Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 28 May 2024 – Wednesday, 12 June 2024
Tuesday, 2 July 2024 – Monday, 8 July 2024
Monday, 2 December 2024 – Friday, 6 December 2024
Monday, 16 December 2024 – Friday, 20 December 2024
Tuesday, 18 February – Friday 28, February 2025
Monday, 14 April 2025 – Thursday, 17 April 2025
Tuesday, 22 April 2025 – Thursday, 24 April 2025
Monday, 9 June 2025 – Friday, 27 June 2025
Monday, 14 July 2025 – Thursday, 24 July 2025
Monday, 11 August 2025 – Friday, 22 August 2025
Monday, 17 November 2025 – Friday, 21 November 2025
Monday, 22 June 2026 – Wednesday, 24 June 2026
Monday, 29 June 2026 – Tuesday, 30 June 2026

Virtual Hearing

Name of Registrant:	Lydia Edwards
NMC PIN:	06E0616O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (24 May 2006)
Relevant Location:	Bristol
Type of case:	Lack of competence
Panel members:	Pamela Johal (Chair, Lay member) Claire Martin (Registrant member) Beverley Blythe (Lay member)
Legal Assessor:	John Donnelly (28 May – 11 June 2024) Michael Levy (12 June 2024) Fiona Moore (2 – 5 July 2024, 2 – 6 December 2024, 16 – 20 December 2024, 14 – 17 April 2025) Attracta Wilson (8 July 2024) Neil Fielding (18 – 21 February 2025) Graeme Sampson (24 – 28 February 2025)

	Monica Daley (22 – 24 April 2025) Joseph Magee (9 – 16 June 2025) Sean Hammond (17 – 27 June 2025, 14 – 24 July 2025) Charles Conway (11 – 22 August 2025) Sharmistha Michaels (17 – 21 November 2025) Georgina Goring (22 June 2026 – 24 June 2026) Trevor Jones (29 June 2026 – 30 June 2026)
Hearings Coordinator:	Franchessca Nyame (28 May 2024 – 12 June 2024, 2 – 8 July 2024, 2 – 6 December 2024) Clara Federizo (16 – 20 December 2024) Tyrena Agyemang (18 February 2025) Catherine Blake (19 – 28 February 2025, 14 – 24 April 2025, 9 – 11 June 2025, 16 – 25 June 2025, 14 – 23 July 2025, 11 August 2025 – 22 August 2025, 17 November 2025 – 21 November 2025, 22 June 2026 – 24 June 2026, 29 June 2026 – 30 June 2026) Fabbiha Ahmed (12 – 13 June 2025) Margia Patwary (26 June 2025 – 27 June 2025) Rene Aktar (24 July 2025)
Nursing and Midwifery Council:	Represented by Rebecca Butler, Case Presenter (28 May 2024 – 24 April 2025) Mohsin Malik, Case Presenter (11 August 2025 – 24 June 2026)
Ms Edwards:	Present and represented by Melissa Jones, instructed by the Royal College of Nursing (RCN) (28 May 2024 – 28 February 2025) Represented by Neomi Bennet of Equality 4 Black Nurses (14 April 2025 – 24 June 2026)
Facts proved:	A1, A2, A3, A4, A6, A7, A8, A9, A10, A11, A12, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22, A23, A24, A25, A26, B1, B2, B3, B4, B5, B6, B7, B8, B9, B10, B13, B15, B16, B17, B18, B19, B20, B21, B22, B23, B24, B25, B26, B27, B28, B29, B30, B31, B32, B33, C1, C3, C4, C8, C9, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25b, C26, C27, C28, C29, C30, C31, C33, C34, C35, D1, D4, D5, D6, D8, D10, D11, D12, D13, E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E13, E14,

	E15 and E16
Facts not proved:	B11, B12, B14, C25a, D9 and E12
No evidence offered:	A5, C5, C6, D2 and D3
No case to answer:	A27, C2, C7, C32 and D7
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

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

Ms Jones, on your behalf, made an application for this case be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Butler, on behalf of the Nursing and Midwifery Council (NMC), indicated that she did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to [PRIVATE], the panel decided to go into private session as and when such issues are raised.

Detail of charges

That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:

1) Assessment of patients as set out on or more occasions in Schedule A **[PROVED BY ADMISSION]**

2) Medication administration as set out on or more occasions in Schedule B **[PROVED BY ADMISSION]**

3) Time management as set out on or more occasions in Schedule C **[PROVED BY ADMISSION]**

4) Documentation/record-keeping as set out on or more occasions in Schedule D **[PROVED BY ADMISSION]**

5) Communication as set out on or more occasions in Schedule E **[PROVED BY ADMISSION]**

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

SCHEDULE A – ASSESSMENT OF PATIENTS		
GICU		
1	9/11/2019	Was unable to define a patients current airway status
2	9/11/2019	Was unfamiliar with/failed to complete the full ABCDE assessment
3	9/11/2019	Was unfamiliar with full ABG test results
4	9/11/2019	Demonstrated a lack of awareness in respect of equipment alarms
~~5~~	~~18/11/2019~~	~~Lacked understanding of the Glasgow Coma Score~~ **[NO CASE TO ANSWER]**
6	19/11/2019	Was unable to complete a full ABCDE assessment
7	22/11/2019	Was unfamiliar with the Glasgow Coma Score
8	22/11/2019	Failed to identify a normal blood pressure reading
9	22/11/2019	Was unable to confirm part of the ABCDE assessment
10	22/11/2019	Failed to recognise or act when an alarm was sounding that a patient had low blood pressure
11	24/11/2019	Was unable to correctly demonstrate/complete the ABCDE assessment without assistance
12	24/11/2019	Did not identify that a patient required hourly observations
13	24/11/2019	Identified incorrect pupil size measurements
14	24/11/2019	Failed to notice patient becoming hypotensive despite machine alarm sounding
15	25/11/2019	Did not go back to listen to airway bases after being given details of how to peel pads back
16	25/11/2019	Was unaware of infusion pumps alarm sounding
17	On a date between	Incorrectly demonstrated capillary refill time

	16/9/2019 – 25/11/2019	
	WARD C708/C805 [CARDIAC SURGERY]	
18	19/6/2020	Failed to complete a full risk assessment
19	26/6/2020	Was unable to identify the appropriate response to a spike in temperature
20	26/6/2020	Did not escalate a patient to the appropriate medical team
21	2/7/2020	Was unable to identify the correct order of nursing tasks required
	GATE 9A MEDICINE DIVISION AT NBT	
22	5/11/2022	Did not undertake any medical examination on an elderly person who had fallen over whilst visiting a relative **[PROVED BY ADMISSION]**
23	8/11/2022	Failed to demonstrate an understanding of the procedures required for patient falls/safe moving and handling of patients on the floor
24	23/11/2022	Failed to properly assess that a post falls patient with confusion and under a DOLS required an escort **[PROVED BY ADMISSION]**
25	On 23/11/2022 or 24/11/2022	Had to be prompted twice to carry out neuro observations on a post fall patient
26	30/1/2023	Required prompting throughout the shift, to carry out patient observations
27	30/1/2023	Had to redo the BP observations for one patient, several times **[NO CASE TO ANSWER]**

SCHEDULE B- MEDICATION ADMINISTRATION		
GICU		
1	9/11/2019	Intended to attach an IV line containing air bubbles to a patient's central line
2	9/11/2019	Failed to do a correct calculation of Terlipressin dose
3	9/11/20219	Failed to recognise the correct usage of a bio patch **[PROVED BY ADMISSION]**
4	9/11/2019	Failed to demonstrate understanding on the administration of Noradrenaline
5	9/11/2019	Demonstrated a lack of awareness of required medication checks at start of shift
	WARD C708/C805 [CARDIAC SURGERY]	
6	9/6/2020	Had to be prompted on one or more occasions to check patient details and/or allergies before administering medication

7	13/6/2020	Required prompting on one or more occasions to check patient identification against their drug chart and allergy status
8	13/6/2020	Had to be reminded on one or more occasions to check patient observations before administering anti-hypertensive medication
9	13/6/2020	Approached a patient with the medication prescribed for a different patient
10	15/6/2020	Required reminding to administer medication to one, or more, patient
11	17/6/2020	Did not check prescription charts in a logical/methodical manner **[NOT PROVED]**
12	17/6/2020	Had to be prompted to administer medication to 2 patients **[NOT PROVED]**
13	17/6/2020	Failed to demonstrate an understanding of the process for ambiguous medicine charts
14	19/6/2020	Was unable to effectively explain to patients the purpose of medication and associated risks **[NOT PROVED]**
15	25/6/2020	Had to be prompted on one or more occasions to check drug charts in a systematic manner
16	25/6/2020	Had to be prompted to recheck the stop date for an oral antibiotic
17	26/6/2020	Missed the administration of newly prescribed medication
18	26/6/2020	Administered the wrong dosage of amitriptyline
19	29/6/2020	Used Wikipedia to source information on unfamiliar medications
20	29/2/2020	Missed the administration of 2 medications
21	2/7/2020	Failed to demonstrate the correct process for incomplete/ambiguous prescriptions
	GATE 9A MEDICINE DIVISION AT NBT	
22	8/11/2022	Administered medication with associated risks, on one or more occasions, without first checking the observations.
23	8/11/2022	Failed to administer medication at the time prescribed on the drugs chart
24	24/11/2022	Drew up an IV of furosemide whilst not supervised **[PROVED BY ADMISSION]**
25	24/1/2023	Had to be corrected, on one or more occasions, in the dispensing and administration of medication
26	24/1/2023	Failed to identify that a dosage of insulin was due **[PROVED BY ADMISSION]**
27	28/1/2023	Did not fully read drug charts/prescriptions
28	28/1/2023	Failed to administer prescribed inhalers to 3 patients after signing for them in the drugs charts

29	28/1/2023	Incorrectly dispensed a dosage of 1.25mg when 2.50mg was to be administered
30	30/1/2023	Failed to demonstrate an understanding on the preparation of the correct dosage of cleanxe
31	30/1/2023	Did not dispose of unwanted medication in the correct way
32	30/1/2023	Removed oxygen from a patient without supervision and without informing supervisor **[PROVED BY ADMISSION]**
33	30/1/2023	Re-administered oxygen on the same patient without supervision and without informing supervisor **[PROVED BY ADMISSION]**

SCHEDULE C – TIME MANAGEMENT		
GICU		
1	9/11/2019	Took around 2 and half hours/too long to perform an incomplete safety check
2	9/11/2019	Took around 15 – 20 minutes/too long to aspirate a NG tube **[NO CASE TO ANSWER]**
3	9/11/2019	Failed to do tasks without being prompted to do so
4	9/11/2019	Was unable to effectively prioritise tasks
~~5~~	~~18/11/2019~~	~~Failed to complete medication checks in a timely manner~~ **[NO CASE TO ANSWER]**
6	18/11/2019	Was unable to prioritise cases effectively
7	19/11/2019	Was unable to complete a set of observations in a timely manner **[NO CASE TO ANSWER]**
8	19/11/2019	Took around 1 hour 30 minutes/too long to prepare a handover
9	24/11/2019	Took around 2 hours to complete safety checks/A-E assessment, ABG and enteral feed for one patient
10	24/11/2019	Required regular prompting to ensure tasks were completed in a timely manner
11	25/11/2019	Demonstrated poor time management skills by starting tasks before completely finishing other tasks
12	25/11/2019	Failing to complete observations on CIS fully on any hour **[PROVED BY ADMISSION]**
	WARD C708/C805 [CARDIAC SURGERY]	
13	13/6/2020	Failed to complete nursing notes for 2 patients in a timely manner
14	13/6/2020	Failed to complete medication round in timely manner
15	15/6/2020	Took around 1 hour/too long to complete medication round for 3 patients
16	15/6/2020	Failed to complete nursing notes in a timely manner
17	17/6/2020	Took around 1 hour 45 minutes/too long to complete medication round for 4 patients

18	17/6/2020	Required prompting with prioritising workload throughout the shift
19	19/6/2020	Was unable to prioritise workload
20	19/6/2020	Took around 1 hour to complete 1 risk assessment
21	25/6/2020	Took around 1 hour 45 minutes/too long to complete medication round for 4 patients
22	26/6/2020	Took around 1 hour 25 minutes/too long to complete medication round for 4 patients
23	29/6/2020	Took around 1 hour 45 minutes/ too long to complete medication round for 6 patients
24	29/6/2020	Failed to complete 2 patient safety discharge check lists in a timely manner
25	29/6/2020	Failed to complete an ECG in a timely manner. **[NOT PROVED]**
	29/6/2020	Was unable to prioritise workload
26	2/7/2020	Took around 50 minutes/too long to complete medication round for 2 patients
27	2/7/2020	Required prompting to prioritise workload
	GATE 9A MEDICINE DIVISION AT NBT	
28	6/11/2022	Failed to complete nursing notes in the allocated time frame
29	23/11/2022	Required multiple promptings to carry out tasks
30	23/11/2022	Failed to complete the drugs round in a timely manner
31	24/11/2022	Took around an hour and 30 minutes/too long to complete the drugs round for 5 patients
32	24/1/2023	Was unable to complete a leg dressing in a timely manner **[NO CASE TO ANSWER]**
33	28/1/2023	Took around 3 hours/too long to complete a medication round
34	30/1/2023	Failed to complete the drugs round in a timely manner
35	30/1/2023	Failed to complete all documentation in a timely manner

SCHEDULE D – DOCUMENTATION / RECORD KEEPING		
GICU		
1	19/11/2019	Failed to complete or record patient observations
~~2~~	~~22/11/2019~~	~~Failed to document a patient's pain score before selecting the maximum prescription dosage of Oxynorm medication~~ **[WITHDRAWN]**
~~3~~	~~22/11/019~~	~~Failed to complete patient care plans and observation charts~~ **[WITHDRAWN]**
4	24/11/2019	Failed to complete documentation of ABCDE assessment of a patient
5	24/11/2019	Failed to fully complete a patient observation chart
6	24/11/2019	Failed to complete patient's care plan

7	25/11/2019	Failed to document NGT fully **[NO CASE TO ANSWER]**
8	25/11/2019	Failed to complete documentation/observation notes in a timely manner and/or at all
	WARD C708/C805 [CARDIAC SURGERY]	
9	19/6/2020	Failed to fully complete observation notes for a patient **[NOT PROVED]**
10	19/6/2020	Failed to fully document a risk assessment
11	29/6/2020	Failed to fully document nursing notes for patients being discharged
	GATE 9A MEDICINE DIVISION AT NBT	
12	5/11/2022	Did not document the fall of an elderly relative until prompted to do so **[PROVED BY ADMISSION]**
13	30/1/2023	Required prompting to fully complete documentation throughout the shift

SCHEDULE E – COMMUNICATION		
GICU		
1	9/11/2019	Failed to use medical language/terminology
2	9/11/2019	Was unable to use the correct names for medical equipment
3	19/11/2019	Failed to provide a complete/effective handover
4	19/11/2019	Failed to use medical language/terminology
5	19/11/2019	Was unable to use the correct names for medical equipment
6	24/11/2019	Failed to provide a complete/effective handover
	WARD C708/C805 [CARDIAC SURGERY]	
7	17/6/2020	Failed to provide an effective handover
8	19/6/2020	Received a handover without supervision
9	19/6/2020	Failed to provide an effective/complete handover
10	19/6/2020	Gave incorrect and incomplete patient information to a doctor
11	25/6/2020	Failed to provide an effective/complete handover
12	26/6/2020	Informed a patient they were wrong when the patient correctly queried an incorrect dosage of amitriptyline **[NOT PROVED]**
13	26/6/2020	Failed to provide an effective handover
14	29/6/2020	Provided an ineffective/incomplete and inaccurate handover in respect of a deteriorating patient
	GATE 9A MEDICINE DIVISION AT NBT	
15	5/11/2022	Did not report the fall of an elderly person who was visiting a relative **[PROVED BY ADMISSION]**
16	23/11/2022	Struggled with providing effective handovers

Facts found proved by admission

The panel heard from Ms Jones that you made admissions to sub-charges A22, A24, B3, B24, B26, B32, B33, C12, D12 and E15.

The panel therefore found the above sub-charges proved by way of your admissions in accordance with Rule 24(5).

Background

You were employed by University Hospitals Bristol and Weston NHS Foundation Trust (‘UHBW’) as a registered nurse from October 2007.

In April 2019, you were issued with a first written warning for misconduct. UHBW found that, in December 2018, you had raised your voice against a colleague in the presence of patients and other staff members. You appealed the decision; however, the outcome was upheld and it was agreed that you could no longer work within the surgery division.

In September 2019, you moved to the General Intensive Care Unit (‘GICU’) and commenced an initial standard six-week supernumerary induction. During this time, concerns were raised regarding your medicines management practice; patient assessment and escalations of these results; standard of record keeping and lack of insight into your own competence. In response to these concerns, GICU extended your supernumerary period beyond the standard six-weeks to assist your development.

By 25 November 2019, UHBW felt you had not shown any improvement and your practice posed a risk to patient safety. You were subsequently suspended from duty pending a local investigation.

In March 2020, UHBW held a disciplinary hearing. The disciplinary hearing panel decided to give you a further six weeks to demonstrate the Band 5 required competencies on a ward-based placement.

In June 2020, you moved to a Cardiac Surgery ward (C708/C805) and worked under direct supervision. During this time, further concerns regarding medicines management; effective communication and lack of insight were raised. UHBW felt you had failed to demonstrate the core skills of a Band 5 Nurse and ended the placement early to ensure patient safety.

Your disciplinary hearing reconvened and, in November 2020, UHBW summarily dismissed you for lack of competency. You lodged an unfair dismissal claim with ACAS.

UHBW referred you to the NMC on 18 January 2021.

In September 2022, you were employed by North Bristol NHS Trust (‘NBT’) as a Band 5 registered nurse. NBT were fully aware that you were subject to an NMC investigation and that you had explicit conditions of practice at this time. During your initial supernumerary period, concerns were raised regarding your general nursing practice. NBT extended your period of full supervision as they felt your practice posed a significant risk to patient safety.

In January 2023 [PRIVATE] you returned to work. Your competence had notably deteriorated and, following an incident where you had administered oxygen without supervision, NBT felt you did not recognise your scope of practice boundaries and posed a significant risk to patient safety.

On 9 February 2023, you were moved to a non-patient facing role [PRIVATE].

Application to admit hearsay evidence of Lucy Alford

The panel heard an application made by Ms Butler under Rule 31 to allow the Supernumerary Feedback Summary, which is a contemporaneous feedback report, completed by Lucy Alford and dated 18 November 2019 into evidence.

Ms Butler submitted that the hearsay evidence is relevant as it goes to sub-charges A5, C5 and C6, namely that you allegedly lacked understanding of the Glasgow Coma Score, failed to complete medical medication checks in a timely manner and were unable to prioritise cases effectively.

Ms Butler raised the issue that there is some uncertainty about whether or not sub-charges A5, C5 and C6 relate to a shift you and Ms Alford worked together on 18 November 2019 or 19 November 2019.

Ms Butler acknowledged that, if the panel were to admit the hearsay evidence, there would be no opportunity to cross examine Ms Alford. However, she stated that, in local interviews and your reflections, you have made admissions to not understanding these competencies, particularly the Glasgow Coma Score.

Ms Butler made reference to the cases of *El Karout v NMC* [2019] EWHC 28 (Admin) and *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that the hearsay evidence is not the sole and decisive evidence in relation to sub-charges A5, C5 and C6. She added that the panel has heard multiple witnesses refer to this aspect of patient assessment and their testimony has been that the competencies involved in these sub-charges are understood and developed as a student nurse and are competencies a Band 5 registered nurse ought to be familiar with.

With regard to the nature and extent of the challenge, Ms Butler highlighted that every witness has had the same suggestions put to them at this stage; that they have forgotten certain details which has been characterised as misremembering, that they are lying, or that their testimony is motivated by racial bias. She stated that, since you have admitted to

not being able to do the Glasgow Coma Score, it would not be possible for Ms Jones to suggest to Ms Alford that you were perfectly competent in this regard.

Ms Butler submitted that, whilst it has been suggested in cross examination that witnesses may not be truthful, it has not been suggested that the evidence has been fabricated thus far.

Ms Butler further submitted that you were given notice of this hearsay evidence in the Case Management Conference and in documentation sent to you by the NMC. She stated that you were advised of what the evidence is against you and that you have always known that the Supernumerary Feedback Summary would be submitted as an exhibit in these proceedings.

Ms Butler informed the panel that the decision to not obtain first-hand evidence was based on the proportionality argument. When this case was being prepared, there were more than enough witnesses from GICU and there are six clinical witnesses. She told the panel that the NMC decided Ms Alford was not required as their evidence was only relevant for three of the sub-charges and it would be disproportionate in time and expense to bind yet another professional witness.

Ms Jones opposed the application.

Ms Jones stated that the NMC's submission that the hearsay evidence is not sole or decisive evidence in relation to sub-charges A5, C5 and C6 is incorrect. She highlighted that Ms Alford has not provided a witness statement which raises questions as to the appropriateness of this application being a course of getting the evidence in, and whether or not the application could be considered a way to admit the evidence "*by the back door*".

In relation to the Supernumerary Feedback Summary, Ms Jones informed the panel that you were not working on 18 November 2019 meaning the document is misdated and incorrect on the basis of when it was drafted.

Ms Jones also informed the panel that there are concerns in terms of your receipt of this document given that you did not receive all of the documentation for this hearing until one working day before it commenced.

Ms Jones submitted that there is no good reason for Ms Alford to not be in attendance for the relevant cross examination and challenge. She added that this application is effectively being used to ensure that the hearsay evidence is seen by the panel and, whether or not the hearsay evidence is admitted, this is unacceptable.

Ms Jones further submitted that it would be inherently unfair to accept a hearsay application where Ms Alford has provided sole and decisive evidence on three of the sub-charges and you are at a huge disadvantage in not being able to challenge it.

In relation to your alleged admissions in respect of not being able to do the Glasgow Coma Score in a local interview, Ms Jones submitted that it cannot be entirely clear as it is made plain at the outset of the interview that the interview notes are not '*a verbatim account*'.

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

In reaching its decision, the panel therefore first considered whether the hearsay evidence was relevant, and secondly whether it would be fair to admit it as evidence.

Decision and reasons on application to admit the evidence of Ms Alford

The panel was satisfied that the hearsay evidence was relevant to sub-charges A5, C5 and C6.

The panel acknowledged that it should not admit the hearsay as a matter of routine and that it must carefully consider whether it is fair for it to be admitted.

The panel therefore had regard to the following considerations:

- Whether the hearsay evidence was the sole and decisive evidence in relation to the relevant sub-charges;
- The nature and extent of the challenge to the hearsay evidence;
- Whether there was any suggestion that the primary witness had reasons to fabricate the allegation;
- The seriousness of the charge, taking into account the impact which adverse findings might have on your career;
- Whether there was a good reason for the non-attendance of the primary witness;
- Whether the NMC had taken reasonable steps to secure the attendance of the primary witness; and
- Whether you had notice of the application.

The panel considered each of these points in turn.

The panel determined that the hearsay evidence is the sole and decisive evidence in relation to you allegedly lacking understanding of the Glasgow Coma Score, failing to complete medical administration pre-checks in a timely manner and being unable to prioritise actions effectively on 18 November 2019. The panel considered Ms Butler's submissions regarding other supportive evidence to be tenuous and so the panel determined that it had no other evidence before it to support those sub-charges for 18 November 2019.

The panel was mindful that you challenge the evidence of Ms Alford and deny sub-charges A5, C5 and C6. The panel also noted that the Supernumerary Feedback

Summary is misdated and you were, in fact, not working on 18 November 2019, and in the absence of the witness this could not be explored or tested.

The panel was satisfied that there was no specific evidence before it to suggest that the hearsay evidence had been fabricated.

The panel was of the view that sub-charges A5, C5 and C6 are serious and could have an adverse effect on your career if found proven.

In relation to Ms Alford's non-attendance at this hearing and steps taken by the NMC to secure their attendance, the panel noted that the NMC made no direct attempt to engage Ms Alford as a witness and instead made a unilateral decision based on proportionality which has not been placed before the panel. In the panel's view, this did not amount to a good cogent reason for the non-attendance of Ms Alford.

Having balanced the above factors, the panel was not satisfied that it would be just and fair to admit the hearsay evidence and therefore refused the application.

Application to offer of no evidence in respect of sub-charges A5, C5 and C6

Ms Butler submitted that the NMC will be offering no evidence on sub-charges A5, C5 and C6 following the panel's determination that Ms Alford's hearsay evidence is inadmissible.

Ms Jones did not object.

The panel was mindful of the NMC guidance DMA-3 and the judgements in the cases of *Ruscillo v The Council for the Regulation of Healthcare Professionals [2004] EWCA Civ 1356* and *PSA v NMC and X [2018] EWHC 70 (Admin).* The panel was satisfied that, as a result of its decision not to admit the hearsay evidence of Ms Alford, there has been a change in the available evidence since the Case Examiners determined there was a case to answer. There was no longer a realistic prospect of sub-charges A5, C5 and C6 being

found proved. Furthermore, having regard to the case as a whole, the panel determined that it would not be appropriate or proportionate to direct the NMC to seek any further evidence at this stage. Accordingly, the panel decided to allow the NMC's application to offer no evidence in respect of these sub-charges.

Application to admit hearsay evidence of Tess Sims

The panel heard an application made by Ms Butler under Rule 31 to allow the contemporaneous feedback reports completed by Ms Sims and dated 17 June 2020, 25 June 2020, 29 June 2020 and 2 July 2020 into evidence.

Again, Ms Butler referred the panel to the factors to take into account when considering fairness set out in the *Thorneycroft* case.

Ms Butler submitted that this hearsay evidence is not the sole or decisive evidence in relation to the following sub-charges:

B	11	17/6/2020
B	12	17/6/2020
B	13	17/6/2020
C	17	17/6/2020
C	18	17/6/2020
E	7	17/6/2020
B	15	25/6/2020
B	16	25/6/2020
C	21	25/6/2020
E	11	25/6/2020
B	19	29/6/2020
C	23	29/6/2020
C	24	29/6/2020
C	25	29/6/2020
C	25-B	29/6/2020
A	21	2/7/2020
B	21	2/7/2020
C	26	2/7/2020
C	27	2/7/2020

Ms Butler highlighted that, in your reflections, you accepted that you were incompetent and needed more time to better understand some competencies.

Further, Ms Butler stated that it can be seen in the feedback reports that the feedback you received was not exclusively negative given that it attests to your progress and you received some positive comments as your supernumerary period developed. However, she highlighted that a recurring theme throughout the reports is your alleged failings in relation to time management and a general lack of competence. She therefore submitted that this hearsay evidence is not sole or decisive as it does not raise any matters the panel has not already heard.

Ms Butler submitted that the nature and extent of the challenge is the same, namely that witnesses are misremembering, lying, or that their testimony is motivated by racial bias. She also submitted that the evidence has not been fabricated and that it would be conspicuous if it were.

Ms Butler further submitted that you were given notice of this hearsay evidence in the Case Management Conference and in documentation sent to you by the NMC.

Ms Butler informed the panel that Tess Sims could not attend to give evidence at this hearing [PRIVATE].

Ms Butler informed the panel that the NMC actively sought to obtain a witness statement from Ms Sims and secure her attendance but was not able to [PRIVATE].

Ms Jones opposed the application.

Ms Jones highlighted that this hearsay evidence goes to 15 sub-charges which is not insignificant. She therefore submitted that [PRIVATE] it goes without saying that you would be at a disadvantage in not being able to cross examine Ms Sims's evidence.

Ms Jones further submitted that this hearsay evidence is the sole and decisive evidence in respect of the shifts where Ms Sims was the nurse supervisor on 17 June 2020, 25 June 2020, 29 June 2020 and 2 July 2020.

As such, Ms Jones submitted that it would be unfair to accept a hearsay application where Ms Sims has provided sole and decisive evidence on 15 of the sub-charges and you are at a huge disadvantage in not being able to challenge it.

[PRIVATE].

Ms Butler reiterated the nature and extent of your challenge and that you have admitted lacking competence. She submitted that Ms Sims was not in a senior enough position to be involved with management decisions relating to you, and so their evidence does not go to your defence.

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

Decision and reasons on application to admit the evidence of Ms Sims

In reaching its decision, the panel therefore first considered whether the hearsay evidence was relevant, and secondly whether it would be fair to admit it as evidence.

The panel was satisfied that the hearsay evidence was relevant to some of the sub-charges set out in the above table. It noted that Ms Sims did not provide evidence in relation to sub-charges B19, C23, C24, C25a, and C25b. Despite requests from the panel, the accuracy of the table was never established by the NMC.

The panel acknowledged that it should not admit the hearsay as a matter of routine and that it must carefully consider whether it is fair for it to be admitted.

The panel therefore had regard to the aforementioned factors and considered each of the points in turn.

The panel determined that the hearsay evidence is the sole and decisive evidence in relation to the sub-charges on the dates when Ms Sims supervised your practice and contemporaneously completed a feedback report.

The panel noted that you challenged the evidence of Ms Sims and would wish to cross examine her.

The panel was satisfied that there was no specific evidence before it to suggest that the hearsay evidence had been fabricated. The panel noted that the feedback was standardised, utilising what appears to be UHBW's pro forma documentation.

The panel was of the view that sub-charges are very serious and could have an adverse effect on your career if found proven.

[PRIVATE].

The panel noted that you have been on notice of this application for some time.

The panel determined Ms Sims's evidence to be the sole and decisive evidence in relation to multiple sub-charges where her contemporaneous feedback reports are the only direct evidence. The panel was mindful that, when weighing the competing factors in relation to whether it would be fair to admit the hearsay evidence, it must be satisfied either that the evidence is demonstrably reliable, or that there will be some means of testing its reliability. The panel determined that the evidence is demonstrably reliable because Ms Sims's evidence is in the form of contemporaneous feedback report, and evaluations following

supervised medication round records. The panel noted that these contemporaneous feedback reports and evaluations were all standard documents completed by Ms Sims in her role as your mentor reflecting her part professionally in your support plan and targeted bespoke objective setting for this placement. The panel further noted that copies of all these documents were exhibited to Ms Thomas's witness statement.

Having balanced the above factors, the panel was satisfied that it would be fair to admit the hearsay evidence of Ms Sims. The panel will determine what weight to attach to it once it has evaluated all the evidence when reaching its decision on the disputed facts. Accordingly, the panel exercised its discretion under Rule 31 and allowed the application.

Application to admit hearsay evidence of Hannah Morris

The panel heard an application made by Ms Butler under Rule 31 to allow the contemporaneous feedback reports dated between 5 November 2022 and 8 November 2022 exhibited alongside Hannah Morris's witness statement into evidence.

Ms Butler went through the factors to take into account when considering fairness set out in the *Thorneycroft* case.

Ms Butler submitted that this hearsay evidence is not the sole or decisive evidence in relation to the sub-charges against you at the placement at Gate 9A. She highlighted that the documents exhibited by Ms Morris are written contemporaneous feedback reports provided by witnesses who are going to give live evidence and standard Trust documents.

Ms Butler stated that parties are now very familiar with the nature and extent of your challenge and that your defence remains the same. She submitted that the extent to which your defence "*holds water*" is becoming a very "*shallow pool*". She informed the panel that Ms Morris was called to be a witness after UHBW referred you to the NMC and so to argue that they are forgetful is weak. Further, Ms Butler added that, if Ms Jones wanted to raise questions regarding the racial aspect of your defence, these could be put to other

witnesses who actually supervised you and gave you feedback. She also reiterated her submission that the feedback you received was not exclusively negative.

Ms Butler submitted that Ms Jones has not at any point suggested that the evidence is fabricated.

Ms Butler informed the panel that no prior notice was given regarding this hearsay application as it was not anticipated that Ms Morris would no longer be able give oral evidence at this hearing.

Ms Butler further informed the panel that Ms Morris can no longer attend to give evidence at this hearing [PRIVATE].

Ms Butler stated that the NMC had taken steps to obtain firsthand evidence from Ms Morris as she was called upon for a witness statement and to give oral evidence.

Ms Butler acknowledged the significance of cross examination. However, she said that all parties have heard the questions raised in Ms Jones' cross examination many times and so, in terms of their probative value, there would be nothing new to emerge from cross examination in these circumstances.

Ms Jones opposed the application.

Ms Jones submitted that you would be at a disadvantage in not being able to cross examine Ms Morris's evidence.

Ms Jones further submitted that that the application had been made prematurely.

As such, Ms Jones submitted that the fairness here weighs overwhelmingly in favour of rejecting the application since it would be unfair to accept a hearsay application where Ms

Morris has provided sole and decisive evidence and you are at a huge disadvantage in not being able to challenge it.

Ms Butler responded and said to suggest that Ms Morris was critical in terms of analysis and decision making is entirely incorrect. She stated that, as a Band 7 nurse, Ms Morris was in charge of nurses practising safely and you being supervised. She added that Ms Morris was not instructive in what the feedback from the supervisors was, and, from their own evidence, they were not instrumental in any decisions relating to you.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is relevant and it would be fair to admit it, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also made reference to the case of *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin).

Decision and reasons on application to admit the evidence of Ms Morris

In reaching its decision, the panel therefore first considered whether the hearsay evidence was relevant, and secondly whether it would be fair to admit it as evidence.

The panel was satisfied that the hearsay evidence was relevant to sub-charges A23, B22 and B23.

The panel acknowledged that it should not admit the hearsay as a matter of routine and that it must carefully consider whether it is fair for it to be admitted.

The panel therefore had regard to the aforementioned factors and considered each of the points in turn.

The panel determined that the hearsay evidence was the sole and decisive evidence in relation to sub-charges A23, B22 and B23. Ms Morris had an oversight role in relation to the feedback provided by others. In this regard, the panel noted that Ms Morris's evidence provided important context for your support on this ward. The panel noted that the contemporaneous feedback reports relevant to sub-charges A23, B22 and B23 were provided by Aiden Mankee, who supervised you on the date as charged. Mr Mankee has not confirmed his availability to attend to give oral evidence, and therefore the evidence of Ms Morris, who exhibits these contemporaneous feedback reports, is currently the only evidence in relation to these sub-charges.

The panel noted that you challenged the evidence of Ms Morris and would wish to cross examine her. It also noted that there are positive testimonials in the feedback which could assist your case.

The panel was satisfied that there was no specific evidence before it to suggest that the hearsay evidence had been fabricated.

The panel was of the view that the sub-charges in respect of Gate 9A are serious and could have an adverse effect on your career if found proven.

[PRIVATE].

The panel noted that you have been on notice of this application.

Having determined Ms Morris's evidence is the sole and decisive evidence in relation to sub-charges A23, B22 and B23, the panel was mindful that, when weighing the competing factors in relation to whether it would be fair to admit the hearsay evidence, it must be satisfied either that the evidence is demonstrably reliable, or that there will be some means of testing its reliability. The panel determined that the evidence is demonstrably reliable because Ms Morris's evidence in relation to sub-charges A23, B22 and B23 was based on the contemporaneous feedback report created by Mr Mankee, which was a

standard document completed by Mr Mankee in his role as your supervising nurse on 8 November 2022.

