4) On 20 November 2021:

b) did so in the absence of a second nurse to witness and sign as a second checker;
c) asked Colleague 2 to sign Patient B's MAR chart and/or the Controlled Drugs Book retrospectively"

The charges are found proved.

In reaching this decision, the panel took into account Patient B's MAR chart dated 20 November 2021, which showed that Miss Johnson had administered morphine to Patient B on this date and signed the MAR chart. The panel noted that there was no second signature on the MAR chart.

It took into account the following from the Trust's Medicines Management Policy:

> *'…3.6.7 Single person administration A registered nurse, medical practitioner or other authorised practitioner may undertake single-person administration of medicines with the following exceptions in the hospital settings. A second authorised person must be involved in all stages of the checking process for controlled drugs…'*

It took into account the witness statement of Lucy Weeks dated 27 January 2025 which stated the following:

> *'…When I asked Miss Johnson about this, she said she didn't know why the nurse signed and said she didn't ask her to do it, however when I spoke to the agency nurse, she said she had been asked by Miss Johnson to sign the CDB. As the agency nurse was a newly qualified nurse and hadn't worked many shifts at the hospital, she felt influenced by a superior nurse, and she thought it may have been common practice at the hospital which is why she retrospectively signed the CDB.*

The agency nurse was quite shaken when I spoke to her, and I advised her on the proper process for administering controlled drugs. The agency nurse confirmed that Miss Johnson did not tell her about the medication error…'

The panel also took into account a file note dated 21 December 2021 referred to in the statement of Lucy Weeks which stated the following:

'… Gail admits her plan was always to give him his CD on her own; she wasn't going to call on anyone for support with this…

It also noted the following statement in the file note from the person who had observed the controlled drug book at the time:

'…There are currently 2 signatures in the CD book for this particular drug administration and the second signature appears to be the agency nurse who was working that night. Gail assures me she didn't ask the nurse to sign this drug and the agency nurse 'must have just signed it'. I informed Gail I would be speaking to the agency nurse herself too to clarify this and it strikes me as odd that the nurse would sign a drug she didn't witness when she wasn't asked to and hadn't been told of the error…'

The controlled drug book was not before the panel. The panel also noted that in an email from Lucy weeks dated 31 October 2024 that:

'…the CD book has been destroyed as we only keep them for 2 years…'

The panel was satisfied that Miss Johnson had administered medication to Patient B and did so in the absence of a second nurse to witness and sign as a second checker.

The panel accepted the evidence of Lucy Weeks, and it was satisfied that on the balance of probabilities, that on 20 November 2021, Miss Johnson had asked Colleague 2 to sign Patient B's MAR chart retrospectively.

For these reasons, the panel found charges 4b and 4c proved.

Charge 4d)

" That you, a registered nurse:

4) On 20 November 2021:

d) did not inform Patient B of the error at 4(a)"

This charge is found proved.

In reaching this decision, the panel noted the following from the Datix Incident Review Form, dated 20 November 2021, submitted at 08:03 by Gail Johnson. Under the heading of Incident Triage and Outcome the Ward Manager stated:

> *'…At this point, the patient is not aware and has had no ill effects following the incident…'*

The panel also took into account the witness statement of Lucy Weeks dated 27 January 2025 which stated the following:

> *'…On 20 November 2021 Miss Johnson didn't explain to patient A she had given the wrong drug as she was supposed to do even though the patient came to no harm. Patient A struggled with pain and passed away not long after the incident and there may have been another reason that Miss Johnson or other staff chose not to tell the patient, but I don't know if there was a reason. The decision not to tell Patient A may have been related to his presented condition, which was that he was receiving palliative care…'*

The panel accepted the evidence of Lucy Weeks, and the panel was satisfied that her evidence is reliable, as this is corroborated by the Datix Report and therefore, found that Miss Johnson did not inform Patient B of the error at 4(a).

Therefore, it found charge 4d proved.

Charge 4e)

"That you, a registered nurse:

4) On 20 November 2021:

e) did not undertake adequately, or at all, observations for Patient B following administration of the wrong medication, or in the alternative, did not document observations in Patient B's record"

This charge is found NOT proved.

