Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 23 July- Wednesday, 29 July 2026

Virtual Hearing

Name of Registrant:	**Doreen Elizabeth Yarnold**
NMC PIN:	78E2606E
Part(s) of the register:	Registered Nurse (Sub Part 2) Adult Nursing – RN2 - 14 May 1980 Registered Nurse (Sub Part 1) Adult Nursing – RN1 - 28 November 1995
Relevant Location:	Dudley
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, lay member) Alison Thomson (Registrant member) Matthew Wratten (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Hanifah Choudhury
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Mrs Yarnold:	Not present and not represented
Offer no evidence:	Charge 9
Facts proved:	Charges 1b, 1c, 1d and 6
Facts not proved:	Charges 1a, 2, 3, 4, 5, 7, 8 and 10
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order for 12 months (with review)**

Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Yarnold was not in attendance and that the Notice of Hearing letter had been sent to Mrs Yarnold's registered email address by secure email on 24 June 2026.

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Yarnold's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Yarnold has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Yarnold

The panel next considered whether it should proceed in the absence of Mrs Yarnold. It had regard to Rule 21 and heard the submissions of Mr Malik who invited the panel to continue in the absence of Mrs Yarnold.

Mr Malik referred the panel to the email from Mrs Yarnold, dated 3 July 2026, which stated:

> *'I am no longer in practice as a nurse I retired to become my husband's carer…*

I cannot attend any way'

A further email from Ms Yarnold sent to the NMC on 3 July 2026 confirming that she was content for the hearing to proceed in her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Mrs Yarnold. In reaching this decision, the panel considered the submissions of Mr Malik, the emails from Mrs Yarnold, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Yarnold has informed the NMC that she will not be attending the hearing and is content for the hearing to proceed in her absence;
- No application for an adjournment has been made by Mrs Yarnold;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are scheduled to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023 and 2024;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Yarnold in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Yarnold's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Yarnold. The panel will draw no adverse inference from Mrs Yarnold's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) On 21 November 2023, on one or more occasion:
   a) failed to take Resident A's blood sugar levels every 2 hours;
   b) following high blood sugar reading, failed to check Resident A's ketone levels;
   c) failed to document, adequately or at all, Resident A's blood sugar readings and/or ketone levels;
   d) failed to provide an adequate handover in relation to Resident A's care;

2) Between 3 February 2024 and 8 February 2024, on one or more occasion, failed to chase the GP for a repeat prescription of Furosemide for Resident B;

3) On 7 February 2024 failed to take and/or document, daily notes for Resident B;

4) On 8 February 2024, copy and pasted one or more entry from Resident B's care plan from previous dates and documented it as being an accurate reflection of care;

5) On or around 12 February 2024, following receipt of Resident B's medication, failed to check that the prescription for Furosemide was the correct dose;

6) On 14 February 2024, failed to sign for Resident C's pain relief medication;

7) On 16 February 2024, failed to:
   a) request Oxycodone for Resident D;
   b) adequately manage Resident D's pain levels;
   c) update Resident D's care records to indicate that they could not have Morphine;
   d) provide an adequate handover to the night shift in that you did not inform them that Resident D could not have Morphine;

8) Having been made the subject of an interim order by the Nursing and Midwifery Council on 21 May 2024, you failed to notify your employer of the interim order of conditions attached to your practice;

9) Between 21 May 2024 and 20 August 2024, breached one or more of the following conditions of your interim order:
   a) Condition 2;
   b) Condition 3;
   c) Condition 7;

10) Your actions at charge 8 were dishonest as you sought to conceal that there were conditions attached to your practice.

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

Decision and reasons on application to offer no evidence on charge 9

At the outset of the hearing Mr Malik informed the panel that the NMC will be offering no evidence on charge 9 in its entirety on the basis that there was no evidence to support this charge.

The panel considered the NMC's application to offer no evidence in respect of charge 9.

Having considered the material before it, the panel was satisfied that the application was made out in consideration of the material before it. Accordingly, the panel granted the NMC's application to offer no evidence in respect of charge 9.

Decisions and reasons on the admissibility of Lloyd Emeny's witness statement and accompanying exhibit as hearsay evidence

Contained within the NMC's exhibit bundle was a document titled 'Employment reference from Royal Park Nursing Home'. This document had not been exhibited by any of the witnesses called by the NMC and its provenance was not established by the evidence before the panel.

The panel heard an application made by Mr Malik under Rule 31 to admit the statement of Mr Lloyd Emeny and his accompanying exhibit of the reference from Royal Park Nursing Home into evidence. He relied upon the principles set out in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) in relation to whether the hearsay evidence should be admitted.

Mr Malik submitted that the employment reference from Park Royal Nursing Home was the sole and decisive evidence in relation to charge 8 and the associated charge of dishonesty in charge 10. He said that Mrs Yarnold had been aware throughout the proceedings that the NMC intended to rely upon the reference, as it had always formed part of the hearing bundle. He submitted that Mr Emeny's statement simply exhibited the reference received by the NMC during its investigation and that there was no suggestion that the document had been fabricated.

Mr Malik submitted that the document was plainly relevant and that it would be fair to admit it into evidence. He submitted that the issue of the weight to be attached to the document was a matter for the panel.