Having balanced the above factors, the panel was satisfied that it would be fair to admit all of the hearsay evidence of Ms Morris, including both her contextual evidence, the evidence she collated from others, and the specific multiple hearsay evidence in respect of sub-charges A23, B22 and B23. The panel will determine what weight to attach to it once it has evaluated all the evidence when reaching its decision on the disputed facts. Accordingly, the panel exercised its discretion under Rule 31 and allowed the application.

Decision and reasons on application to offer no evidence for sub-charges D2 and D3

During the presentation of the NMC's case, and following the completion of Siobhan Lanigan's evidence, Ms Butler made an application to offer no evidence in respect of sub-charges D2 and D3. This was on the basis that Ms Lanigan's testimony was the only evidence in support of these sub-charges, and taken at its highest was not of sufficient quality to find them proved.

Your representative indicated you did not object to this application.

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

On this basis, the panel took into account that the NMC had no evidence to support the sub-charge and therefore there was not a realistic prospect that it would find the facts of sub-charge D2 and D3 proved. The panel therefore found these sub-charges not proved.

The panel was mindful of the NMC guidance DMA-3 and the judgements in the cases of *Ruscillo v The Council for the Regulation of Healthcare Professionals [2004] EWCA Civ 1356* and *PSA v NMC and X [2018] EWHC 70 (Admin).* The panel noted that the only evidence to support sub-charges D2 and D3 was from Ms Lanigan. Having heard Ms

Lanigan's oral evidence, the panel determined that there was insufficient evidence to support D2 and no evidence to support D3. In the panel's view, there was no longer a realistic prospect of sub-charges D2 and D3 being found proved. Furthermore, having regard to the case as a whole, the panel determined that it would not be appropriate or proportionate to direct the NMC to seek any further evidence at this stage. Accordingly, the panel decided to allow the NMC's application to offer no evidence in respect of these sub-charges.

Decision and reasons on application to withdraw admissions

Ms Jones made an application to withdraw admissions made by you in relation to sub-charges B26 and B32 as follows:

B26	On 24 January 2023, failed to identify that a dosage of insulin was due.
B32	On 30 January 2023, removed oxygen from a patient without supervision and without informing supervisor.

Ms Jones and Ms Butler both provided the panel with written submissions in respect of the application.

Ms Jones referred the panel to *Phipson on Evidence*, chapters four to eight. Pursuant to Rule 14(1)(5) of the Civil Procedure Rules ('CPR'), courts are given power to permit a party to amend or withdraw a formal admission made after the commencement of proceedings.

Further, Ms Jones drew the panel's attention to Practice Direction 14(7) which sets out a non-exhaustive list of factors to which the court must have regard when considering an application to withdraw a Part 14 admission, whether made before or after the commencement of proceedings. These include:

a) *‘the grounds upon which the applicant seeks to withdraw the admission including whether or not new evidence has come to light which was not available at the time the admission was made;*

b) *the conduct of the parties, including any conduct which led the party making the admission to do so;*

c) *the prejudice that may be caused to any person if the admission is withdrawn;*

d) *the prejudice that may be caused to any person if the application is refused;*

e) *the stage in the proceedings at which the application to withdraw is made, in particular in relation to the date or period fixed for trial;*

f) *the prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the offer was made; and*

g) *the interests of the administration of justice.’*

Ms Jones submitted that the grounds upon which you seek to withdraw your admissions to sub-charges B26 and B32 is that ‘*the admissions were mistakenly made’* and ‘*The error was an oversight…*’.

Ms Jones further submitted that ‘[t]*here is nothing to suggest that either party has acted untoward or unfairly. As stated, the admissions arose as a genuine mistake*’.

In her submissions, Ms Jones stated that, should the panel accede to the application to withdraw the admissions, there will be no prejudice to any party as the NMC will be able to pursue the sub-charges by way of adducing evidence.

Ms Jones said in her submissions that, given the potential seriousness of the sub-charges if proven, the adverse impact and prejudice arising from proceeding with admissions where they have been mistakenly entered is significant, and it would be unjust to proceed in those circumstances.

Ms Jones highlighted that this application has been made during the evidence stage, and prior to the relevant evidence for sub-charges B26 and B32 being heard. She therefore submitted that the issue was identified and the application was made prior to the relevant witnesses being called, and so there ought to be no issue with the change of plea.

Ms Jones put forth submissions with regard to the prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the offer was made. She stated that the panel is hearing evidence from approximately 20 witnesses in relation to 125 sub-charges, and so must consider each of the sub-charges in full and determine the factual matrix in respect of those which are not accepted. She submitted that, in the interests of fairness, prospects of success is not necessarily relevant here.

In the interests of the administration of justice, Ms Jones invited the panel to accede to the application. She said '*in a case where there are perhaps an overwhelming number of charges, it is reasonable that an error could be made in good faith.*' Regarding proportionality, she added that there will be no delay to the proceedings and no impact upon resources.

Ms Butler opposed the application for you to withdraw your admissions to sub-charges B26 and B32.

Ms Butler made reference to the case of *Cavell v Transport for London* [2015] EWHC 2283 (QB). She stated that the panel must consider what reasons have been put forward by you to found the principle of '*mistake*'.

Ms Butler highlighted the '*mistake*' with reference to a brief chronology provided by Ms Jones:

> '*16 May 2024 Response to charge sheet received from* [you] *by* [your] *legal representatives in a word document format.*
>
> *16 May 2024* [You] *amended the response document but did not send it through to* [your] *legal representatives.* [You] *intended to put a "N" but instead recorded a "Y" next to the charges in question.*'

Regarding your conduct, Ms Butler submitted that, given this is Day 22 [sic] of the hearing and you are properly represented, '*it defies logic to believe that this can be attributed to mistake*' and that you have '*simply changed* [your] *mind at the eleventh hour and that is conduct which must be taken into account*.'

Ms Butler further submitted:

> '*… that there is motivation. The reason* [you have] *done so is the realisation that having admitted to B24 (drawing up IV Furosemide whilst not supervised), and B32 removing Oxygen whilst not supervised have consequences beyond lack of competence. At the relevant time, all drugs had to be administered supervised. (Oxygen is a prescription only treatment).*
>
> *B26 goes to failing to notice Insulin as a time critical drug administration.* [You] *will appreciate now the seriousness of this charge in lack of competence.*
>
> *Furthermore,* [you are] *not simply a defendant in a criminal trial,* [you are] *a Nursing Professional who has no excuse to offer by way of ignorance of the proceedings or not appreciating the consequence of* [your] *own actions. Or not speaking up sooner than today about these two charges.*'

Ms Butler referenced the following passage from *Briggs J in Kojima v HSBC Bank Plc* [2011] EWHC 611 (Ch):

> "*Once a party has admitted a claim, and judgment has been given against him on that claim, the other party is in principle entitled to assume that, barring any appeal, there is an end to the matter*."

In relation to the above, Ms Butler submitted that the prejudice to the NMC goes to a legitimate expectation of how the case is to proceed and be conducted.

Ms Butler reiterated that the application was made on Day 16 [sic] of the final hearing. She therefore stated that this issue should have been clarified prior to trial between 16 May 2024 and 28 May 2024, or, at the latest, when you entered your pleas on Day 3, 30 May 2024.

Ms Butler also put forth submissions with regard to the prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the offer was made. She took the panel to '*definitive evidence*' in the documentation before it in relation to sub-charge B(26). She also drew the panel's attention to meeting notes dated 30 January 2023, particularly that:

> *'[You report you] checked the patient and he was on O2 …. Sometimes this patient takes his O2 off so I decided to take the O2 down…*
>
> *[You] said [you] put 02 back on thinking ABG had been completed but it had not.'*

Ms Butler submitted that the above is an admission made by you on the day of the incident so it is hard to understand how a reversal of plea in relation to this sub-charge can result in any other result than a finding of fact found proved.

Ms Butler stated that, *'if the accused was represented when she entered her guilty plea it will obviously be very difficult to convince the court that the plea was entered by a genuine mistake*'. She submitted that '*it is an abuse of process*' by you at this stage and after years of representation by solicitor and counsel to withdraw your plea.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. Specifically, the legal assessor referred the panel to 'The Regulation of Healthcare Professionals: Law, Principle and Process (2nd Ed), para 25-063:

> *'Where a legal representative for a registrant seeks to resile from a formally admitted fact; The position varies according to the procedural rules. Where the rules refer to neither the law of evidence in civil or criminal proceedings, reference is likely to be made, it is submitted, to the criminal rules. In both criminal and civil proceedings, the court's permission is required to withdraw a formal admission. Clear evidence of mistake or misunderstanding is required to withdraw an admission, where that admission was made formally and with the benefit of legal advice*: *R v Kolton* [2000] Crim LR 761.'

The panel's determination on withdrawal application

The panel had regard to the factors outlined in Practice Direction 14(7). The panel considered each of the points in turn:

a) The panel considered that no new evidence has come to light which was not available at the time your admissions were made. The panel noted that the grounds upon which you seek to withdraw your admission to sub-charges B26 and B32 is that '*…the admissions were mistakenly made.*'; also, the confusion arising from the large number of charges brought against you.

   The panel further noted your explanation that you forgot to send an amended

response to the Case Management Form on 16 May 2024. However, the panel determined that it had no independent evidence before it as to the veracity of your version of events. Further, it did not consider the number of sub-charges to be relevant to the accuracy of your admissions, given the limited number of sub-charges to which admissions were made.

b) The panel was mindful to disregard subjective points made with regard to the alleged motivation behind your conduct. The panel has not been provided with any evidence indicating malevolence on your part. The panel also acknowledged Ms Jones' clarification that you did not have access to an evidence matrix outlining the allegations and your admissions, as this had not been provided to you by her.

   The panel was of the view that, given the small number of allegations you have admitted and the fact that you have been legally represented throughout proceedings, there is a reasonable expectation that you should have been clear as to the precise sub-charges you made admissions to.

   Moreover, the panel took into account that you have actively requested a pause in proceedings on multiple occasions throughout the hearing process thus far to confer with Ms Jones in order to put your case across accurately. The panel determined that you had ample opportunity to raise this issue at a much earlier stage in proceedings.

c) If your admissions are withdrawn, the panel recognised that prejudice may be caused to the NMC, which had relied on your admissions for case management purposes and in respect of the time resources available to conclude this stage of proceedings. The panel determined that this is a relevant factor for its decision making.

d) The panel acknowledged that, if the application is refused, the panel will not be able to hear evidence in relation to sub-charges B26 and B32. However, the panel

considered this prejudice to be mitigated by this being a lack of competence case and that these sub-charges are only a small part of a large number of allegations of lack of competence, and therefore not in themselves determinative of the wider competence issue. As such, the panel determined there to be minimal prejudice to you.

e) Whilst the panel acknowledged that it has yet to hear from relevant witnesses in relation to sub-charges B26 and B32, and so parties are not inconvenienced in respect of that, the panel considered it to be very late in the day for a legally represented registrant to raise this issue. The panel was mindful that the case has been ongoing since 28 May 2024 with breaks between hearings which would have allowed for reflection, review and consultation with your representative.

f) The panel determined that the prospect of success is uncertain. The panel has yet to hear your defence or witness evidence in relation to these two sub-charges. The panel noted, however, that the NMC, in its own submissions, has argued that the evidence against you is "*overwhelming*".

g) The panel considered the interests of the administration of justice. It recognised the need to balance your right to a fair hearing with the wider issues of fair administration of justice. It had regard to paragraph 16 of the *Cavell* case:

> '*It cannot be in [the interests of the administration of justice] to permit the withdrawal of an admission made after mature reflection of a claim by highly competent professional advisors when there is not a scintilla of evidence to suggest that the admission was not properly made. Were it to be otherwise civil litigation on any sensible basis would be impossible.'*

The panel also noted Ms Jones' submission that '*…there will be no delay to the proceedings and no impact upon court resources*.' The panel considered that there has already been significant interruption of proceedings to deal with this matter,

with two witnesses requiring to be rescheduled while two days were allocated to this application.

The panel was of the view that, in the spirit of fairness to all parties and the maintenance of the integrity of the hearing process, and in consideration of all of the relevant factors outlined in Practice Direction 14(7), the panel could find no compelling reasons to allow the withdrawal of your admissions to sub-charges B26 and B32.

The panel therefore decided to refuse your application to withdraw these two admissions.

Application to admit hearsay evidence for Charlotte Kidner

Ms Butler made an application under Rule 31 to allow Charlotte Kidner's statement and exhibits as hearsay evidence. She specifically directed the panel to pertinent passages of Ms Kidner's witness statement.

Ms Butler went through the factors to take into account when considering fairness set out in the *Thorneycroft* case.

Ms Butler submitted that, given the large number of sub-charges and the fact that this is a lack of competence case, it is clear that these matters are not single incidents but rather a course of conduct. As such, the panel has heard many instances of the same allegations against you, so Ms Kidner's witness statement and exhibits are not the sole and decisive evidence.

It was Ms Butler's submission that the nature and extent of the challenge in this case is:

- Given more time, you would have demonstrated competence in your clinical practice. However, the panel has not heard in this case that you were capable and had demonstrated competence in those specific areas. Ms Butler also highlighted that you have made admissions to some of the sub-charges

- Suggestions of racism despite the fact that the panel heard evidence that white nurses were in the minority group on GICU

Ms Butler acknowledged that you would be denied the ability to cross examine if the evidence was admitted. However, she submitted that there is nothing unique about Ms Kidner's evidence in the wider remit of this case and Ms Jones would be open to make any submissions on the quality and weight of the evidence without being "*pushed back*" in cross examination.

Ms Butler further submitted that it has not been put to any of the witnesses that they have fabricated the allegations or lied, only that they have either misremembered, misheard or did not give you ample opportunity to prove your clinical skills.

In relation to seriousness, Ms Butler submitted that, taken individually, the sub-charges relating to assessment, medication, time management and communication are not serious but the volume of the sub-charges combined makes them serious.

[PRIVATE].

Ms Butler informed the panel that she had raised the potential for a submission for a hearsay application with Ms Jones on a number of occasions during the hearing and therefore you had prior notice of it.

Ms Jones submitted that Ms Kidner's evidence goes to approximately 30 sub-charges in this case. She added that Ms Kidner's evidence is clearly very important and it was always anticipated that they would be in attendance at this hearing to give oral evidence which could be appropriately challenged. Now that Ms Kidner is no longer attending, she submitted that there is a huge disadvantage to your case since Ms Kidner's evidence is sole and decisive in relation to those sub-charges.

Ms Jones explained that Ms Kidner's evidence goes to about seven shifts that she worked with you, where she was the supervisory nurse providing feedback at the time. These issues could only be dealt with by Ms Kidner; thus the evidence is sole and decisive.

Ms Jones submitted that, during her cross examination of the witnesses, questions have been put in respect of witnesses misremembering or opportunities not being given to you. She added that the ability to cross examine is hugely important here as it is your case that positive oral feedback was provided by Ms Kidner which is somewhat in contrast to the written feedback that was provided, and it is your position that that written feedback was withheld from you.

[PRIVATE].

Ms Jones further submitted that to admit this evidence as hearsay is unfair to you, not only because the evidence could not be tested in the context of cross examination, but by the fact that all the direct evidence with regard to your competence on your Cardiac Surgery rotation would have been admitted by hearsay.

Accordingly, Ms Jones invited the panel to refuse the application.

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

Decision and reason on application to admit hearsay evidence of Ms Kidner

In reaching its decision, the panel therefore first considered whether the hearsay evidence was relevant, and secondly whether it would be fair to admit it as evidence.

The panel was satisfied that the hearsay evidence was relevant to the sub-charges on the shifts when Ms Kidner was supervising you as your mentor.

The panel acknowledged that it should not admit the hearsay as a matter of routine and that it must carefully consider whether it is fair for it to be admitted.

The panel therefore had regard to the aforementioned factors and considered each of the points in turn.

The panel determined that the hearsay evidence is the sole and decisive evidence in relation to the sub-charges on the dates when Ms Kidner supervised your practice and contemporaneously completed a feedback report.

The panel noted that you challenged the evidence of Ms Kidner and would wish to cross examine her.

The panel was satisfied that there was no specific evidence before it to suggest that the hearsay evidence had been fabricated. The panel noted that the feedback was standardised, utilising what appears to be UHBW's pro forma documentation.

The panel was of the view that sub-charges are very serious and could have an adverse effect on your career if found proven.

[PRIVATE].

The panel noted that you have been on notice of the potential for this application for some time.

The panel determined Ms Kidner's evidence to be the sole and decisive evidence in relation to multiple sub-charges where her contemporaneous feedback reports are the only direct evidence. The panel was mindful that, when weighing the competing factors in relation to whether it would be fair to admit the hearsay evidence, it must be satisfied either that the evidence is demonstrably reliable, or that there will be some means of testing its reliability. The panel determined that the evidence is demonstrably reliable

because Ms Kidner's evidence is in the form of contemporaneous feedback reports, and supervised medication round records. The panel noted that these feedback reports and supervised medication round records were all standard document templates completed by Ms Kidner in her role as your mentor reflecting her part professionally in your support plan and targeted bespoke objective setting for this placement. The panel noted that copies of the feedback reports, starter pack, and Cardiac Surgery day-to-day guide document exhibited to Ms Kidner's witness statement and further copies of the supervision records were exhibited to Ms Thomas's witness statement.

Having balanced the above factors, the panel was satisfied that it would be fair to admit the hearsay evidence of Ms Kidner. The panel will determine what weight to attach to it once it has evaluated all the evidence when reaching its decision on the disputed facts. Accordingly, the panel exercised its discretion under Rule 31 and allowed the application.

Decision and reasons on application to admit hearsay evidence for Aiden Mankee

Ms Butler made an application under Rule 31 to allow the hearsay evidence of Mr Mankee into evidence. She informed the panel that Mr Mankee supervised you for one shift on 8 November 2022 and goes to three sub-charges: A23, B22 and B23.

Ms Butler directed the panel to the pertinent passages of Ms Morris's witness statement. Ms Butler submitted that the above is clear documentary hearsay in that Ms Morris had seen the document Mr Mankee produced, having witnessed firsthand the shift of 8 November 2022 with you, and they rely on the contents of that document to produce their witness statement.

Ms Butler informed the panel that Mr Mankee was not called by the NMC to produce a witness statement due to proportionality; Mr Mankee only went to one shift and three sub-charges.

Ms Butler acknowledged that Mr Mankee's evidence is the sole and decisive evidence in support of the sub-charges relating to 8 November 2022.

In relation to the nature and extent of your challenge, Ms Butler referred the panel to your reflection on the shift of 8 November 2022 and invited the panel to consider what admissions you make. She summarised your reflection, stating that your contemporaneous version of events amounts to:

> "*I didn't do any of the things I was meant to do, I just assumed somebody else would do it.*"

In addition, racism and needing more time remain part of your challenge to the charges.

Ms Butler submitted that there is absolutely nothing in the evidence to suggest that a professional witness complying with the requirements of their role would have reason to fabricate their evidence.

Further, Ms Butler raised the point that this is a lack of competence case, thus there is nothing unique in these sub-charges in isolation. However, the multiple instances of the same conduct adds to the seriousness of the sub-charges.

Ms Butler told the panel that Mr Mankee is willing to attend. The NMC were not minded to call him because of proportionality; the cost, the delays and the length of this hearing, just for such a small feedback and relating only to one shift. Further, she stated that there is no time to hear this witness due to the scheduling of other witnesses.

Ms Butler highlighted that you had prior notice that a hearsay application would be made in relation to this witness.

Ms Jones submitted that Mr Mankee's evidence is sole and decisive as he was the supervising nurse in question and so are the only individual who can give the direct

evidence as to that shift. She highlighted that Mr Mankee provides a very brief feedback report which lacks detail, and that you dispute the factual contents of this feedback report. She said that the feedback would require exploration within cross examination.

Ms Jones noted that Ms Butler referred to your reflection as "*admissions*". She submitted that the reflection does not constitute admissions but rather your account of what happened on that shift.

Ms Jones raised the point that Ms Morris's statement was admitted as hearsay, and since he will not be in attendance, this is effectively unchallenged evidence from Mr Mankee by the back door.

Ms Jones reminded the panel that Mr Mankee is available to give oral evidence and is a ready and willing witness. She therefore submitted that it is not right to admit this hearsay evidence.

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

Decision and reasons on the application to admit the hearsay evidence of Mr Mankee

The panel determined that Aiden Mankee's evidence is not the sole and decisive evidence in relation to sub-charges A23, B22 and B23 because the panel has already granted the NMC's application to admit the hearsay evidence of Ms Morris who exhibits the contemporaneous supervision report purportedly completed by Mr Mankee.

The panel noted that Mr Mankee has not provided a witness statement and that the contemporaneous supervision report exhibited by Ms Morris is unsigned by Mr Mankee and there is no reference to him as the author of this document.

The panel noted that you deny these sub-charges and wish to cross examine Mr Mankee.

The panel further noted that there is no good and cogent reason for the non-attendance of Mr Mankee at this hearing. On the contrary, the panel has been informed that Mr Mankee is available and willing to give evidence.

For these reasons, the panel was not satisfied that it would be fair in the circumstances to admit this hearsay evidence. It therefore refused the application.

Application to admit hearsay evidence in relation to Elizabeth Leech

The panel heard an application made by Ms Butler under Rule 31 to allow the reports written by Elizabeth Leech, as contained within the appendices of Ms Thomas, into evidence. Ms Butler adopted her written submissions in which she addressed the factors identified in the case of *Thorneycroft* as follows:

> *'The Panel must make a careful assessment, taking into account the following principles:*
>
> - *Whether the statement is the sole and decisive evidence in support of the charges; It doesn't go to any charges*
> - *The nature and extent of the challenge to the contents of the statement; The previous cross examination has been explained above. It has been consistent throughout the entire proceedings.*
> - *Whether there was any suggestion that the witness had reason to fabricate their allegation; These are professionals acting objectively.*
> - *The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career; There is no charge relating to this evidence.*
> - *Whether there was a good reason for the non-attendance of the witness; Irrelevance to the charges, does not speak to facts or impairment.*

- *Whether the regulator had taken reasonable steps to secure the witness's attendance; Not relevant in this application. The witness has not been contacted as deemed unnecessary.*
- *Whether the registrant did not have prior notice that the witness statement would be read. Yes. Many months.'*

Ms Jones objected to the application and adopted her written submissions, which included:

> *'6. In applying the relevant law, the facts of this specific case demand that the application is refused. In considering the criteria outlined in Thorneycroft, the following is of particular note:*
>
> *<u>Whether the statements were the sole and decisive evidence in support of the charges</u>*
>
> *7. The application relates to the evidence of [Ms Leech] who was the ward manager on the Cardiac ward at the time of LE's placement. [Ms Leech] does not attest to any of the charges before the panel. However, [Ms Leech] played a crucial role in the assessment and management of LE during her time on the Cardiac ward, and the fairness of that process.*
>
> *8. The panel heard the evidence of [Melanie Broad] who highlighted the important role played by [Ms Leech] in her discussions with LE regarding the feedback provided and LE's progress during that placement.*
>
> *9. Whilst not sole and decisive evidence for any of the charges, it is sole and decisive evidence of the meetings held between [Ms Leech] and LE, the discussions that took place and the information that was shared with LE. The panel will be aware that LE's position is [Ms Leech] did not provide her with the written feedback until 28 June 2020 – and that these feedback sheets were markedly different than the positive verbal feedback LE was receiving during shifts with her*

mentors. The withholding of feedback is a running theme of this case, affecting [Ms Leech], together with [Ms Russell] and [Ms Morris].

10. LE's position is that this disparity between the oral and written feedback hindered her ability to reflect on the issues that were identified, and indeed were not reflective of her practice which she considered to be positive. Thus, it is imperative that LE is afforded the opportunity to cross-examine [Ms Leech] and explore these key issues in more detail.

The nature and extent of the challenge to the contents of the statements, and whether there is any suggestion of fabrication

11. There is significant challenge to be levied against the evidence of [Ms Leech]. The position of LE is that she does not accept [Ms Leech]'s evidence; LE avers that the feedback is inaccurate and that tasks were done well during shifts. Consequently, it is necessary to put to [Ms Leech] that she is lying, misremembering and/or misrepresenting those events in her summaries.

The seriousness of the charge

12. Whilst there are no specific charges to which [Ms Leech] goes – it is worth noting that [Ms Leech] did not have any direct clinical experience of LE and is entirely reliant on the accounts of others – [Ms Leech] is significant for the wider context of the placement and the treatment of LE. Hence, it is essential that she is appropriately cross-examined.

13. The NMC are seeking to rely on the "global picture" formed by what they consider a pattern/repetition of behaviours and errors. However, each witness can only comment on what is within their direct knowledge. Without the facility to cross-examine witnesses, the registrant's ability to effectively put their case is curtailed. This must be a considerable factor in the panel's decision around the application

before it. Clearly, the impact adverse findings might have on LE's career would be significant, and this weighs in favour of the application being refused.

Whether there was a good reason for the non-attendance of the witnesses

14. The NMC are understood to rely on the principle of proportionality in support of their application. The writer has not been provided with a good reason for the non-attendance of the witness. The panel is urged to exercise caution in such circumstances, particularly where there is meaningful cross-examination to be put to [Ms Leech]. This supports the contention that the application should be refused.

Whether the NMC had taken reasonable steps to secure the attendance of the witness

15. It is unclear what steps have been taken to secure the attendance of the witness. Of note, there is no formal witness statement before the panel and the evidence itself comprises a number of written feedback sheets.

16. Whilst these feedback sheets are exhibited within the statement of another witness, the panel must be careful not to "admit evidence by the back door" so to speak. The panel must consider the relevant factors when determining the admissibility of evidence.

Whether prior notice was given

17. It is accepted that prior notice has been given.

Concluding Remarks

18. Taking into account the relevant factors as outlined above, the panel is invited to refuse the NMC's application to admit the evidence of [Ms Leech] by way of hearsay."

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

The panel was satisfied that Ms Leech's evidence is relevant. Whilst the panel accepted that parts of Ms Leech's evidence may not appear to be directly relevant to the specific individual allegations, it determined that her evidence provides relevant context in relation to the totality of the placement within the Cardiac Surgery ward. Ms Leech's role as the ward manager, who is ultimately responsible for patient safety, staff development and specifically in this case, feedback consolidation, placed her at the centre of the processes assessing and supporting your competency during the relevant period. The panel was of the view that Ms Leech's insights are potentially essential for understanding the support and assessment processes, which are central to the alleged lack of competence.

The panel does not find that it is reasonable in the circumstances to admit the appendices as hearsay because Ms Leech is potentially a crucial witness, given her central role in feedback coordination and the assessment process, and it would be unfair to not allow you the opportunity to cross-examine her. It concluded that in order to assess your competence, it must consider the support you received, the coordination of that and the fairness of the assessment process. The panel determined that whilst Ms Leech's evidence is not sole or decisive to the facts, it is sole and decisive in the context of the assessment of your competence, and the level of support given during this placement.

The panel also noted the alleged discrepancies between verbal and written feedback and the disagreement over the timeliness of feedback. The panel considered that whilst these issues were explored with other witnesses during their oral evidence, they lacked the

direct oversight, which Ms Leech can provide as she had more direct involvement arising from her role and written reports. The panel determined that to allow Ms Leech's evidence as hearsay would deny you the right to fully examine these alleged discrepancies through cross-examination.

The panel determined that Ms Leech's oral evidence could be crucial to provide clarity on these matters and to assess her credibility.

In reaching its decision, the panel applied the principles set out in *Thorneycroft*:

Sole and Decisive Evidence: While Ms Leech's evidence is not sole or decisive in supporting any specific allegations, her evidence could be critical to understanding the assessment and feedback process during your placement.

Challenge to Evidence: The panel considered your significant challenge to the accuracy of Ms Leech's evidence and your concerns of potential misrepresentation due to your assertion of late and inconsistent feedback. Therefore, the panel determined that to allow the hearsay application would deny you the opportunity to test the reliability of this evidence through cross-examination.

Seriousness of the Case: The panel recognised the broader importance of Ms Leech's evidence in shaping the context of your placement. It considered the potential adverse impact on your career and that the inability to cross-examine Ms Leech could significantly disadvantage you.

Non-Attendance of the Witness: The panel had no information before it of sufficient good reason for Ms Leech's absence. It noted that the NMC did not intend to call her as a witness.

Efforts to Secure Attendance: The panel had no information before it that reasonable steps were taken to secure Ms Leech's attendance.

Notice: The panel acknowledged prior notice of the hearsay application was given.

The panel determined that admitting Ms Leech's written evidence as hearsay would be unfair and potentially cause you prejudice. In these circumstances the panel refused the application to admit Ms Leech's written feedback reports contained in the appendices as hearsay evidence.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Butler to amend the wording of sub-charge A27.

The proposed amendment was to strike out the sub-charge A27 as written, and to introduce a new sub-charge at the end of schedule E. It was submitted that the evidence offered in support of A27 pertains to communication with a patient, which is covered by schedule E, rather than errors in assessment, as covered by schedule A. Ms Butler submitted that the proposed amendment would provide clarity and more accurately reflect the evidence.

> *'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:*
>
> *1) Assessment of patients as set out on or more occasions in Schedule A*
>
> *…*
>
> *5) Communication as set out on or more occasions in Schedule E*
>
> *AND in light of the above, your fitness to practise is impaired by reason of your lack of competence'*

SCHEDULE A – ASSESSMENT OF PATIENTS

~~*27*~~	~~*30/1/2023*~~	~~*Had to redo the BP observations for one patient, several times*~~

SCHEDULE E – COMMUNICATION

17	***30/1/2023***	***Failed to provide effective communication to a patient in order to complete Blood Pressure monitoring***

The panel heard submissions from Ms Jones that the patient in question did not appear to understand the instructions, and that the evidence is clear that the issue was one of communication and not the process of undertaking the blood pressure measurement.

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

The panel took account of the evidence and considered that the concern pertains to how well you understood the needs of your patient, and not how well you communicated with them. The panel was of the view that it would be oppressive to permit what was effectively the putting of a new sub-charge at this stage when the NMC had closed its case. The panel was therefore satisfied that there would be prejudice to you and injustice by the proposed amendment being allowed. It was therefore not appropriate to amend the sub-charge.

The panel was of the view that such an amendment, as applied for, was unjust in the circumstances.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Jones that there is no case to answer in respect of the following sub-charges: A2, A3, A4, A9, A11, A13, A23, A27, B2, B9, B25, B31, C2, C7, C31, C32, D5, D6, D7 and E6. This application was made under Rule 24(7).

In relation to this application, Ms Jones referred the panel to limb two of the test in *R v Galbraith [1981] EWCA Crim J0519-1*. She provided written submissions that the evidence in support of the sub-charges listed, taken at its highest, is insufficient to find them proved:

'A2 [Teresa Pogorzelska] confirmed in her oral evidence that LE finished the A-E assessment ***…*** *and accepted that it may have been slower as this was used as a learning opportunity* ***…*** *Clearly, LE was familiar with and able to complete the A-E assessment. Therefore the charge is not proved and there is no case to answer.*

A3 [Teresa Pogorzelska] accepted in her oral evidence that LE knew how to collect a sample for the ABG tests, was able to analyse and explain the parameters of normal range … [Teresa Pogorzelska] further accepted that LE was still learning and that this "is a process and it takes time" ***…****The evidence supports the contention that LE understood ABG testing and that any gaps in knowledge could be remedied with time. Thus, there is no case to answer in respect of this charge.*

A4 [Teresa Pogorzelska] stated that LE told her she had noticed the alarms and accepted that she could not say whether LE looked at the alarms when they were sounding as she did not know... On the basis of [Teresa Pogorzelska's] account and that she could not say and did not know whether LE looked at the alarms, there is insufficient evidence in respect of the charge that LE demonstrated a lack of awareness in respect of equipment alarms. There is no case to answer.

*A9 [Siobhan Lanigan] stated in her oral evidence, "I don't want to blanketly say someone doesn't understand" and confirmed that she could not recall whether LE understood what D stood for in the A-E assessment **…** There is insufficient evidence that LE was unable to confirm part of the A-E assessment and therefore there is no case to answer.*

*A11 [Sophie Hewer] confirmed that LE undertook a thorough A-E assessment with some prompting **…** Prompting and support is clearly part of the supernumerary process. In view of the thorough assessment undertaken, there is insufficient evidence to prove this charge and there is no case to answer in respect of this issue.*

*A13 [Sophie Hewer] accepted that LE scored the pupil size correctly**...** Given that LE undertook this task correctly, there is insufficient evidence to suggest that LE identified the incorrect pupil size. Consequently there is no case to answer.*

A23 [Aiden Mankee] confirmed that LE had notified him (as the nurse in charge) that a patient had fallen, and these were appropriate steps to take... On the basis of the evidence before the panel, LE actioned appropriate steps in the circumstances of a patient fall. There is no case to answer.

A27 [Joanna Williams] confirmed that LE did not have to undertake BP observations for one patient several times, but that the patient was moving their arm during that process which extended the time it took to complete this. The transcript is currently unavailable and no amended charge has yet been received. The charge is not proven as it is factually incorrect and there is no case to answer. Notwithstanding this, the author understands the NMC proposes to amend that this be altered to a communication charge. Even taking the proposed amendment and evidence in support at its highest, LE has acted appropriately in the circumstances.

B2 [Siobhan Lanigan] could not recall LE's response regarding the Terlipressin dosage calculation and use of the universal formula, and further accepted her memory was limited... There is insufficient evidence and therefore no case to answer.

B9 The NMC assert that LE approached a patient with the medication prescribed for a different patient and rely upon the feedback from [Charlotte Kidner] in support of this. [Charlotte Kidner] states that LE "asked the patient to confirm their name and date of birth"...Taking the evidence at its highest, at that stage, LE would have realised the error and would not have administered that medication. There is insufficient evidence in respect of this issue.

B25 [Trequene Duncan-McKenzie] accepted in her oral evidence that LE was undertaking the medication round correctly... There is insufficient evidence that LE had to be corrected on one or more occasions in the dispensing and administration of medication. There is no case to answer.

B31 [Joanna Williams] was clear in her oral evidence that she had seen other nurses dispose of clexane in the way originally demonstrated by LE, but that this was not the "gold standard". Whilst not the gold standard, it was a method utilised by <u>some</u> nursing staff (emphasis added)... There is insufficient evidence to support a finding that LE did not dispose of unwanted medication in the correct way and therefore there is no case to answer.

C2 [Siobhan Lanigan] accepted in her oral evidence that she could not be sure about timings for the NG tube **…** *[Siobhan Lanigan] said, "I cannot remember, I cannot recall … I cannot recall how much volume of the gastric contents [to be aspirated]". [Siobhan Lanigan] further accepted in her*

evidence that if there was a significant volume of gastric contents, that 15-20 minutes would not be an unreasonable amount of time... There is insufficient evidence of the timings for this task being undertaken for this charge to be proved.