In reaching this decision, the panel took into account a file note dated 21 December 2021 referred to in the statement of Lucy Weeks which stated the following:

> *'…She took the Morphine out of the CD cupboard (alone) and administered 2mg (prescription that was crossed out was for 2.5mg). She signed this CD out alone. Once Gail returned to the CD cupboard, she realised she had given the wrong medication but did not inform anyone about this error. The patient was not spoken to and had no adverse reactions to the Morphine. No additional obs were carried out on the patient…'*

It also took into account the witness statement of Lucy Weeks dated 27 January 2025 which stated the following:

'…Despite not having a conversation with the patient, it would be expected that Miss Johnson did additional monitoring of the patient however she didn't do this. Patient A was no longer prescribed Morphine Sulphate, and this was crossed out on Patient A's chart because there was a possibility that the medication caused seizures. However, it wasn't confirmed there was a direct correlation between the medication and the seizures…'

The panel noted that the above quote refers to Patient A incorrectly, the exhibit LW/06 is the MAR chart dated November 2021 referring to Patient B as set out in the charge.

Further, the panel took into account the Datix Incident Review Form submitted at 08:03 by Gail Johnson under the heading of Incident Triage and Outcome, dated 20 November 2021 where it was stated that Miss Johnson monitored the patient after realising her error. The panel noted that it was presented with contradictory evidence from Lucy Weeks. It also noted that the patient notes as submitted in evidence were not attributable to an individual named patient.

The panel had no evidence before it defining adequacy or frequency of monitoring in regard to undertaking patient observations following a medication error. It also had not been provided with the Trust policy, or the observation chart in question. Therefore, it had nothing to measure the evidential information before it against and could not be sure that monitoring of Patient B had not taken place.

For these reasons, it found charge 4e not proved.

Charge 4f)

" That you, a registered nurse:

4) On 20 November 2021:

f) failed to report the medication administration error"

This charge is found NOT proved.

The panel noted that the charge was worded differently in the NMC evidence matrix which added the words *'in a timely manner'.* However, the panel took the charge as it stands in the Proof of service document which had been sent to Miss Johnson on 11 June 2026 informing her of this meeting, in which it states, *'failed to report the medication administration error.'*

In reaching this decision, the panel took into account the Disciplinary Investigation Report dated 30 June 2022:

> *'…In the Datix raised following the incident above, the ward manager recorded as part of her RCA investigation, "After the morning handover, the nurse concerned informed me that she had made a drug error overnight which involved a controlled medication. The nurse had administered a subcutaneous medication to a patient on the ward and she did not follow the procedures in place for checking. The nurse concerned (RN GJ) got a controlled medication out of the cupboard independently and gave the patient s/c morphine instead of oxycodone. Both drugs were prescribed on the drug chart but the morphine had been stopped. At the time, the other trained nurse was on her break. The nurse realised her mistake and monitored the patient but she did not report the mistake to anybody overnight. I asked the nurse to completed a Datix and complete a statement. I also asked her to inform the medical team caring for the patient about the error. I informed senior nurses of the mistake. At this point, the patient is not aware, and has had no ill effects following the incident…'*

The panel took into account the Datix Incident Review Form, dated 20 November 2021, submitted at 08:03 by Gail Johnson.

It took into account the witness statement of Lucy Weeks dated 27 January 2025, which stated the following:

'…On 20 November 2021, Miss Johnson was on night shift on an 11 bedded ward, and it wasn't a challenging night. She would have had time to submit a Datix Incident Report before she reported her medication error to [the Ward Manager]

After reporting her errors [the Ward Manager] *prompted Miss Johnson to submit an incident report. I'm not sure that Miss Johnson would have completed the incident report had she not been prompted by her manager to do so…'*

The panel noted that Miss Johnson had informed her line manager on the Ward, at the handover between the night shift and the day shift, of the medication error she had made on 20 November 2021. The panel noted that Miss Johnson was then told to create a Datix report, which she did at 8:03 on 20 November 2021. The panel was of the view that the charge does not state the timeframe of when an incident should be reported.

The panel did not accept the evidence of Lucy Weeks in relation to this charge. It was of the view that the statements of Lucy Weeks referred to above were her opinion and it had no evidence before it to support those statements.

For these reasons, the panel found charge 4f not proved.