In response to questions from the panel Mr Malik accepted that the NMC had made no attempts to secure the attendance of the author of the reference or to obtain a witness statement from her. He also accepted that no evidence had been obtained from the NMC investigator who had requested or received the document.

Mr Malik said that, so far as he understood, Mr Emeny's role was limited to exhibiting the reference as a document received by the NMC during its investigation. He acknowledged that he could not identify the reason why the reference had been created or provide a complete evidential chain demonstrating how it had been obtained. He accepted that, given the seriousness of the dishonesty allegation, attempts should have been made to obtain evidence from the author of the reference, but submitted that, at this stage, the best the NMC had been able to do was to obtain a statement from an NMC employee exhibiting the document.

The panel accepted the advice of the legal assessor on the provisions of Rule 31 and the principles which would inform its approach to the admission of hearsay evidence.

The panel considered the NMC's application to admit the statement of Mr Emeny and the employment reference from Park Royal Nursing Home as hearsay evidence.

The panel accepted that the document was relevant to charges 8 and 10. However, it noted that the employment reference was the sole and decisive evidence relied upon by the NMC in support of those charges, which included an allegation of dishonesty. Given the seriousness of the allegations and the potential consequences for Mrs Yarnold, the panel considered that it would expect the NMC to produce robust evidence in support of the charges.

The panel noted that there was no suggestion that the document had been fabricated. However, it was concerned that the provenance of the document had not been established. The panel had provided the NMC with an opportunity to adduce

evidence to explain the provenance of the document and the circumstances in which it had been obtained but no such evidence was produced. The panel further noted that the NMC had provided no good reason for the non-attendance of the author of the reference and accepted Mr Malik's confirmation that no attempts had been made to secure the attendance of that witness or obtain a witness statement. In those circumstances, the panel considered that there was no satisfactory evidential chain establishing the document's origin or authenticity.

The panel recognised that Mrs Yarnold had been aware of the document throughout the proceedings and had chosen not to attend the hearing or engage with the process. Whilst this meant that she had not challenged the document despite having had the opportunity to do so, the panel did not hold her non-attendance against her. Rather, the panel considered that the inability to test the evidence, together with the absence of any witness capable of speaking to the provenance of the document, rendered it unfair to admit.

Having balanced the factors set out in *Thorneycroft*, the panel concluded that, although the document was relevant, its admission would not be fair. Accordingly, the panel refused the NMC's application to admit the hearsay evidence.

Background

Mrs Yarnold was employed as a registered nurse at Ashgrove Care Home (the Home) between 6 November 2023 and 19 February 2024. On 10 April 2024, the NMC received a referral from Beverley Murrain, the Registered Manager of the Home raising concerns about Mrs Yarnold's fitness to practise. The allegations related to a number of incidents said to have occurred between November 2023 and February 2024.

The NMC allege that Mrs Yarnold failed to monitor and record Resident A's blood glucose levels and ketones in accordance with medical instructions, resulting in the resident developing diabetic ketoacidosis and requiring hospital admission. Following that incident, Mrs Yarnold was placed on an action plan and received a period of additional support and supervision. The NMC further allege that Mrs Yarnold failed to appropriately manage Resident B's medication, maintain accurate clinical records,

administer and record medication correctly, escalate outstanding pain medication for Resident D, and update Resident C's care plan on admission.

Mrs Yarnold's employment at Ashgrove Care Home ended on 19 February 2024 after she did not successfully complete her probationary period.

Ms Yarnold subsequently commenced employment at Park Royal Nursing Home on 10 April 2024. On 21 May 2024, an interim conditions of practice order was imposed upon her. The NMC allege that Mrs Yarnold failed to inform Park Royal Nursing Home that she was subject to the interim conditions of practice order and the NMC investigation and that, by failing to do so, acted dishonestly.

Mrs Yarnold has informed the NMC that she is now a full-time carer for her husband and considers herself retired from nursing.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Yarnold.

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:

- Beverley Murrain: Registered Manager at the Home.

- Barbary Morby: Deputy Manager at the Home.
- Jackie Webb: Community Diabetes Nurse.
- Jasbir Kaur: Agency Nurse at the Home at the material time.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a)

That you, a registered nurse:

1) On 21 November 2023, on one or more occasion:
   a) failed to take Resident A's blood sugar levels every 2 hours;

This charge is found NOT proved.

In reaching its decision, the panel had regard to the evidence before it, including the discharge letter relied upon by the NMC as setting out the instructions for the monitoring of Resident A's blood sugar levels. The panel noted that the NMC's case was that the discharge letter required blood sugar levels to be taken every two hours. The letter stated:

> *'Please give insulin on time at 8am and 8pm. Accepted BM range is 6-22. If higher than this give 2 units of short acting insulin then wait 2 hours for sugars to fall before checking/ repeating the insulin dose (only repeat insulin dose if absolutely necessary- in hospital we are lenient with hypoglycaemia) monitor ketones when above 22 units.'*

The panel noted that the letter did not state that Resident A's blood sugar levels were required to be checked every two hours. Rather, it referred to checking blood sugar levels two hours after the administration of short-acting insulin where a further dose may be required.