C7 [Kathryn Pollock] accepted in her oral evidence that she did not know how long it took LE to undertake observations…There is insufficient evidence to support a finding that LE did not complete such observations in a timely manner and thus there is no case to answer.

C31 [Charlotte Elvy] accepted in her oral evidence that she could not remember the time taken by LE to undertake the drug round on 24 November 2022 for 5 patients: "I'm really sorry, I can't. I can't remember so I don't know if it was quicker than the hour and a half or not" ***…*** *Taking it at its highest, there is insufficient evidence in relation to timings for this drug round and consequently there is no case to answer.*

C32 [Trequene Duncan-McKenzie] accepted in oral evidence that she had not specified timings for how long it took LE to undertake the leg dressing and could not now remember ***…*** *"so no, there's no time in my feedback … to be fair, it would be an assumption 'cause I did not start a clock and time her". The evidence on this issue is insufficient to prove the charge in question.*

D5 [Sophie Hewer] could not recall which aspects of the patient observation chart she says LE missed…The evidence in relation to this is tenuous and vague. Consequently, the panel should find there is no case to answer.

D6 [Sophie Hewer] accepted that she could not recall a conversation whereby she told LE explicitly to complete the patient's care plan ***…*** *"I don't recall [explicitly stating to LE that it was her responsibility] … yes, I can't recall having a conversation specifically about that". LE should not be criticised for*

not completing tasks which she did not know were her responsibility, particularly whilst she was supernumerary. Taking the evidence at its highest, it is insufficient to prove this charge and there is no case to answer.

D7 [Rachel Brennan] accepted in her evidence that details of the NG tube were minimal and further accepted that she could not indicate what information was missing... Taking the evidence at its highest, the evidence is too vague to be considered capable of proving the charge, and the panel ought to conclude there is no case to answer.

E6 [Sophie Hewer] accepted in her oral evidence that LE included relevant information in her handover and that she could not recall the approach used by LE, and whether this was the SBAR approach... The evidence is insufficient in respect of this handover and there is no case to answer.'

In these circumstances, Ms Jones submitted that these sub-charges should not be allowed to remain before the panel.

Ms Butler submitted that there remains a case to answer in respect of the sub-charges. She submitted that Ms Jones' application is founded exclusively on the basis of the transcribed oral testimony by cross-examination of the witnesses. She submitted there is no reference to the contemporaneous feedback reports, contemporaneous local investigation interviews or the sworn statements of the witnesses. There is also no reference to your responses at the local investigation.

Ms Butler submitted that the application ignores the documentary evidence supporting the sub-charges. She submitted that the cross-examination in respect of these documents did not go to their veracity.

Ms Butler submitted that Ms Jones' application failed to establish how the second limb of the test in *Galbraith* is made out.

In oral submissions, Ms Jones directed the panel to her references to the exhibit bundle within her application.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage with regard to the sub-charges listed in the application. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved on the balance of probabilities and whether you had a case to answer.

The panel took account that Ms Jones' cross examination of the NMC witnesses focussed on their reliability. The cross examination focussed on allegations of racism, mistaken recollection, or dishonesty on the part the NMC's witnesses. Considering these allegations, the panel noted them, but there was no admission to any of them and it has seen no specific evidence at this stage.

The panel was of the view that any inconsistencies in the witnesses' oral testimony could be explained by the significant passage of time between the incidents alleged and the cross examination. The panel also determined these inconsistencies were minor and could be resolved with reference to the contemporaneous documentation.

The panel has assessed the contemporaneous documents as reliable due to them being focussed and structured feedback prepared as part of professional duties by those experienced in offering support and supervision of other nurses. The panel has seen no evidence to suggest that those documents are unreliable.

The panel also noted at the outset of its considerations that there were two employer's investigations in which you had an opportunity to put your case, and the main focus of your case is that you needed more time and support to complete your competencies.

The panel also made a general observation that these sub-charges arose during multiple periods of extended induction in various clinical areas. The panel noted that due to your supernumerary period being extended you remained under supervision and assessment.

Sub-charge A2

The NMC relied upon the evidence of Teresa Pogorzelska and subsequent investigation by Samantha Burgess. Ms Jones identified that in Ms Pogorzelska's oral evidence she indicated that the length of time you took in completing A-E assessment was longer due to this being a teaching opportunity. In oral evidence Ms Pogorzelska indicate that performing the A-E assessment took longer because you were not performing the task as expected. This implies that if you had the skills the assessment would be quicker and that this goes to your competency.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Pogorzelska and Ms Burgess at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A3

The NMC relied upon the evidence of Ms Pogorzelska. Ms Jones identified that in Ms Pogorzelska's oral evidence she indicated that you were still learning and that the process takes time. The panel noted that this assessment was undertaken six weeks after you

started working in the clinical area, and that the allowance of time was not relevant to the issue in this sub-charge.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Pogorzelska at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A4

The NMC relied upon the evidence of Ms Pogorzelska. Ms Jones submitted that in Ms Pogorzelska's oral evidence she could not confirm whether you actually looked at the alarms. The panel noted that your awareness of the alarms ought to be determined by how you responded to them, and whether you sought support from your supervisor if you did not know how to respond. The panel considered Ms Pogorzelska's evidence is that you ought to have asked for assistance when an alarm went off but did not.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Pogorzelska at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A9

The NMC relied upon the evidence of Ms Lanigan. Ms Jones identified that in her oral evidence Ms Lanigan indicated that she did not conduct a direct assessment of your understanding of the A-E assessment at the time. The panel noted that Ms Lanigan was clear, even with the passage of time, that you did not know what the D stood for in the A-E assessment.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Lanigan at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A11

The NMC relied upon the evidence of Sophie Hewer. Ms Jones identified that in her oral evidence Ms Hewer indicated that you required 'prompting' to complete your A-E assessment. The panel noted Ms Hewer's evidence that the initial assessment indicated an appropriate understanding, but further and more detailed feedback in the round generated concerns about your ability to complete this task independently. The panel further noted that Ms Hewer firmly stood by her statement.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Hewer at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A13

The NMC relied upon the evidence of Ms Hewer. Ms Jones identified that in her oral evidence Ms Hewer indicated that she accepted that you had scored the pupil size correctly after prompting and numerous attempts. The panel noted the documentary evidence at the time that this had been done incorrectly.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Hewer at this stage and that while there is an inconsistency in the evidence, there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A23

The NMC relied upon the evidence of Mr Mankee. Ms Jones identified that in his oral evidence Mr Mankee indicated that you had notified him that a patient had fallen and that this was the appropriate action. The panel, however, noted Mr Mankee’s evidence that multiple further actions were not carried out by you and that protocols were not followed, such as conducting a full body assessment or taking clinical observations.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Mr Mankee at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge A27

The NMC relied upon the evidence of Ms Williams. Ms Jones identified that in her oral evidence Ms Williams indicated that she accepted you were capable and competent to undertake the blood pressure reading. In the written submissions provided by the NMC regarding the application to amend this sub-charge, the NMC conceded that the evidence of Ms Williams did not substantiate this sub-charge. The panel were not aware of any other evidence advanced by the NMC in support of this sub-charge.

In the circumstances, the panel determined there was no evidence upon which it could find this sub-charge proved. Accordingly, the submission of no case to answer is accepted in relation to this sub-charge.

Sub-charge B2

The NMC relied upon the evidence of Ms Lanigan. Ms Jones submitted that in her oral evidence Ms Lanigan indicated that she could not recall your response regarding the Terlipressin dosage calculation and use of the universal formula. The panel noted that Ms Lanigan had in her oral evidence maintained that these were not calculated correctly, and that was supported by her contemporaneous written feedback.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Lanigan at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge B9

The NMC relied upon the evidence of Ms Kidner. Ms Jones identified that in her witness statement Ms Kidner indicated that you approached a patient with medication prescribed for a different patient, and did not administer it after checking their wristband. The panel noted the precise wording of the sub-charge and considered that Ms Kidner's evidence as outlined supports it.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Kidner at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge B25

The NMC relied upon the evidence of Trequene Duncan-McKenzie. Ms Jones identified that in her oral evidence Ms Duncan-McKenzie indicated that she accepted you undertook the medication round correctly. However, the panel noted that Ms Duncan-McKenzie's oral evidence indicated that you did require correction on a number of occasions and whilst there was pattern of improvement in undertaking the medication rounds, that improvement was not maintained.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Duncan-McKenzie at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge B31

The NMC relied upon the evidence of Ms Williams. Ms Jones identified that in her oral evidence Ms Williams indicated that there was a culture of disposing of clexane inappropriately. The panel noted that, regardless of whether other nurses disposed of medication in this fashion, this sub-charge alleges that you did dispose of it in the manner described, and that this method was not appropriate.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Williams at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge C2

The NMC relied upon the evidence of Ms Lanigan. Ms Jones identified that in her oral evidence Ms Lanigan indicated that she could not be sure about the timings for the NG tube: *'I cannot remember, I cannot recall … I cannot recall how much volume of the gastric contents [to be aspirated]'*. The panel has seen evidence that Ms Lanigan could not be sure how long the procedure would take. The panel determined that there was insufficient additional evidence in support of this sub-charge, and a lack of specificity.

In the circumstances, the panel determined there was insufficient evidence to find this sub-charge proved. Accordingly, the submission of no case to answer is accepted in relation to this sub-charge.

Sub-charge C7

The NMC relied upon the evidence of Kathryn Pollock. Ms Jones identified that in her oral evidence Ms Pollock indicated that she did not know how long it took you to undertake observations. The panel also noted Ms Pollock’s oral evidence that she was not there at the time of this sub-charge.

In the circumstances, the panel determined there was insufficient evidence to find this sub-charge proved. Accordingly, the submission of no case to answer is accepted in relation to this sub-charge.

Sub-charge C31

The NMC relied upon the evidence of Charlotte Elvy. Ms Jones identified that in her oral evidence Ms Elvy indicated that she could not remember the time you took to undertake a drug round on 24 November 2022. The panel noted that Ms Elvy’s documentary evidence provides explicit contemporaneous feedback that you took one hour and 30 minutes to complete the drug round, and that this was excessive for the number of patients. There is no suggestion that the documentary evidence is incorrect. The panel determined that Ms Elvy’s lack of specificity in oral evidence indicates only a potential lack of recall rather than an inaccuracy of documentation.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Elvy at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge C32

The NMC relied upon the evidence of Ms Duncan-McKenzie. Ms Jones identified that in her oral evidence Ms Duncan-McKenzie indicated that she accepted she had not documented timings for how long it took you to undertake the leg dressing and could not recall in cross examination how long those tasks took, nor other contextual details for this sub-charge. The panel noted Ms Duncan-McKenzie's evidence that she was undertaking other tasks at the time of this sub-charge, just that Ms Duncan-McKenzie had assigned the task to you and that it took you time to complete. The panel also noted that the original contemporaneous evidence is not specific, and could not be clarified by Ms Duncan-McKenzie under cross examination.

In the circumstances, the panel determined there was insufficient evidence to find this sub-charge proved. Accordingly, the submission of no case to answer is accepted in relation to this sub-charge.

Sub-charge D5

The NMC relied upon the evidence of Ms Hewer. Ms Jones identified that in her oral evidence Ms Hewer indicated that she could not recall which aspects of the patient observation chart you missed. The panel noted in Ms Hewer's oral evidence that, while she could not specify exactly what was missing, she was adamant that the documentation had not been completed fully. The panel noted that this was supported by the contemporaneous documentation.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Hewer at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge D6

The NMC relied upon the evidence of Ms Hewer. Ms Jones identified that in her oral evidence Ms Hewer indicated that she could not recall a conversation whereby she told you explicitly to complete the patient's care plan. The panel noted Ms Hewer acknowledged in oral evidence that she did not explicitly direct you to complete the care plan. However, the panel considered this does not go to the concern of this sub-charge. It noted that at the time of this sub-charge your supernumerary period had been extended due to numerous concerns, and also that there was a requirement for the care plan of a patient in your care to be completed as part of your standard nursing duties.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Hewer at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

Sub-charge D7

The NMC relied upon the evidence of Rachel Brennan. Ms Jones identified that in her oral evidence Ms Brennan indicated that she accepted details of the NG tube were minimal, and that she could not indicate what information was given other than it was not completed fully. The panel noted the contemporaneous documentary evidence of Ms Brennan, and that it contains just four words regarding the NG tube on written feedback: *'not documenting NGT fully'.* The panel determined that in the absence of any supporting evidence, this is too vague and tenuous to find the sub-charge proved. The panel found that this sub-charge failed the test set out in the second limb of *Galbraith*.

Accordingly, the submission of no case to answer is accepted in relation to this sub-charge.

Sub-charge E6

The NMC relied upon the evidence of Ms Hewer. Ms Jones identified that in her oral evidence Ms Hewer indicated that she accepted that you included relevant information on your handover and that she could not recall the framework used by you and whether this was the Situation Background Assessment Recommendation (SBAR) approach. The panel noted that, while Ms Hewer was unable to recall the exact framework, she was clear in reiterating that it was incomplete and not structured. This is supported by her contemporaneous notes. The panel considered that the theme of this sub-charge is that there was a lack of a complete and/or effective handover.

The panel noted the assertions on your behalf that you were competent in respect of these matters. It does not have the benefit of hearing your evidence or any other supporting evidence at this stage.

In the circumstances, the panel proceeded on the basis that there was no reason to reject the evidence of Ms Hewer at this stage and that there was a case to answer against you.

Accordingly, the submission of no case to answer is rejected in relation to this sub-charge.

The panel concluded that, taking account of all the evidence before it, there was no case to answer in relation to sub-charges A27, C2, C7, C32, and D7. The panel determined that there was a case to answer in relation to all the other sub-charges in the application.

Decision and reasons on application for adjournment at the resuming hearing on 14 April 2025

At the outset of the resuming hearing, your representative at Equality 4 Black Nurses, Ms Bennet, made an application to adjourn the hearing for one day. She made this application under Rule 32, on the basis that she required more time to acquire relevant

documentation. In particular, she submitted that she was yet to receive the transcripts from 4 and 6 December 2024.

Ms Butler indicated that she did not support the application. She submitted that missing two days of transcript was not sufficient to justify an adjournment given the amount of transcripts you had already received. She referred to content covered in the missing transcripts and submitted that you could address other matters in this case today while waiting for the missing days to be provided.

The Hearings Coordinator informed the parties that she had located the transcripts in question, and then distributed them to all parties.

The panel heard and accepted the advice of the legal assessor which contained reference to the case of *Crown Prosecution Service v Picton [2006] EWHC 1108 (Admin).*

The panel took into account that you have a new representative, and that the hearing is at the stage where you are about to commence your case. The panel determined that an adjournment would afford you and your representative extra time to prepare your case, and that this extra time was necessary. The panel decided that an adjournment was in the interests of fairness.

The panel decided to adjourn the hearing until 10:00 on 15 April 2025, with a view that you will be ready to commence your case at 10:00.

Decision and reasons on application to admit new evidence

After Ms Butler concluded your cross-examination, Ms Bennet made an application for additional documents to be put before the panel to assist her re-examination. She submitted that it was relevant to your case and should therefore be admitted.

Ms Butler opposed the application in respect of a letter to you from solicitors acting for UHBW in relation to an ACAS and Employment Tribunal Claim. She informed the panel that the letter states, ‘Without prejudice save as to cost’ and is therefore inadmissible. She further submitted that the contents of the letter cannot be referred to in re-examination as they do not concern matters raised during cross-examination.

The panel heard and accepted the advice of the legal assessor, which contained reference to Rule 31(1).

In making its decision, the panel considered whether any prejudice may be caused to either party if this document was admitted at this stage of the proceedings.

The panel noted that the NMC has closed its case, and has therefore not had the opportunity to put this document to its witnesses who have now been released. The panel took into account that Ms Bennet has joined as your representative quite recently, and that this is why she did not make the application earlier. However, the panel also noted that you have been legally represented throughout these proceedings by the RCN, and that at no stage has it been suggested that this document is necessary for proper presentation of your case until very recently.

The panel determined that this document could not be admitted without great unfairness to the NMC. In reaching this decision the panel noted that the NMC has closed its case and would therefore not be able to put the contents of the letter to its witnesses. The panel also considered that the author of the document could not now be called as a witness, given the late stage.

Accordingly, the panel decided to refuse the application.

Proposal to amend some of the charges

During its deliberation of facts, the panel considered several amendments to the charges pursuant to the Rules**.** Rule 28 permits the panel to amend a charge or its factual particulars at any time before making findings of fact, provided that doing so would not cause injustice.

The panel of its own volition therefore decided that, subject to representations of the parties, it wished to amend the charges as follows to ensure clarity and accuracy and to better reflect the evidence.

The panel noted that each head of charge is drafted *'…as set out on or more occasions…'* for each schedule. The panel considered that this does not make grammatical sense and is likely a typographical error. The panel was of the view that this should likely read *'…as set out on **one** or more occasions…'*.

The panel also noted that the evidence in support of sub-charge B12 pertains to just one patient instead of two. The panel proposed to amend this sub-charge to concern just one patient instead of two to better reflect the evidence presented.

Further, the panel noted that the date for sub-charge B20 '*29/2/2020'* does not correlate to the dates you were working on Cardiac Surgery Ward C708/C805. The panel bore in mind that all other dates in the schedule for this ward are from June 2020, and given that the date is written numerically, the panel considered this to likely be a typographical error. The panel therefore suggested to amend this to '*29/6/2020'* to ensure accuracy reflected in the contemporaneous record.

The panel invited submissions from the parties as to the following amendments:

'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:

1) *Assessment of patients as set out on* ***one*** *or more occasions in Schedule A*

2) *Medication administration as set out on* ***one*** *or more occasions in Schedule B*

3) *Time management as set out on* ***one*** *or more occasions in Schedule C*

4) *Documentation/record-keeping as set out on* ***one*** *or more occasions in Schedule D*

5) *Communication as set out on* ***one*** *or more occasions in Schedule E*

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

SCHEDULE B- MEDICATION ADMINISTRATION

WARD C708/C805 [CARDIAC SURGERY]

12	*17/6/2020*	*Had to be prompted to administer medication to ~~2 patients~~* ***1 patient***
20	*~~29/2/2020~~* ***29/6/2020***	*Missed the administration of 2 medications*

Submissions on proposal to amend the charges

Mr Malik, on behalf of the NMC, did not oppose the amendments. He submitted that they were sensible and fair.

Ms Bennet opposed the proposal in respect of sub-charge B12. She submitted that the amendment would cause unfairness to you.

Ms Bennet submitted that the amendment was impermissible for following reasons:

- You gave evidence and were cross-examined on the sub-charge as framed that it concerned two patients
- The NMC presented its case on that basis and now to alter the sub-charge to a lesser standard is to reframe the case mid-deliberation without offering you an opportunity to respond to the new information

Ms Bennet submitted that, in respect of sub-charge B12, this is not a typographical error, it is a material reduction of the scope of the charge.

Ms Bennet submitted that a finding of fact cannot be engineered retrospectively and referred the panel to the case of *Bonhoeffer v GMC [2011] EWCA 1585 (Admin)*, which provides that a panel may not amend down a charge during deliberations in order to secure a finding.

Ms Bennet submitted that were the panel to amend sub-charge B12 as applied, you would be found guilty of a different allegation than the one originally charged. She submitted this was a breach of article 6 of the European Convention on Human Rights (ECHR). She also submitted that to amend the sub-charge would be procedurally unfair under rule 28. Ms Bennet submitted that sub-charge B12 should be dismissed.

Ms Bennet further opposed the proposed amendment to sub-charge B20. Although she accepted it was likely a typographical error, she submitted that it would cause an injustice to you because you had been cross-examined on the basis that the allegation occurred in February. Ms Bennet also submitted that the proposed amendment should have been made earlier by the NMC and therefore it would be unfair to change it now.

Ms Bennet did not oppose the proposed amendment adding ‘one’ to each head of charge.

Decision and reasons on proposal to amend the charges

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

The panel took account of the submissions of the parties and determined not to amend sub-charge B12.

The panel determined that to amend the sub-charge would cause an injustice as you gave evidence and were cross-examined on the basis that sub-charge B12 concerned two patients instead of one. The panel determined that to allow the proposed amendment would materially change the scope of the sub-charge and that this would be unfair to you.

The panel determined to allow the amendments to the heads of charge and sub-charge B20. The panel determined that the proposed amendments to the heads of charge and sub-charge B20 were to correct minor typographical/grammatical errors and that these did not alter the substance of the allegations and would cause no injustice to either party. The panel were of the view that you must have known that the allegation in sub-charge B20 related to June 2020 and not February 2020 because this was the date of the incident referred to in the bundle of papers which both you and your representative have had. Furthermore, in cross-examination Ms Butler took you to the evidence of Ms Kidner and explicitly stated this was June 2020. The panel therefore do not accept that you were cross-examined on the basis that this incident took place in February 2020. The panel also note that you began your supervised placement on this ward on 2 June 2020 and this was put to you in cross-examination. The panel do not consider that the correction of a typographical error in sub-charge B20 affects your right to a fair trial under article 6 of the ECHR.

Decision and reasons on facts

At the outset of its deliberations, the panel noted that the instances in the schedules to the charges span multiple placements and address your clinical performance in three clinical

areas: intensive care unit at UHBW (GICU), cardiac surgical ward at UHBW (Cardiac Surgery C708/C805), and medical complex care ward at NBT (Gate 9A).

In reaching its decision, the panel was mindful that during the hearing you changed your legal representation, and that you significantly changed the focus of your defences to the charges as a result. In order to ensure fairness to you and the NMC, and to reflect the development of your defence, the panel has considered each of your defences insofar as they apply to each incident alleged. The panel also considered that your defence initially included admissions to some of the items in the schedules, but that these did not carry over into your defence in the latter part of the hearing.

The panel also bore in mind the length of time this hearing has taken, and that it has heard extensive evidence and submissions in relation to the items alleged in the schedule. To ensure fairness to you and the NMC, the panel has taken into account all the evidence it has seen in making its decision on each item in the schedules.

The panel accepted the advice of the legal assessor and had particular regard to the judgement in *Hindle v The Nursing and Midwifery Council [2025] EWHC 373 (Admin),* and had regard to the working environment and conditions in the clinical areas.

In considering the charges, the panel also had regard to the expectations and duties placed upon a Registered Nurse (Band 5) as set out across all three clinical areas.

In GICU, these are the Supernumerary Orientation Pack, the Induction and Supernumerary Period Pack, Job Description and Medication Policy. These documents outlined the baseline clinical and observational competencies required of a newly appointed Band 5 nurse. The panel also took into account the A-E Guidelines, which provided a framework for conducting and recording patient assessments, the Trust's Record Keeping Policy, and the Clinical Protocol on Recording Patient Observations and Early Warning Scores, as well as Clinical Protocol Recording Patient Observations, Pain Level and Early Warning Score in Adults using the National Early Warning Score, which

clarified the required standards when responding to deteriorating patients. The panel also considered the Trust's Record Keeping Principles and Standards and Record Keeping Standards in Health Records Policy. These materials informed the panel's understanding of your duties during the relevant periods and the standard expected. The panel noted that the supernumerary documentation was part of an explicit assessment pathway with required competency signoff by relevant supervisory staff.

On the Cardiac Surgery C708/C805 ward, these documents include the C708 new starter pack document and Cardiac Surgery Day to day guide, as well as those Trust-wide documents identified above. The panel also noted prior to commencement of your placement on this ward, you were set these explicit, bespoke objectives:

1. To complete all appropriate online training during orientation period and provide written reflective evidence of how she applies this to her practice.
2. To explain the procedure to be followed in the event of a range of difference NEWS scores, provide written examples that she has done this correctly, and explain what Trust documents and sources support this process.
3. To complete a full clinical assessment on identifying a deteriorating patient and provide effective handover.
4. To safely demonstrate admission, transfer and discharge of patients, correct identification when reassessment of patient risks and appropriate application of trust documentation, policies and procedures
5. To complete at least 10 drug rounds under minimal supervision, demonstrating safety and perform these in a timely manner. To be able to discuss, in detail, the NMC policies on medicine administration. To prepare and administer intravenous medication on at least 10 occasions.
6. To work consistently, demonstrate clinical competence and care, preparation for the weekly meetings should not detract from clinical activities whilst on shift, use the NMC reflective account template and present this at every meeting.
7. To meet with a senior nurse to discuss the care and treatment needs of a patient of her choosing. To explain how to address the patient's needs whilst applying her understanding of her responsibilities and accountability set out in the NMC code.

On Gate 9A, these documents included Induction New Starter pack, Training and Competency checklist, an Orientation Workbook, and a checklist for newly qualified nurses. The panel also took into account the Band 5 Job Description, and the Patient Falls Prevention Policy. The panel also noted prior to commencement of your placement on Gate 9A, a support plan was provided outlining targeted NMC conditions of practice identified as:

- supervised medicines management and administration;
- escalation of concerns regarding deterioration of patients;
- record keeping; and
- communication.

The panel noted that at the time of the charges, you were progressing through sequential extended induction and assessment periods while working on GICU, Cardiac Surgery C708/C805, and Gate 9A. The panel noted that in these environments you were being continually assessed in accordance with the assessment protocols that had been put in place to support new staff.

The panel noted you were under the responsibility of a teaching team in all three clinical environments.

The panel determined that the level of observational monitoring was standardised procedure to ensure patient safety, and to provide a safe learning environment for new staff, and crucial for integrating new employees into a new role.

The panel had sight of a bundle initially submitted by you, and relied upon by your previous counsel during cross-examination. The panel also received an additional bundle submitted during the course of the hearing. This documentation in totality included:

- your written statement
- reflective accounts
- feedback and testimonials

- various documents relating to issues of discrimination
- a copy of the NMC Independent Culture Review and Ambition for Change documents
- correspondence related to historical internal disciplinary issues
- your original NMC Referral

The panel considered carefully throughout its deliberations the submissions made on your behalf that aspects of your treatment during your placement had been affected by racial bias. Namely that you had been subject to disproportionate scrutiny, inconsistent feedback practices, and assumptions about your conduct that were not applied to your peers. The panel was referred to the NMC's Culture Review as well as other evidence of institutional racism at the Trusts. It was submitted that, in addition to individual conscious racial bias, 'unconscious' racial bias contributed to the number and tone of the concerns raised against you. The panel took careful account of these submissions and acknowledged the importance of remaining alert to the possibility of bias, both individual and institutional, conscious and unconscious in making its findings of fact.

The panel reminded itself that the NMC bears of the burden of proving the facts, and that the applicable standard of proof is the civil standard, namely the balance of probabilities.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Kathryn Pollock: Band 7 Sister on GICU and Practice Educator
- Teresa Pogorzelska: Deputy Sister within GICU
- Siobhan Lanigan: Sister and Team Lead within GICU
- Sophie Hewer: Critical Care Sister within GICU
- Rachel Brennan: Practice Educator within GICU

- Rebecca Russell: Band 7 Sister on GICU at the time of the charges
- Samantha Burgess: Matron at UHBW
- Charlotte Elvy: Band 6 Nurse at the NBT
- Trequene Duncan-McKenzie: Band 5 Nurse at the NBT
- Joanna Williams: Clinical Practice Facilitator at the NBT
- Shelley Thomas: Deputy Head of Nursing for Surgery at NBT
- Aiden Mankee: Staff Nurse at the NBT
- Elizabeth Leech: Practice Development Nurse on GICU
- Melanie Broad: Matron on the Cardiac Surgery Ward at the time of the charges
- Erin Trinidad: Band 5 Nurse on Gate 9A

The panel considered the hearsay evidence from the following witnesses:

- Tess Sims: Ward Sister/Band 6 Nurse on the Cardiac Surgery Ward
- Hannah Morris: Ward Manager on Gate 9A

- Charlotte Kidner: Band 6 Senior Staff Nurse on the Cardiac Surgery Ward at the time of the charges

The panel also heard evidence from you under oath.

The panel noted that there are five charges, each supported by a detailed schedule and that you have admitted to at least one item in each schedule.

Charge 1

> *'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:*
>
> *1) Assessment of patients as set out on one or more occasions in Schedule A'*

The panel had regard to the wording of this head of charge that requires it to be proved if one or more items in Schedule A is made out. It noted your admission to A22 and A24 and accordingly found this charge proved by your admission. For completion, the panel considered the evidence supporting the other sub-charges in Schedule A and made findings on each.

A1, A2, A3 and A4

The panel had regard to sub-charges A1, A2, A3 and A4 and noted that the evidence in support of each sub-charge comes from the same witness. The panel has considered each sub-charge separately.

The panel had regard to the oral and documentary evidence of Ms Pogorzelska, which included her witness statement, a contemporaneous feedback report from shift dated 9

November 2019, and local investigation interview notes dated 19 December 2019. The panel also had regard to your oral and documentary evidence.

A1

1	9/11/2019	Was unable to define a patients current airway status

The panel found the facts alleged at sub-charge A1 proved.

The panel had regard to Ms Pogorzelska's written statement, which provided clarity on the contemporaneous feedback report dated 9 November 2019: *'In my feedback* "Airway – could not define" *means that Lydia could not define the patient's airway.'*

In her oral evidence, Ms Pogorzelska confirmed the prevalence of intubation as a method of airway management on the GICU (sometimes referred to as ITU or ICU), as she stated usually more than 75% of patients on the unit were intubated. She reinforced the importance of a registered nurse being able to identify the correct airway and said that you were unable to describe the type of airway and size for an intubation.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing concerns with your clinical practice you indicated you required a consistent mentor, and more time in practice to have your competencies signed off to enable you to practise independently.

In cross-examination, it was put to Ms Pogorzelska that she had worked one shift with you and had only observed a snapshot of your practice. Your counsel asserted that you were competent. This was not accepted by Ms Pogorzelska.

In oral evidence you stated that you were aware of the definition of airway status, but did not realise you were being assessed on it.

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel bore in mind that the unit had a structured, standard induction protocol for all new staff following national guidelines to support care of patients in GICU. The panel bore in mind that you were supernumerary at the time, and as is standard practice, required a full sign off of all of your competencies prior to commencing unsupervised practice. Therefore, ongoing assessment should have been expected and appreciated that it was required in order to ensure patient safety. It was unclear to the panel why being continually assessed would have impacted negatively on your performance.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

A2

2	9/11/2019	Was unfamiliar with/failed to complete the full ABCDE assessment

The panel found the facts alleged at sub-charge A2 proved.

The panel noted that you were working on the unit as a registered nurse and that a requirement of the role is to complete full ABCDE assessments.

The panel took into account Ms Pogorzelska's written statement that '*as stated in my feedback Lydia was not familiar with the "ABCD[sic] approach" assessment when performing the safety checks'.* The panel noted Ms Pogorzelska's oral evidence that at six weeks supernumerary you, as an experienced recovery nurse, ought to have been able to perform a complete ABCDE assessment.

The panel took into account the clinical standard operating procedure (SOP) for ABCDE assessments of patients in GICU. It noted the general evidence of Ms Burgess that a nurse of your experience ought to have been able to work through an ABCDE assessment in the correct order as it is a training requirement of working on GICU. The panel bore in mind that the SOP is implemented to ensure patient safety and consistent evidence-based standards. The panel was satisfied on this basis that you had a duty to complete a full ABCDE assessment.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing your understanding of the ABCDE assessment you indicated prior knowledge but limited use, and said *'I get it now…The way we do things is slightly different I will get into their routines'.* Thereby indicating that you were lacking confidence in this clinical skill at the point of your assessment.

In cross-examination, it was put to Ms Pogorzelska that she had only worked one shift with you and had therefore observed only a snapshot of your practice. Your counsel asserted that you were competent. This was not accepted by Ms Pogorzelska.

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge A2, is relevant to the competency concerned:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In oral evidence you again claimed that you were competent and indicated that you had never seen Ms Pogorzelska's feedback. You were asked in cross-examination: '*Does it mean that the contents of this document are untrue because you haven't seen it?'* and responded *'It is untrue - they were writing stuff behind my back'.*

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel noted the changes in your defence. The position at the investigation dated 12 and 19 December 2019 was that you required more time to become competent in this aspect of practice. Your position at this hearing, however, has changed considerably. You claim that Ms Pogorzelska was being untruthful in her feedback report, and unnecessarily scrutinising you. The panel prefer the clear and consistent evidence of Ms Pogorzelska and do not accept your various versions of events.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found sub-charge A2 proved.

A3

3	9/11/2019	Was unfamiliar with full ABG test results

The panel found the facts at sub-charge A3 proved.

The panel took into account the following from Ms Pogorzelska's contemporaneous feedback report dated 9 November 2019: *'Lidia[sic] memorised 3 parameters (only) from the ABG results but she doesn't understand the blood gas exchange concept'*. This was confirmed in her written statement and she was consistent in her oral evidence.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing concerns with your clinical practice you indicated you required a consistent mentor, and more time in practice to have your competencies signed off to enable you to practise independently.

In cross-examination, it was put to Ms Pogorzelska that you did understand the ABG and blood gas exchange concept, but were still cementing your learning. Ms Pogorzelska refuted this.

This issue was raised with you in cross-examination, and you were asked to explain the ABG concept and you were unable to do so.

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

Accordingly, the panel preferred the evidence of Ms Pogorzelska and found this sub-charge proved.

A4

4	9/11/2019	Demonstrated a lack of awareness in respect of equipment alarms

The panel found the facts alleged at sub-charge A4 proved.

The panel took into account the following from Ms Pogorzelska's contemporaneous feedback report dated 9 November 2019: *"Lydia didn't respond to any alarms, neither from the cardiac monitor, nor from the ventilator. When pointed this out that she needs to be aware of the alarms and be able to respond appropriately, Lydia stated that she "heard" them but she wasn't able to say what parameter was alarming."* This was confirmed in her written statement and she was consistent in her oral evidence.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing concerns with your clinical practice you indicated an awareness and requirement to respond to alarms. You also indicated that

you do not recall being told to respond.

In cross-examination, it was put to Ms Pogorzelska that it can take time for a new starter to understand what each alarm represents and how to respond to them. Ms Pogorzelska agreed it can take time, but that you were in your final of six weeks of supernumerary and would have been exposed to different alarms many times during that period. It was then put to Ms Pogorzelska that you had been alert in terms of acknowledging the alarms, to which Ms Pogorzelska was unable to comment as you had not responded to them.