Charge 4g)

"4) On 20 November 2021:

g) failed to escalate and/or seek advice from a doctor and/or medical team"

This charge is found NOT proved.

The panel had no information or evidence before it to demonstrate that Miss Johnson was required to escalate and/or seek advice from a doctor and/or medical team. Also, the panel had no patient notes before it that definitively demonstrated that Miss Johnson did not escalate and/or seek advice from a doctor and/or a medical team.

The panel determined that the NMC did not discharge its burden of proof in relation to this charge and therefore, it found charge 4g not proved.

Charge 5)

"That you, a registered nurse:

5) On 20 November 2021:

Your conduct at charge 4(c) was dishonest as you sought to mislead others into believing that a second checker was present when the medication was administered when you knew that they were not"

This charge is found proved.

The panel applied the *'Ivey'* test in accordance with the legal assessor's advice:

'*(a) what was the defendant's actual state of knowledge or belief as to the facts and*

(b) was his conduct dishonest by the standards of ordinary decent people?'

In reaching this decision, the panel took into account Patient B's MAR chart dated 13 November 2021, the Datix Incident Review Form dated 20 November 2021, submitted at 08:03 by Gail Johnson, the Disciplinary Investigation Report and the Trust's Medicines Management Policy.

The panel also took into the witness statement of Lucy Weeks dated 27 January 2025, which stated the following:

'…When I spoke to the agency nurse she told me, that after returning from her break, Miss Johnson asked her to retrospectively sign the CDB and Patient A's

chart, but she also said that Miss Johnson had not told her about her medication error. Miss Johnson said that she hadn't had the opportunity to tell the agency nurse about her medication error and I found it odd that she asked the nurse to sign the CDB book without telling her there was an error and then denying she asked her to sign the book and I found Miss Johnson was being dishonest…'

The panel did not have the relevant controlled drug book before it.

The panel accepted all of the evidence cited above. It concluded that Miss Johnson did not seek to conceal that she had administered the medication but rather sought to conceal the fact that the medication had been administered without a second witness. The panel found that on this occasion Miss Johnson obtained a retrospective signature from a newly qualified nurse who was influenced by Miss Johnson and was persuaded by the fact she was a more experienced colleague.

The panel determined that the evidence demonstrated that Miss Johnson had intended to mislead others into believing that a second checker was present when the medication was administered when she knew that they were not. The panel was satisfied that Miss Johnson had deliberately attempted to create the false impression that the required checking procedure had been followed when administering medication, and her conduct in charge 4(c) was dishonest by the standards of ordinary people.

For these reasons, the panel found charge 5 proved.

Charge 6)

"That you, a registered nurse:

6) Your conduct at charge 4(d) was in breach of the duty of candour in that you failed to inform Patient B of the medication error"

This charge is found proved.

In reaching this decision, the panel took into account the Trust's Duty of Candour process. It noted that the process in regarding the identification of an incident was that the nurse at the time should have apologised immediately and explained to the patient the error that occurred, and the next steps that would be undertaken. It is noted that the medication was administered at 01:50. The panel noted the following from the Datix Incident Review Form, dated 20 November 2021, submitted at 08:03 by Gail Johnson. Under the heading of Incident Triage and Outcome, dated 21 November 2021, which was completed by the Ward Manager who stated:

> *'…At this point, the patient is not aware and has had no ill effects following the incident…'*

The panel noted that Patient B was under palliative care and had reported experiencing side effects from morphine, the patient's medication was changed to oxycodone as a result of this. Taking into account the Duty of Candour process and the Datix Incident Review Form, the panel was of the view that Miss Johnson did not inform Patient B of the medication error and therefore, was in breach of the duty of candour.

For these reasons, the panel found charge 6 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Johnson's 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, Miss Johnson's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC requires the panel to bear in mind its overarching objective 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. The panel had regard to the case of *Roylance v GMC (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. The standard of 3 propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.'*

The NMC also referred to the case of *Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin)*, respectively:

> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired.'*
>
> *And*
>
> *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'*

The NMC invited the panel to take the view that (if it found) the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its

decision. The NMC identified the specific, relevant standards where Miss Johnson's actions amounted to misconduct.

The NMC submitted that Miss Johnson's conduct as detailed in the charges has fallen significantly short of what is and would have been expected of a registered professional.