The panel heard evidence from a number of witnesses regarding the interpretation and implementation of these instructions.

Ms Morby and Ms Murrain accepted in their oral evidence that the instructions contained within the discharge letter may have changed over time. Furthermore, in oral evidence when questioned by the panel concerning Mrs Yarnold's responsibilities relating to this charge, Ms Morby stated *'all of us are equally at fault for not checking and checking what the document meant.'* Ms Webb's evidence was that she had not made any changes to the instructions and that any amendments would have been made by the GP and recorded within the care notes. However, the panel did not have sight of those care notes. Ms Kaur accepted that she had not seen the discharge letter and believed that staff were following different instructions. The panel was therefore unable to determine precisely what instructions the nursing staff were working to at the relevant time.

The panel also considered the root cause analysis completed following the incident. This identified a number of contributing factors, including:

> *'ambiguous notes from hospital. No spare glucose machine. No ketone sticks compatible with Libre blood glucose monitoring system.'*

The panel noted that the evidence before it demonstrated a degree of ambiguity and confusion surrounding the discharge instructions. The witnesses themselves considered the instructions to be unclear, and Ms Webb's evidence was that she could not identify the instruction said to require checks every two hours.

The panel further noted that there was no evidence before it of a specific requirement for Resident A's blood sugar levels to be checked every two hours. Ms Kaur's evidence was that blood sugars would usually be taken around the time of

medication rounds. The panel also noted that it had not been provided with Resident A's MAR charts which may have assisted in determining the timing of insulin administration and blood sugar monitoring. In addition, there appeared to be no clear care plan in place, with Ms Webb stating in her evidence that there was not one that she was aware of.

The panel considered whether the charge could be amended to reflect a failure to check blood sugar levels two hours after the administration of short-acting insulin. However, the panel concluded that it would be wholly unfair to amend the charge in circumstances where the evidence before it was inconsistent and Mrs Yarnold had faced a specific allegation that she had failed to check blood sugar levels every two hours.

The panel accepted that there were concerns regarding the care provided to Resident A and that all nurses involved had a responsibility to ensure appropriate monitoring took place. However, the burden remained on the NMC to prove the charge on the balance of probabilities.

Having considered all of the evidence, the panel was not satisfied that the NMC had established that Mrs Yarnold was subject to a requirement to take Resident A's blood sugar levels every 2 hours or that she had breached such a requirement.

Accordingly, the panel found that charge 1a) was not proved.

Charge 1b)

1) On 21 November 2023, on one or more occasion:
   b) following high blood sugar reading, failed to check Resident A's ketone levels;

This charge is found proved.

The panel considered the evidence regarding Resident A's blood glucose monitoring records. The panel noted that there were a number of entries recording high blood glucose readings, including readings recorded as *"HI"* and a reading of 27.1 mmol/L

on the Libre system. The panel further noted that Mrs Yarnold had signed next to the relevant entries, indicating that she had seen and was aware of those readings.

The panel considered the evidence of Ms Webb, who explained that a '*HI'* reading indicated a significant risk of a patient developing diabetic ketoacidosis and required action to be taken. In her witness statement, she stated:

> *'I explained that a 'HI' reading meant that there was a significant risk of a patient developing Diabetic Ketoacidosis, which is dangerous, and that she needed to act on it, even so if she thought 'HI' meant a reading above 22mmol, she should have done a capillary ketone test. Any reading of 'HI' means that the patient's blood glucose level is above 13.9mmol/L and, at the very least, that they need to do a capillary ketone test. If the ketone test reads above 3mmol/L, then medical help should be sought immediately.'*

Ms Webb confirmed this evidence during her oral evidence before the panel.

The panel was satisfied that Mrs Yarnold was aware of the high blood glucose readings, as evidenced by her signatures alongside the recorded entries. However, there was no evidence before the panel that she undertook ketone testing following those readings, nor was there any record that ketone levels had been checked. The panel considered the absence of such records significant, particularly given the risk associated with elevated blood glucose levels and the potential development of diabetic ketoacidosis.

The panel also considered the evidence regarding the availability of equipment required to undertake ketone testing. Ms Morby in her oral evidence said that there were sufficient ketone sticks available. Ms Kaur confirmed in her oral evidence that she had undertaken ketone testing on Resident A during the night shift and that the equipment required to carry out the test was readily available.

Having considered the evidence in its entirety, the panel was satisfied that, following high blood sugar readings, Mrs Yarnold failed to check Resident A's ketone levels. The panel therefore determined that charge 1b) was proved.

Charge 1c)

1) On 21 November 2023, on one or more occasion:
   c) failed to document, adequately or at all, Resident A's blood sugar readings and/or ketone levels;

This charge is found proved.

The panel considered the hospital discharge letter, which stated:

'monitor ketones when above 22 units.'

The panel was satisfied that this instruction placed a requirement on the nursing staff to monitor and appropriately record Resident A's ketone levels where the blood glucose readings exceeded the specified threshold.