The panel took into account the following from your written statement, and noted that it pertains to your response to the alarms rather than your awareness of them, as charged:

> ***'Failure to Respond to Alarms (9 & 25 November 2019)***
> *I **dispute** this allegation. I was under full supervision. No patient was harmed. I worked collaboratively and communicated with colleagues. These claims exaggerate or distort what actually happened on shift.'*

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel do not accept your rationale in relation to sub-charge A4. The panel determined that the fact that there was no patient harm is irrelevant as you were subject to full supervision, and any incident that could lead to patient harm would have been responded to before harm occurred. The panel do not accept your claim of a lack of familiarity with the alarms in this setting at over six weeks supernumerary with daily ongoing exposure to the alarms.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

A6

6	19/11/2019	Was unable to complete a full ABCDE assessment

The panel found the facts alleged at sub-charge A6 proved.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Rebecca Russell with a contemporaneous feedback report of the shift she supported you on, dated 19 November 2019, a subsequent email sent to Ms Russell following this shift but undated in the bundle, and local investigation interview notes dated 21 January 2020. The panel also had regard to your oral and documentary evidence.

The panel had regard to the oral evidence of Ms Pollock, who said that the ABCDE assessment was part of the daily practice on the unit for every patient, and that every supernumerary and substantive registered nurse was expected to complete it. Ms Pollock described the amount of support that was offered to you during your supernumerary period.

Ms Pollock supervised you during your shift on 19 November 2019 and informed the panel of her concern that, despite her support and direction, you were unable to complete a full ABCDE assessment. Ms Pollock was sufficiently concerned that she promptly escalated her concerns in a contemporaneous summary of the shift to Ms Russell via the undated email.

The panel noted that your supernumerary period had been extended from the standard six weeks, and you were advised as being in your seventh week at this point.

The panel had regard to Ms Pollock's written statement, which in the panel's view supports this contemporaneous feedback.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing your understanding of the ABCDE assessment you indicated prior knowledge but limited use, and said *'I get it now…The way we do things is slightly different I will get into their routines'.* Thereby indicating that you were not competent at the point of your assessment.

In cross-examination, it was put to Ms Pollock that you did know how to complete an ABCDE assessment, but that on this occasion you were under stress and that affected your ability to effectively complete the assessment. Your position was that a lack of one consistent mentor impacted on your learning and progression. This was refuted by Ms Pollock.

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge A6, is relevant to the competency concerned:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In oral evidence you again claimed that you were competent. You maintained the position that Ms Pollock failed to adequately support you.

In cross-examination you initially called Ms Pollock a liar and a racist who was supporting a previous manager as part of a conspiracy against you. You later retracted the statement that Ms Pollock was a liar.

The panel considered Ms Pollock to be a reliable witness. The panel took account of all of Ms Pollock's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pollock's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

It was clear to the panel that your responses to this sub-charge were overall inconsistent in respect of your initial investigation interview by your employer, the cross-examination by your original representative of Ms Pollock, the written statements that you gave in examination in chief, and your subsequent cross-examination.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock and found this sub-charge proved.

A7, A8, A9 and A10

The panel had regard to sub-charges A7, A8, A9 and A10 and noted that the evidence in support of each sub-charge comes from the same witness. The panel has considered each sub-charge separately.

The panel had regard to the oral and documentary evidence of Ms Lanigan, which included her witness statement, a contemporaneous feedback report from shift dated 22 November 2019, and local investigation interview notes dated 3 January 2020. The panel also had regard to your oral and documentary evidence.

A7

7	22/11/2019	Was unfamiliar with the Glasgow Coma Score

The panel found the facts alleged at sub-charge A7 proved.

The panel had regard to Ms Lanigan's contemporaneous feedback report dated 22 November 2019, in which she identifies that you were unable to remember how to assess Glasgow Coma Score and what it was called. In oral evidence, Ms Lanigan indicated that this competency is within the expected skillset of a student nurse. Ms Lanigan also informed the panel that *'In ITU every patient every four hours has a Glasgow Coma Score assessment'.* The panel concluded that you would have had to complete a Glasgow Coma Score assessment during your training, previous roles, and during your time on GICU.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, where you state you had limited prior knowledge and application of the Glasgow Coma Score. You said that you had not used it recently in your previous role, that you needed to work on it, and that you did it successfully at a later date with Ms Hewer.

In cross-examination, it was put to Ms Lanigan that she was wrong in her recollection in that she misremembered or misrecorded the discussions around the Glasgow Coma Score, or she was not telling the truth about your discussions. Ms Lanigan refuted this. Furthermore, it was suggested that there was racial bias influencing the way that you were treated. Ms Lanigan refuted this.

In oral evidence you stated that Ms Lanigan was lying about you not being able to complete a Glasgow Coma Score assessment, and this was '*all part of institutional racism'*. The panel noted it has before it general evidence from you concerning racism at this Trust but the panel were not taken to any specific examples of racism on this unit at the material time within those reports.

The panel considered Ms Lanigan to be a reliable witness. The panel took account of all of Ms Lanigan's evidence and determined it to be consistent and cogent throughout,

including under cross-examination. The panel determined that Ms Lanigan's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

Furthermore, the panel did not accept your multiple different explanations as set out above, and note your response closer to the date in question for this sub-charge, where you acknowledge skill attrition in this clinical area and where you do not raise any allegations of racism. The panel note your position has changed to a position that racism is the reason Ms Lanigan assessed you negatively. The panel accepted the evidence of Ms Lanigan that she was not racially prejudiced and could find no specific evidence that she was.

It was clear to the panel that your responses to this sub-charge were overall inconsistent in respect of your initial investigation interview by your employer, the cross-examination by your original representative of Ms Lanigan, the written statements that you gave in examination in chief, and your subsequent cross-examination.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Lanigan and found this sub-charge proved.

A8

8	22/11/2019	Failed to identify a normal blood pressure reading

The panel found the facts alleged at sub-charge A8 proved.

The panel had regard to Ms Lanigan's witness statement, local investigation interview notes dated 3 January 2020, in which she identifies that when undertaking safety checks you were unable to advise what a normal blood pressure range was. This was confirmed in Ms Lanigan's oral evidence.

The panel took into account the supernumerary pack for GICU. It noted that being able to identify a blood pressure reading is contained within the ABCDE assessment, and considered the general evidence of Ms Burgess that a nurse of your experience ought to have been able to work through an ABCDE assessment, which includes taking a blood pressure reading, in the correct order as it is a competency requirement of working on GICU. The panel bore in mind that the supernumerary pack is utilised to ensure patient safety and a consistent evidence-based standard. The panel was satisfied on this basis that you had a duty to identify a normal blood pressure reading.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing concerns with your clinical practice you indicated you required a consistent mentor, and more time in practice to have your competencies signed off to enable you to practise independently.

In cross-examination, it was put to Ms Lanigan that you were confident you were aware of normal ranges and that Ms Lanigan's recording was inaccurate on this matter and that she misremembered or mis-recorded the discussions around blood pressure, or she was not telling the truth about your discussions. Ms Lanigan refuted this.

In oral evidence you stated that you knew what blood pressure was and that Ms Lanigan was lying about you not being able to, and this was '*all part of the institutional racism attack on me'*.

The panel considered Ms Lanigan to be a reliable witness. The panel took account of all of Ms Lanigan's evidence and determined it to be consistent and cogent throughout. It was clear to the panel that your responses to this sub-charge is one of general defence that you were able to identify a normal blood pressure range. The panel does not accept your evidence that you were able to identify a normal blood pressure range on this occasion given the clear and consistent evidence of Ms Lanigan. The panel was therefore satisfied it was more likely than not that you did not identify a normal blood pressure range on the date in question.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Lanigan and found this sub-charge proved.

A9

9	22/11/2019	Was unable to confirm part of the ABCDE assessment

The panel found the facts alleged at sub-charge A9 proved.

The panel had regard to Ms Lanigan's witness statement, contemporaneous feedback report dated 22 November 2019 and local investigation interview notes dated 3 January 2020, in which she identifies that you were unable to accurately identify what 'D' (disability) stood for in the ABCDE assessment. This was confirmed in Ms Lanigan's oral evidence.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing your understanding of the ABCDE assessment you indicated prior knowledge but limited use, and said *'I get it now…The way we do things is slightly different I will get into their routines'.* Thereby indicating that you were not competent at the point of your assessment.

In cross-examination, it was put to Ms Lanigan that you did know what 'D' stood for in the ABCDE assessment and that her recollection of this was wrong. It was then put to Ms Lanigan that she was not telling the truth or had misremembered. Your position was put that racial bias influenced your treatment and you did not receive the same opportunities for learning and training. Ms Lanigan refuted this.

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge A9, is relevant to the competency concerned:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In oral evidence you again claimed that you were competent. You maintained the position that Ms Lanigan has lied about you. You stated that the reason you were unable to confirm part of the ABCDE assessment was as a result of systemic or supervisor failings by Ms Lanigan, rather than your fundamental lack of understanding.

The panel considered Ms Lanigan to be a reliable witness. The panel took account of all of Ms Lanigan's evidence and determined it to be consistent and cogent throughout. The panel considered your assertion that the supervision provided by Ms Lanigan was inadequate. However, the panel bore in mind that the unit had a structured, standard staff induction protocol following national guidelines to ensure the safe care of patients in ICU.

The panel had no reason to believe that the support provided was inadequate to assist your learning.

Further, it was clear to the panel that your responses to this sub-charge overall were inconsistent in respect of your recorded initial investigation interview by your employer, the cross-examination by your original representative of Ms Lanigan, the written statements that you gave in examination in chief, and your subsequent cross-examination.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Lanigan and found this sub-charge proved.

A10

10	22/11/2019	Failed to recognise or act when an alarm was sounding that a patient had low blood pressure

The panel found the facts alleged at sub-charge A10 proved.

The panel had regard to Ms Lanigan's witness statement, contemporaneous feedback report dated 22 November 2019 and local investigation interview notes dated 3 January 2020, in which she identifies that you did not react to the alarm which indicated a drop in blood pressure nor did you alert Ms Lanigan to this alarm. Furthermore, she stated that you were not reacting in a way in which you should have been when a patient in your care

had low blood pressure with an alarm going off. This was confirmed in Ms Lanigan's oral evidence.

The panel took into account the supernumerary pack for GICU, which noted that being able to identify types of alarms is a training requirement of working on GICU. The panel bore in mind that the supernumerary pack is implemented to ensure patient safety and a consistent evidence-based standard. The panel was satisfied on this basis that you had a duty to identify the relevant alarms on GICU.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing how you would react to low blood pressure alarm you indicated that you would always respond and seek support and direction.

In cross-examination, it was put to Ms Lanigan that you would have gone to go and get somebody to assist. It was then put to Ms Lanigan that she was not telling the truth or had misremembered or mis-recorded this incident. Ms Lanigan refuted this. Your position was that racial bias influenced your treatment and you did not receive the same opportunities for learning and training. Ms Lanigan refuted this.

The panel noted that within your evidence in chief you did not specifically address sub-charge A10, relating to this incident on 22 November 2019. However, overall you claimed that you were competent. You maintained the position that Ms Lanigan has lied about you.

As above, the panel considered Ms Lanigan to be a reliable witness. The panel took account of all of Ms Lanigan's evidence and determined it to be consistent and cogent throughout with no obvious motive to misrepresent the facts. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination.

It was clear to the panel that your responses to this sub-charge is one of general defence that you were able to identify and respond to alarms on GICU. The panel does not accept

your evidence that you were able to identify the alarms and preferred the evidence of Ms Lanigan. The panel was therefore satisfied that you did not identify alarms on the date in question.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to “get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Lanigan and found this sub-charge proved.

A11, A12, A13 and A14

The panel had regard to sub-charges A11, A12, A13 and A14 and noted that the evidence in support of each sub-charge comes from the same witness. The panel has considered each sub-charge separately.

The panel had regard to the oral and documentary evidence of Ms Hewer, which included her witness statement, a contemporaneous feedback report from shift dated 24 November 2019 and an undated letter sent by Ms Hewer to Ms Russell. Although the letter was undated, the panel noted that in oral evidence Ms Hewer confirmed that this was sent following the shift. The panel also had regard to your oral and documentary evidence.

A11

11	24/11/2019	Was unable to correctly demonstrate/complete the ABCDE assessment without assistance

The panel found the facts alleged at sub-charge A11 proved.

The panel had regard to Ms Hewer's witness statement, contemporaneous feedback report dated 24 November 2019, a letter following the 24 November 2019 shift and oral evidence. Ms Hewer stated that you were unable to correctly demonstrate the *'ABCDE'* assessment independently and that you required prompting, supervision and support with this task. This was confirmed in Ms Hewer's oral evidence.

The panel noted your recorded responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing your understanding of the ABCDE assessment you indicated prior knowledge but limited use, and said *'I get it now…The way we do things is slightly different I will get into their routines'.* Thereby indicating that you were not competent at the point of your assessment.

In cross-examination, it was put to Ms Hewer that you did know how to complete the ABCDE assessment. It was put to Ms Hewer that she was either wrong, misremembered or mis-recorded the feedback or in the alternative that she had not been truthful. Furthermore, it was suggested that there was racial bias influencing the way that you were treated. Ms Hewer refuted this.

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge A11, is relevant to the competency concerned:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In oral evidence you again claimed that you were competent with this skill.

The panel considered Ms Hewer to be a reliable witness. The panel took account of all of Ms Hewer's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Hewer's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

Further, it was clear to the panel that your responses to this sub-charge were overall inconsistent in respect of your initial investigation interview by your employer, the cross-examination by your original representative of Ms Hewer, the written statements that you gave in examination in chief, and your subsequent cross-examination. The panel also note your own comments close in time to the event in question where you acknowledged an inability to effectively undertake this task.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

A12

12	24/11/2019	Did not identify that a patient required hourly observations

The panel found the facts alleged at sub-charge A12 proved.

The panel had regard to Ms Hewer's witness statement, the undated letter following the 24 November 2019 shift and oral evidence. Ms Hewer stated, in her oral evidence, that you required prompting with hourly observations and could not action this independently.

In cross-examination, it was put to Ms Hewer that you were very aware of observations when they were required and that you were confident and able to determine what level of observations a patient needed. Ms Hewer refuted this, maintaining consistency with her written statement and evidence in chief. It was put to Ms Hewer that she was either mistaken, had misremembered or mis-recorded the feedback, or, in the alternative had not been truthful. Ms Hewer refuted this.

This sub-charge was not explicitly addressed by you in your evidence in chief, however in your written statement you expressed in general *'I completed observations – told I missed them'*.

The panel considered Ms Hewer to be a reliable witness. Her oral evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Hewer's evidence and determined it to be consistent and cogent with no obvious motive to misrepresent the facts.

The panel noted that your response to this sub-charge was one of a general defence that you 'completed observations'. The panel does not accept that you did complete observations on this occasion given the clear and consistent evidence of Ms Hewer. The panel was therefore satisfied it was more likely than not that you did not identify that a patient required hourly observations on the date in question.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

A13

13	24/11/2019	Identified incorrect pupil size measurements

The panel found the facts alleged at sub-charge A13 proved.

The panel considered the same evidence from Ms Hewer that had been relied upon in relation to sub-charge A12.

Ms Hewer stated that you identified the pupil size as 2.5, which was incorrect.

In cross-examination, it was put to Ms Hewer that there was a misunderstanding, and you eventually completed this task correctly. Ms Hewer indicated the need for several conversations required for you to come to the correct conclusion.

This sub-charge was not explicitly addressed by you in your evidence in chief.

The panel considered Ms Hewer to be a reliable witness. Her oral evidence was consistent with the contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Hewer's evidence and determined it to be consistent and cogent with no obvious motive to misrepresent the facts.

The panel noted your position put by counsel that you were eventually able to complete this task correctly, however the panel noted that this was only after intervention by your supervisor. The panel therefore was satisfied that you incorrectly identified pupil size measurements.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

A14

14	24/11/2019	Failed to notice patient becoming hypotensive despite machine alarm sounding

The panel found the facts alleged at sub-charge A14 proved.

The panel considered the same evidence from Ms Hewer that had been relied upon in relation to sub-charge A12 and A13.

The panel took into account the supernumerary pack for GICU, which noted that being aware of a medical plan and adapting care appropriately in relation to a target mean arterial pressure (MAP), of which hypotension would be a symptom needing to be responded to, is a competency requirement of working on GICU. The panel bore in mind that the supernumerary pack contains the required nursing practice to ensure patient safety and a consistent evidence-based standard. The panel also determined that noticing a deteriorating patient and attending to subsequent patient alarms is a fundamental aspect of nursing practice. The panel was satisfied on this basis that you had a duty to notice the patient in question becoming hypotensive.

Ms Hewer stated that you did not recognise the patient becoming hypotensive despite the cardiac monitor alarming. Ms Hewer in her letter stated that she had to immediately intervene to ensure the patient's safety.

Although this sub-charge was not explicitly addressed by you in your evidence in chief, in cross-examination, it was put to Ms Hewer that you were away from the immediate bed space and did not hear the alarm. It was put to Ms Hewer that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Hewer refuted this and stated to the best of her knowledge that you were in the room when the alarm sounded and asserted that she was truthful.

The panel considered Ms Hewer to be a reliable witness. Despite there being a dispute between the witness evidence and your version of events, the panel had regard to a letter sent by Ms Hewer to her team lead which represents the first account of these events. The panel preferred this contemporaneous record of Ms Hewer outlining in detail the events on shift. The panel did not accept your explanation that you were away from the bed space

and did not hear the alarm. The panel was satisfied it was more likely than not that you failed to notice patient becoming hypotensive despite machine alarm sounding.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

A15 & A16

The panel had regard to sub-charges A15 and A16 and noted that the evidence in support of each sub-charge comes from the same witness. The panel has considered each sub-charge separately.

The panel had regard to the oral and documentary evidence of Ms Brennan, which included her witness statement, a contemporaneous feedback report from shift dated 25 November 2019. The panel also had regard to your oral and documentary evidence.

A15

15	25/11/2019	Did not go back to listen to airway bases after being given details of how to peel pads back

The panel found the facts alleged at sub-charge A15 proved.

The panel had regard to Ms Brennan's contemporaneous feedback report dated 25 November 2019, which stated '*also didn't go back to listen to airway bases after I had explained how to peel back artic[sic] sunpads'*. This was confirmed in Ms Brennan's oral evidence.

This sub-charge was not explicitly addressed in your response at the local investigation interview dated 12 and 19 December 2019.

In cross-examination, in relation to sub-charge A15, it was put to Ms Brennan that this was the first time that you used the pads, but you assert that you were not directed to go back and recheck the airway bases. It was put to Ms Brennan that she was either mistaken, had

misremembered this, or, in the alternative had not been truthful. Furthermore, it was suggested that there was racial bias influencing the way that you were treated. Ms Brennan refuted this and stated that she stood by her evidence.

This sub-charge was not explicitly addressed by you in your evidence in chief.

The panel considered Ms Brennan to be a reliable witness. Her oral evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Brennan's evidence and determined it to be consistent and cogent with no obvious motive to misrepresent the facts. The panel determined that Ms Brennan's assessment was objective and balanced, and there was no reason to disbelieve her evidence and the panel preferred the evidence of Ms Brennan.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Brennan and found this sub-charge proved.

A16

16	25/11/2019	Was unaware of infusion pumps alarm sounding

The panel found the facts alleged at sub-charge A16 proved.

The panel had regard to Ms Brennan's contemporaneous feedback report dated 25 November 2019, which stated *'Lydia did not respond appropriately to infusion pump alarms – seeming to be unaware where alarms were coming from-being hypervigilant of alarms in another bed space but not reacting quickly to those in ours'.* This was confirmed in Ms Brennan's oral evidence.

This sub-charge is not explicitly addressed in your response at the local investigation interview dated 12 and 19 December 2019.

In cross-examination, in relation to sub-charge A16, it was put to Ms Brennan that you were competent in your ability to respond and that you had not been told what all of those alarms related to. It was put to Ms Brennan that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Furthermore, it was suggested that there was racial bias influencing the way that you were treated. Ms Brennan refuted this and stated that she stood by her evidence.

The panel took into account the following from your written statement, and noted that it pertains to your response to the alarms rather than your awareness of them, as charged:

> ***'Failure to Respond to Alarms (9 & 25 November 2019)***
> *I **dispute** this allegation. I was under full supervision. No patient was harmed. I worked collaboratively and communicated with colleagues. These claims exaggerate or distort what actually happened on shift.'*

The panel considered Ms Brennan to be a reliable witness. Her oral evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Brennan's evidence and determined it to be consistent and cogent with no obvious motive to misrepresent the facts. The panel determined that Ms Brennan's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel do not accept your rationale in relation to sub-charge A16. The panel determined that the fact that there was no patient harm is irrelevant as you were subject to full supervision, and any incident that could lead to patient harm would have been responded to before harm occurred. The panel do not accept your claim of exaggeration and distortion, and it preferred the evidence of Ms Brennan to the explanation put forward by you.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Brennan and found this sub-charge proved.

A17

17	On a date between 16/9/2019 – 25/11/2019	Incorrectly demonstrated capillary refill time

The panel found the facts alleged at sub-charge A17 proved.

The panel had regard to the oral and documentary evidence of Ms Russell, which included her witness statement, and local investigation interview notes dated 12 December 2019, and Ms Pogorzelska, which included her contemporaneous feedback report dated 9

November 2019 and local investigation interview notes dated 19 December 2019. The panel also had regard to your oral and documentary evidence.

Although not referred to in her witness statement, the panel noted that this incident is recorded in contemporaneous feedback report dated 9 November 2019 by Ms Pogorzelska:

> *'CRT – Lidia[sic] knew what the CRT represents but when asked to demonstrate how to measure CRT, her timing to press and count was incorrect.'*

Ms Pogorzelska confirmed this in her local investigation interview notes dated 19 December 2019, and also in her oral evidence.

This was also supported by the local investigation interview notes with Ms Russell dated 12 December 2019, in which Ms Russell confirmed that Ms Pogorzelska had identified this concern with your practice.

You did not address this sub-charge in your local investigation interview at the time.

In cross-examination, it was put to Ms Pogorzelska that you were competent in your ability to demonstrate capillary refill time. It was put to Ms Pogorzelska that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Pogorzelska refuted this and stated that she stood by her evidence.

In cross-examination, you maintained that you were competent, that Ms Pogorzelska was wrong *'she has got it in for me, she is undermining me'*. You stated it could not be true otherwise you would have received the contemporaneous feedback report.

As above, the panel determined Ms Pogorzelska to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel

determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

Whilst acknowledging that you have consistently maintained that you were competent in your ability to demonstrate capillary refill time, the panel prefer the evidence of Ms Pogorzelska and the contemporaneous documentation presented. The panel took into account the structure and support that was available to you on the unit to support your learning and afford you the opportunity to demonstrate your competencies, and did not find this support lacking. Further, the panel did not accept your assertion that you never received any form of feedback.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

A18, A19, A20

The panel had regard to sub-charges A18, A19 and A20 and noted that the evidence in support of each sub-charge comes from the same witness, Ms Kidner. The panel was mindful that the evidence of Ms Kidner, which included her witness statement, new starter pack, and seven contemporaneous feedback reports dated from 19 June 2020 to 29 June 2020, was admitted by the panel as disputed hearsay evidence.

When determining what weight to attach to Ms Kidner's evidence, the panel took into account:

- Ms Kidner's evidence was sole and decisive in relation to these sub-charges
- Ms Kidner's evidence was not sworn
- You have been unable to test Ms Kidner's evidence by cross-examination
- Ms Kidner provided a witness statement containing a declaration of truth dated 16 February 2023
- Ms Kidner's evidence was based on the seven contemporaneous feedback reports she completed in her role as your mentor

- The contemporaneous feedback reports were standard routine documents completed as part of Ms Kidner's professional role
- There was no evidence that Ms Kidner had a motive to fabricate the content of these documents
- There was evidence of teaching, learning and signposting to assist you in the feedback
- The panel also considered Ms Kidner to have provided balanced feedback on your clinical practice

Having balanced the above factors, the panel determined that the contemporaneous and professional nature of the documents was such that it could attach considerable weight to Ms Kidner's hearsay evidence.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

The panel considered each sub-charge separately.

A18

18	19/6/2020	Failed to complete a full risk assessment

The panel found the facts alleged at sub-charge A18 proved.

In Ms Kidner's statement and written contemporaneous feedback report of 19 June 2020 it was confirmed that you were tasked with completing a routine patient risk assessment. This is a basic process that you would have observed many times across clinical areas, and is identified in the job description for a Band 5 nurse and explicitly in the cardiac surgery day to day guide provided to you.

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 19 June 2020 in which she stated:

> *‘Lydia was asked to complete a risk assessment of a patient. Lydia had witnessed this process several times... Risk assessments are a very common across* [UHBW] *and can be completed by our Band 2 healthcare assistants. Lydia took over an hour to complete 1 assessment and di[sic] not record the patients[sic] correct weight or complete a skin integrity check. I explained the importance of these checks and how they can impact the patient. Lydia appeared to have no understanding of what was required of her. She asked how to ask the questions which was as simple as reading out the question to the patient and recording their yes or no answer.’*

You did not provide evidence specific to this sub-charge or an alternative version of events. The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

When cross-examined about Ms Kidner’s evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was ‘*part of the plan to get rid of me and destroy my career*’.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

Ms Kidner’s written statement was supported by contemporaneous notes, which were written in the course of her professional duty as your mentor, and was consistent

throughout. The panel therefore attached considerable weight to the contemporaneous feedback report and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

A19

19	26/6/2020	Was unable to identify the appropriate response to a spike in temperature

The panel found the facts alleged at sub-charge A19 proved.

In Ms Kidner's statement and written contemporaneous feedback report of 26 June 2020 she stated that:

> *'Whilst carrying out observations, a patients[sic] temperature had spiked. Lydia was unable to identify that the patient required a sepsis screening, blood samples, and failed to escalate the situation to the appropriate medical team. Again this is a process which had been covered in detail with Lydia on several occasions.'*

You did not provide evidence specific to this sub-charge or an alternative version of events. The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing

progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

Ms Kidner's written statement was supported by contemporaneous notes, which were written in the course of her professional duty as your mentor, and was consistent throughout. The panel therefore attached considerable weight to the contemporaneous feedback report and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

A20

20	26/6/2020	Did not escalate a patient to the appropriate medical team

The panel found the facts alleged at sub-charge A20 proved.

The panel noted the starter pack, which outlines the escalation to colleagues of a patient's deteriorating condition using SBAR/sepsis 6 pathway as one of your explicit identified nursing objectives. In Ms Kidner's statement and written contemporaneous feedback report of 26 June 2020 she stated that:

> *'Lydia was unable to identify that the patient required a sepsis screening, blood samples, and failed to escalate the situation to the appropriate medical team. Again this is a process which would have been covered in detail with Lydia on several occasions. The fact that Lydia was not able to identify any of the relevant steps was*

very concerning and if she had been working alone there could have been a significant risk of patient harm.'

You did not provide evidence specific to this sub-charge or an alternative version of events. The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career'*.

Ms Kidner's written statement was supported by contemporaneous feedback, which was written in the course of her professional duty as your mentor, and was consistent throughout. The panel therefore attached considerable weight to the contemporaneous feedback report and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

A21

21	2/7/2020	Was unable to identify the correct order of nursing tasks required

The panel found the facts alleged at sub-charge A21 proved.

The panel was mindful that the evidence of Ms Sims, which included a contemporaneous feedback report dated 2 July 2020, was admitted by the panel as disputed hearsay evidence.

When determining what weight to attach to Ms Sims's evidence, the panel took into account:

- Ms Sims's evidence was sole and decisive in relation to this sub-charge
- Ms Sims's evidence was not sworn
- Ms Sims did not produce a witness statement
- You have been unable to test Ms Sims's evidence by cross-examination
- Ms Sims's evidence was contained within the contemporaneous feedback report she completed in her role as your mentor
- The contemporaneous feedback reports were standard routine documents completed as part of Ms Sims's professional role
- There was no evidence that Ms Sims had a motive to fabricate the content of these documents
- There was evidence of teaching, learning and signposting to assist you in the feedback

Having balanced the above factors, the panel determined that the contemporaneous and professional nature of the documents was such that it could attach considerable weight to Ms Sims's hearsay evidence.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's written contemporaneous feedback report of 2 July 2020 she stated that on multiple occasions you required correcting by your mentor with regards to the priority order of nursing tasks required of you. Your mentor notes the requirement to reprioritise to ensure patient safety.

You did not provide evidence specific to this sub-charge or an alternative version of events. The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Shelley Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process and did not amount to undue surveillance or monitoring. Furthermore, there was no evidence that Ms Sims had worked with others to fabricate evidence that did not exist.

Ms Sims's contemporaneous feedback was written in the course of her professional duty as your mentor. The panel therefore attached considerable weight to the contemporaneous feedback report and found Ms Sims's notes to be reliable, and preferred this to your evidence.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

A23

23	8/11/2022	Failed to demonstrate an understanding of the procedures required for patient falls/safe moving and handling of patients on the floor

The panel found the facts alleged at sub-charge A23 proved.

The panel had regard to the oral and documentary evidence of Mr Mankee, which included his witness statement and a written contemporaneous feedback report dated 8 November 2022, as well as UHBW's patient falls prevention policy, which establishes your duty in regards to this sub-charge. The panel also had regard to your oral and documentary evidence.

Mr Mankee confirmed in his evidence in chief that the contents of the written contemporaneous feedback report had not been misrepresented and that it was a true, honest and professional assessment of the shift that he worked with you. He also described for the panel the correct procedure you should have followed in this circumstance, and stated that you had not done so.

In cross-examination, in relation to sub-charge A23, it was put to Mr Mankee that you did in fact complete the appropriate observations, knew what was required and acted accordingly. Mr Mankee disagreed with this. It was put to Mr Mankee that he had worked one shift with you and had only observed a snapshot of your practice. You maintained through your counsel that you were competent, and that your response demonstrated an understanding of the falls protocol. This was refuted by Mr Mankee who indicated multiple other actions that you failed to take on the day, and particularly prior to safely moving the patient.

It was further put to Mr Mankee that there was racial bias influencing the way you were treated. Mr Mankee refuted this.

You did not provide evidence specific to this sub-charge or an alternative version of events. The panel noted that your reflection closest to the event dated 8 November 2022 went some way to agree with Mr Mankee's version of events: *'I have reflected on this and*

I should have stayed with the patient to continue to monitor her while the HCA go and get or look for the hoist'.

The panel considered Mr Mankee to be a reliable witness. Despite there being some differences between the witness evidence and your version of events, the panel had regard to the written contemporaneous supervision report dated 8 November 2022. The panel preferred this contemporaneous record of Mr Mankee outlining in detail the events on shift, which was consistent with his oral evidence. The panel did not accept your explanation noting the inconsistencies with your oral evidence to the panel compared to your written reflections closer to the time of the event.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Mr Mankee and found this sub-charge proved.

A25

25	On 23/11/2022 or 24/11/2022	Had to be prompted twice to carry out neuro observations on a post fall patient

The panel found the facts alleged at sub-charge A25 proved.

The panel had regard to the oral and documentary evidence of Ms Elvy, which included her witness statement and a contemporaneous feedback report from shift dated 24 November 2022. The panel also had regard to your oral and documentary evidence.

The panel took into account Ms Elvy's written statement:

> *'As stated further in my feedback dated 24 November 2022 I had to remind Lydia twice to carry out neurological observations on a patient who had a fall on the morning of 23 November 2022.'*

In oral evidence, Ms Elvy confirmed that you needed to be prompted to carry out neuro observations on a post-fall patient.

In cross examination, it was put to Ms Elvy that you did in fact complete the neuro observations. Ms Elvy refuted this and confirmed her evidence.

This sub-charge was not explicitly addressed by you in your evidence.

The panel took into account the notes from the meeting with Ms Morris dated 25 November 2022, and noted that your response to discussing concerns with responding to falls is that you have reflected on this, but no further information has been offered. In your cross-examination, when discussing Ms Elvy, you acknowledged she had given you positive feedback at times, however then asserted that she became part of '*the system'* and was writing about you with the aim of getting rid of you.

As above, the panel determined Ms Elvy to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Elvy's evidence and determined it to be consistent and cogent throughout and noted that it was also consistent with the evidence contained within the contemporaneous feedback report dated 24 November 2022. The panel determined that Ms Elvy's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel assessed your assertions about the reliability of Ms Elvy, and was of the view that they were not logical nor consistent.

Accordingly, the panel accepted the evidence of Ms Elvy and found this sub-charge proved.

A26

26	30/1/2023	Required prompting throughout the shift, to carry out patient observations

The panel found the facts alleged at sub-charge A26 proved.

The panel had regard to the oral and documentary evidence of Ms Williams, which included her witness statement and contemporaneous feedback report attached to an email to Ms Morris dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

The panel considered Ms Williams's written statement and that it supports the content of the contemporaneous feedback report dated 30 January 2023. It was confirmed in Ms Williams's oral evidence that you required prompting to carry out patient observations throughout the shift in question.

In cross-examination, in relation to sub-charge A26, it was put to Ms Williams that you were confident in your ability to take observations and that Ms Williams was wrong. Ms Williams refuted this. [PRIVATE]. Ms Williams maintained that her supervision was supportive of your learning, and that any intervention was to prevent patient harm.

This sub-charge was not explicitly addressed by you in your evidence.

The panel considered Ms Williams to be a reliable witness. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Williams's evidence and determined it to be consistent and cogent. In contrast, the panel heard very little from you in relation to this

concern, but noted the conflicting positions put forward by your original counsel. The panel preferred the evidence of Ms Williams.

Accordingly, the panel found this sub-charge proved.

Charge 2

> *'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:*
>
> *2) Medication administration as set out on one or more occasions in Schedule B'*

The panel had regard to the wording of this head of charge that requires it to be proved if one or more sub-charges in Schedule B is made out. It noted your admission to B3, B24, B26, B32 and B33 and accordingly found this charge proved by your admission. For completion, the panel considered the evidence supporting the other sub-charges in Schedule B and made the following findings.

B1

1	9/11/2019	Intended to attach an IV line containing air bubbles to a patient's central line

The panel found the facts alleged at sub-charge B1 proved.

The panel had regard to Ms Pogorzelska's written statement, which provided clarity on the contemporaneous feedback report dated 9 November 2019: *'When discussed, Lydia was aware of the risk from attaching an IV line containing air bubbles to a patient, that it can be life threatening due to the risk of embolism. I had to reiterate this to Lydia because she told me:* "If I were on my own, I would connect this to the patient".*'*

In her oral evidence, Ms Pogorzelska confirmed that the level of risk of introducing air into the IV of a patient could be fatal.

The panel also had regard to your employer’s initial investigation interview dated 12 and 19 December 2019, where this particular sub-charge was of such concern that it was discussed in great detail. In Ms Burgess’s written statement, she outlined your response to the incident and reiterated that such actions could result in extreme patient harm and you did not demonstrate an understanding of your intended actions at that time.

The panel noted your responses to your employer’s initial investigation of 12 and 19 December 2019 when discussing this specific incident on 9 November 2019. Initially you stated there was one tiny bubble, indicated the approximate size, and recognised that air bubbles of that size can cause embolisms. However, you stated in your professional judgement that that bubble at that time would not have had an adverse consequence.