The NMC submitted that over a short period of time, Miss Johnson has twice either administered wrong medication to a patient or failed to follow procedures in relation to controlled drugs, namely, to administer controlled drugs in the presence of a second checker. On both occasions, instead of admitting her error and following the proper course of action, Miss Johnson sought to conceal her errors and mislead others by asking two separate colleagues to sign patient documentation retrospectively.

The NMC consider the misconduct particularly serious in relation to charges 4, 5 and 6 which relate to the incident on 20 November 2021 because Miss Johnson breached multiple professional standards in relation to a controlled drug, and concerning a vulnerable patient. Furthermore, Miss Johnson knowingly attempted to conceal her actions by asking a newly qualified colleague to breach protocol and sign documentation retrospectively.

While the evidence is that after following this incident in November 2021 Miss Johnson was remorseful and apologetic, charges 1, 2 and 3 relate to a separate incident on 2 April 2022. The NMC consider the misconduct particularly serious in relation to these charges because Miss Johnson once again, breached multiple professional standards in relation to controlled drug administration. Furthermore, Miss Johnson again, knowingly attempted to conceal her actions from her employer by asking another colleague to breach protocol. By repeating the misconduct, Miss Johnson has demonstrated a lack of regard for her actions.

In relation to dishonesty, NMC Guidance SAN-4 specifies the following:

> *'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted*

dishonestly will always be at some risk of being removed from the register. …
Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):
…
• direct risk to people receiving care
… '

In regard to impairment the NMC referred to the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:

i. 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
ii. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
iii. 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
iv. has in the past acted dishonestly and/or is liable to act dishonestly in the future.in written submissions and submitted that the four limbs are engaged in this case.

The NMC submitted that Miss Johnson's conduct, as detailed in the charges demonstrated a significant departure from the principles of practising effectively, preserving safety, and promoting professionalism and trust in the profession, which would no doubt be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. The NMC guidance DMA-1 provides that:

'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.'

The NMC submitted that limbs (a) to (d) can be answered in the affirmative in this case, limb a is engaged because on two separate occasions, Miss Johnson breached multiple professional standards in relation to the administration of controlled drugs. Breaches of professional standards place patients at unwarranted risk of harm. The incident on 20 November 2021 is particularly serious as Miss Johnson administered an incorrect medication to a vulnerable patient. Having done so, Miss Johnson is said to have tried to cover that the wrong medication was administered by not immediately reporting it and instead, asking a newly qualified colleague to sign the documentation relating to Patient A retrospectively. [The panel noted that the NMC appeared to have incorrectly referred to Patient A instead of Patient B as set out in the charges relating to November 2021.

The second check process exists to safeguard patients and staff by reducing the scope for medication errors. By not having a second checker present when administering medication there is an elevated risk of medication errors, such as the wrong drug or dosage being administered. Such medication errors, especially where controlled drugs are in use, can have significant and life changing implications for patients.

The NMC submitted that limb b engaged because on both occasions, Miss Johnson knowingly attempted to conceal her actions from her employer by asking two separate colleagues to breach protocol by signing documentation retrospectively. Furthermore, in relation to charge 6 specifically, Miss Johnson failed in her duty of candour by not informing a patient of a medication error. Registered professionals occupy a position of privilege and trust in society, and trust is a fundamental tenet of nursing. Breaches of professional standards undermine that trust and place patients at unwarranted risk of harm Miss Johnson’s actions would undoubtedly bring the nursing profession into disrepute.

The NMC submitted that limb c is engaged because through her actions Miss Johnson has repeatedly breached the fundamental tenets of prioritising people, practising effectively, preserving safety and promoting professionalism and trust in the profession. These are integral to the standards expected of a registered nurse and are fundamental tenets of the Code. It submitted that in addition, limb d is engaged because on both occasions Miss Johnson acted dishonestly by seeking to mislead others into believing that a second checker was present when medication was administered, knowing that this was not the case. Because of this dishonesty, patients were exposed to risk of harm.

The NMC submitted that Miss Johnson's actions have already proved not to be easily remediable and that the risk of repetition remains high. The evidence is that after the first medication error in November 2021 she was remorseful and apologetic. However, a similar medication error occurred within a short space of time in April 2022. It is submitted that, having made a medication error in November 2021, the material similarity between the two separate medication errors demonstrates an absence of any proactive steps taken by Miss Johnson following the medication error in November 2021 to reduce the risk of her repeating that medication error, leading to a repeat of that error in April 2022.