Ms Murrain's evidence was that there were no records of Resident A's blood sugar levels and no comments within the daily notes relating to such monitoring. This was supported by the documentary evidence provided to the panel, including Resident A's daily records. The panel noted that there was no entry within Resident A's daily notes recording blood sugar readings or ketone levels.

The panel accepted that there was evidence that Mrs Yarnold had recorded Resident A's blood glucose levels as *'HI'* but had not gone on to record the actual levels.

Having considered the evidence as a whole, the panel was satisfied that Mrs Yarnold failed to adequately document Resident A's blood sugar readings and/or ketone levels.

The panel therefore determined that charge 1c) was proved.

Charge 1d)

That you, a registered nurse:

1) On 21 November 2023, on one or more occasion:
    d) failed to provide an adequate handover in relation to Resident A's care;

This charge is found proved.

In reaching this decision, the panel relied upon the evidence of Ms Kaur, the night nurse to whom Mrs Yarnold handed over on 21 November 2023.

In her oral evidence, Ms Kaur explained that she would have expected Mrs Yarnold to inform her of Resident A's high blood sugar readings during handover so that she could prioritise checking Resident A's blood sugar levels and take any necessary action immediately.

The panel noted Ms Kaur's evidence that handovers were completed both verbally and by way of a written handover document. Whilst there was a written framework for handovers, the panel did not have sight of the completed handover documentation. Ms Kaur's evidence was that she received an overall handover from Mrs Yarnold but was not provided with any specific information regarding Resident A's high blood sugar readings. As a result, Ms Kaur only checked Resident A as part of her routine checks rather than being aware of the need for more immediate monitoring.

The panel found Ms Kaur to be a credible and reliable witness. She was clear in her evidence as to what information she would have expected to receive during handover and the importance of being informed of Resident A's elevated blood sugar readings. The panel accepted her evidence that she was not informed of those readings by Mrs Yarnold.

Having considered the evidence as a whole, the panel was satisfied that Mrs Yarnold failed to provide an adequate handover in relation to Resident A's care. The panel therefore found that charge 1d) was proved.

Charge 2

2) Between 3 February 2024 and 8 February 2024, on one or more occasion, failed to chase the GP for a repeat prescription of Furosemide for Resident B;

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence of Ms Morby who stated that responsibility for chasing medication was shared between the nurses and that no one nurse had sole responsibility for following up prescriptions. In her oral evidence, Ms Morby accepted that *"we all could have done better"* and that *"no one nurse had responsibility in chasing medication".* The panel therefore considered that it could not properly attribute responsibility for chasing the prescription solely to Mrs Yarnold where the evidence suggested that this was a shared responsibility amongst the nursing staff.

The panel noted that a chase-up email was sent by Delecta Woolery on 7 February 2024, which stated:

> *'Can a prescription be done for Resident B for his furosemide, omeprazole.'*

The panel further noted that Mrs Yarnold followed this up with an email sent on 8 February 2024, stating:

> *'Resident B has run out of omeprazole 20mg, Rivaroxaban 10mg, and only has 2 furosemide 40mg tablets left to complete the cycle could you please provide an interim script for him.'*

The panel was satisfied that this correspondence fell within the period of the charge and demonstrated that Mrs Yarnold had taken steps to chase the prescription. There

was no evidence before the panel that Mrs Yarnold was required to chase the prescription on a daily basis.

The panel also considered the medication policy. The panel noted that the responsibility of ensuring medication was available to residents when required rested with the registered manager, whereas the registered nurse had clinical responsibility for the management and administration of medication. The panel was not satisfied that the evidence established that Mrs Yarnold had a specific responsibility to chase the prescription in the manner alleged.

Having considered the evidence as a whole, the panel was not satisfied that the NMC had discharged the burden of proving that Mrs Yarnold failed to chase the GP for a repeat prescription of Furosemide for Resident B. Accordingly, the panel determined that charge 2 was not proved.

Charge 3

3) On 7 February 2024 failed to take and/or document, daily notes for Resident B;

This charge is found NOT proved.

The panel considered the evidence regarding whether Mrs Yarnold was responsible for Resident B's care on 7 February 2024. The panel noted that there was no clear evidence before it confirming that Mrs Yarnold had been allocated responsibility for Resident B on that date. The panel heard evidence that the Home was separated into two floors and that staff members could be allocated to different floors. However, there was no written evidence before the panel identifying which residents Mrs Yarnold was responsible for caring for on 7 February 2024.

The panel noted that there was an entry in Resident B's daily notes made by Ms Woolery on 7 February 2024. The panel considered that, if Mrs Yarnold had been responsible for Resident B, it was unclear why such an entry would have been made by Ms Woolery on that date. The panel also noted that Ms Woolery sent a chase-up email regarding Resident B's medication on the same day. The panel considered

that this evidence suggested, or made it more likely, that Ms Woolery was the nurse responsible for Resident B on that date.

The panel considered Ms Murrain's evidence that staff could have changed floors during their shifts but she was unable to explain why Ms Woolery had made the relevant entry or why the responsibility for Resident B would have rested with Mrs Yarnold on that day. The panel also noted that carers completed the majority of daily notes.