In cross-examination, it was put to Ms Pogorzelska that she had worked one shift with you and had only observed a snapshot of your practice. You maintained through your counsel that you were competent and that there was a tiny bubble on the edge that would have been safe to connect the IV. It was put to Ms Pogorzelska that her recollection was incorrect or exaggerated. This was refuted by Ms Pogorzelska who confirmed that her concern was such that she had to include this feedback as she was very worried.

In oral evidence you stated that no air bubbles were present as claimed. You asserted that Ms Pogorzelska was lying, and that this was all part of a plan to get rid of you. At a later stage in evidence you indicated that a 3mm bubble was not significant, and failed to address whether this would pose a risk to a patient. You acknowledged that if you witnessed another nurse who could potentially connect a line with a bubble, you would not leave them alone.

You said that Ms Pogorzelska’s statement was written behind your back. You also said ‘*it is a racist attack on me a bubble in the line’.*

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel also determined that Ms Burgess's evidence supported Ms Pogorzelska's.

The panel determined that your evidence was inconsistent throughout as to whether there was an air bubble in the line, and also to the risk that this posed. The panel also considered your assertion that '*this charge was a racist attack'*. The panel noted it has before it general evidence from you concerning racism at this Trust. The panel could find no evidence to support any assertion by you that this allegation was motivated by racism, or that it was part of a conspiracy by others to 'get rid of you'. Therefore, the panel did not find this assertion to be credible. The panel accepted the evidence of Ms Pogorzelska and Ms Burgess, and rejected your evidence.

Accordingly, the panel found this sub-charge proved.

B2

2	9/11/2019	Failed to do a correct calculation of Terlipressin dose

The panel found the facts alleged at sub-charge B2 proved.

The panel took into account the supernumerary pack for GICU. It noted that being able to correctly administer Terlipressin is identified as a competency of working on GICU. The panel bore in mind that the supernumerary pack is implemented to ensure patient safety and a consistent evidence-based standard. The panel was satisfied on this basis that you had a duty to correctly calculate doses of Terlipressin.

The panel had regard to Ms Pogorzelska's witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. In particular, the panel noted in the interview notes Ms Pogorzelska stated that you *'could not make a calculation of how much [Terlipressin] this patient needed'.* Ms Pogorzelska's statement clarified that *'If [an] incorrect dose of Terlipressin is administered it can cause serious harm to [the] patient'.* In oral evidence Ms Pogorzelska confirmed her contemporaneous feedback report that you failed to correctly calculate a dose of Terlipressin. Ms Pogorzelska also gave information to the panel of the formula contained within the 'correct universal calculation' that nurses are required to use to calculate correct medication doses.

In cross-examination, it was put to Ms Pogorzelska that you were confident you were able to calculate the correct dosage of Terlipressin and that Ms Pogorzelska's recording was inaccurate on this matter and that she misremembered or mis-recorded the discussions around calculating the dosage. Ms Pogorzelska refuted this.

In oral evidence you stated that you understood the importance of getting a drug dosage right, that you did not make an error on that day, and that you have never calculated a drug dosage incorrectly. As per sub-charge A2, you again claimed that you were competent and indicated that you had never seen Ms Pogorzelska's feedback. You were asked in cross-examination: '*Does it mean that the contents of this document are untrue because you haven't seen it?'* and responded *'It is untrue - they were writing stuff behind my back'.*

The panel considered Ms Pogorzelska to be a credible and reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined there was no reason to disbelieve her evidence, and no obvious motive to misrepresent the facts.

The panel noted that your response to this sub-charge was one of denial, and that you are competent in calculating drug dosage. The panel does not accept that you did correctly calculate the dose of Terlipressin on this occasion given the clear and consistent evidence of Ms Pogorzelska. The panel was therefore satisfied that Ms Pogorzelska's evidence was more persuasive and consistent with the contemporaneous report and across time.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

B4

4	9/11/2019	Failed to demonstrate understanding on the administration of Noradrenaline

The panel found the facts alleged at sub-charge B4 proved.

The panel took into account the supernumerary pack for GICU, as well as the Trust's medication policies. It noted that being able to correctly administer Noradrenaline is identified as a competency of working on GICU. The panel bore in mind that the supernumerary pack is implemented to ensure patient safety and a consistent evidence-based standard. The panel was satisfied on this basis that you had a duty to understand how to administer Noradrenaline.

The panel had regard to Ms Pogorzelska's oral and documentary evidence including her witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. In particular, the panel noted in the supervision report Ms Pogorzelska stated *'…Lydia knew what group Noradrenaline belongs to (we didn't get a chance to discuss any further), but Lydia stated that she doesn't know "when to increase or decrease, by how much" (lack of understanding how Noradrenaline works)'.* Ms Pogorzelska's statement expressed the seriousness of this failure for the patient and indicated there was a standard operating procedure (SOP) available for nurses on the unit in which this is explained. Ms Pogorzelska's local

investigation interview further explained that Noradrenaline would be used on every shift, and that you would have been directed to the SOP.

In cross-examination, it was put to Ms Pogorzelska that you did understand what Noradrenaline was for and how it was used, but that you had not been shown the plan or where to access the Noradrenaline plan specific to this patient. Ms Pogorzelska did not accept this, and stated that you would have received this information verbally in handover, and would have had access to this information in the bed space in a written form. Furthermore, Ms Pogorzelska stated if they are a nurse they know *'…how the Noradrenaline works and when to increase or decrease. They would be able to apply this knowledge for a specific patient'.*

In oral evidence you stated that you knew what Noradrenaline was, and that you did not know how to access the inotrope patient prescription due to a lack of consistent mentoring. You indicated that, if someone had been responsible for you, they would have shown you where to find the patient prescription on the system: *'ICU professionals needed to show me patient MAP on their system and they failed to do that'.*

The panel considered Ms Pogorzelska to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska was credible, and there was no reason to disbelieve her evidence, and no obvious motive to misrepresent the facts.

The panel noted that your responses to this sub-charge, and the panel considered that you could not demonstrate an understanding of how to administer Noradrenaline on this occasion given the clear and consistent evidence of Ms Pogorzelska. The panel did not accept your explanation that your lack of understanding was the fault of your mentors. The panel determined that an understanding of how to administer Noradrenaline, or how to find that information, is a fundamental aspect of nursing, and noted that you had been on the unit for approximately six weeks at the time of the sub-charge. The panel was therefore

satisfied that Ms Pogorzelska's evidence was more persuasive and consistent with the contemporaneous record.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

B5

9/11/2019	Demonstrated a lack of awareness of required medication checks at start of shift

The panel found the facts alleged at sub-charge B5 proved.

The panel took into account the following from Ms Pogorzelska's contemporaneous feedback report dated 9 November 2019: *'Checking meds, infusion, etc. – Lidia[sic] didn't know what she supposed [sic] to be checking'.* This was confirmed in her written statement, local investigation interview of 19 December 2019, and she was consistent in her oral evidence.

In cross-examination, it was put to Ms Pogorzelska that you were familiar with the required medication checks and that Ms Pogorzelska was wrong about this matter. Ms Pogorzelska refuted this, and expressed clear recall of this incident.

This sub-charge was not explicitly addressed by you in your evidence in chief.

The panel considered Ms Pogorzelska to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska was credible, and there was no reason to disbelieve her evidence, and no obvious motive to misrepresent the facts. The panel was therefore satisfied that Ms Pogorzelska's evidence was more persuasive and consistent with the contemporaneous record.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

B6

6	9/6/2020	Had to be prompted on one or more occasions to check patient details and/or allergies before administering medication

The panel found the facts alleged at sub-charge B6 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel noted that objective five for this placement required you to *'complete at least ten patient drug rounds under minimal supervision to demonstrate that you can perform this safely and in a timely manner'.*

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 9 June 2020 in which she stated that you *'needed reminding to check patients[sic] details and allergies before giving the medications to patients. I have shown Lydia, how to use drug finder[sic] and how to access Medusa.'*

In your documentary evidence you provided written feedback from a supervised medication round record by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence. When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career'*. However, you also stated that Ms Kidner was telling you that you were doing well.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B7

7	13/6/2020	Required prompting on one or more occasions to check patient identification against their drug chart and allergy status

The panel found the facts alleged at sub-charge B7 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 13 June 2020 in which she stated that you *'Lydia needed to be reminded to check patient identification against the patient's drug chart and their allergy status at times'.* The panel also had regard to the appendix to the local investigation report by Shelley Thomas (undated), which reports Ms Kidner's evidence of your inconsistent practice in respect of checking patient identification against their drug chart and allergy status. The panel also had regard to your oral and documentary evidence.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In cross-examination, you acknowledged being reminded about adhering to standard drug administration procedures but stated that your errors were due to being under stress and not being supported on the ward. You also stated that you were '*being judged'* and unjustly monitored.

In response to panel questions, you confirmed that checking patient identification against a drug chart is a core nursing skill. You said that the incident alleged had been taken out of context, and referenced again being monitored.

The panel had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her unjustly monitoring you.

The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision.

The panel also note that, in your oral evidence, you acknowledged having made errors, that you state were due to stress and not being supported.

Therefore, the panel note your acknowledged errors for this sub-charge, and accepted the contemporaneous evidence of Ms Kidner.

Accordingly, the panel found this sub-charge proved.

B8

8	13/6/2020	Had to be reminded on one or more occasions to check patient observations before administering anti-hypertensive medication

The panel found the facts alleged at sub-charge B8 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner’s evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 13 June 2020 in which she stated that you *'There were also a couple of occasions she needed to be reminded to check patient observations before administering antihypertensives.'* The panel also had regard to the appendix to the local investigation report by Ms Thomas (undated), which reports Ms Kidner's evidence of your inconsistent practice in respect of checking patient observations before administering antihypertensives: *'reminders re patient identification and allergies check and observations pre anti-hypertensives'*. The panel also had regard to your oral and documentary evidence.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In cross-examination, you maintained you checked patient observations before administering medications, that this sub-charge was not true and Ms Kidner was lying. When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'. However, you also stated that Ms Kidner was telling you that you were doing well, and your own evidence comprises documentary evidence from Ms Kidner from another date attesting to a medicine round without mistakes.

The panel had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well

as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation and preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B9

9	13/6/2020	Approached a patient with the medication prescribed for a different patient

The panel found the facts alleged at sub-charge B9 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 9 June 2020 in which she stated that you *'Lydia went to the wrong patient with another patient's medications, as Lydia asked the patient to confirm their name and date of birth I intervened and told her she was at the wrong patient.'*

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

You did not explicitly address this sub-charge in your evidence. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 - B8.

The panel took note of the specific wording of the sub-charge that you '*approached a patient'*, and considered the evidence from Ms Kidner that this did happen. The panel accepted the evidence of Ms Kidner, however, the panel determined that on this occasion your supervisor could have in fact intervened prematurely, denying you the opportunity to finish the appropriate checks and respond accordingly.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B10

10	15/6/2020	Required reminding to administer medication to one, or more, patient

The panel found the facts alleged at sub-charge B10 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her witness statement and a contemporaneous feedback report from shift dated 15 June 2020 in which she stated that *'During the drug round Lydia needed to be reminded of a number of medications due, which she missed from the drug chart'.* The panel also had regard to the appendix to the local investigation report by Ms Thomas (undated), which reports Ms Kidner's evidence of missed medications. The panel also had regard to your oral and documentary evidence.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In cross-examination, this was not addressed explicitly. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

The panel had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her unjustly monitoring you nor could the panel see evidence of any conspiracy. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

The panel determined that one successful supervised medication round on a different date does not indicate consistent and safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B11

11	17/6/2020	Did not check prescription charts in a logical/methodical manner

The panel found the facts alleged at sub-charge B11 not proved.

The panel was mindful that the evidence of Ms Sims, which included a contemporaneous feedback report and a write up of a supervised medication round record both dated 17 June 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's written contemporaneous feedback report it was confirmed that *'Lydia does show she is able to check individual prescriptions in a methodical way'* and only comments on this being a lengthy process. Within the supervised medication round record, Ms Sims when responding to the statement of '*did the staff member check the prescription chart in a logical/methodical manner?'* stated 'N' for no, but also comments *'the drug round was mostly done in methodical[sic] manner'.*

You did not provide evidence specific to this sub-charge or an alternative version of events.

The panel considered the contemporaneous records of Ms Sims and determined them to be inconsistent in relation to this sub-charge. Therefore, on the balance of probabilities, the panel was not satisfied the NMC had discharged its burden of proof.

Accordingly, the panel found this sub-charge not proved.

B12

12	17/6/2020	Had to be prompted to administer medication to 2 patients

The panel found the facts alleged at sub-charge B12 not proved.

The panel was mindful that the evidence of Ms Sims, which included a contemporaneous feedback report and a write up of the supervised medication round record both dated 17 June 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at sub-charge A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above. The panel also had regard to your oral and documentary evidence.

The panel considered the contemporaneous records of Ms Sims, which indicated a clear requirement for prompting in relation to only one patient. Moreover, the contemporaneous records do not indicate this occurred for two patients.

On 18 August 2025 the panel sought submissions from the parties regarding a proposed amendment to this sub-charge so that it refers to only one patient, as this would best reflect the evidence. For the reasons stated above, the panel determined not to amend this sub-charge. Therefore, the panel found that there was no evidence that you had to be prompted to administer medication to two patients on 17 June 2020.

Accordingly, the panel found this sub-charge not proved.

B13

13	17/6/2020	Failed to demonstrate an understanding of the process for ambiguous medicine charts

The panel found the facts alleged at sub-charge B13 proved.

The panel bore in mind that the ability to understand the process for ambiguous medicine charts is part of the safe administration of medicines, and this is included in the responsibilities of a registered nurse. The panel also took into account the template for the supervised medication round record, and the cardiac ward day to day guide, and noted that both identify understanding the process for ambiguous medicine charts as a clear area of assessment and required knowledge. The panel note your professional duty to complete this process correctly.

The panel was mindful that the evidence of Ms Sims, which included a supervised medication round record dated 17 June 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's write up of the supervised medication round record it was confirmed that *'There was one prescription which did not have a route written. Lydia was asked whether we should give or not'* Ms Sims had to then explain the correct procedure you ought to have followed.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

You did not provide evidence specific to this sub-charge or an alternative version of events, but agreed that safe administration of medicines is a fundamental nursing skill.

Your general assertions regarding the motivation and reliability of Ms Sims have been noted above in sub-charge A21.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process and did not amount to unnecessary surveillance or monitoring. Furthermore, there was no evidence that Ms Sims had worked with others to fabricate evidence that did not exist. As per its findings at A21 in relation to your allegations of racial bias and institutional racism, the panel found no evidential basis for this at the material time for this charge.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported. However, in oral evidence you did not elaborate on this further or indicate any relevance to this particular sub-charge.

Ms Sims's contemporaneous notes were written in the course of her professional duty as your mentor. The panel therefore attached considerable weight to the contemporaneous records and found Ms Sims's notes to be reliable.

The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

B14

14	19/6/2020	Was unable to effectively explain to patients the purpose of medication and associated risks

The panel found the facts alleged at sub-charge B14 not proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her contemporaneous feedback report from shift dated 19 June 2020 in which she stated that you *'cannot confidently explain the purpose of each medication to patients and associated risks'.* This was confirmed in Ms Kidner's witness statement: '*Lydia was not confident in explaining the purpose of the medications and associated risks to each patient'.*

The panel also had regard to your oral and documentary evidence.

In written submissions, you produced an example of a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

In cross-examination, this was not addressed explicitly. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

The panel bore in mind the wording of the sub-charge, and that it focusses on whether you can explain the purpose of medication and associated risks 'effectively', while the evidence it has seen pertains to your 'confidence' in this area. It has seen no evidence pertaining to your effectiveness. The panel did not consider these two terms to be interchangeable, neither did it consider it appropriate to infer a lack of effectiveness.

Accordingly, the panel found this sub-charge not proved.

B15

15	25/6/2020	Had to be prompted on one or more occasions to check drug

		charts in a systematic manner

The panel found the facts alleged at sub-charge B15 proved.

The panel was mindful that the evidence of Ms Sims, which included a supervised medication round record and a contemporaneous feedback report, both dated 25 June 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above.

The panel had regard to the supervised medication round record dated 25 June 2020: *'This is still not consistent. A couple of times I needed to remind Lydia to work through the drug chart in a systematic way'.* This was confirmed in Ms Sims's contemporaneous feedback report from 25 June 2020 where she wrote *'I did need to challenge on a couple of occasions why she was skipping ahead to the next prescription without completing the previous'.*

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

You did not provide evidence specific to this sub-charge or an alternative version of events. Your general assertions regarding the motivation and reliability of Ms Sims have been noted above in sub-charge A21.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process and did not amount to unnecessary surveillance or monitoring. Furthermore, there was no evidence that Ms Sims had worked with others to fabricate evidence that did not exist. As per its findings at A21 in relation to your allegations of racial bias and institutional racism, the panel found no evidential basis for this at the material time for this charge.

Accordingly, the panel attached considerable weight to the contemporaneous record and found Ms Sims's evidence to be reliable and accepted it. The panel found this sub-charge proved.

B16

16	25/6/2020	Had to be prompted to recheck the stop date for an oral antibiotic

The panel found the facts alleged at sub-charge B16 proved.

The panel was mindful that the evidence of Ms Sims, which included a supervised medication round record dated 25 June 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above.

The panel had regard to the supervised medication round record dated 25 June 2020: *'I needed to prompt Lydia to recheck the stop date for an oral antibiotic'.*

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward

You did not provide evidence specific to this sub-charge or an alternative version of events. Your general assertions regarding the motivation and reliability of Ms Sims have been noted above in sub-charge A21.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process and did not amount to unnecessary surveillance or monitoring. Furthermore, there was no evidence that Ms Sims had worked with others to fabricate evidence that did not exist. As per its findings at A21 in relation to your allegations of racial bias and institutional racism, the panel found no evidential basis for this at the material time for this charge.

Accordingly, the panel attached considerable weight to the contemporaneous record and found Ms Sims's evidence to be reliable and accepted it. The panel found this sub-charge proved.

B17

17	26/6/2020	Missed the administration of newly prescribed medication

The panel found the facts alleged at sub-charge B17 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her contemporaneous feedback report from shift dated 26 June 2020 in which she stated that *'at the lunchtime medication round she missed newly started medications that had been prescribed… when I asked her why she has not administered the medicine prescribed. She is unable to provide an answer as to why'.* This was confirmed in Ms Kidner's witness statement: *'Lydia completed the lunch and evening medications rounds, during which she missed medication'.* The panel also had regard to the appendix to the local investigation report by Ms Thomas (undated), which reports '*several missed medicines – unable to explain why missed'* in her chronology of Ms Kidner's feedback.

The panel also had regard to your oral and documentary evidence.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

In cross-examination, this sub-charge was not addressed explicitly. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing

progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. The panel attached considerable weight to the contemporaneous record and found Ms Kidner's evidence to be reliable. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel found this sub-charge proved.

B18

18	26/6/2020	Administered the wrong dosage of amitriptyline

The panel found the facts alleged at sub-charge B18 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her contemporaneous feedback report from shift dated 26 June 2020 in which she stated that you *'on the evening drug round she gave a patient half the dose of prescribed amitriptyline'.*

The panel also had regard to your oral and documentary evidence.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

In cross-examination, this sub-charge was not addressed explicitly. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B19

19	29/6/2020	Used Wikipedia to source information on unfamiliar medications

The panel found the facts alleged at sub-charge B19 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her supervised medication round record from shift dated 29 June 2020, in which she stated that:

> '*Lydia was able to identify she would use the BNF [British National Formulary], if she was unfamiliar with a medication. However, when faced with an unfamiliar medication Lydia googled the medication and used Wikipedia to source the information. I informed Lydia Wikipedia is not a reliable source. When faced with the same situation she again used Wikipedia'.*

This version of events was confirmed in the contemporaneous feedback report from shift of 29 June 2020 and also in Ms Kidner's witness statement:

> '*During the medication round, Lydia informed me she could refer to the BNF to source information on any medication she was unsure of however I witnesses[sic] Lydia using Wikipedia which is not a reliable or approved source of information.'*

The panel also had regard to the appendix to the local investigation report by Ms Thomas (undated), which reports that on 10 June 2020, 15 June 2020 and 25 June 2020 you were

‘*shown, directed and prompted to use the BNF app for medications’* in her summary of the ward’s feedback.

The panel also had regard to your oral and documentary evidence.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

During your oral evidence in response to panel questions you stated you never used Wikipedia for checking. You told the panel you ‘*had BNF on your phone and always used BNF or Medusa for IV’*. You also reasserted your claims that colleagues were writing about you without your knowledge.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her writing about you or gossiping behind your back.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round record on a different date does not indicate consistent safe practice in this area. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner, which was supported by evidence of the ward’s

feedback, identifying you requiring ongoing prompts to use the BNF app. The panel attached considerable weight to the contemporaneous record and found Ms Kidner's evidence to be reliable and preferred it to your explanation.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

B20

20	29/6/2020	Missed the administration of 2 medications

The panel found the facts alleged at sub-charge B20 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons given by the panel at sub-charges A18, A19 and A20, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel had regard to the documentary evidence of Ms Kidner, which included her contemporaneous feedback report dated 29 June 2020, in which she stated that:

> '*During the drug round 2 medications were missed from patient's drug charts and Lydia need to be informed to administer the medication.'*

This was confirmed in Ms Kidner's witness statement:

> '*Lydia also missed medications'*

The panel also had regard to your oral and documentary evidence.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported. Your general assertions regarding the motivation and reliability of Ms Kidner have been noted above in sub-charges B6 – B9.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

Accordingly, the panel accepted Ms Kidner's evidence and found this sub-charge proved.

B21

21	2/7/2020	Failed to demonstrate the correct process for incomplete/ambiguous prescriptions

The panel found the facts alleged at sub-charge B21 proved.

The panel bore in mind that the ability to understand the process for ambiguous medicine charts is part of the safe administration of medicines, and this is included in the

responsibilities of a registered nurse. The panel also took into account the template for the supervised medication round record, and the cardiac ward day to day guide, and noted that both identify understanding the process for ambiguous medicine charts as a clear area of assessment and required knowledge. The panel note your professional duty to complete this process correctly.

The panel was mindful that the evidence of Ms Sims, which included a supervised medication round record dated 2 July 2020, was admitted by the panel as disputed hearsay evidence.

In determining this sub-charge, the panel had regard to its previous decision on the reliability of Ms Sims's evidence at A21. The panel determined that the contemporaneous and professional nature of Ms Sims's evidence was such that it could attach considerable weight to Ms Sims's hearsay evidence, for the same reasons as outlined above.

The panel had regard to the supervised medication round record dated 2 July 2020. This feedback identified in great detail two drugs where you failed to identify incomplete/ambiguous prescriptions and the correct process for remedy. This is supported within the contemporaneous feedback report for this shift.

The panel noted your reflective accounts from June 2020, where you explicitly identify receiving feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result whilst on this ward.

In written submissions, you produced a supervised medication round record from 6 June 2020 by Ms Kidner in which no errors appear to be reported.

You did not provide evidence specific to this sub-charge or an alternative version of events. Your general assertions regarding the motivation and reliability of Ms Sims have been noted above in sub-charge A21.

In cross-examination you did not address this sub-charge explicitly, but agreed that safe administration of medicines is a fundamental nursing skill.

Ms Sims's contemporaneous feedback report was written in the course of her professional duty as your mentor. The panel therefore attached considerable weight to the contemporaneous records and found Ms Sims's notes to be reliable. As per its findings at A21 in relation to your allegations of racial bias and institutional racism, the panel found no evidential basis for this at the material time for this charge.

The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel accepted the evidence of Ms Sims.

Accordingly, the panel found this sub-charge proved.

B22

22	8/11/2022	Administered medication with associated risks, on one or more occasions, without first checking the observations.

The panel found the facts alleged at sub-charge B22 proved.

The panel had regard to the oral and documentary evidence of Mr Mankee, which included his witness statement and a contemporaneous feedback report dated 8 November 2022: '*Drugs with associated risks (beta blockers etcetera) without checking observations prior to administration on more than one occasion.'* The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one. The panel also had regard to your oral and documentary evidence.

Mr Mankee confirmed in his evidence in chief that the contents of the contemporaneous feedback report had not been misrepresented and that it was a true, honest and professional assessment of the shift that he worked with you.

In cross-examination, it was put to Mr Mankee that you did in fact complete the appropriate observations prior to administering medications, and that Mr Mankee was wrong. Mr Mankee disagreed with this. It was further put to Mr Mankee that due to 'dipping in and out', and the level of supervision he provided there were times he would not have had oversight of you. He refuted this, and stated that he would not have been away long enough for you to log on to the system and for observations to be done. It was further put to Mr Mankee that he had misremembered this incident. Mr Mankee again refuted this. Finally, it was put to Mr Mankee that he had worked one shift with you and only observed a snapshot of your practice. Mr Mankee stated that the shift was 12 and a half hours long.

This sub-charge was not explicitly addressed by you in your evidence in chief, nor in your written reflection of the shift in question.

In cross-examination, you said Mr Mankee was 'part of it' and *'they were happy for [you] to be portrayed as a bad nurse'.* You then reasserted you were the subject of a wider conspiracy across the numerous Trusts and units/wards.

The panel considered Mr Mankee to be a reliable witness. Despite there being a dispute between the witness evidence and your version of events, the panel had regard to the contemporaneous feedback report dated 8 November 2022. The panel preferred this contemporaneous record of Mr Mankee outlining in detail the events on shift, which was consistent with his oral evidence. The panel also did not accept your general assertion that there was a plan to get rid of you and destroy your career and note the evidence before it that your conditions of practice required you to be robustly assessed on medicines management and administration.

Accordingly, the panel accepted the evidence of Mr Mankee and found this sub-charge proved.

B23

23	8/11/2022	Failed to administer medication at the time prescribed on the drugs chart

The panel found the facts alleged at sub-charge B23 proved.

The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Mr Mankee, including his contemporaneous feedback report dated 8 November 2022 in which Mr Mankee noted: '*Further concerns over safety were raised by the time taken to complete the drug round I supervised as drugs were being given multiple hours later than prescribed on the drug chart.'* The panel also had regard to your oral and documentary evidence.

Mr Mankee confirmed in his evidence in chief that the contents of the contemporaneous feedback report had not been misrepresented and that it was a true, honest and professional assessment of the shift that he worked with you. He also described for the panel the consequences to patient safety where there are delays in a medication round for this specific group of patients and the subsequent effect to future medication administration. Mr Mankee also reinforced that administering medication in a timely manner is within the skillset of a registered nurse and explicitly expressed the importance of a nurse 'protecting your drug round' from other distractions.

In cross-examination, it was put to Mr Mankee that you did in fact administer the medication at the appropriate times, and that there was no delay. Mr Mankee disagreed

with this. It was also put to Mr Mankee that he ought to have intervened if he felt there was a risk to patients. Mr Mankee said that he checked ahead for the medicines to assess any immediate risk to patients. It was then put to Mr Mankee that he was exaggerating or misremembering in his oral evidence compared to his feedback. Mr Mankee refuted this. Mr Mankee was asked why these concerns were not verbally reported to you immediately at the time. Mr Mankee indicated that introducing an extra topic to you was not going to help. He further stated that other tasks appeared to take your priority.

The panel had regard to your reflection on the shift of 8 November 2022, and whilst you provide details that you undertook three supervised drug rounds on that day, you do not comment on timeliness or any delays.

In cross-examination, you said you were not unsafe with medication and advised the panel ‘I work slowly with a desire to take care and be safe’. You then reasserted you were the subject of a wider conspiracy across the numerous Trusts and units/wards.

In response to panel questions you stated ‘*I don’t time myself I make sure medications are given at the right time. I prioritise medication’.*

The panel considered Mr Mankee to be a reliable witness. Despite there being a dispute between the witness evidence and your version of events, the panel had regard to the contemporaneous supervision report dated 8 November 2022. The panel preferred this contemporaneous record of Mr Mankee outlining in detail the events on shift, which was consistent with his oral evidence. The panel also did not accept your general assertion that there was a plan to get rid of you and destroy your career and note the evidence before it that your conditions of practice required you to be robustly assessed on medicines management and administration.

Accordingly, the panel accepted the evidence of Mr Mankee and found this sub-charge proved.

B25

25	24/1/2023	Had to be corrected, on one or more occasions, in the dispensing and administration of medication

The panel found the facts alleged at sub-charge B25 proved.

The panel had regard to the oral and documentary evidence of Ms Duncan-McKenzie which included her witness statement and an email date 27 January 2023 sent by Ms Duncan-McKenzie to Ms Morris. The panel noted this email gave a summary of your shift supervised by Ms Duncan-McKenzie on 24 January 2023. The panel had regard to your initial support plan for this ward, and the subsequent supporting performance improvement plan (PIP) signed by you and dated 27 January 2023. The panel also had regard to your oral and documentary evidence.

Ms Duncan-McKenzie described in her witness statement several examples of where you required correcting in the dispensing and administration of medication to prevent medication errors during the shift. The panel noted that one of these incidents included a diabetic patient and issues with the administration of insulin. The panel noted that you were described as being unable to offer a reason for your decision-making regarding various medications. This was directly supported by the feedback contained in the email of 27 January 2023.

The panel noted the PIP dated 27 January 2023 indicated the performance issue concerning ‘having the correct knowledge, skills and ability to safely manage patient medication’ was still identified as an area of competence to be demonstrated by you. The panel also saw notes of a meeting dated 30 January 2023, which was convened to discuss your performance. In this meeting you were explicitly asked about your knowledge of your need to be on a supportive program for administering medication, and that this meant you could not work unsupervised, which you acknowledged, however responded ‘only for medication’.

In oral evidence, Ms Duncan-McKenzie confirmed her expectation of understanding and safety on a medicine round by a newly qualified nurse as achievable within a two-week period.

In cross-examination it was put to Ms Duncan-McKenzie that you were competent in your ability to dispense and administer medication and that Ms Duncan-McKenzie was wrong. This was refuted by Ms Duncan-McKenzie. It was put to Ms Duncan-McKenzie that the tone of her feedback had changed from positive in November 2022 to more negative related to the shift on 24 January 2023. Ms Duncan-McKenzie explicitly commented that your abilities had deteriorated during this time [PRIVATE]. It was put to Ms Duncan-McKenzie that she was making assumptions about you and was wrong about your level of understanding. This was refuted by Ms Duncan-McKenzie. Finally, it was put to Ms Duncan-McKenzie that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Duncan-McKenzie refuted this and stated that she stood by her evidence.

In your oral evidence you stated that Ms Duncan-McKenzie told the panel that you were *'doing everything right'*.

In cross-examination, when asked to explain why Ms Duncan-McKenzie would 'call you out' you said *'[Ms Duncan-McKenzie] had been told to do that'* and that this was due to Ms Morris, who *'started to get Black people on board'*.

The panel considered Ms Duncan-McKenzie to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Duncan-McKenzie's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Duncan-McKenzie's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Duncan-McKenzie outlining in detail the events on shift,

which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Duncan-McKenzie 'on board' in targeting you.

Accordingly, the panel accepted the evidence of Ms Duncan-McKenzie and found this sub-charge proved.

B27

27	28/1/2023	Did not fully read drug charts/prescriptions

The panel found the facts alleged at sub-charge B27 proved.

The panel had regard to the oral and documentary evidence of Erin Trinidad which included her witness statement and an email date 30 January 2023 sent by Ms Trinidad to Ms Morris. The panel noted this email gave a summary of your shift supervised by Ms Trinidad on 28 January 2023. The panel had regard to your initial support plan for this ward, and the subsequent supporting PIP signed by you and dated 27 January 2023. The panel also had regard to your oral and documentary evidence.

Ms Trinidad described your issues reading drug charts in the email of 30 January 2023:

> *'Lydia was unable to read the drug charts properly i.e not reading drug allergies, only looking at the medication name and time circled rather than the whole thing (route, dose, indication and further instructions'.*

Ms Trinidad's contemporaneous record contains reference to her directing and explaining the need for comprehensive review of drug charts to ensure patient safety. She also explicitly identified providing verbal feedback on the day, and noted your response to how the day had gone as '*could have done better with the morning med rounds'*. This is confirmed in Ms Trinidad's witness statement.

In oral evidence, Ms Trinidad confirmed her contemporaneous record and witness statement, and confirmed that you were unable to fully read the drug charts/prescriptions.

In cross-examination it was put to Ms Trinidad that you can read a drug chart properly and that Ms Trinidad was wrong. This was refuted by Ms Trinidad, and she expressed the need for consistency in successfully completing a drug round without errors, and the need to do this with all patients:

> '*doing this for one or two out of nine [patients] is not effectively reading [the drug chart]'*.

It was further put to Ms Trinidad that her verbal feedback on 28 January 2023 was more balanced than that which was written in her email of 30 January 2023, and further that you had not received the written feedback. Ms Trinidad stated that her written feedback was accurate and that she had highlighted her concerns to you verbally, further stating you were no longer new to this ward. It was put to Ms Trinidad that, with further support and training, you could have made changes, and that the concerns with your practice were not insurmountable, to which Ms Trinidad responded:

> *'but for how long? We do not have months and months to support people'.*

Finally it was put to Ms Trinidad that she was either mistaken, had misremembered the events of the shift, or, in the alternative had not been truthful. Ms Trinidad refuted this and stated that she stood by her evidence.

In cross-examination, when asked '*why would [Ms Trinidad], a black nurse be making racist allegations against you. Why would a black nurse do that if you're right?'* you responded that Ms Trinidad '*was telling a lie'*. You also expressed that Ms Trinidad did not provide you with written feedback, and in verbal feedback stated '*you did really, really well today'*.

In cross-examination, when asked to explain why Ms Trinidad would 'call you out' you said*:*

> *'[Ms Trinidad] became part of it because they realised that I have had conversation with [Ms Morris] and I raised racism about what I'm experiencing and throughout*

from ITU and cardiac – it was only one black nurse who was part of the bigger part to destroy my career. And so [Ms Morris] became part of the big managers and then started to get black people on board.'

The panel considered Ms Trinidad to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Trinidad's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Trinidad's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Trinidad outlining in detail the events on shift, which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Trinidad 'on board' in targeting you. The panel also did not accept your general assertion that there was a plan to get rid of you and destroy your career.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Trinidad and found this sub-charge proved.

B28

28	28/1/2023	Failed to administer prescribed inhalers to 3 patients after signing for them in the drugs charts

The panel found the facts alleged at sub-charge B28 proved.

The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Ms Trinidad which included her witness statement and an email date 30 January 2023 sent by Ms Trinidad to Ms Morris. The panel noted this email gave a summary of your shift supervised by Ms Trinidad on 28 January 2023.

The panel also had regard to your oral and documentary evidence.