It is further submitted that it is not just a material similarity between the two separate medication errors that is of concern, but that despite the evidence that after the first of these two incidents in November 2021 Miss Johnson was remorseful and apologetic, Miss Johnson went on to display a similar pattern of dishonest behaviour following the incident in April 2022. This element of the concern is not easily remediable due to an underlying attitudinal element to her actions. The NMC considers that there is a continuing risk to the public due to Miss Johnson's lack of remediation or insight. It is therefore submitted that her practice is impaired on the ground of public protection.

The NMC submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Miss Johnson's conduct engages the public interest because members of the public would be appalled to hear of a nurse who, made repeated clinical errors which could have caused serious harm to someone in her care, and then sought to conceal those errors from both her employer and the patients concerned. Members of the public would similarly be appalled to hear of a nurse apologise for such medical errors, only to repeat both the error and the attempts to conceal them. The NMC submitted that Miss Johnson has brought the profession into disrepute by the very nature of her conduct. Nurses occupy a position of trust and must act with and promote integrity at all times. Professionalism and integrity are fundamental tenets of the profession that have been breached in this case. The public has the right to expect high standards of registered professionals. The seriousness and repeated nature of Miss Johnson's conduct are such that it calls into question her professionalism in the workplace. This has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute. It is submitted that

the attempts to conceal medication errors by any means, and especially by asking colleagues, including newly qualified colleagues, to breach protocol, is behaviour that is not consistent with that expected of a registered nurse. Miss Johnson's conduct is fundamentally incompatible with being a registered professional because the qualities required of Miss Johnson have been significantly undermined and compromised.

Therefore, the NMC invited the panel to find Miss Johnson's fitness to practise impaired on the grounds of public protection and public interest.

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

Decision and reasons on misconduct

The panel had regard to the case of *Roylance v GMC (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 of the view that Miss Johnson's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Johnson's actions amounted to a breach of the Code. Specifically:

> ***'8 Work cooperatively***
> ***8.2*** *maintain effective communication with colleagues*
> ***8.6*** *share information to identify and reduce risk*
> ***10 Keep clear and accurate records relevant to your practice***
> ***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*
> ***14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place***

14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*
14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*
14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*
18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*
19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
20 Uphold the reputation of your profession at all times
20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It was of the view that Miss Johnson's conduct in the charges found proved were sufficiently serious in nature that each would meet the threshold for misconduct

The panel noted the following in the witness statement of Lucy Weeks dated 27 January 2025:

> *'…When I asked Miss Johnson about this, she said she didn't know why the nurse signed and said she didn't ask her to do it, however when I spoke to the agency nurse, she said she had been asked by Miss*

Johnson to sign the CDB. As the agency nurse was a newly qualified nurse and hadn't worked many shifts at the hospital, she felt influenced by a superior nurse, and she thought it may have been common practice at the hospital which is why she retrospectively signed the CDB…'

Further, the panel noted that part of the NMC Code is to keep service users informed. It took into account that Patient B believed that the morphine caused them to have seizures and informed the staff of this. The panel also noted that although no harm was caused by Miss Johnson there was a serious risk that a seizure could have caused a carotid artery blowout and could have been fatal to Patient B. It also noted that it appeared that Miss Johnson may not have conducted the five (5) R's when preparing and administering the medication to Patient B: *'…the right patient, the right drug, the right time, the right dose, and the right route…'*

The panel found that Miss Johnson's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The panel determined that her conduct could have resulted in serious harm to vulnerable, unwell patients and could have impeded colleagues in their work on the Ward, potentially resulting in further issues. The panel determined that Miss Johnson's actions would be considered deplorable by fellow practitioners, especially regarding her attempt to obtain a retrospective signatures in patient's records from a newly qualified nurse whilst she was in a position of seniority.

The panel agreed with the submissions of the NMC and found that Miss Johnson's actions proved in charges 1a, 1b, 2a, 2b, 3, 4a, 4b, 4c, 4d, 5 and 6 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel noted that in the documents there are instances where Patient A and Patient B are referenced incorrectly. It referred to the MAR charts throughout it's deliberations to ensure that it was referring to the correct incidents and dates in it's decision making.