Having considered the evidence as a whole, the panel was not satisfied that Mrs Yarnold was responsible for completing Resident B's daily notes on 7 February 2024. Accordingly, the panel was not satisfied that the NMC had discharged the burden of proving the charge. The panel therefore determined that Charge 3 was not proved.

Charge 4

4) On 8 February 2024, copy and pasted one or more entry from Resident B's care plan from previous dates and documented it as being an accurate reflection of care;

This charge is found NOT proved.

The panel noted that Mr Malik conceded that the NMC had not met the evidential standard required in respect of this charge.

In light of there being no evidence before the panel upon which it could properly make a finding that the charge was proved, the panel determined that charge 4 was not proved.

Charge 5

5) On or around 12 February 2024, following receipt of Resident B's medication, failed to check that the prescription for Furosemide was the correct dose;

This charge is found NOT proved.

The panel considered the evidence before it and noted that there was no evidence to establish that Mrs Yarnold received the medication in question or that it was her responsibility to check the dosage of the prescription. The panel heard evidence from Ms Morby that it was the responsibility of the nurse who received the medication to check that it was correct. The panel found Ms Morby to be a credible witness and noted that her evidence was the only evidence before the panel in relation to this charge.

The panel further noted that there was no evidence to establish that Mrs Yarnold was working on 12 February 2024. The panel had sight of the staff rotas which did not show the roster for 12 February 2024 so could not confirm whether Mrs Yarnold was on shift that day.

Having considered the evidence as a whole, the panel was not satisfied that the NMC had established that Mrs Yarnold received the medication, that she was responsible for checking the dosage, or that she was on duty on the relevant date.

Accordingly, the panel determined that the NMC had not discharged the burden of proof and found charge 5 not proved.

Charge 6

6) On 14 February 2024, failed to sign for Resident C’s pain relief medication;

This charge is found proved.

The panel considered the evidence regarding Mrs Yarnold’s attendance at work on the relevant date. The panel had sight of the staff roster, which confirmed that Mrs Yarnold was working 07:00 to 19:00 on 14 February 2024. The panel was therefore satisfied that Mrs Yarnold was present at the Home on the date of the alleged incident.

The panel considered the medication and care records for Resident C. The panel noted that there was no entry within the records confirming the administration of Resident C's pain relief medication or demonstrating that Mrs Yarnold had signed for the medication as required.

The panel also considered the file note which recorded that a conversation had taken place in relation to the administration and recording of Resident C's pain relief medication. The panel considered that this further supported that there was an issue regarding the recording of the medication.

Having considered the evidence as a whole, the panel was satisfied that Mrs Yarnold failed to sign for Resident C's pain relief medication on 14 February 2024. Accordingly, the panel determined that charge 6 was proved.

Charge 7a)

7) On 16 February 2024, failed to:
a) request Oxycodone for Resident D;

This charge is found NOT proved.

The panel considered the evidence of Ms Morby who referred to an email in her file note dated 19 February 2024. The file note stated:

> *'Whilst on duty, at around 1730, you received an email from the Palliative Care Team stating that the resident could not tolerate the doses of Oramorph needed to reduce his pain and that we needed to treat pain with Oxycodone.'*

However, the panel did not have sight of the email itself. The panel was therefore unable to determine the content of that communication or whether it contained a request or instruction for a prescription of Oxycodone to be obtained.

The panel had sight of the care records for Resident D, which included an entry made on 16 February 2024 by Mrs Yarnold. The entry stated:

‘seen professional the palliative care team rang concerning Resident D’s oramorph, whilst in hospital he did have a few problems with it. Not suiting him did have a few issues did not understand why discharged on it if possible might be better to avoid giving it until seen by the doctor to prescribe an alternative continue with paracetamol for now.’

The panel considered that, from this entry, it was plausible that Mrs Yarnold was awaiting further advice from the GP or appropriate healthcare professional regarding alternative pain relief, whilst continuing to manage Resident D’s pain with paracetamol. The panel noted that Resident D had been admitted for end-of-life care and that the circumstances surrounding his pain management required clinical consideration.

The panel also considered the evidence of Geraldine Bondoc, the registered nurse on duty for 16/17 February 2024, whose note recorded:

‘Resident D appears to be settled, assisted with personal care, complaining of pain paracetamol given from homely remedy, but he said it does not helping much, he was requesting for his oramorph but explained to it that I can not give it yet until further discussion from hospital.’

The panel considered that Ms Bondoc’s entry was consistent with the information recorded by Mrs Yarnold and indicated that there had been ongoing discussions regarding Resident D’s pain relief.

Having considered the evidence as a whole, the panel was not satisfied that the NMC had established that Mrs Yarnold was responsible for requesting Oxycodone on 16 February 2024. The panel had no evidence before it confirming the contents of the email referred to by Ms Morby or that such a request had been made to Mrs Yarnold. Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof and determined that charge 7a) was not proved.

Charge 7b)

7) On 16 February 2024, failed to:

b) adequately manage Resident D's pain levels;

This charge is found NOT proved.

The panel noted that there were concerns regarding Resident D's ongoing pain and the suitability of his prescribed Oramorph. However, the panel also noted that the evidence demonstrated that steps were being taken to manage his pain and to seek further advice regarding alternative medication.