Ms Trinidad described the incident in the email of 30 January 2023:

> *'Whilst doing the drug rounds, Lydia also failed to give [patients] their prescribed inhalers (3 different patients) despite signing for it in the drug chart.'*

Ms Trinidad's contemporaneous record contains reference to her directing and explaining the importance of giving these inhalers to ensure patient comfort and safety. She also explicitly identified providing verbal feedback on the day, and noted your response to how the day had gone as '*could have done better with the morning med rounds'*. This is confirmed in Ms Trinidad's witness statement.

In oral evidence, Ms Trinidad confirmed her contemporaneous record and witness statement, and advised of the risk of exacerbation of symptoms in patients with asthma and COPD when they do not receive their prescribed inhalers.

In cross-examination it was put to Ms Trinidad that you did administer these inhalers correctly and that Ms Trinidad was wrong. This was refuted by Ms Trinidad:

> '*I had to urge her to look at the drug chart again. I recall she could not remember what she had signed for.'*

It was further put to Ms Trinidad that her verbal feedback on 28 January 2023 was more balanced than that which was written in her email of 30 January 2023, and further that you had not received the written feedback. Ms Trinidad stated that her written feedback was accurate and that she had highlighted her concerns to you verbally, further stating you were no longer new to this ward. It was put to Ms Trinidad that, with further support and training, you could have made changes, and that the concerns with your practice were not insurmountable, to which Ms Trinidad responded:

> *'but for how long? We do not have months and months to support people'.*

Finally it was put to Ms Trinidad that she was either mistaken, had misremembered the events of the shift, or, in the alternative had not been truthful. Ms Trinidad refuted this and stated that she stood by her evidence.

In cross-examination, when asked '*why would [Ms Trinidad], a black nurse be making racist allegations against you. Why would a black nurse do that if you're right?'* you responded that Ms Trinidad '*was telling a lie'*. You also expressed that Ms Trinidad did not provide you with written feedback, and in verbal feedback stated '*you did really, really well today'*.

In cross-examination, when asked to explain why Ms Trinidad would 'call you out' you said*:*

> *'[Ms Trinidad] became part of it because they realised that I have had conversation with [Ms Morris] and I raised racism about what I'm experiencing and throughout from ITU and cardiac – it was only one black nurse who was part of the bigger part to destroy my career. And so [Ms Morris] became part of the big managers and then started to get black people on board.'*

The panel considered Ms Trinidad to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Trinidad's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Trinidad's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Trinidad outlining in detail the events on shift, which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Trinidad 'on board' in targeting you. The panel also did not accept your general assertion that there was a plan to get rid of you and destroy your career.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Trinidad and found this sub-charge proved.

B29

29	28/1/2023	Incorrectly dispensed a dosage of 1.25mg when 2.50mg was to be administered

The panel found the facts alleged at sub-charge B29 proved.

The panel had regard to the oral and documentary evidence of Ms Trinidad which included her witness statement and an email date 30 January 2023 sent by Ms Trinidad to Ms Morris. The panel noted this email gave a summary of your shift supervised by Ms

Trinidad on 28 January 2023. The panel had regard to your initial support plan for this ward, and the subsequent supporting PIP signed by you and dated 27 January 2023. The panel also had regard to your oral and documentary evidence.

Ms Trinidad described the incident in the email of 30 January 2023:

> *'[You] took the right medication from the trolley but dispensed the wrong dose (1.25mg instead of 2.5mg).'*

This is confirmed within Ms Trinidad's witness statement. Further, Ms Trinidad in this statement confirms the relevant medication was bisoprolol which is used to treat high blood pressure and heart failure, which can affect heart rate, and sets out the serious impact of an underdose on a patient.

Ms Trinidad's contemporaneous record explicitly identified providing verbal feedback on the day, and noted your response to how the day had gone as '*could have done better with the morning med rounds'*. This is confirmed in Ms Trinidad's witness statement.

In cross-examination it was put to Ms Trinidad you did give the correct dose and that she was wrong in her recollection of this incident. This was refuted by Ms Trinidad and she stated:

> '*I had recognized that mistake and I have actually at the time asked her to read the drug chart again, but she failed to recognize that even after I've prompted her to look at the drug chart and look at the medication she was holding. She could not recognise that she's only dispensed 1.25 rather than the 2.5 that was due.'*

It was further put to Ms Trinidad that her verbal feedback on 28 January 2023 was more balanced than that which was written in her email of 30 January 2023, and further that you had not received the written feedback. Ms Trinidad stated that her written feedback was accurate and that she had highlighted her concerns to you verbally, further stating you were no longer new to this ward. It was put to Ms Trinidad that, with further support and

training, you could have made changes, and that the concerns with your practice were not insurmountable, to which Ms Trinidad responded:

> *'but for how long? We do not have months and months to support people'.*

Finally it was put to Ms Trinidad that she was either mistaken, had misremembered the events of the shift, or, in the alternative had not been truthful. Ms Trinidad refuted this and stated that she stood by her evidence.

In cross-examination, when asked '*why would [Ms Trinidad], a black nurse be making racist allegations against you. Why would a black nurse do that if you're right?'* you responded that Ms Trinidad '*was telling a lie'*. You also expressed that Ms Trinidad did not provide you with written feedback, and in verbal feedback stated '*you did really, really well today'*.

In cross-examination, when asked to explain why Ms Trinidad would 'call you out' you said*:*

> *'[Ms Trinidad] became part of it because they realised that I have had conversation with [Ms Morris] and I raised racism about what I'm experiencing and throughout from ITU and cardiac – it was only one black nurse who was part of the bigger part to destroy my career. And so [Ms Morris] became part of the big managers and then started to get black people on board.'*

The panel considered Ms Trinidad to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Trinidad's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Trinidad's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Trinidad outlining in detail the events on shift, which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Trinidad 'on board'

in targeting you. The panel also did not accept your general assertion that there was a plan to get rid of you and destroy your career.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to “get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Trinidad and found this sub-charge proved.

B30

30	30/1/2023	Failed to demonstrate an understanding on the preparation of the correct dosage of clexane

The panel noted the original wording of the sub-charge and that there is a typographical error in the spelling of ‘clexane’. The panel determined to amend the sub-charge to provide clarity.

The panel found the facts alleged at sub-charge B30 proved.

The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Joanna Williams, which included her witness statement, and a contemporaneous feedback report attached to an email to Ms Morris and meeting notes both dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Williams's contemporaneous feedback report:

> *'When we had a patient who needed 50mg, Lydia was going to just squeeze a little cleanxe[sic] out of 6omg[sic] injection. I explained this was not safe as we do not know the exact dosage as it is not clear to see. I shown[sic] her a way where she can draw up the measurement, she requires using a syringe and needle, so the dosage and measure is correct and can be easily seen. This took several attempts'*

This was supported in Ms Williams's statement and she further identifies the impact this error could have on a patient:

> *'If the wrong dosage of clexane had been administered to the patient there could have been serious consequences. For example, overdosing could have had an adverse affect[sic] on patient's blood as clexane is a blood thinning medication.'*

Furthermore, in the notes of the meeting of 30 January 2023, which you attended with Ms Williams and other senior nursing staff, Ms Williams said: *'You could not draw up the clexane and dispose of [it] appropriately'.*

In oral evidence, Ms Williams gave further details with regards to exactly how the correct dose of clexane should be prepared and the precision measurement required. Ms Williams indicated you should have known how this was done based on your experience and previous work placement, that this should not have been new to you, and that the method you demonstrated was one that should not be used and that it was 'lazy'. She indicated that your method was inaccurate. This was confirmed in panel questions.

In the notes of the meeting of 30 January 2023, your response to Ms Williams in relation to her feedback is recorded as *'sorry I am not saying I am not agreeing with what you are saying, I always take constructive feedback and learn from the feedback'.*

In cross-examination it was put to Ms Williams that the method Ms Williams indicated she used was one of a gold standard or reflecting her preference, and that other nurses also used your method. Ms Williams refuted this strongly and indicated that any nurse seen using the incorrect method would have been challenged as this was not safe practice.

It was further put to Ms Williams [PRIVATE] that her supervisory role should have included prompts where required. Ms Williams stated this was not correct and it was for her to watch and find gaps in your practice and to support you in those areas. Ms Williams stated her role was to step back and allow things to happen, intervening only if patients were put in danger. This, she asserted, was intended to support you and was in line with your support plan.

In written submissions, you stated:

> *'I **deny** mishandling the medication. I used 50mg from a 60mg syringe carefully and according to common practice. I did not "squirt it everywhere" as alleged — that description is a gross misrepresentation intended to embarrass and discredit me.'*

You reconfirmed in oral evidence that you deny any mishandling of the clexane.

In cross-examination in relation to the motivations of the concerns raised on Gate 9A about your practice, you were asked if these were based on racial bias and your history following you. You responded that Gate 9A became part of the bigger plan to get rid of you. You indicated Ms Williams previously had no concerns with your practice, but that this changed after your employment tribunal.

The panel considered Ms Williams to be a reliable witness. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross

examination. The panel took account of all of Ms Williams's evidence and determined it to be consistent and cogent throughout. The panel note your position in your written submissions whereby you confirm the method you used as common practice. The panel determined that this did not meet the required standard. The panel preferred the evidence of Ms Williams, given your own submissions on this point. The panel did not accept your general assertion that there was a plan to get rid of you and destroy your career.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel found this sub-charge proved.

B31

31	30/1/2023	Did not dispose of unwanted medication in the correct way

The panel found the facts alleged at sub-charge B31 proved.

The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Ms Williams, which included her witness statement, and contemporaneous feedback report attached to an

email to Ms Morris and meeting notes both dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

In Ms Williams's statement she stated that you:

> *'disposed of the medication incorrectly by discarding the unwanted liquid medicine (clexane) into the same plastic tray with other medications which needed to be given to patients and thus contaminating those medications with clexane.'*

Ms Williams's contemporaneous feedback report and witness statement both confirm you were then shown the correct way to dispose of the medication.

Furthermore, in the notes of the meeting of 30 January 2023, which you attended with Ms Williams and other senior nursing staff, Ms Williams said: *'You could not draw up the clexane and dispose of [it] appropriately'.*

In oral evidence, Ms Williams confirmed that the method demonstrated by you of squirting the medication from the syringe was never acceptable for safe disposal and that blue sharp bins should be used. Ms Williams also gave further details with regards to exactly how clexane should be disposed of. Ms Williams indicated you should have known how this was done based on your experience and previous work placement, that this should not have been new to you, and that the method you demonstrated was one that should not be used and that it was 'lazy'. She indicated that your method was inaccurate.

In the notes of the meeting of 30 January 2023, your response to Ms Williams in relation to her feedback is recorded as *'sorry I am not saying I am not agreeing with what you are saying, I always take constructive feedback and learn from the feedback'.*

In cross-examination it was put to Ms Williams that you were going to dispose of the medication correctly. Ms Williams refuted this and confirmed her written feedback and witness statement on this matter.

In cross-examination it was put to Ms Williams [PRIVATE] that her supervisory role should have included prompts where required. Ms Williams stated this was not correct and it was for her to watch and find gaps in your practice and to support you in those areas. Ms Williams stated her role was to step back and allow things to happen, intervening only if patients were put in danger. This, she asserted, was intended to support you and was in line with your PIP.

In written submissions, you stated:

> *'I **deny** mishandling the medication. I used 50mg from a 60mg syringe carefully and according to common practice. I did not "squirt it everywhere" as alleged — that description is a gross misrepresentation intended to embarrass and discredit me.'*

You reconfirmed in oral evidence that you deny disposing of unwanted medication incorrectly.

In cross-examination in relation to the motivations of the concerns raised on Gate 9A about your practice, you were asked if these were based on racial bias and your history following you. You responded that Gate 9A became part of the bigger plan to get rid of you. You indicated Ms Williams previously had no concerns with your practice, but that this changed after your employment tribunal.

In relation to panel questions, you denied you disposed of medication incorrectly and you gave information to the panel that demonstrated knowledge of the correct disposal.

The panel considered Ms Williams to be a reliable witness. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Williams's evidence and determined it to be consistent and cogent throughout. Despite you describing the correct procedure to be applied for the disposal of medications, the panel notes the contemporaneous evidence provided by Ms Williams, which speaks explicitly to your incorrect implementation of that

knowledge on the day. The panel are unaware of any reason why Ms Williams might fabricate her account. The panel preferred the evidence of Ms Williams. The panel did not accept your general assertion that there was a plan to get rid of you and destroy your career.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Williams and found this sub-charge proved.

Charge 3

> *'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:*
>
> *3) Time management as set out on one or more occasions in Schedule C'*

The panel had regard to the wording of this head of charge that requires it to be proved if one or more sub-charges in Schedule C is made out. It noted your admission to C12 and accordingly found this charge proved by your admission. For completion, the panel considered the evidence supporting the other sub-charges in Schedule C and made the following findings.

C1, C3 and C4

The panel had regard to sub-charges C1, C3 and C4 and noted that the evidence in support of each sub-charge comes from the same witness. The panel has considered each sub-charge separately.

The panel had regard to the oral and documentary evidence of Ms Pogorzelska, which included her witness statement, a contemporaneous feedback report from shift dated 9 November 2019, and local investigation interview notes dated 19 December 2019. The panel also had regard to your oral and documentary evidence.

C1

1	9/11/2019	Took around 2 and half hours/too long to perform an incomplete safety check

The panel found the facts alleged at sub-charge C1 proved.

The panel took into account the following from Ms Pogorzelska's local investigation interview notes of 19 December 2019: *'Lydia spent 2.5 hr on performing safety checks I mentioned this earlier'…* This was confirmed in her written statement, contemporaneous feedback report dated 9 November 2019 and she was consistent in her oral evidence.

In your local investigation interviews of the 12 and 19 December 2019, it appears that you acknowledged that safety checks are different from those in recovery and that this may have contributed to you taking a long time. You are recorded as indicating that you were getting used to GICU and trying hard and that you made the unit aware that you were struggling.

In cross-examination, it was put to Ms Pogorzelska that the safety checks took this length of time due to Ms Pogorzelska utilising the time as a teaching opportunity, rather than you being overly slow. Ms Pogorzelska responded teaching was required due to you not performing the task as expected and concluded that if you had the skills, the assessment would be quicker.

This sub-charge was not explicitly addressed by you in your evidence in chief. You said in your statement that when you asked to revisit basic tasks you were accused of delay. You also made general assertions whilst on GICU, that you did not know you were being assessed, were inadequately supported, and that you did not receive any written feedback as you claimed that the written feedback was provided to your manager but not to you.

The panel considered Ms Pogorzelska to be a reliable witness. The panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Pogorzelska outlining in detail the events of the shift, and did not accept your explanation that you were unsupported, did not know you were being assessed, did not receive any written feedback and just needed more time. The panel noted that you were approximately six weeks supernumerary, and had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice learning team.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

C3

3	9/11/2019	Failed to do tasks without being prompted to do so

The panel found the facts alleged at sub-charge C3 proved.

The panel took into account the following from Ms Pogorzelska's written statement:

> *'It is important for a nurse to effectively prioritise tasks because this is a fundamental skill to judge how urgent a task is.'*

The panel was satisfied on this basis that you had a duty to complete tasks in a timely manner and without prompting.

The panel had regard to Ms Pogorzelska's witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. In particular, the panel noted in the supervision report dated 9 November 2019 Ms Pogorzelska stated *'she made no any [sic] task without prompting'.* Ms Pogorzelska's statement confirmed that it is important that a critical care nurse performs their task without prompting in order to be able to practice independently, summarising *'I had to prompt Lydia to do anything'.* Ms Pogorzelska confirmed this in her local investigation interview notes. In oral evidence Ms Pogorzelska confirmed her contemporaneous feedback report that you required ongoing prompting and stated that by the end of week 6 (in GICU) she would have expected a nurse to be independent and able to make decisions about what needs to be done.

In cross-examination, it was put to Ms Pogorzelska that her feedback was wrong on this matter and issues with miscommunication could account for any problems identified. Ms Pogorzelska refuted this stating "I cannot recall any task she performed without me prompting her".

This sub-charge was not explicitly addressed by you in your evidence in chief. In response to panel questions you denied needing prompting on the date in question and when asked why this would have been recorded, you stated that "I believe these things are written to bring me down". You made general assertions whilst on GICU, that you did not know you were being assessed, were inadequately supported, and that you did not receive any written feedback as you claimed that the written feedback was provided to your manager but not to you.

The panel considered Ms Pogorzelska to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel

determined that Ms Pogorzelska was credible, and there was no reason to disbelieve her evidence, and no obvious motive to misrepresent the facts. The panel preferred the evidence of Ms Pogorzelska. The panel did not accept your explanation that you were unsupported, did not know you were being assessed, did not receive any written feedback and just needed more time. The panel noted that you were approximately six weeks supernumerary and had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice learning team.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

C4

4	9/11/2019	Was unable to effectively prioritise tasks

The panel found the facts alleged at sub-charge C4 proved.

The panel had regard to Ms Pogorzelska's witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. In particular, the panel noted in the supervision report dated 9 November 2019 Ms Pogorzelska stated *'prioritising of task was very poor – Lidia[sic] didn't demonstrate that she possess[sic] skills to prioritise tasks'.* Ms Pogorzelska's statement confirmed that *'it is important for a nurse to affectively prioritise tasks because this is a fundamental skill to judge how urgent a task is'.* Ms Pogorzelska confirmed this in her local investigation interview notes. In oral evidence Ms Pogorzelska confirmed her contemporaneous feedback report that you failed to prioritise and stated that by the end of week 6 (in GICU) she would have expected a nurse to be prioritising independently and able to make decisions about the next task required.

In cross-examination, it was put to Ms Pogorzelska that you did prioritise your task load. Ms Pogorzelska stated based on the shift on 9 November 2019, *'I do not accept this'.*

This sub-charge was not explicitly addressed by you in your evidence in chief. You said in your statement that when you asked to revisit basic tasks you were accused of delay. You also made general assertions whilst on GICU, that you did not know you were being assessed, were inadequately supported, and that you did not receive any written feedback as you claimed that the written feedback was provided to your manager but not to you.

The panel considered Ms Pogorzelska to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Pogorzelska's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pogorzelska was credible, and there was no reason to disbelieve her evidence, and no obvious motive to misrepresent the facts. The panel preferred the evidence of Ms Pogorzelska. The panel did not accept your explanation that you were unsupported, did not know you were being assessed, did not receive any written feedback and just needed more time. The panel noted that you were approximately six weeks supernumerary and had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice learning team.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

C8

8	19/11/2019	Took around 1 hour 30 minutes/too long to prepare a handover

The panel found the facts alleged at sub-charge C8 proved.

The panel has approached this sub-charge on the basis that the preparation and delivery of the handover was inextricably linked as a task and that the concern addressed in the sub-charge relates to an excessive period of time being taken.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Ms Russell with

a feedback summary of the shift she supported you on, dated 19 November 2019, a subsequent email sent to Ms Russell following this shift but undated in the bundle, and local investigation interview notes dated 21 January 2020. The panel also had regard to your oral and documentary evidence.

In particular, the panel noted in the local investigation interview dated 21 January 2020, that Ms Pollock when commenting on you undertaking a handover advised that *'she took the best part of 1 hour [and a] half when it should take 30 minutes'.*

In oral evidence Ms Pollock confirmed her local investigation interview notes and reiterated the length of time it took you and further advised that concerning this matter Ms Pollock would not *'sign you off as competent'*. Ms Pollock described the amount of support that was offered to you during your supernumerary period.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, whilst not explicit to this shift, indicates that at the beginning of your time in GICU it appears that you acknowledged you were struggling with giving handover.

In cross-examination, it was put to Ms Pollock that in relation to your handover on this date, on 19 November 2019, you had received negative feedback that day and you were under stress and that affected your ability to effectively prepare/deliver the handover. Ms Pollock advised you were not pressured to undertake this task and were allowed to attempt it as you requested to. Furthermore, modelling of evidence-based practice by another nurse was utilised to consolidate your learning. Ms Pollock stated observations of handovers would have occurred on every shift you would have undertaken. Finally, it was put to Ms Pollock that a lack of a consistent mentor impacted on your learning and progression. Ms Pollock refuted this and advised that you always had a mentor supervising and she did not believe having the same mentor would have changed the outcome.

The panel also took into account the following from your written statement which, whilst not specific in relation to sub-charge C8, is relevant to the competency concerned:

> *'Many of the witnesses claim I was slow or unsure. But that is not incompetence, that is the reality of a nurse trying to learn under stress, while being constantly watched, judged, and profiled.'*

In cross-examination you maintained the position that Ms Pollock failed to adequately support you. Further you claim you never received any feedback and that Ms Pollock 'wrote all of these things behind my back'. You reiterated that you were being monitored and treated differently. You initially called Ms Pollock a liar and a racist who was supporting a previous manager as part of a conspiracy against you. You later retracted the statement that Ms Pollock was a liar.

The panel considered Ms Pollock to be a reliable witness. The panel took account of all of Ms Pollock's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Pollock's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel preferred the evidence of Ms Pollock to your explanation and noted that effective handovers of patients and clinical information is a basic, core and transferable skill of a registered nurse. This task would be observed at least at the start and end of each shift from your training days onwards. The panel noted that your supernumerary period had been extended from the six week standard and you were in your seventh week at this stage. The panel also noted that there is no indication that you requested to stop giving your handover due to stress.

The panel did not accept your explanation that you were unsupported, did not know you were being assessed, did not receive any written feedback and just needed more time. The panel noted that you had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice

learning team.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock and found this sub-charge proved.

C9

9	24/11/2019	Took around 2 hours to complete safety checks/A-E assessment, ABG and enteral feed for one patient

The panel found the facts alleged at sub-charge C9 proved.

The panel had regard to Ms Hewer's witness statement, contemporaneous feedback report dated 24 November 2019, a letter following the 24 November 2019 shift and oral evidence. Ms Hewer confirmed in her statement:

> *'the above four tasks (safety checks, A-E assessment, taking arterial blood gas (ABG) measurements and enteral feed) took Lydia two hours to complete. I would expect a new nurse on their supernumerary to complete these tasks in around 45 minutes or within one hour maximum'.*

In cross-examination, it was put to Ms Hewer that her timings were wrong and that these tasks took a lot less time than was recorded. Ms Hewer refuted this and stated this was accurate in her contemporaneous feedback report. It was also put to Ms Hewer that if

these tasks did take slightly longer this may be because of a confidence issue and a wish to do them well and properly. Ms Hewer acknowledged this, she expressed the need for a balance of prioritising tasks, meeting all of the patients' needs in a timely manner and she stated at the pace you demonstrated this would impact on patient safety.

The panel took into account the following from your written statement which, whilst not specific in relation to sub-charge C9, is relevant to the competency concerned:

> *'Many of the witnesses claim I was slow or unsure. But that is not incompetence, that is the reality of a nurse trying to learn under stress, while being constantly watched, judged, and profiled.'*

In cross-examination you stated that you believed that white nurses were better supported in comparison to you and that you never received written feedback.

The panel considered Ms Hewer to be a reliable witness. The panel took account of all of Ms Hewer's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Hewer's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel do not accept your explanation that you were constantly being watched, judged, and profiled. The panel noted that you had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice learning team.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to

“get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

C10

10	24/11/2019	Required regular prompting to ensure tasks were completed in a timely manner

The panel found the facts alleged at sub-charge C10 proved.

The panel had regard to Ms Hewer’s witness statement, contemporaneous feedback report dated 24 November 2019, a letter following the 24 November 2019 shift and oral evidence. Ms Hewer in her statement said *“I needed to regularly prompt Lydia to ensure tasks were completed in a timely manner”.* This was confirmed in oral evidence.

In cross-examination, it was put to Ms Hewer that her timings were wrong and that these tasks took a lot less time than was recorded. Ms Hewer refuted this and stated this was accurate in her contemporaneous record. It was also put to Ms Hewer that if these tasks did take slightly longer this may be because of a confidence issue and a wish to do them well and properly. Ms Hewer acknowledged this, she expressed the need for a balance of prioritising tasks, meeting all of the patients’ needs in a timely manner and she stated at the pace you demonstrated this would impact on patient safety.

The panel took into account the following from your written statement which, whilst not specific in relation to sub-charge C10, is relevant to the competency concerned:

> *‘Many of the witnesses claim I was slow or unsure. But that is not incompetence, that is the reality of a nurse trying to learn under stress, while being constantly watched, judged, and profiled.’*

In cross-examination you stated that you believed that white nurses were better supported in comparison to you and that you never received written feedback.

The panel considered Ms Hewer to be a reliable witness. The panel took account of all of Ms Hewer's evidence and determined it to be consistent and cogent throughout, including under cross-examination. The panel determined that Ms Hewer's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel do not accept your explanation that you were constantly being watched, judged, and profiled. The panel noted that you had been subject to a standard induction process requiring ongoing assessment and ongoing dynamic feedback delivered by an experienced practice learning team.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

C11

11	25/11/2019	Demonstrated poor time management skills by starting tasks before completely finishing other tasks

The panel found the facts alleged at sub-charge C11 proved.

The panel had regard to the oral and documentary evidence of Ms Brennan, which included her witness statement and the contemporaneous feedback report dated 25 November 2019. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Brennan's contemporaneous feedback report:

> *'Poor time management skills, often starting one task before another one is completely finished then getting side tracked –for example observations on CIS not completed fully on any hour.'*

This was supported in Ms Brennan's oral evidence:

> *'she would start one task like writing up notes, then move to another without completing the first. This became a pattern…'*

Whilst Ms Brennan's written statement indicated that, due to the passage of time, she was unable to recall the incident in detail, the panel noted the following from her statement:

> *'As a supervisor, I had a responsibility to ensure that my feedback was accurate, therefore I would not have written anything in my feedback exhibited at **RB/1** that was inaccurate.'*

You did not address this sub-charge in your local investigation interview at the time.

In cross-examination it was put to Ms Brennan that you demonstrated good time management on the shift in question, and that your abilities would improve as you became more accustomed to the workload and setting. Ms Brennan reiterated that she stood by her contemporaneous feedback. It was put to Ms Brennan that you were being responsive to changing priorities and were trying to help. Ms Brennan agreed that responding was important but emphasised that poor time management undermined overall patient care.

It was put to Ms Brennan that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Furthermore, it was suggested that there was racial bias

influencing the way that you were treated. Ms Brennan refuted this and stated that she stood by her evidence.

This sub-charge was not explicitly addressed by you in your evidence in chief. In cross examination, you stated that you were being monitored.

In response to panel questions asking for your perspective on what you were doing and why on this shift, you *said ‘I did not know I was being monitored so I did not know’.*

The panel considered Ms Brennan to be a reliable witness. Her oral evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel took account of all of Ms Brennan’s evidence and determined it to be consistent and cogent with no obvious motive to misrepresent the facts. The panel determined that Ms Brennan’s assessment was objective and balanced, and there was no reason to disbelieve her evidence.

Having regard to the above, the panel preferred the evidence of Ms Brennan to the position put forward by counsel on your behalf and your response to panel questions.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to “get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Brennan and found this sub-charge proved.

C13

13	13/6/2020	Failed to complete nursing notes for 2 patients in a timely manner

The panel found the facts alleged at sub-charge C13 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

In Ms Kidner's written contemporaneous feedback report it was confirmed that you *'wrote the nursing notes for two patients today, this took a prolonged period of time'.* The panel was satisfied that it could properly infer from this evidence that you were under a duty to complete the nursing notes in a timely manner.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

You did not provide evidence specific to this sub-charge or an alternative version of events. However, you did agree that it was important to complete nursing notes in a timely manner. When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and preferred this to your evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C14

14	13/6/2020	Failed to complete medication round in timely manner

The panel found the facts alleged at sub-charge C14 proved.

The panel bore in mind that completing a medication round in a timely manner is part of the safe administration of all medication, and this is the responsibility and duty of a registered nurse. The panel noted that performing medication rounds in a timely manner was an explicit objective (objective five) set for you at this placement.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

In Ms Kidner's written contemporaneous feedback report it was confirmed that *'As Lydia is still becoming familiar with completing drug rounds, this still takes her a prolonged period of time'.* In Ms Kidner's witness statement, she confirmed the need to ensure a timely medication round to reduce risk to patient safety.

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

In cross examination you agreed that it was important to be timely on the medications. When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and note your own contemporaneous reflective evidence indicates agreement with Ms Kidner's assessment of this skillset. The panel noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of harm.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C15

15	15/6/2020	Took around 1 hour/too long to complete medication round for 3 patients

The panel found the facts alleged at sub-charge C15 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

In Ms Kidner's written contemporaneous feedback report dated 15 June 2020 it was confirmed that *'Lydia commenced the morning drug round with myself supervising this morning, however it took one hour to do three patients therefore I took over to ensure patients had medication on time'.* This was confirmed in Ms Kidner's witness statement.

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

In cross examination, you denied this sub-charge and indicated Ms Kidner was mistaken. You claimed you were diligent and again stated that '*I didn't know she was monitoring me and reported recording my, you know, watching and recording my time, I didn't know'.* You further stated Ms Kidner gave you good verbal feedback which was different to what had been written.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***

Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'

The panel noted that this amounts to an acknowledgement that you worked slowly.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable. The panel noted your own contemporaneous reflective evidence, and that it indicates agreement with Ms Kidner's assessment of this skillset. The panel further noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of

harm. The panel accepted the evidence of Ms Kidner that she had to intervene to finish the medication round and therefore determined that you were taking too long.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C16

16	15/6/2020	Failed to complete nursing notes in a timely manner

The panel found the facts alleged at sub-charge C16 proved.

The panel established you had a duty to complete nursing notes in a timely manner through reference to UHBW's Record-Keeping Standard in Health Records Policy.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

In Ms Kidner's written contemporaneous feedback report dated 15 June 2020 it was confirmed that *'I encouraged Lydia to write the notes for a bay of patients, we discussed what to write for each patient. This took quite a long period of time, coming towards the end of the shift I completed the outstanding nursing notes she didn't get around to doing'.* Ms Kidner, in her witness statement, confirmed the need to intervene to finish your task and stated *'I had to complete the outstanding records. This was a simple task which I expected Lydia to complete with no issues.'*

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but you did not explain the relevance of this document within your oral evidence.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C17

17	17/6/2020	Took around 1 hour 45 minutes/too long to complete medication round for 4 patients

The panel found the facts alleged at sub-charge C17 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 17 June 2020, and a supervised medication round record dated 17 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's written contemporaneous feedback report it was stated that:

> *'the 08:00 drug round was completed in 1 hour 45 minutes for four patients. Our usual workload would be 8 patients. We discussed this after the drug round where I explained that Lydia absolutely must be administering medications safely and this is paramount, however, taking this amount of time to complete a drug round for four patients is not acceptable, as had there been 8 patients half of them would not have received their medication within 90 minutes as per policy.'*

In the supervised medication round record, Ms Sims further indicated that:

> *'The lengthy drug round would mean delays to patient care ie preparations for procedures.'*

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
>
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel attached considerable weight to the contemporaneous records and found Ms Sims's evidence to be reliable. The panel noted your own contemporaneous evidence, and that it indicates agreement with Ms Sims's assessment of this skillset. The panel further noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration impacts on current and future drug rounds and puts patients at risk of harm.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards

you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

C18

18	17/6/2020	Required prompting with prioritising workload throughout the shift

The panel found the facts alleged at sub-charge C18 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 17 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's contemporaneous feedback report it was stated that:

> *'After completing the drug round I started by asking Lydia which tasks she would start with. Lydia struggled to answer and I needed to explain how I would prioritise care i.e. clinical need/preparing for procedures/discharges, Lydia required a lot of prompting with prioritising workload for the entire shift.*
>
> *…*

‘Lydia requires constant prompts and support with prioritising tasks and workload. I do not believe she would be able to complete all of the required tasks needed without constant assistance.’

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Sims’s evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and ‘*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things’* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel attached considerable weight to the contemporaneous records and found Ms Sims’s evidence to be reliable, and preferred this to your inconsistent evidence.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to “get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

C19

19	19/6/2020	Was unable to prioritise workload

The panel found the facts alleged at sub-charge C19 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's written statement:

> *'Throughout the shift Lydia and I discussed prioritising patients, escalation of deteriorating patients and effective communication using the SBAR mechanism (Situation, Background, Assessment, and Recommendation). Lydia was unable to use the information we had discussed when completing her tasks. For example, I asked Lydia to plan her shift which involved prioritising the patients. When asked what she intended to do, she responded with "check all patients are ok". This is not the type of response I would expect even from a newly qualified nurse. I expected Lydia to explain her tasks and her rationale such as, patient a is ready for discharge so we need to check cannulas are removed, dressings are removed if clean and dry, arranging medications, etc. Then move on to patient b, and so on.'*

This confirmed Ms Kidner's contemporaneous feedback report.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C20

20	19/6/2020	Took around 1 hour to complete 1 risk assessment

The panel found the facts alleged at sub-charge C20 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's written statement:

> *'Lydia was asked to complete a risk assessment of a patient. Lydia had witnessed this process several times. This is a very basic task as it involves asking the patient a number of questions and recording their answers which should normally take between 5 to 10 minutes. Risk assessments are a very common across* [UHBW] *and can be completed by our Band 2 healthcare assistants. Lydia took over an hour to complete 1 assessment and did not record the patients correct weight or complete a skin integrity check. I explained the importance of these checks and how they can impact the patient. Lydia appeared to have no understanding of what was required of her. She asked how to ask the questions which was as simple as reading out the question to the patient and recording their yes or no answer.'*

This confirmed Ms Kidner's contemporaneous feedback report.

The panel noted in your reflective account dated 19 June 2020, you acknowledge that your mentor (Ms Kidner) took you through a risk assessment. You stated:

> *'I learned how to do risk assessment correctly by asking patients the questions and looking at all the pressure areas and weighing them, and not just taking patient's answers and if a patient declines, documenting it on patients notes'.*

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

However, when cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and preferred this to your evidence. The panel noted that within your contemporaneous reflection you acknowledge that you received considerable input from your mentor to learn how to do an effective and robust risk assessment, which contradicts your latter comments claiming you never received feedback.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C21

21	25/6/2020	Took around 1 hour 45 minutes/too long to complete medication round for 4 patients

The panel found the facts alleged at sub-charge C21 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 25 June 2020, and a supervised medication round record dated 25 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's supervised medication round record it was stated that:

> *'The drug round took 1 hour and 45 minutes to complete for 4 patients. We discussed, again, the importance of ensuring safety but that all patients would be expected to receive their medication within 90 minutes and this would not have happened if we would have had our usual 8 patients in the team.'*

This was confirmed in the contemporaneous feedback report of 25 June 2020.