The panel also noted that it did not have the controlled drug book for the incident on 20 November 2021 before it and that it had been destroyed after two years, in line with local policy.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Johnson's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that all four limbs are engaged in this case. The panel finds that patients were put at risk of harm as a result of Miss Johnson's misconduct, specifically Patient B a vulnerable palliative care patient. The panel also finds that Miss Johnson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel had regard to the case of *Cohen v General Medical Council* and considered the following factors:

- whether the misconduct is capable of being addressed;
- whether it has been addressed; and
- whether the misconduct is highly unlikely to be repeated.

The panel considered whether Miss Johnson's conduct was capable of being addressed. However, it noted that Miss Johnson had not engaged with the NMC in relation to this hearing.

Regarding insight, the panel noted that Miss Johnson had not provided any meaningful reflections or any evidence demonstrating any insight into the potential harm or failure her conduct had on patients, staff and the reputation of the profession. Also, it noted that Miss Johnson had requested to be removed from the register, but she has not taken the necessary steps despite being sent the appropriate information by the NMC on at least two occasions. Further, the panel considered that the misconduct in this case included dishonesty which is inherently more difficult to remediate as it raises attitudinal concerns. The panel was of the view that there appeared to be a pattern of misconduct as Miss Johnson repeated medication administration errors on 2 April 2022, despite receiving support in the form of medication competency training from her employer in relation to the errors made on 20 November 2021. The panel concluded that there is no evidence of remediation or strengthening of practice, and there is a risk of this conduct being repeated by Miss Johnson. The panel therefore determined that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that the public would expect the NMC to take regulatory action where a registered nurse has demonstrated a pattern of repeated misconduct despite support from her employer. It was also of the view that a member of the public in possession of all the facts in this case would be surprised if a finding of impairment was not made by this regulator, given that this case involves breaches of professional standards in relation to controlled drugs and attempting to conceal medication errors, which is behaviour that is difficult to remediate.

For these reasons, the panel also finds Miss Johnson's fitness to practise impaired on the ground of public interest.

Having regard to all of the above, the panel determined that Miss Johnson's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Johnson off the register. The effect of this order is that the NMC register will show that Miss Johnson has been struck-off the register.

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).

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 11 June 2026, the NMC had advised Miss Johnson that it would seek the imposition of a striking-off order if the panel found Miss Johnson's fitness to practise currently impaired.

The NMC has considered the following aggravating factors:

a) Miss Johnson's dishonesty;
b) The potential for patient harm;
c) The allegations relate to basic nursing skills;
d) The allegations relate to more than one incident of similar nature;
e) Miss Johnson's lack of insight;
f) No evidence of strengthened practice due to Miss Johnson not appearing to have worked in a clinical setting since the last referred incident in November 2022.

The NMC has considered the following mitigating factors:

a) Miss Johnson may have retired;
b) This is the first time Miss Johnson has been referred to their regulator in a reasonably lengthy career as a nurse;
c) Miss Johnson has expressed a wish to be removed from the NMC's register. However, to date, it does not appear that she has submitted the appropriate application for voluntary removal.

The NMC submitted that taking no further action (SAN-3a) or imposing a caution order (SAN-3b) would be wholly inappropriate as they would not reflect the seriousness of the misconduct, nor would they protect the public or maintain the public confidence in the profession.

The NMC submitted that imposing a conditions of practice order would be inappropriate. The Guidance (SAN-3c) says that a conditions of practice order is appropriate when the concerns can easily be remediated and when conditions can be put in place that will be sufficient to protect the public and address the areas of concern to uphold public confidence. It is submitted that the concerns in their entirety cannot easily be remediated. While it may be possible to formulate conditions that address Miss Johnson's clinical failings, dishonesty is serious and cannot be addressed through conditions. As such, the NMC submitted that there are no practical conditions that can be imposed to reflect the seriousness of the facts of this case, nor address public protection and public interest concerns. In any case, Miss Johnson does not appear to have worked as a nurse, or in a clinical setting since she resigned from her role in 2022. As such, there are no practical or workable conditions that would be appropriate. Furthermore, Miss Johnson has expressed a desire to remove herself from the NMC Register. Therefore, there is a real risk that any conditions imposed would not be complied with.