The panel considered Mrs Yarnold's entry in the care records dated 16 February 2024, which stated:

> *'seen professional the palliative care team rang concerning resident d's oramorph, whilst in hospital he did have a few problems with it. Not suiting him did have a few issues did not understand why discharged on it if possible might be better to avoid giving it until seen by the doctor to prescribe an alternative continue with paracetamol for now.'*

The panel considered that this entry demonstrated that Mrs Yarnold had identified concerns regarding Resident D's medication and was awaiting further clinical advice regarding an alternative approach. It also demonstrated that Mrs Yarnold had provided paracetamol to help with Resident D's pain.

The panel also considered the evidence of Ms Bondoc, whose note in Resident D's care notes recorded:

> *'Resident D appears to be settled, assisted with personal care, complaining of pain paracetamol given from homely remedy, but he said it does not helping much, he was requesting for his oramorph but explained to it that I can not give it yet until further discussion from hospital.'*

The panel considered that this evidence was consistent with Mrs Yarnold's record and demonstrated that the issue of Resident D's pain relief was being considered and managed pending further advice.

Furthermore, the panel considered the evidence of Ms Morby who referred to an email in her file note dated 19 February 2024. The file note stated:

> *'Whilst on duty, at around 1730, you received an email from the Palliative Care Team stating that the resident could not tolerate the doses of Oramorph needed to reduce his pain and that we needed to treat pain with Oxycodone.'*

However, the panel did not have sight of the email itself. The panel was therefore unable to determine the content of that communication or whether it contained a request or instruction for a prescription of Oxycodone to be obtained.

Having considered the evidence as a whole, the panel was not satisfied that Mrs Yarnold failed to adequately manage Resident D's pain levels. The panel accepted that Resident D remained in pain and that his pain relief required further review, but it was not satisfied that this amounted to a failure by Mrs Yarnold to manage his pain appropriately in the circumstances. Accordingly, the panel determined that charge 7b) was not proved.

Charge 7c)

7) On 16 February 2024, failed to:
c) update Resident D's care records to indicate that they could not have Morphine;

This charge is found NOT proved.

The panel considered the care records and noted that there was an entry made by Mrs Yarnold at 11:18 which said:

> *'seen professional the palliative care team rang concerning resident d's oramorph, whilst in hospital he did have a few problems with it. Not suiting*

him did have a few issues did not understand why discharged on it if possible might be better to avoid giving it until seen by the doctor to prescribe an alternative continue with paracetamol for now.'

The panel was satisfied that Mrs Yarnold had documented her concerns regarding Resident D's tolerance of Oramorph and the issue with his prescribed pain relief. The panel noted that there was no evidence before it to contradict the information recorded by Mrs Yarnold in the care records.

Furthermore, the panel was not satisfied that the evidence established that Resident D could not have Morphine at all. Rather, the evidence indicated that there were concerns regarding the suitability and effectiveness of Oramorph and that further advice was being sought regarding alternative pain management.

Having considered the evidence as a whole, the panel was not satisfied that Mrs Yarnold failed to update Resident D's care records as alleged. Accordingly, the panel determined that charge 7c) was not proved.

Charge 7d)

7) On 16 February 2024, failed to:
d) provide an adequate handover to the night shift in that you did not inform them that Resident D could not have Morphine;

This charge is found NOT proved.

The panel noted that it did not have the benefit of direct evidence from the night nurse who received the handover, Ms Bondoc. The evidence before the panel in relation to what was communicated during the handover was therefore hearsay evidence. The panel considered the weight that could properly be attached to that evidence.

The panel considered the entry made at 04:08 by Ms Bondoc which stated:

‘Resident D appears to be settled, assisted with personal care, complaining of pain paracetamol given from homely remedy, but he said it does not helping much, he was requesting for his oramorph but explained to it that I can not give it yet until further discussion from hospital.’

The panel considered that this entry demonstrated some level of understanding by the night nurse regarding the concerns surrounding Resident D’s Oramorph and was consistent with the information recorded by Mrs Yarnold earlier in the day.

The panel was not satisfied that the evidence established that Mrs Yarnold failed to communicate relevant information regarding Resident D’s pain relief during handover. In the absence of direct evidence from Ms Bondoc and having considered the available records, the panel was unable to conclude that the alleged failure occurred.

Accordingly, the panel determined that charge 7d) was not proved.

Charge 8

8) Having been made the subject of an interim order by the Nursing and Midwifery Council on 21 May 2024, you failed to notify your employer of the interim order of conditions attached to your practice;

This charge is found NOT proved.

The panel had evidence before it confirming that an interim order of conditions of practice was imposed on Mrs Yarnold by a panel of the Investigating Committee on 21 May 2024.

However, the panel noted that there was no evidence before it to establish that Mrs Yarnold failed to notify her employer of the existence of that interim order or the conditions attached to her practice.

In the absence of evidence demonstrating that Mrs Yarnold had failed to notify her employer of the interim order, the panel was unable to make a finding that the charge was proved.

Accordingly, the panel determined that charge 8 was not proved.

Charge 10

10) Your actions at charge 8 were dishonest as you sought to conceal that there were conditions attached to your practice.