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel attached considerable weight to the contemporaneous records and found Ms Sims's evidence to be reliable and note your most contemporaneous reflective evidence indicates agreement with Ms Sims's assessment of this skillset. The panel noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of harm.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

C22

22	26/6/2020	Took around 1 hour 25 minutes/too long to complete medication round for 4 patients

The panel found the facts alleged at sub-charge C22 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

In Ms Kidner's contemporaneous feedback report dated 26 June 2020 stated *'Today's morning drug round took 1 hour and 25 minutes to complete for only 4 patients'.*

This was confirmed in Ms Kidner's witness statement: *'Lydia took approximately 20 to 25 minutes with each patient and if she was working alone this would cause delays and risk patient safety.'*

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

In cross examination, you denied this sub-charge and indicated Ms Kidner was mistaken. You claimed you were diligent and again stated that '*I didn't know she was monitoring me and reported recording my, you know, watching and recording my time, I didn't know'.* You further stated Ms Kidner gave you good verbal feedback which was different to what had been written.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your agreed objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and note your own contemporaneous reflective evidence indicates agreement with Ms Kidner's assessment of this skillset. The panel noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of harm.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C23

23	29/6/2020	Took around 1 hour 45 minutes/ too long to complete medication round for 6 patients

The panel found the facts alleged at sub-charge C23 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

Ms Kidner's written contemporaneous feedback report dated 29 June 2020 stated:

> *'This morning drug round took 1 hour and 45 minutes to administer medication to 6 people. The first patient alone the medication administration took 30 minutes. I took over the last patients medications as by this time it was 09:30am.'*

This was supported by a separate supervised medication round record from the same shift, and also confirmed in Ms Kidner's witness statement.

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

In your documentary evidence you provided written feedback from a supervised medication round by Ms Kidner on 26 June 2020, which indicated there were no concerns with this assessment but did not explain the relevance of this document within your oral evidence.

In cross examination, you denied this sub-charge and indicated Ms Kidner was mistaken. You claimed you were diligent and again stated that '*I didn't know she was monitoring me and reported recording my, you know, watching and recording my time, I didn't know'.* You further stated Ms Kidner gave you good verbal feedback which was different to what had been written.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The

panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness.

Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career. The panel determined that one successful supervised medication round on a different date does not indicate consistent safe practice in this area, neither did it meet your agreed objective of completing ten medication rounds with minimal supervision. Therefore, the panel did not accept your explanation, and preferred the contemporaneous evidence of Ms Kidner.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable. The panel noted your own contemporaneous reflective evidence, and that it indicates agreement with Ms Kidner's assessment of this skillset. The panel further noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of harm. The panel accepted the evidence of Ms Kidner that she had to intervene to finish the medication round and therefore determined that you were taking too long.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C24

24	29/6/2020	Failed to complete 2 patient safety discharge check lists in a timely manner

The panel found the facts alleged at sub-charge C24 proved.

The panel bore in mind that completing patient safety discharge documentation is the responsibility and duty of a registered nurse. The panel noted that safely demonstrating

admission, transfer and discharge of patients was an explicit objective (objective four) agreed for this placement. The panel note the cardiac ward day to day guide, and Recording-Keeping Standards in Health Records Policy also establish this duty.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

Ms Kidner's written contemporaneous feedback report dated 29 June 2020 stated:

> *'Today we had two patients being discharged; we have gone through the discharge process for cardiac surgery patients previously together on a number of occasions. Lydia had no idea how to prepare patients for discharge; I tried to prompt the information from Lydia. However, she needed to be re-informed of the task involved in safely discharging patients. Lydia does not prioritise discharges; she is extremely slow preparing patients and writing their nursing notes… She doesn't seem to understand by discharging patients in a timely manner from the ward, facilitates patient flow between cardiac theatres, CICU[sic] and the ward…*
>
> *'…Lydia has been very slow completing tasks today; it took approximately 30 minutes to complete 2 patient safety discharge checklists…'*

The panel noted your reflective accounts from June 2020, where you discuss an experience of patient discharges. The panel note that you identify your learning on a previous shift in relation to this skillset and indicated that by watching your mentor, and combined with your previous experience, you believed you had learned how to discharge patients safely.

This sub-charge was not explicitly addressed by you in your evidence in chief.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable. The panel further noted that within your contemporaneous reflective evidence you described requiring further teaching on this skillset despite this being a basic nursing skill. Therefore, the panel preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C25(a)

25	29/6/2020	Failed to complete an ECG in a timely manner.

The panel found the facts alleged at sub-charge C25(a) not proved.

The panel heard no evidence that you had a duty to complete an ECG in a set time, only that you had a duty to complete it correctly. The panel has seen evidence that you took 20

minutes to complete an ECG, but in the absence of any further evidence was not satisfied that this was excessive.

Accordingly, the panel found this sub-charge not proved.

C25(b)

	29/6/2020	Was unable to prioritise workload

The panel found the facts alleged at sub-charge C25(b) proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's written contemporaneous feedback report:

> *'As usual after our drug round I asked Lydia to make a plan for each patient for the day and write a list of tasks to be fulfilled. We then discussed each of the patients and Lydia was asked how she was going to prioritise her patients. This is something I would expect a registered nurse, to be able to do with very minimal assistance. However, Lydia struggles to complete the task appropriately; she is not able to identify the patient that we need to prioritise care for. Her top priority tasks are completing the weekly update of risk assessments or tracing bloods from ICE when they have not long been taken.'*

This confirmed Ms Kidner's written statement.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Kidner was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back. The panel note it has been presented with your evidence of Ms Kidner being able to present positive as well as negative feedback of you, which the panel determined suggests objectivity and fairness. Furthermore, there was no evidence to support your assertion that there was a plan to get rid of you and destroy your career.

The panel attached considerable weight to the contemporaneous records and found Ms Kidner's evidence to be reliable, and preferred this to your inconsistent evidence.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

C26

26	2/7/2020	Took around 50 minutes/too long to complete medication round for 2 patients

The panel found the facts alleged at sub-charge C26 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 2 July 2020, and a supervised medication round record dated 2 July 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's contemporaneous feedback report it was stated that:

> *'I needed to take over the drug round after this patient as it had taken Lydia 50 minutes to dispense 2 patients' medications. I have had a number of conversations with Lydia about the importance of being safe whilst ensuring that patients receive their medication in a timely manner.'*

This was confirmed in the supervised medication round record:

> *'Unable to complete a whole drug round assessment as it took 50 minutes to dispense the first 2 patients[sic] medications and, therefore, I needed to take over.'*

The panel noted your reflective accounts from June 2020, where you discuss medication rounds on this ward on multiple occasions. The panel note a recurrent theme where you identify a need to be quicker, and an understanding of the importance of the timeliness of administering medication for patient safety.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel also considered the evidence of Ms Leech set out in the meeting notes dated 2 July 2020:

> *'Medication rounds are routinely taking a long time. Lydia understands that medication must be given within 90 minutes of prescription for routine medication. Lydia currently needs approximately 30 minutes per patient and is still missing things on the drug round.'*

The panel further took into account the evidence of Ms Broad set out in the meeting notes dated 28 June 2020:

> *'On review, the reflective accounts were descriptions of what Lydia has done. It mentions learning about medication rounds and how she has sped up. However, these did not align with the feedback reports and the supervised medication reports. When I asked Lydia about this she wasn't able to respond or explain these differences and verbally acknowledges that the feedback was accurate.'*

The panel note that the evidence of Ms Leech and Ms Broad supports your mentor's assessment that the amount of time it was taking you to undertake the medication round was excessive.

The panel attached considerable weight to the contemporaneous records and found Ms Sims's evidence to be reliable, and note your most contemporaneous reflective evidence indicates agreement with Ms Sims's assessment of this skillset. The panel noted that within your contemporaneous reflections you acknowledge that you were slow, and that this required improvement to maintain patient safety. The panel considered that delays in medication administration can impact not only on current and future drug rounds, but also planned care, surgery and sleep, and puts patients at risk of harm.

Accordingly, the panel accepted the evidence of Ms Sims, Ms Leech and Ms Broad and found this sub-charge proved.

C27

27	2/7/2020	Required prompting to prioritise workload

The panel found the facts alleged at sub-charge C27 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 2 July 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

In Ms Sims's written contemporaneous feedback report it was stated that:

> *'Lydia is still requiring prompts with giving effective handovers, prioritising workload and timekeeping.'*

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

The panel also had regard to the evidence contained in the local investigation report that during this time you were subject to a clear plan of assessment, which required ongoing feedback and support, and formal meetings with senior nurses to discuss your ongoing progress towards achieving your agreed nursing objectives. Therefore, the panel determined that the feedback recorded by Ms Sims was part of this formal process, and did not amount to her inappropriately writing about you or gossiping behind your back.

The panel attached considerable weight to the contemporaneous records and found Ms Sims's evidence to be reliable, and preferred this to your inconsistent evidence.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

C28

28	6/11/2022	Failed to complete nursing notes in the allocated time frame

The panel found the facts alleged at sub-charge C28 proved.

The panel had regard to the oral and documentary evidence of Ms Elvy, which included her witness statement and a contemporaneous feedback report from shift dated 6 November 2022. The panel also had regard to your oral and documentary evidence.

The panel had regard to the job description from NBT, and also to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which record keeping was one. The panel considered this conveys a duty on you to complete nursing notes within a set time frame.

In determining this time frame, the panel took into account the following from Ms Elvy's written statement, which confirms the contemporaneous feedback report:

> *'Lydia needed to improve her time management skills. In my feedback … I have given an example when I asked Lydia to complete nine clinical notes in one hour, and it took her much longer than that. Lydia completed only four out of nine notes in one hour and I took over and wrote the rest five of the nine notes myself as we had to proceed to work on other tasks. I said to Lydia that we could not take any longer on completing those notes, which is why I took over and completed the outstanding five notes.'*

The panel was satisfied on the basis of Ms Elvy's evidence that you were under a duty to complete nursing notes within an hour.

In Ms Elvy's oral evidence she confirmed her statement and the contemporaneous feedback report, noting that you were accepting of her feedback and keen to learn.

The panel took into account the notes from the review meeting with Ms Burgess and Ms Morris dated 25 November 2022. The purpose of this meeting was to review your progress on this ward and to review questions/conditions from the NMC that included medication as a targeted area of practice:

> *'Lydia reports she found the NMC allegation very upsetting at first and was 'not happy' with her previous employer regarding this, but she has since reflected. She feels most of the allegations are untrue but accepts documentation could have been improved…*
>
> *…*
>
> *… Lydia reports that she previously discussed paperwork with [Ms Elvy] who gave some feedback about improvement, [Ms Elvy] has since told the ward manager that Lydia's paperwork is now 'fantastic'. Lydia reports that she is a fast learner and is keen to improve based on the feedback she receives.'*

In your cross-examination, when discussing Ms Elvy, you acknowledged she had given you positive feedback at times, however then asserted that she became part of '*the system'* and was writing about you with the aim of getting rid of you.

As above, the panel determined Ms Elvy to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Elvy's evidence and determined it to be consistent and cogent throughout and noted that it was also consistent with the evidence contained within the contemporaneous feedback report dated 6 November 2022. The panel determined that Ms Elvy's assessment was objective and balanced, and there was no reason to disbelieve her evidence.

The panel also did not accept your general assertion that there was a plan to get rid of you and note the evidence before it that your conditions of practice required you to be robustly assessed on medicines management and administration.

Accordingly, the panel accepted the evidence of Ms Elvy and found this sub-charge proved.

C29

29	23/11/2022	Required multiple promptings to carry out tasks

The panel found the facts alleged at sub-charge C29 proved.

The panel had regard to the oral and documentary evidence of Ms Duncan-McKenzie, which included her witness statement and contemporaneous feedback report dated 23 November 2022. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Duncan-McKenzie's contemporaneous feedback report:

> *'When asked to complete a task she will do it but will most times require multiple promptings and reminders to carry out this task. Her pace of work has been found to be very slow, which has been impacting on her not completing tasks, or taking longer than is necessary to complete it.'*

This was confirmed in Ms Duncan-McKenzie's written statement:

> *'I constantly had to remind Lydia what the next steps of the ward's routine were such as doing a medication round, dressings, taking patients' blood sugar. For example, blood sugar had to be taken at 12:00 pm before lunch and I needed to always remind Lydia at that time to take blood sugar of patients.'*

In cross-examination it was put to Ms Duncan-McKenzie that you were working on your time management. It was put to Ms Duncan-McKenzie that her feedback from 23 November 2022 was wrong. This was refuted by Ms Duncan-McKenzie. Finally, it was put to Ms Duncan-McKenzie that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Duncan-McKenzie refuted this and stated that she stood by her evidence.

In your oral evidence you said stated that Ms Duncan-McKenzie told the panel that you were *‘doing everything right’*.

In cross-examination, when asked to explain why Ms Duncan-McKenzie would ‘call you out’ you said *‘[Ms Duncan-McKenzie] had been told to do that’* and that this was due to Ms Morris, who *‘started to get Black people on board’*.

The panel considered Ms Duncan-McKenzie to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Duncan-McKenzie’s evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Duncan-McKenzie’s assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Duncan-McKenzie outlining in detail the events on shift, which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Duncan-McKenzie ‘on board’ in targeting you.

Accordingly, the panel accepted the evidence of Ms Duncan-McKenzie and found this sub-charge proved.

C30

30	23/11/2022	Failed to complete the drugs round in a timely manner

The panel found the facts alleged at sub-charge C30 proved.

The panel bore in mind that completing a medication round in a timely manner is part of the safe administration of all medication, and this is the responsibility and duty of a registered nurse. The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A,

which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Ms Duncan-McKenzie, which included her witness statement and the contemporaneous feedback report dated 23 November 2022. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Duncan-McKenzie's written statement:

> *'Drug rounds vary in complexity. However, at the time of Lydia working on the ward we did not have complicated drug rounds. A morning drug round would start between 7:30 - 7:45 am and should be finished by 10:00 am. Lydia would finish that drug round by 11 – 11:30 am, (causing a delay of 1– 1.5 hours.) Otherwise I would have to take over the round so as to ensure it is completed in a timely manner.'*

The panel took into account the notes from the review meeting with Ms Burgess and Ms Morris dated 25 November 2022. The purpose of this meeting was to review your progress on this ward and to review questions/conditions from the NMC that included medication as a targeted area of practice:

> *'[Ms Thomas] informed Lydia that the answers to the question from the NMC will have to reflect some of the observations we have received around Lydia's practice with regards to medications management and length of time taken to complete this. Lydia stated that she doesn't understand all the medications as she hasn't been a ward nurse (theatre background) – but reports that she is taking time to look these up on the BNF App to learn. We discussed that having had accusations made regarding medication competence previously that Lydia wants to take her time so that she doesn't make mistakes.'*

The main action plan from this meeting was for you to undertake work on medication safety/speed of a safe drug round and the meeting identified that when this takes a long time, patient care is delayed and care for the entire day can then become delayed.

In cross-examination it was put to Ms Duncan-McKenzie that by 23 November 2022, she had supervised up to 10 medication rounds by you in which she had identified continuous improvement. Ms Duncan-McKenzie acknowledged your progress but indicated regression in this skillset on this date [PRIVATE]:

> *'Whatever happened when she returned, she was not at that stage anymore'*

It was put to Ms Duncan-McKenzie that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Duncan-McKenzie refuted this and stated that she stood by her evidence.

In your oral evidence you said stated that Ms Duncan-McKenzie told the panel that you were *'doing everything right'*.

The panel took into account the following from your written statement:

> ***'Medication Rounds Taking Too Long***
> *Yes, I worked slowly at times — but this was out of care and a desire to be safe. I was working in new settings, often under scrutiny, and without consistent mentorship. This should have been supported, not weaponised.'*

The panel noted that this amounts to an acknowledgement that you worked slowly.

In cross-examination, when asked to explain why Ms Duncan-McKenzie would 'call you out' you said *'[Ms Duncan-McKenzie] had been told to do that'* and that this was due to Ms Morris, who *'started to get Black people on board'*.

The panel considered Ms Duncan-McKenzie to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Duncan-McKenzie's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The

panel determined that Ms Duncan-McKenzie's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel also noted that Ms Duncan-McKenzie was able to acknowledge when you completed tasks within a reasonable time. The panel preferred this contemporaneous record of Ms Duncan-McKenzie outlining in detail the events on shift, which was consistent with her oral evidence. The panel further noted that slowness in completing your drug rounds was a key focus for your review meeting to discuss your progress to date on this ward. The panel also did not accept your assertion that Ms Morris had gotten Ms Duncan-McKenzie 'on board' in targeting you. The panel also note your contribution at this review meeting where it is reported you acknowledged still working slowly.

Accordingly, the panel accepted the evidence of Ms Duncan-McKenzie and found this sub-charge proved.

C31

31	24/11/2022	Took around an hour and 30 minutes/too long to complete the drugs round for 5 patients

The panel found the facts alleged at sub-charge C31 proved.

The panel had regard to the oral and documentary evidence of Ms Elvy, which included her witness statement and a contemporaneous feedback report from shift dated 24 November 2022. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Elvy's written statement:

> *'It took Lydia an hour and a half to administer the medications for her five patients, one patient of which I believe had no medications. There were no IVs or complicated medications on that medication round, therefore it should have taken between 45 minutes to 1 hour approximately.'*

This confirms the contemporaneous feedback report.

In Ms Elvy's oral evidence she confirms her statement and the contemporaneous feedback report, noting that you were accepting of her feedback and keen to learn.

In cross examination, it was put to Ms Elvy that you were careful when undertaking tasks in relation to medication. Ms Elvy acknowledged this, however stated her concerns were more about the length of time it was taking you and indicated that if medications were more complicated the task would have taken even longer. It was put to Ms Elvy that in relation to this sub-charge you were actually quicker than the hour and a half alleged. Ms Elvy indicated she could not now recall. However, at re-examination Ms Elvy referred back to her contemporaneous record from that shift and confirmed it took one and a half hours.

The panel took into account the notes from the review meeting with Ms Burgess and Ms Morris dated 25 November 2022. The purpose of this meeting was to review your progress on this ward and to review questions/conditions from the NMC that included medication as a targeted area of practice:

> *'[Ms Thomas] informed Lydia that the answers to the question from the NMC will have to reflect some of the observations we have received around Lydia's practice with regards to medications management and length of time taken to complete this. Lydia stated that she doesn't understand all the medications as she hasn't been a ward nurse (theatre background) – but reports that she is taking time to look these up on the BNF App to learn. We discussed that having had accusations made regarding medication competence previously that Lydia wants to take her time so that she doesn't make mistakes.'*

The main action plan from this meeting was for you to undertake work on medication safety/speed of a safe drug round and the meeting identified that when this takes a long time, patient care is delayed and care for the entire day can then become delayed.

In your cross-examination, when discussing Ms Elvy, you acknowledged she had given you positive feedback at times, however then asserted that she became part of '*the system'* and was writing about you with the aim of getting rid of you.

As above, the panel determined Ms Elvy to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Elvy's evidence and determined it to be consistent and cogent throughout and noted that it was also consistent with the evidence contained within the contemporaneous feedback report dated 24 November 2022. The panel determined that Ms Elvy's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel further noted that slowness in completing your drug rounds was a key focus for your review meeting to discuss your progress to date on this ward. The panel assessed your assertions about the reliability of Ms Elvy, and was of the view that they were not logical nor consistent. The panel also note your contribution at this review meeting where it is reported you acknowledged still working slowly. The panel accepted that thoroughness is important, but found that on this occasion the length of time taken was excessive for the number of patients and was not clinically justified on the evidence available.

On balance, the panel preferred the evidence of Ms Elvy and was satisfied that it was more likely than not that you took around one hour and 30 minutes/too long to complete the medication round for five patients on the date in question.

Accordingly, the panel accepted the evidence of Ms Elvy and found this sub-charge proved.

C33

33	28/1/2023	Took around 3 hours/too long to complete a medication round

The panel found the facts alleged at sub-charge C33 proved.

The panel had regard to the oral and documentary evidence of Ms Trinidad which included her witness statement and an email date 30 January 2023 sent by Ms Trinidad to Ms Morris. The panel noted this email gave a summary of your shift supervised by Ms

Trinidad on 28 January 2023. The panel also had regard to your oral and documentary evidence.

Ms Trinidad described the incident in the email of 30 January 2023:

> *'When Lydia realized she was quite behind with medications (started med rounds @ 0745 and finished 10:45), she became quite panicky and anxious about pts taking their meds late and that lunch time meds will have to be pushed back.'*

This is confirmed within Ms Trinidad's witness statement. Further, Ms Trinidad in this statement confirms that *'for nine patients the medication round should take no longer than 1.5 – 2 hours'.*

Ms Trinidad's contemporaneous record explicitly identified providing verbal feedback on the day and noted your response to how the day had gone as '*could have done better with the morning med rounds'*. This is confirmed in Ms Trinidad's witness statement. Ms Trinidad also stated that '*Lydia understood and was grateful for the feedback'.*

In cross-examination it was put to Ms Trinidad that delays to the medication round that day may have been due to external factors ie a patient falling. This was refuted by Ms Trinidad and she asserted that no patient had fallen that day. It was next put to Ms Trinidad that you had not received written feedback on this issue. Ms Trinidad stated that all of these issues had been discussed with you on the day. Finally, it was put to Ms Trinidad that this shift was not indicative of your normal capabilities. Ms Trinidad did not agree with this.

At sub-charge B29 above, the panel has previously identified Ms Trinidad's evidence during cross-examination regarding your feedback and training on the ward, as well as her memory and truthfulness regarding this sub-charge.

The panel further took account of its decision above at sub-charge C31, and noted that medication safety/speed of drug round was identified as a targeted area of practice for you to improve on.

The panel also took account of its assessment of your response to the medication round sub-charges in your written statement in its decision at sub-charge C30.

At sub-charge B29 above, the panel has previously identified your responses in cross-examination regarding your assertion that Ms Trinidad was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge B29, the panel determined Ms Trinidad to be a reliable witness. The panel did not accept your assertion that they were targeting you.

The panel further noted that slowness in completing your drug rounds was a key focus for your review meeting to discuss your progress to date on this ward. The panel also note your contribution at this review meeting where it is reported you acknowledged still working slowly. The panel accepted that thoroughness is important, but found that on this occasion the length of time taken was excessive for the number of patients and was not clinically justified on the evidence available.

On balance, the panel preferred the evidence of Ms Trinidad and was satisfied that it was more likely than not that you took around three hours/too long to complete the medication round on the date in question.

Accordingly, the panel accepted the evidence of Ms Trinidad and found this sub-charge proved.

C34

34	30/1/2023	Failed to complete the drugs round in a timely manner

The panel found the facts alleged at sub-charge C34 proved.

The panel bore in mind that completing a medication round in a timely manner is part of the safe administration of all medication, and this is the responsibility and duty of a registered nurse. The panel took into account the New Starter Pack for Gate 9A, which identifies the ability to satisfactorily complete a drug round to be a duty of a registered nurse. The panel also had regard to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which supervised medicines management and administration was one.

The panel had regard to the oral and documentary evidence of Ms Williams, which included her witness statement and contemporaneous feedback report attached to an email to Ms Morris dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Williams's contemporaneous feedback report:

> *'Lydia and I had 5 patients, the drug round took 1 hour and 20 minutes. Lydia was checking correctly and asking the patients Identification, but the time was not reasonable, one patient had no medications and the 4 others all had one drug chart with only a couple of drugs on. Maximum time would have been 30-40 minutes to complete the drug.'*

This was confirmed in Ms Williams's statement and also in her oral evidence where Ms Williams confirmed that a drug round for four patients should take a maximum of 40 minutes for a nurse of your experience. She confirmed that medication delays impact on the care provided to the patients and to future drug rounds.

At sub-charge B30 above, the panel has previously identified Ms Williams's evidence during cross-examination regarding her supervision of you and how this would facilitate your support plan.

The panel further took account of its decision above at sub-charge C31, and noted that medication safety/speed of drug round was identified as a targeted area of practice for you to improve on.

The main action plan from your review meeting with Ms Burgess and Ms Morris dated 25 November 2022 was for you to undertake work on medication safety/speed of a safe drug round and the meeting identified that when this takes a long time, patient care is delayed and care for the entire day can then become delayed.

The panel also took account of its assessment of your response to the medication round sub-charges in your written statement in its decision at sub-charge C30.

At sub-charge B30 above, the panel has previously identified your responses in cross-examination regarding your assertion that Ms Williams was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge B30, the panel determined Ms Williams to be a reliable witness. The panel did not accept your assertion that they were targeting you.

The panel further noted that slowness in completing your drug rounds was a key focus for your review meeting to discuss your progress to date on this ward. The panel also note your contribution at this review meeting where it is reported you acknowledged still working slowly. The panel accepted that thoroughness is important, but found that on this occasion the length of time taken was excessive and not clinically justified on the evidence available.

On balance, the panel preferred the evidence of Ms Williams and was satisfied that it was more likely than not that you failed to complete the drug round in a timely manner.

Accordingly, the panel accepted the evidence of Ms Williams and found this sub-charge proved.

C35

35	30/1/2023	Failed to complete all documentation in a timely manner

The panel found the facts alleged at sub-charge C35 proved.

The panel had regard to the job description from NBT, and also to your support plan for your placement on Gate 9A, which provided targeted NMC conditions of practice, of which record keeping was one. The panel considered that completing documentation in a timely manner is a requirement of basic nursing practice.

The panel had regard to the oral and documentary evidence of Ms Williams, which included her witness statement and contemporaneous feedback report attached to an email to Ms Morris dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Williams's contemporaneous feedback report:

> *'Lydia was not able to complete all her documentation to a high standard, she was not able to record in a timely manner during her shift for her 5 patients. This included their SSKIN, intentional rounds and care plans. Prompts and assistance were needed by myself throughout the day.'*

This was confirmed in Ms Williams's written statement and also in her oral evidence.

At sub-charge B30 above, the panel has previously identified Ms Williams's evidence during cross-examination regarding her supervision of you and how this would support your support plan.

You did not explicitly address this sub-charge in your written statement. In your oral evidence you stated that you need time to get used to the documentation when working in a new place.

At sub-charge B30 above, the panel has previously identified your responses in cross-examination regarding your assertion that Ms Williams was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge B30, the panel determined Ms Williams to be a reliable witness. The panel did not accept your assertion that they were targeting you.

The panel considered your oral evidence that a new working environment would lead to slower completion of documentation, and that this is an acknowledgement that you may have taken longer to complete the documentation than expected. The panel noted you had been working on this ward for a few months by the time of this sub-charge, and that completing the documentation would have been a regular requirement on every shift. The panel determined that a nurse of your experience ought to have been able to complete the documentation in a timely manner by the date of this sub-charge.

Accordingly, the panel accepted the evidence of Ms Williams and found this sub-charge proved.

Charge 4

'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:

4) Documentation/record-keeping as set out on one or more occasions in Schedule D'

The panel had regard to the wording of this head of charge that requires it to be proved if one or more sub-charges in Schedule D is made out. It noted your admission to D12 and accordingly found this sub-charge proved by your admission. For completion, the panel considered the evidence supporting the other sub-charges in Schedule D and made the following findings.

D1

1	19/11/2019	Failed to complete or record patient observations

The panel found the facts alleged at sub-charge D1 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy, and the supernumerary pack for GICU and was satisfied that you had a duty to complete and record patient observations.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Ms Russell with a feedback summary of the shift she supported you on, dated 19 November 2019, and a subsequent email sent to Ms Russell following this shift but undated in the bundle. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Pollock's written statement:

> *'Continuing our shift together I asked Lydia to complete a set of observations, recording them on our Computer Information System ("CIS"). This is a very basic nursing skill and should not take any longer than 10 – 15 minutes to complete. I did not directly witness Lydia complete the observations however I reviewed CIS and noted that Lydia had missed a substantial amount of information.'*

This confirms Ms Pollock's contemporaneous feedback report dated 19 November 2019.

In oral evidence Ms Pollock confirmed you would have received training in how to record observations on the system during induction and orientation, otherwise you would not have received a password to access the CIS.

In cross examination it was put to Ms Pollock that your previous workplace had used a different system for recording patient observations, and that with further time and support you would have been able to complete comprehensive notes. Ms Pollock disagreed and stated that at seven weeks supernumerary this should not have been an issue.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, namely that when discussing concerns with your clinical practice you indicated you required a consistent mentor, and more time in practice to have your competencies signed off to enable you to practise independently.

The panel also took into account the following from your written statement:

> '*I completed observations — told I missed them.'*

In cross-examination you denied you received any feedback in relation to this sub-charge, and asserted Ms Pollock had only worked with you for six hours.

At sub-charge C8 above, the panel has previously identified your responses in cross-examination regarding your assertion that Ms Pollock was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge C8, the panel determined Ms Pollock to be a reliable witness. The panel noted that completing patient observations is a basic, core and transferable skill of a registered nurse. The panel did not accept your initial assertion that Ms Pollock was not supporting you, nor that you were being targeted. The panel further noted the inconsistency in your evidence over time in relation to this sub-charge, and preferred the evidence of Ms Pollock.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock and found this sub-charge proved.

D4

4	24/11/2019	Failed to complete documentation of ABCDE assessment of a patient

The panel found the facts alleged at sub-charge D4 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy, and the supernumerary pack for GICU, including the 'Top-to-Toe Assessment SOP' and was satisfied that you had a duty to complete documentation of an ABCDE assessment. The panel was satisfied that there was a clear professional duty, supported by UHBW's ABCDE Guidelines, for you to complete and record all elements of an ABCDE assessment when indicated.

The panel had regard to Ms Hewer's witness statement, contemporaneous feedback report dated 24 November 2019, a letter from Ms Hewer to Ms Russell following the 24 November 2019 shift and oral evidence. Ms Hewer stated that you were unable to correctly document the *'ABCDE'* assessment independently and that you required prompting, supervision and support with this task. This was confirmed in Ms Hewer's oral evidence.

The panel noted the following from Ms Hewer's letter to Ms Russell:

> *'Lydia required my constant assistance to document this assessment. She missed charting several aspects of this, even though I advised her to take some time to go through and update the chart.'*

The panel also considered the following from Ms Hewer's written statement:

> *'It is important for an intensive care nurse to be able to complete an A-E assessment independently because the patients are unwell and their clinical state may change quickly/ If the nurse is not able to complete an A-E assessment without assistance, any critical changes in patients may go unnoticed without appropriate action taken which can cause harm to patients.'*

The panel is satisfied that, from this evidence, it can properly infer that to complete an ABCDE assessment fully, requires it to be documented correctly.

In cross-examination, it was put to Ms Hewer that you did know how to complete the ABCDE assessment. It was put to Ms Hewer that she was either wrong, misremembered or mis-recorded the feedback or in the alternative that she had not been truthful. Furthermore, it was suggested that there was racial bias influencing the way that you were treated.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, specifically that when discussing your understanding of the ABCDE assessment you required ongoing prompting from others present to explain the assessment fully, and your explanation lacked the required specificity.

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge D4, is relevant to the competency concerned:

> ***'Documentation Errors***

I did my best to complete the documentation thoroughly. Where anything was missed, I was still in training and was not given the time or space to consolidate my learning. At no point was I dishonest, evasive, or negligent.

'Use of Medical Terminology / ABCDE Understanding
I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'

In oral evidence you again claimed that you were competent with this skill.

In response to panel questions, you indicated you understood the need for documentation and claimed you always documented. However, you also stated that you had not been shown how to document on this unit. You then asserted you were the victim of racial bias and this is why you were not shown how to document.

For the same reasons and analysis outlined above at sub-charge A11, the panel determined Ms Hewer to be a reliable witness. The panel did not accept your assertion that Ms Hewer's negative feedback of you was racially motivated.

The panel noted Ms Hewer's evidence that you did complete the assessment slowly and with supervision and assistance. The panel determined however, that the ability to document ABCDE assessments independently is a fundamental aspect of this skill and that you failed to do so. The panel noted your responses to this sub-charge over time have been inconsistent.

Ms Hewer's contemporaneous feedback was detailed, consistent with her oral evidence, and aligned with the documentary exhibits. Your own multiple accounts lack consistency and are not accepted by the panel.

The panel therefore preferred Ms Hewer's clear and corroborated account to your explanation and determined that the NMC had proved, on the balance of probabilities, that you failed to complete the documentation of the ABCDE assessment of the patient on 24 November 2019.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to “get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

D5

5	24/11/2019	Failed to fully complete a patient observation chart

The panel found the facts alleged at sub-charge D5 proved.

The panel took into account UHBW’s Record Keeping Principles and Standards policy, and the supernumerary pack for GICU and was satisfied that you had a duty to complete and record patient observations fully.

The panel had regard to Ms Hewer’s witness statement, contemporaneous feedback report dated 24 November 2019, a letter from Ms Hewer to Ms Russell following the 24 November 2019 shift and oral evidence.

The panel also considered the following from Ms Hewer’s written statement:

‘Lydia required my constant assistance to document this assessment. She missed charting several aspects of this, even though I advised her to take some time to go through and update the chart. I do not remember what aspects Lydia missed in the observation chart. But I remember there was more than one thing which was missing from the records made by Lydia in the observation chart. It is important that a nurse on the GICU fully completes a patient observation chart because the patients are unwell. Lydia’s patient had acuity level three and was supported with the ventilator. Full completion of the observation chart for that patient was important for monitoring fluctuation of their cardiovascular status.

…

‘…I also had to update some aspects of the observation chart from 6pm and 7pm for Lydia’s patient because Lydia had not fully completed those observations on the chart.’

This confirms the contemporaneous letter to Ms Russell.

In cross-examination, it was put to Ms Hewer that she did not remember what aspects of the observation chart you actually missed. Ms Hewer said she could not recall the specific aspects that were missing, but that she had had to stay back to complete the documentation properly. It was put to Ms Hewer that she misremembered this. Ms Hewer refuted this, and reiterated the need for her to stay back beyond the end of her shift. It was then put to Ms Hewer that this was her responsibility as your supervisor. Ms Hewer refuted this and stated she *‘would have expected Lydia in what would normally be somebody's final week of supernumerary to have identified that that documentation was outstanding.’*

The panel noted your responses to your employer’s initial investigation of 12 and 19 December 2019, specifically that when discussing your understanding of the ABCDE assessment you required ongoing prompting from others present to explain the assessment fully, and your explanation lacked the required specificity.

The panel took into account the following from your written statement:

> ***'Documentation Errors***
> *I did my best to complete the documentation thoroughly. Where anything was missed, I was still in training and was not given the time or space to consolidate my learning. At no point was I dishonest, evasive, or negligent.*

The panel took account of its assessment of your response to the documentation errors sub-charges in its decision at sub-charge D4.

The panel found there was a clear professional duty, as set out in UHBW's policy, to ensure patient observation charts are fully completed. The panel considered Ms Hewer's evidence to be detailed, consistent with her contemporaneous feedback, and aligned with the policy requirements.

The panel therefore preferred Ms Hewer's evidence, supported by documentary records, and was satisfied on the balance of probabilities that you failed to fully complete the patient observation chart.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

D6

6	24/11/2019	Failed to complete patient's care plan

The panel found the facts alleged at sub-charge D6 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy and was satisfied that you had a duty to complete the patient's care plan.

The panel also had regard to Ms Hewer's witness statement, contemporaneous feedback report dated 24 November 2019, a letter from Ms Hewer to Ms Russell following the 24 November 2019 shift and oral evidence.