The NMC submitted that a suspension order would be inappropriate as it would only temporarily protect the public. Whilst the guidance at SAN-3d indicates that the misconduct in this case is sufficiently serious to warrant temporary removal from the register, such an order would only be appropriate where there is *'a single incidence of misconduct…", "no evidence of harmful deep-seated personality or attitudinal problems'*

and “the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour”. The NMC submitted that none of those factors apply in the present case and suspension order would not reflect the seriousness of the misconduct. Therefore, public confidence in the profession and professional standards would not be maintained.

The NMC submitted that a striking-off order is the appropriate order in this case as Miss Johnson demonstrated a pattern of misconduct by breaching professional standards in relation to controlled drugs and attempting to conceal medication errors. Having reviewed the key considerations set out in the NMC guidance at SAN-3e and the guidance entitled ‘Sanctions for serious cases’ (SAN-2), the NMC submit that Miss Johnson’s actions raise fundamental concerns about her professionalism and trustworthiness, and the public’s confidence in the profession and the NMC as a regulator would be severely undermined if she were not removed from the register. The misconduct is fundamentally incompatible with staying on the register. Furthermore, the NMC consider that a striking-off order is the only sanction which will be sufficient to not only protect patients and members of the public, but to maintain professional standards.

Decision and reasons on sanction

Having found Miss Johnson’s fitness to practise currently impaired, the panel went on to consider 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 panel had regard to the NMC Guidance on *‘The sanctions available’* (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The potential for patient harm;
- The misconduct concerned fundamental nursing skills;
- The misconduct comprised more than one incident of similar nature;
- Miss Johnson failed to demonstrate insight;

- No evidence of strengthened practice due to Miss Johnson not appearing to have worked in a clinical setting since the last referred incident in November 2022;
- Miss Johnson persuaded a newly qualified nurse who was working through an agency to sign the MAR Chart and Controlled Drug Book to say she had witnessed the administration of the medication when she had not and on a second occasion asked another colleague to do the same;

The panel also took into account the following mitigating features:

- Miss Johnson asserts in her local interview that the Ward was busy;
- [PRIVATE].

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

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 Miss Johnson's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Miss Johnson practise 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 to place a conditions of practice order on Miss Johnson's registration. In considering whether conditions of practice are appropriate, the

panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). Given the dishonesty element in this case and having regard to the nature and seriousness of Miss Johnson's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances and such an order would not adequately address the seriousness of this case or the attitudinal concerns. Miss Johnson has indicated that she does not intend to work as a nurse again, and the panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*

- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel noted that this was not a single incident of misconduct but that of repeated misconduct over a period of time spanning less than six months. The panel determined that Miss Johnson's dishonesty reflected attitudinal concerns. The panel also took into account that Miss Johnson had not engaged with this hearing and as a result the panel had no evidence of meaningful insight, and no remorse or remediation had been demonstrated by Miss Johnson with regard to the misconduct. The panel had no evidence before it to suggest any increase in insight or strengthening of practice and nothing to suggest a period of suspension would mitigate the identified risks. It therefore determined there was a high risk of repetition. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*

- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel was satisfied that in this case, the misconduct was fundamentally incompatible with remaining on the register as this was a pattern of misconduct, and the dishonesty aspect was not confined to a single event. The panel was of the view that Miss Johnson was an experienced nurse requiring her to act with integrity and be a role model of professional behaviour for less experienced colleagues and students, which she did not. The panel considered that as Miss Johnson has not engaged with the NMC, has not provided any insight or remediation, and has indicated she wished for an agreed removal (although has not taken the necessary action to apply for this). It was of the view that there is no realistic possibility that Miss Johnson would address the concerns to such a level where she could return to practise safely.

Miss Johnson's actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Johnson's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Johnson's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Miss Johnson in writing.

Interim order

As the striking-off 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 Miss Johnson's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC. It submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive sanction order takes effect.

The NMC submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

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, in particular the ongoing risk of repetition and associated risk of harm to patients.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to protect the public and the wider public

interest. This interim order will cover the 28-day appeal period and the duration of any appeal should Miss Johnson decide to appeal against the panel's decision.

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

That concludes this determination.