This charge is found NOT proved.

In the absence of a finding that Mrs Yarnold failed to notify her employer in charge 8, the panel could not properly go on to consider that her actions were dishonest.

Accordingly, the panel determined that Charge 10 was not proved.

Fitness to practise

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

Submissions on misconduct

Mr Malik submitted that Mrs Yarnold's conduct fell seriously short of the standards required by the Code and amounted to serious professional misconduct. He submitted that the proved charges, including poor medication practice, failure to check Resident A's ketone levels, inadequate record keeping, an inadequate handover, and failure to sign for pain relief medication, demonstrated significant failings in Mrs Yarnold's clinical practice and ability to practise safely and effectively. He submitted that such failings created a risk of harm to vulnerable patients and that poor medication practice and record keeping could adversely affect patient care and future clinical decision-making.

Mr Malik submitted that Mrs Yarnold's conduct represented a serious departure from the standards expected of a registered nurse and would be regarded as deplorable by fellow practitioners. He submitted that the conduct breached paragraphs 1.2, 8.2, 8.3, 8.6, 10.1, 10.2, 13.1 and 20.1 of the Code and was sufficiently serious to amount to misconduct.

Submissions on impairment

Mr Malik moved on to the issue of impairment and addressed the panel on the need to have regard to protecting 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Malik submitted that three of the four limbs in *Grant* were engaged. He submitted that Mrs Yarnold had placed vulnerable patients at a risk of harm by failing to check Resident A's ketone levels following a high blood glucose reading, providing an inadequate handover, failing to record blood glucose readings, and failing to sign for

a resident's pain relief medication. Although the medication had been administered, he submitted that the omission created a risk of a double dose being given. He submitted that, in the absence of insight or remediation, the risk of repetition and future harm remained. He further submitted that Mrs Yarnold's conduct had brought the nursing profession into disrepute and breached the fundamental tenets of the profession, including the duties to prioritise people, preserve safety, and promote professionalism and trust.

Mr Malik submitted that Mrs Yarnold had provided no reflective statement, had not participated in the proceedings, had shown no acknowledgement of the impact of her actions, and had produced no evidence of remediation, such as training or CPD. Although she had informed the NMC that she was retired from nursing and acting as a full-time carer for her husband, he submitted that there was no evidence that she had addressed the concerns identified by the panel. He therefore submitted that the concerns had not been remedied and remained highly likely to be repeated.

Mr Malik submitted that a finding of current impairment was necessary on public protection grounds as Mrs Yarnold's lack of insight and remediation meant there remained a risk of repetition and unwarranted harm to patients. He further submitted that a finding of impairment was required in the wider public interest to uphold proper professional standards and maintain public confidence in the nursing profession and the NMC. He submitted that Mrs Yarnold's failure to check Resident A's ketone levels following a high blood glucose reading amounted to knowingly taking a risk with a vulnerable patient's safety and that, in all the circumstances, her fitness to practise was currently impaired.

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

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of*

general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Yarnold's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Yarnold's actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
***1.2** make sure you deliver the fundamentals of care effectively*

8 Work cooperatively
To achieve this, you must:
***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
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*

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

In relation to charges 1b, 1c and 1d, the panel considered that Mrs Yarnold's failings related to fundamental aspects of nursing practice. The panel noted that, although she was new to the Home, she was an experienced registered nurse and was expected to possess the basic clinical knowledge and skills required to recognise and respond appropriately to Resident A's condition.

The panel found that Mrs Yarnold's failure to act upon Resident A's elevated blood glucose readings, including her omission to check ketone levels, represented a serious departure from the standards expected of a registered nurse. The panel accepted Ms Webb's evidence that diabetes management is complex; however, it considered that recognising the significance of high blood glucose levels and escalating concerns were fundamental nursing responsibilities. The panel also found that Mrs Yarnold failed to provide an adequate handover to the night nurse, resulting in important clinical information not being communicated. These omissions placed Resident A at a risk of harm and had the potential to result in serious harm. Taken together, the panel was satisfied that Mrs Yarnold's conduct amounted to misconduct.

In relation to charge 6, the panel considered that Mrs Yarnold administered Resident C's pain relief medication but failed to sign the medication administration record, despite this being a fundamental requirement of safe medicines management. Accurate recording of medication administration is an essential aspect of nursing practice and ensures continuity and safety of patient care.

The panel determined that Mrs Yarnold's omission had the potential to result in another nurse believing that the medication had not been administered and giving a further dose, thereby exposing Resident C to a risk of harm. The panel was satisfied

that this represented a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Yarnold'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. 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 Mrs Yarnold's misconduct placed residents at potential risk of harm.

The panel determined that Mrs Yarnold's misconduct constituted serious breaches of fundamental tenets of the nursing profession as she 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.

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 considered that the misconduct was capable of remediation. However, there was no evidence before it that Mrs Yarnold had taken any steps to address the concerns identified. She had provided no reflective piece, no evidence of relevant training or strengthened practice, and demonstrated no insight into her misconduct.

The panel noted that Mrs Yarnold had been a registered nurse for many years and that the failings related to fundamental aspects of nursing practice. In the absence of any evidence of insight, remediation or training, there was nothing before the panel to reassure it that the misconduct would not be repeated or that Mrs Yarnold could practise safely and effectively without restriction. Although Mrs Yarnold had informed the NMC that she had retired from nursing, the panel considered that this did not remove the risk of repetition should she return to practice. Accordingly, the panel concluded that Mrs Yarnold's fitness to practise is currently impaired on public protection grounds.

The panel also considered whether a finding of impairment was required in the wider public interest. It concluded that Mrs Yarnold's misconduct represented a serious departure from the standards expected of a registered nurse and involved failings in fundamental aspects of nursing practice. The panel was satisfied that a well-informed member of the public would expect a finding of current impairment in these circumstances. A finding of impairment is therefore necessary to uphold proper professional standards and to maintain public confidence in the nursing profession and the NMC as its regulator. Accordingly, the panel concluded that Mrs Yarnold's fitness to practise is also currently impaired on public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mrs Yarnold’s name on the NMC register will show that she is subject to a conditions

of practice order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Mr Malik submitted that, in accordance with the NMC's Sanctions Guidance (SAN-1), the panel should consider the aggravating and mitigating factors. He submitted that the aggravating features included Mrs Yarnold's wide-ranging clinical failings, poor record keeping, limited insight, the real risk of patient harm, the absence of remediation, and her failure to engage with the proceedings. He submitted that the only mitigating factor was that no actual patient harm had occurred.

Mr Malik submitted that, although the concerns were clinical and capable of remediation, a conditions of practice order would not be appropriate. He submitted that such an order requires evidence of insight, engagement, and a willingness to comply with conditions and undertake retraining. He submitted that Mrs Yarnold had disengaged from the process, provided no evidence of reflection, remediation or training, and had informed the NMC that she had retired from nursing with no intention of returning to practice. Accordingly, he submitted that workable and measurable conditions could not be formulated.

Mr Malik submitted that a suspension order was the appropriate and proportionate sanction. He submitted that Mrs Yarnold's failings related to fundamental aspects of nursing practice, that there was no evidence of insight or remediation to reduce the risk of repetition, and that Mrs Yarnold's retirement did not remove the risk should she return to practice. He submitted that a suspension order would therefore protect the public, maintain confidence in the profession, uphold professional standards, and represent the least restrictive sanction capable of meeting the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Yarnold'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- conduct which put vulnerable residents at risk of suffering harm
- absence of insight.

The panel could not identify any mitigating features in this case.

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, although Mrs Yarnold's actions were at the lower end of the spectrum, it found that there still remains a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Yarnold's 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 placing conditions of practice on Mrs Yarnold's 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)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *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 noted that Mrs Yarnold had informed the NMC that she had no intention of returning to nursing. However, the panel considered that her circumstances could change in the future and that her current position should not, of itself, prevent the imposition of a conditions of practice order.

The panel was satisfied that Mrs Yarnold's failings were wholly clinical in nature and did not involve attitudinal concerns. It considered that the deficiencies identified were capable of remediation through retraining, supervision and the imposition of appropriate, workable and measurable conditions.

Accordingly, the panel concluded that a conditions of practice order would adequately protect the public, support Mrs Yarnold in addressing the identified concerns should she return to practice, and satisfy the wider public interest. The panel was therefore satisfied that a conditions of practice order was the appropriate and proportionate sanction.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Yarnold's case as the concerns are remediable.

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 limit your employment to one substantive employer. This must not be an agency or bank work.
>
> 2. You must ensure you are supervised any time you are undertaking the management of diabetes until you have been deemed competent by a nurse of Band 6 or equivalent. Evidence of your completed competency must be sent to the NMC within seven days of completion.
>
> 3. You must meet with your line manager or supervisor monthly to discuss:
>   - Record keeping
>   - Management of diabetes
>
> 4. A report from your line manager or supervisor must be sent to the NMC prior to any review hearing detailing discussions on:
>   - Record keeping
>   - Management of diabetes

5. You must provide the NMC with a reflective piece, reflecting on the concerns. This must be sent to the NMC prior to any review hearing.

6. 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.

7. 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.

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

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

10. 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 12 months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Yarnold has 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.

The panel was mindful of the powers available to a future reviewing panel under the NMC's Substantive Order Reviews Guidance (REV-2). It recognised that, at the next review, the reviewing panel would have the power to allow the order to lapse with a finding of impairment in accordance with NMC guidance REV-2H, or, if appropriate, to impose a striking-off order. The panel also noted that, if Mrs Yarnold continued to have no intention of returning to nursing, it would be open to her to engage with the NMC and clearly express that position to a future reviewing panel. Such engagement would enable the reviewing panel to consider whether allowing the order to lapse, rather than directing a striking-off order, would be the appropriate outcome in the circumstances.

Any future panel reviewing this case would be assisted by:

- Evidence of completed training relevant to the concerns identified.
- Mrs Yarnold’s attendance at a future hearing
- Mrs Yarnold’s intentions on nursing.

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

Mr Malik submitted that an interim order for a period of 18 months is necessary to cover any potential period of appeal.

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 Mrs Yarnold is sent the decision of this hearing in writing.

That concludes this determination.