The panel considered the following from Ms Hewer's contemporaneous letter to Ms Russell:

> *'Lydia's handover took over 30 minutes, and she did not at any point identify a need to complete the patient's care plan'*

This was confirmed in Ms Hewer's written statement and oral evidence.

In cross-examination, it was put to Ms Hewer that her initial feedback lacked detail and did not include the completion of a patient's care plan documentation. Ms Hewer explained that the contemporaneous feedback report would not allow further elaboration, and that is why she followed up with a more comprehensive email to Ms Russell. It was then put to Ms Hewer that the completion of the care plan was her responsibility as your supervisor. Ms Hewer refuted this and stated she *'would have expected Lydia in what would normally be somebody's final week of supernumerary to have identified that that documentation was outstanding.'* She maintained that it was your responsibility to complete the documentation and you did not.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019:

> *'I was getting a bit confused about the learning I wanted to. In the beginning I was struggling with the right care plans, and giving handover. It was so different to what I was used to.'*

The panel took account of its assessment of your response to the documentation errors sub-charges in its decision at sub-charge D4, including your response to panel questions.

For the same reasons and analysis outlined above at sub-charge A11, the panel determined Ms Hewer to be a reliable witness. The panel considered Ms Hewer's evidence to be detailed, consistent with her contemporaneous feedback report, and aligned with the policy requirements.

The panel therefore preferred Ms Hewer's evidence, supported by documentary records, and was satisfied on the balance of probabilities that you failed to complete a patient's care plan.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

D8

8	25/11/2019	Failed to complete documentation/observation notes in a timely manner and/or at all

The panel found the facts alleged at sub-charge D8 proved.

The panel established you had a duty to complete nursing notes in a timely manner through reference to UHBW's Record-Keeping Standard in Health Records Policy.

The panel had regard to the oral and documentary evidence of Ms Brennan, which included her witness statement and the contemporaneous feedback report dated 25 November 2019. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Brennan's contemporaneous feedback report:

> *'Observations on CIS poorly documented with lots of gaps. For example, although she assessed the NGT took aspirate & checked the pH, non[sic] of this was documented on CIS.*
>
> *'I ended up sitting down with Lydia to complete the CIS flowsheet step by step. Lydia's level of knowledge was at similar experience to what I would expect from someone in their first week on the Unit not someone at the end of her supernumerary period'*

This was confirmed in Ms Brennan's oral evidence.

Whilst Ms Brennan's written statement indicated that, due to the passage of time, she was unable to recall the incident in detail, the panel noted the following from her statement:

> *'As a supervisor, I had a responsibility to ensure that my feedback was accurate, therefore I would not have written anything in my feedback…that was inaccurate.'*

In cross-examination, it was put to Ms Brennan that her initial feedback lacked specificity and did not include detail on the completion of the documentation/observation notes of this sub-charge. It was then put to Ms Brennan that you were confident you put relevant observations into CIS. Ms Brennan refuted this and reiterated she would not have recorded it as not completed in her feedback if you had done so.

The panel took account of its assessment of your response to the documentation errors sub-charges in its decision at sub-charge D4, including your response to panel questions.

For the same reasons and analysis outlined above at sub-charge C11, the panel determined Ms Brennan to be a reliable witness.

The panel determined that the ability to complete documentation/observation notes fully in a timely manner is a fundamental aspect of nursing practice and that you failed to do this.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Russell and found this sub-charge proved.

D9

9	19/6/2020	Failed to fully complete observation notes for a patient

The panel found the facts alleged at sub-charge D9 not proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. For the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence. However, in relation to this sub-charge, there is nothing in Ms Kidner's witness statement. The only evidence the panel has seen regarding observations is an instance of you taking observations rather than failing to document them within Ms Kidner's contemporaneous feedback report dated 19 June 2020.

Accordingly, the panel determined that the NMC had failed to discharge its burden in relation to this sub-charge, and therefore the panel found this sub-charge not proved.

D10

10	19/6/2020	Failed to fully document a risk assessment

The panel found the facts alleged at sub-charge D10 proved.

The panel established you had a duty to fully document a risk assessment through reference to UHBW's Record-Keeping Standard in Health Records Policy and the Cardiac Surgery New Starter Park.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

At sub-charge C20 above, the panel has previously identified Ms Kidner's evidence regarding the risk assessment on this date.

The panel took account of its assessment of your reflective account regarding this sub-charge in its decision at sub-charge C20, and your assertion that Ms Kidner was part of a

plan to destroy your career. As above, the panel did not accept this assertion, noting you were subject to a clear plan of assessment at the time.

For the same reasons and analysis outlined above at sub-charge C20, the panel was satisfied Ms Kidner's evidence was reliable. It noted the inconsistencies in your evidence in relation to this sub-charge, and preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

D11

11	29/6/2020	Failed to fully document nursing notes for patients being discharged

The panel found the facts alleged at sub-charge D11 proved.

The panel established you had a duty to fully document nursing notes for patients being discharged through reference to UHBW's Record-Keeping Standard in Health Records Policy.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

Ms Kidner's written contemporaneous feedback report dated 29 June 2020 stated:

> *'Lydia needed to adjust her nursing notes several times, she had written information of tasks which were not relevant to the patients and hadn't included tasks which were.'*

The panel also took into account the following from your written statement which, whilst not specified in relation to sub-charge D11, is relevant to the competency concerned:

> ***'Documentation Errors***

I did my best to complete the documentation thoroughly. Where anything was missed, I was still in training and was not given the time or space to consolidate my learning. At no point was I dishonest, evasive, or negligent.'

The panel also took account of its assessment of your reflective account regarding this sub-charge in its decision at sub-charge C24, and your general assertion that Ms Kidner was part of a plan to destroy your career. As above, the panel did not accept this assertion, noting you were subject to a clear plan of assessment at the time.

For the same reasons and analysis outlined above at sub-charge C24, the panel was satisfied Ms Kidner's evidence was reliable. It noted the inconsistencies in your evidence in relation to this sub-charge, and preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

D13

13	30/1/2023	Required prompting to fully complete documentation throughout the shift

The panel found the facts alleged at sub-charge D13 proved.

The panel had regard to the oral and documentary evidence of Ms Williams, which included her witness statement and contemporaneous feedback report attached to an email to Ms Morris dated 30 January 2023. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Williams's contemporaneous feedback report:

'Lydia was not able to complete all her documentation to a high standard, she was not able to record in a timely manner during her shift for her 5 patients. This

included their SSKIN, intentional rounds and care plans. Prompts and assistance were needed by myself throughout the day.'

This was confirmed in Ms Williams's written statement and also in her oral evidence.

In cross-examination it was put to Ms Williams [PRIVATE] that her supervisory role should have included prompts where required. Ms Williams stated this was not correct and it was for her to watch and find gaps in your practice and to support you in those areas. Ms Williams stated her role was to step back and allow things to happen, intervening only if patients were put in danger. This, she asserted, was intended to support you and was in line with your PIP.

You did not explicitly address this sub-charge in your written statement. In your oral evidence you stated that you need time to get used to the documentation when working in a new place.

At sub-charge B30 and C35 above, the panel has previously identified your responses in cross-examination regarding your assertion that Ms Williams was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge B30 and C35, the panel determined Ms Williams to be a reliable witness. The panel did not accept your assertion that they were targeting you.

The panel noted you had been working on this ward for a few months by the time of this sub-charge, and that completing the documentation would have been a regular requirement on every shift. The panel determined that a nurse of your experience ought to have been able to complete the documentation without prompting by the date of this sub-charge.

Accordingly, the panel accepted the evidence of Ms Williams and found this sub-charge proved.

Charge 5

> *'That you, a registered nurse, between 9 September 2019 and 9 February 2023, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse in any and/or all, of the following areas:*
>
> *5) Communication as set out on one or more occasions in Schedule E'*

The panel had regard to the wording of this head of charge that requires it to be proved if one or more sub-charges in Schedule E is made out. It noted your admission to E15 and accordingly found this sub-charge proved by your admission. For completion, the panel considered the evidence supporting the other sub-charges in Schedule E and made the following findings.

E1

1	9/11/2019	Failed to use medical language/terminology

The panel found the facts alleged at sub-charge E1 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy, and the supernumerary pack for GICU, and was satisfied that you had a duty to use the correct medical language and terminology as referred to in these documents. The panel was satisfied that there was a clear professional duty, supported by UHBW's documentation, for you to use standard medical language and terminology to ensure consistency and avoid ambiguity.

The panel had regard to Ms Pogorzelska's witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. The panel also had regard to your oral and documentary evidence.

The panel noted the following from Ms Pogorzelska's statement:

> *'At paragraph five of my feedback… it is stated:* "Lydia's medical/nursing terminology is very poor. She struggled to remember names of the basic medical equipment, such as: transducer, pump, monitor (calling all pieces of equipment: machine), as well as struggled to use a correct terminology when referring to the human anatomy and physiology." *It is important for a nurse to use the correct terminology especially when the nurse may need to alert other health professionals such as doctors, and adequately respond in an emergency.'*

This confirms the local investigation interview notes of 19 December 2019.

Ms Pogorzelska confirmed in oral evidence the importance of using correct medical terminology for effective communication with all professionals. It was put to her in cross examination that you were able to use the correct terminology. Ms Pogorzelska refuted this.

The panel noted the following from your witness statement:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In cross examination you made general assertions that, whilst on GICU, you did not know you were being assessed, were inadequately supported and that you did not know the written feedback was being provided to your manager but not to you.

For the same reasons and analysis outlined above at sub-charge C3, the panel determined Ms Pogorzelska to be a reliable and credible witness. The panel preferred the

evidence of Ms Pogorzelska. As previously identified, the panel did not accept your assertion that you were unsupported on the unit.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

E2

2	9/11/2019	Was unable to use the correct names for medical equipment

The panel found the facts alleged at sub-charge E2 proved.

The panel had regard to Ms Pogorzelska's witness statement, contemporaneous feedback report dated 9 November 2019, and her local investigation interview notes dated 19 December 2019. The panel also had regard to your oral and documentary evidence.

The panel noted the following from Ms Pogorzelska's statement:

> *'At paragraph five of my feedback… it is stated:* "Lydia's medical/nursing terminology is very poor. She struggled to remember names of the basic medical equipment, such as: transducer, pump, monitor (calling all pieces of equipment: machine)…'*It is important for a nurse to use the correct terminology especially when the nurse may need to alert other health professionals such as doctors, and adequately respond in an emergency. Without using the correct names for medical*

equipment, or anatomy/ physiology, a nurse may not provide a doctor with an adequate and clear explanation of a medical problem with a patient.'

This confirms the local investigation interview notes of 19 December 2019.

Ms Pogorzelska confirmed in oral evidence the importance of using the correct names for medical equipment to ensure effective communication with all professionals. It was put to her in cross examination that you were able to use the correct names for medical equipment. Ms Pogorzelska refuted this.

The panel noted the following from your witness statement:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

In cross examination you made general assertions that, whilst on GICU, you did not know you were being assessed, were inadequately supported and that you did not know the written feedback was being provided to your manager but not to you.

For the same reasons and analysis outlined above at sub-charge C3, the panel determined Ms Pogorzelska to be a reliable witness. The panel did not accept your assertion that you were unsupported on the unit.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to

“get rid” of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pogorzelska and found this sub-charge proved.

E3

3	19/11/2019	Failed to provide a complete/effective handover

The panel found the facts alleged at sub-charge E3 proved.

The panel took into account UHBW’s Record Keeping Principles and Standards policy, and the supernumerary pack for GICU, and was satisfied that you had a duty to use a recognised format in which to impart clinical information during any handover. The panel was satisfied that there was a clear professional duty, supported by UHBW’s documentation policy, to ensure a standard handover process, correct language use, and a consistent framework to avoid ambiguity.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Ms Russell with a feedback summary of the shift she supported you on, dated 19 November 2019, a subsequent email sent to Ms Russell following this shift but undated in the bundle, and local interview notes dated 21 January 2020. The panel also had regard to your oral and documentary evidence.

The panel noted the following from Ms Pollock’s written statement:

> *‘I asked Lydia to provide a structured handover of a patient. The handover was disjointed, not systematic and lacked information. Lydia had been with this patient in the morning so she should have been fully aware that the patient had been intubated that morning and that they had also been peri-arrest, which is when the patient’s condition is very unstable and care must be taken to prevent*

> *a full cardiac arrest. Lydia had also been involved in placing the patient in prone position (laying on their front). Lydia explanation was that "the patient had become poorly and needed this" pointing to the ventilator. This was not what I would expect even from a new qualified nurse.'*

In oral evidence Ms Pollock confirmed her local investigation interview notes.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, whilst not explicit to this shift, indicates that at the beginning of your time in GICU you acknowledged you were struggling with giving handover.

In cross-examination, it was put to Ms Pollock that in relation to your handover on this date, on 19 November 2019, you had received negative feedback that day and you were under stress and that affected your ability to effectively prepare/deliver the handover. Ms Pollock advised you were not pressured to undertake this task and were allowed to attempt it as you requested to. Furthermore, modelling by another nurse was utilised to consolidate your learning. Ms Pollock stated observations of handovers would have occurred on every shift you would have undertaken. Your position was that a lack of one consistent mentor impacted on your learning and progression.

In cross-examination you maintained the position that Ms Pollock failed to adequately support you. Further you claim you never received any feedbacks and that Ms Pollock 'wrote all of these things behind my back'. You reiterated that you were being monitored and treated differently. You initially called Ms Pollock a liar and a racist who was supporting a previous manager as part of a conspiracy against you. You later retracted the statement that Ms Pollock was a liar.

For the same reasons and analysis outlined above at sub-charge C8, the panel determined Ms Pollock to be a reliable witness. The panel noted that effective handovers of patients and clinical information is a basic, core and transferable skill of a registered nurse. The panel did not accept your assertion that you were unsupported on the unit.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock found this sub-charge proved.

E4

4	19/11/2019	Failed to use medical language/terminology

The panel found the facts alleged at sub-charge E4 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy, and the supernumerary pack for GICU, and was satisfied that you had a duty to use the correct medical language and terminology as referred to in these documents. The panel was satisfied that there was a clear professional duty, supported by UHBW's documentation, for you to use standard medical language and terminology to ensure consistency and avoid ambiguity.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Ms Russell with a feedback summary of the shift she supported you on dated 19 November 2019, a subsequent email sent to Ms Russell following this shift but undated in the bundle, and local investigation interview notes dated 21 January 2020. The panel also had regard to your oral and documentary evidence.

The panel noted the following from Ms Pollock's written statement:

> *'We had discussed at [you] mid point the importance of using medical terminology to demonstrate professionalism and understanding.'*

The panel further noted the following in the feedback summary of shift:

> *'Lydia finds it difficult using medical language*
> *'Lydia is not aware of or understands some medical acronyms'*

In oral evidence Ms Pollock confirmed her written statement and local investigation interview notes.

Ms Pollock was not cross-examined directly on this sub-charge, however Ms Pollock raised your failure to use medical terminology as a concern when discussing other sub-charges.

The panel noted the following from your witness statement:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

At sub-charge E3 above, the panel has previously identified your responses in cross-examination that you were not adequately supported, as well as your assertion that Ms Pollock was part of a conspiracy against you.

For the same reasons and analysis outlined above at sub-charge E3, the panel determined Ms Pollock to be a reliable witness. The panel noted that use of correct medical language/terminology is a basic, core and transferable skill of a registered nurse. The panel did not accept your assertion that you were unsupported on the unit.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock and found this sub-charge proved.

E5

5	19/11/2019	Was unable to use the correct names for medical equipment

The panel found the facts alleged at sub-charge E5 proved.

The panel had regard to the oral and documentary evidence of Ms Pollock, which included her witness statement, GICU supernumerary orientation pack, an email to Ms Russell with a feedback summary of the shift she supported you on, dated 19 November 2019, a subsequent email sent to Ms Russell following this shift but undated in the bundle, and local investigation interview notes dated 21 January 2020. The panel also had regard to your oral and documentary evidence.

The panel noted the summary of shift dated 19 November 2019:

> *'Lydia explained to me that the patient had become poorly and needed this – pointing to the ventilator.'*

The panel further noted the following in the local interview notes:

> *'She couldn't use medical language; she referred to the ventilator as the breathing machine.'*

In oral evidence Ms Pollock confirmed her written statement, local investigation interview notes, and the summary of shift.

The panel noted the following from your witness statement:

> ***'Use of Medical Terminology / ABCDE Understanding***
> *I made efforts to understand the terminology and processes used in ICU. I asked questions. I attended training. I sought out support. I was not perfect, but I was committed. Instead of being supported, I was scrutinised and punished.'*

At sub-charge E3 above, the panel has previously identified your responses in cross-examination that you were not adequately supported, as well as your assertion that Ms Pollock was part of a conspiracy against you.

The panel considered that using correct medical terminology includes using the correct names for medical equipment. Having found the facts proved at sub-charge E4, and having regard to Ms Pollock's evidence above, the panel was satisfied that you were unable to use the correct names for medical equipment on 19 November 2019.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Pollock and found this sub-charge proved.

E6

6	24/11/2019	Failed to provide a complete/effective handover

The panel found the facts alleged at sub-charge E6 proved.

The panel took into account UHBW's Record Keeping Principles and Standards policy, and the supernumerary pack for GICU, and was satisfied that you had a duty to use a recognised format in which to impart clinical information during any handover. The panel was satisfied that there was a clear professional duty, supported by UHBW's documentation policy, to ensure a standard handover process, correct use of language/terminology, and a consistent framework to avoid ambiguity.

The panel had regard to Ms Hewer's witness statement, contemporaneous feedback report dated 24 November 2019, a letter from Ms Hewer to Ms Russell following the 24 November 2019 shift and her oral evidence. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Hewer's contemporaneous letter:

> *'Lydia handed over to the oncoming night nurse. I told her beforehand that I expected her to use a structured approach such as SBAR or A-E. Lydia did hand over, but did not successfully use a structured approach. Some information was missed, which I interjected with at the end, or repeated 3 times.'*

This was confirmed in Ms Hewer's witness statement, where she also explained the importance of an effective handover:

> *'This information is necessary for the oncoming nurse to assess any deterioration of the patients that are being handed over.'*

This was confirmed in Ms Hewer's oral evidence.

In cross examination it was put to Ms Hewer that the handover given by you broadly contained all the information required. Ms Hewer acknowledged some of the information as correct but reiterated that some of the information was missing. Ms Hewer confirmed that your handover was not structured. It was further put to Ms Hewer that this lack of detail could have stemmed from different expectations from your previous role, and this would explain the missing information. Ms Hewer disagreed and stated that a detailed handover is required regardless of the clinical setting.

The panel noted your responses to your employer's initial investigation of 12 and 19 December 2019, whilst not explicit to this shift, indicates that at the beginning of your time in GICU you acknowledged you were struggling with giving handover. You also asserted you were the victim of racial bias and were subject to greater scrutiny.

For the same reasons and analysis outlined above at sub-charge A11, the panel determined Ms Hewer to be a reliable witness. The panel noted that completing an effective handover is a basic, core and transferable skill of a registered nurse. The panel did not accept your assertion that Ms Hewer's negative feedback of you was racially motivated.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Hewer and found this sub-charge proved.

E7

7	17/6/2020	Failed to provide an effective handover

The panel found the facts alleged at sub-charge E7 proved.

The panel established you had a duty to provide an effective handover through reference to UHBW's Record-Keeping Standard in Health Records Policy and the Cardiac Surgery New Starter Park.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 17 June 2020. The panel also considered Ms Thomas's written statement, which provides details of the importance of completing an effective handover, and Ms Leech's oral evidence and near-contemporaneous written feedback dated 18 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

Ms Sims's written contemporaneous feedback report states:

> *'Lydia agreed to give updates from the nightshift handover to the nurse in charge and day team. She required quite a lot of assistance with some of the medical terms and explaining the plan for these patients. The handover was lengthy and SBAR format was not used.'*

In the appendix to the disciplinary investigation report, Ms Thomas confirms that you did not use the SBAR format and did not provide an effective handover.

The panel noted your duty to complete an effective handover in Ms Thomas's written statement:

> *'On numerous occasions Lydia was shown how to implement the SBAR (Situation, Background, Assessment, Recommendation) mechanism when communicating information to another healthcare professional. This is an extremely important mechanism and is one adopted by all nurses within* [NBT] *and indeed nationally. It is key for communicating critical information that requires attention and action – thus contributing to effective escalation and increased patient safety.'*

Ms Thomas's statement also explicates that one of your agreed nursing objectives was to provide an effective handover.

The panel also had regard to the evidence of Ms Leech, whose written feedback of 18 June 2020 reports asking you to complete some work on a topic using an SBAR format:

> *'Lydia feels unconfident using SBAR'*

In this feedback, Ms Leech also reports:

> *'Lydia said she did a very foolish thing yesterday, and handed over. She said she felt foolish and wish she had waited. I explained that handing over was part of her role and she should be handing over with supervision. I asked is she had given handover in the last two and a half weeks..[sic] Lydia expressed that she is not always able to listen and write at the same time due to stress and being new. She feels this is improving.'*

The panel noted this conversation pertains to a shift on 17 June 2020. The panel considered this indicates that during your time on the cardiac ward, you appear to have struggled with completing an effective handover.

In cross examination, it was put to Ms Leech that you were able to complete an effective handover. At re-examination, Ms Leech confirmed the duty to complete an effective

handover, and reiterated that this skill is a basic, transferable skill expected of even a newly qualified nurse, which you did not demonstrate.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

The panel also took account of its assessment of your reflective account regarding this sub-charge in its decision at sub-charge C18, and your general assertion that Ms Sims was part of a plan to destroy your career. As above, the panel did not accept this assertion, noting you were subject to a clear plan of assessment at the time.

For the same reasons and analysis outlined above at sub-charge C18, the panel was satisfied Ms Sims's evidence was reliable. It noted the inconsistency of your evidence in relation to this sub-charge, and preferred the evidence of Ms Sims.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards

you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and therefore found this sub-charge proved.

E8

8	19/6/2020	Received a handover without supervision

The panel found the facts alleged at sub-charge E8 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's contemporaneous feedback report:

> *'As I arrived back to the ward from my afternoon break, Lydia was independently receiving a handover for a patient whom had come back from the cath labs after having a pacemaker fitted. I interrupted the handover asking the nurse to re-handover. After the nurse had left I asked Lydia if she thought it was appropriate to take handover of a patient without supervision. Lydia explained she was just going to write everything handed over down and give me the paper. Lydia states she told the nurse she was new to the ward and needed them to explain everything that had happened since the patient have been in the labs. I asked Lydia if she understood the content of the handover and appropriate questions to ask the nurse, to which she did not. I have informed Lydia, she needs to be supervised and assessed as competent before completing tasks independently. Lydia has been informed she is not currently at the stage to work independently and to maintain the safety of*

patients she should go and find another registered nurse to take the handover if I am not around.'

In the appendix to the local disciplinary investigation report, Ms Thomas confirms reports that on this shift you:

'Received a patient from lab alone, had not understood handover.'

The panel noted your reflective account date 19 June 2020, and that whilst indicating actions relating to receiving a handover of a patient, it does not reflect your mentor's feedback that you received this patient without the required supervision.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career'*.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

For the same reasons and analysis outlined above at sub-charge D10, the panel was satisfied Ms Kidner's evidence was reliable. The panel did not accept your assertion that there was a conspiracy to get rid of you, noting you were subject to a clear plan of assessment at the time and that this was why your performance was being monitored and feedback provided. It considered Ms Kidner to be an experienced educator, and on the balance of probabilities determined her version of events to be more reliable. The panel preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

E9

9	19/6/2020	Failed to provide an effective/complete handover

The panel found the facts alleged at sub-charge E9 proved.

The panel established you had a duty to provide an effective handover through reference to UHBW's Record-Keeping Standard in Health Records Policy and the Cardiac Surgery New Starter Park.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's contemporaneous feedback report:

> *'Lydia handed over the patients to the night staff this evening, after we spent time today going through the SBAR communication tool. Lydia needed prompting and additional information to be provided. Lydia began using no structure to the handover, before I reminded her [to] start from the beginning of the handover sheet and work her way across. She started to read out all past medical history, I reminded her she only has 20-25 minutes to hand all the patients over and to only read out relevant past medical history… Lydia needs to continue doing the nursing handovers to improve her abilities and confidence. Lydia is yet to use the e-handover to update the handovers, due to her time management with other tasks.'*

The panel also noted the starter pack, which outlines effective handovers as an objective. Ms Thomas's statement also explicates that one of your agreed nursing objectives was to provide an effective handover.

In cross examination, it was put to Ms Leech that you were able to complete an effective handover. At re-examination, Ms Leech confirmed the duty to complete an effective

handover, and reiterated that this skill is a basic, transferable skill expected of even a newly qualified nurse, which you did not demonstrate.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

For the same reasons and analysis outlined above at sub-charge E8, the panel was satisfied Ms Kidner's evidence was reliable. The panel did not accept your assertion that there was a conspiracy to get rid of you, noting you were subject to a clear plan of assessment at the time and that this was why your performance was being monitored and feedback provided. It considered Ms Kidner to be an experienced educator, and on the balance of probabilities determined her version of events to be more reliable. The panel preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

E10

10	19/6/2020	Gave incorrect and incomplete patient information to a doctor

The panel found the facts alleged at sub-charge E10 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's contemporaneous feedback report:

> *'Another patient had spiked a temperature, I asked Lydia to contact the doctor to review the patient and we spent 30 minutes this morning discussing the SBAR communication tool…When she spoke to the doctor she informed the doctor the patient had a temperature of 37c and the patient had a temperature of 39.3c. She also could not remember what procedure the patient was waiting for, despite having the handover and patient notes in front of her. Both these matters were discussed with Lydia.'*

The panel also noted objective three from your set individualised objectives for this ward:

> '*Having identified a deteriorating patient NEWS score Lydia will complete a full clinical assessment and demonstrate an effective patient handover to the responding medical team member.'*

The panel considered that, while this sub-charge does not concern patient handovers formally, the correct relay of important information about patients is a related skillset.

The panel noted your reflective account date 19 June 2020, and that whilst indicating you discussed the patient with a doctor, it does not provide details of the accuracy of that discussion.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

In response to panel questions, you stated that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings.

For the same reasons and analysis outlined above at sub-charge E8, the panel was satisfied Ms Kidner's evidence was reliable. The panel did not accept your assertion that there was a conspiracy to get rid of you, noting you were subject to a clear plan of assessment at the time and that this was why your performance was being monitored and feedback provided. It considered Ms Kidner to be an experienced educator, and on the balance of probabilities determined her version of events to be more reliable. The panel preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

E11

11	25/6/2020	Failed to provide an effective/complete handover

The panel found the facts alleged at sub-charge E11 proved.

The panel established you had a duty to provide an effective handover through reference to UHBW's Record-Keeping Standard in Health Records Policy and the Cardiac Surgery New Starter Park.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 25 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

Ms Sims's written contemporaneous feedback report states:

> *'[Your] handovers are not systematic and [I] feel she may not be prepared to give an adequate handover for a clinically deteriorating/sick patient in an emergency.'*

In the appendix to the disciplinary investigation report, Ms Thomas confirms that your use of SBAR '*requires improvement'* on 25 June 2020.

The panel noted your duty to complete an effective handover in Ms Thomas's written statement:

> *'On numerous occasions Lydia was shown how to implement the SBAR (Situation, Background, Assessment, Recommendation) mechanism when communicating information to another healthcare professional. This is an extremely important mechanism and is one adopted by all nurses within* [NBT] *and indeed nationally. It is key for communicating critical information that requires attention and action – thus contributing to effective escalation and increased patient safety.'*

Ms Thomas's statement also explicates that one of your objectives was to provide an effective handover.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

The panel also took account of its assessment of your reflective account regarding this sub-charge in its decision at sub-charge E7, and your general assertion that Ms Sims was part of a plan to destroy your career. As above, the panel did not accept this assertion, noting you were subject to a clear plan of assessment at the time.

For the same reasons and analysis outlined above at sub-charge E7, the panel was not satisfied of the cogency and reliability of your evidence in relation to this sub-charge.

For the same reasons and analysis outlined above at sub-charge E7, the panel was satisfied Ms Sims's evidence was reliable, and preferred this to your evidence.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

E12

12	26/6/2020	Informed a patient they were wrong when the patient correctly queried an incorrect dosage of amitriptyline

The panel found the facts alleged at sub-charge E12 not proved.

The panel noted that the facts alleged in this item of Schedule E do not pertain to the concern alleged. It noted that the stem of this sub-charge concerns poor communication. The panel further noted that the evidence it has seen for this sub-charge relates to medication administration, and it has seen no evidence of poor communication from you in relation to this sub-charge.

Accordingly, the panel determined that the NMC had failed to discharge its burden in respect of this sub-charge and found it not proved.

E13

13	26/6/2020	Failed to provide an effective handover

The panel found the facts alleged at sub-charge E13 proved.

The panel established you had a duty to provide an effective handover through reference to UHBW's Record-Keeping Standard in Health Records Policy and the Cardiac Surgery New Starter Park.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Kidner. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Kidner's evidence.

The panel considered Ms Kidner's contemporaneous feedback report:

> *'Lydia's nursing handover still remains very time consuming, I have to interrupt for[sic] several times as she doesn't give up to date information.'*

In the appendix to the disciplinary investigation report, Ms Thomas confirms that '*areas for improvement remain handover'* on 26 June 2020.

The panel also noted the starter pack, which outlines effective handovers as an objective. Ms Thomas's statement also explicates that one of your agreed nursing objectives was to provide an effective handover.

In cross examination, it was put to Ms Leech that you were able to complete an effective handover. At re-examination, Ms Leech confirmed the duty to complete an effective handover, and reiterated that this skill is a basic, transferable skill expected of newly qualified nurses, which you did not demonstrate.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Kidner's evidence generally, you said that Ms Kidner was writing about you behind your back, withholding feedback, gossiping, monitoring you, lying, and was '*part of the plan to get rid of me and destroy my career*'.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

For the same reasons and analysis outlined above at sub-charge E8, the panel was satisfied Ms Kidner's evidence was reliable. The panel did not accept your assertion that there was a conspiracy to get rid of you, noting you were subject to a clear plan of assessment at the time and that this was why your performance was being monitored and feedback provided. It considered Ms Kidner to be an experienced educator, and on the balance of probabilities determined her version of events to be more reliable. The panel preferred the evidence of Ms Kidner.

Accordingly, the panel accepted the evidence of Ms Kidner and found this sub-charge proved.

E14

14	29/6/2020	Provided an ineffective/incomplete and inaccurate handover in respect of a deteriorating patient

The panel found the facts alleged at sub-charge E14 proved.

The panel had regard to the fact that the only direct evidence presented by the NMC in support of this sub-charge was the hearsay evidence of Ms Sims. However, for the reasons previously given above, the panel determined that it could attach considerable weight to Ms Sims's evidence.

The panel considered the evidence of Ms Sims, which included a contemporaneous feedback report dated 29 June 2020.

In reaching its decision, the panel also had regard to your oral and documentary evidence.

Ms Sims's written contemporaneous feedback report provides a highly comprehensive and detailed summary relating only to this sub-charge. Her account indicates multiple instances where she needed to intervene due to your omissions, errors and inability to provide an effective handover in respect of a deteriorating patient:

> *'The handover was chaotic and not performed systematically… Once the nurse practitioner logged onto eobs to review the observations it was noted that the patient had been documented as receiving oxygen. The nurse practitioner asked Lydia if this was true to which Lydia stated the patient was not on oxygen. At this point I went to the patient to clarify and reported back that the patient was on 2lo2 via a nasal cannula.'*

The panel noted your duty to complete an effective handover in Ms Thomas's written statement:

> *'On numerous occasions Lydia was shown how to implement the SBAR (Situation, Background, Assessment, Recommendation) mechanism when communicating information to another healthcare professional. This is an extremely important mechanism and is one adopted by all nurses within [NBT] and indeed nationally. It is key for communicating critical information that requires attention and action – thus contributing to effective escalation and increased patient safety.'*

Ms Thomas's statement also explicates that one of your agreed nursing objectives was to provide an effective handover.

The panel noted your reflective accounts from June 2020, where you explicitly identify feedback from your mentors, demonstrating learning from your shifts and identifying how you can change or improve your practice as a result.

When cross-examined about Ms Sims's evidence generally, you said that Ms Sims was monitoring you, that this scrutiny was based in racial bias, and '*when she got training from [Ms Thomas] and all of them, she started saying all the wrong things'* and her evidence was part of the surveillance of you.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

The panel also took account of its assessment of your general assertion that Ms Sims was part of a plan to destroy your career. As above, the panel did not accept this assertion, noting you were subject to a clear plan of assessment at the time.

For the same reasons and analysis outlined above at sub-charge E7, the panel was satisfied Ms Sims's evidence was reliable, and preferred this to your evidence.

The panel noted your assertion that your treatment was influenced by racial bias and amounted to institutional racism. It found the background evidence presented of this to be general and not specific to your case. It found there to be no evidence before it establishing that racial bias existed in the ward or unit in which you were working at the time or that the NMC witnesses were or may have been motivated by racial bias towards you at the time of the concerns or that they were or may have been involved in a plan to "get rid" of you as you have also alleged. The panel concluded that the concern as set out in the sub-charge was genuinely held and substantiated by the evidence presented.

Accordingly, the panel accepted the evidence of Ms Sims and found this sub-charge proved.

E16

16	23/11/2022	Struggled with providing effective handovers

The panel found the facts alleged at sub-charge E16 proved.

The panel had regard to the oral and documentary evidence of Ms Duncan-McKenzie, which included her witness statement and contemporaneous feedback report dated 23 November 2022. The panel also had regard to your oral and documentary evidence.

The panel took into account the following from Ms Duncan-McKenzie's contemporaneous feedback report:

> *'L.E continues to struggle with handing over the patients entrusted in her care, there have been improvements in this area, but more work is required.'*

This was confirmed in Ms Duncan-McKenzie's written statement:

> *'Lydia struggled with handing over of patients. She was not able to adequately hand over such information as patient's name, age or why they had been admitted. She was always anxious and nervous while doing her handovers. She had a lot of*

anxiety with this including the time when she described the incident about the relative's fall referred to above. However, handing over is a basic nursing task.'

In cross-examination it was put to Ms Duncan-McKenzie that you were able to provide effective handovers. Ms Duncan-McKenzie stated that you were anxious and panicky, that you did try and would make an effort but maintained that you struggled with handovers. It was put to Ms Duncan-McKenzie that her feedback from 23 November 2022 was wrong. This was refuted by Ms Duncan-McKenzie. Finally, it was put to Ms Duncan-McKenzie that she was either mistaken, had misremembered this, or, in the alternative had not been truthful. Ms Duncan-McKenzie refuted this and stated that she stood by her evidence.

In your oral evidence you said stated that Ms Duncan-McKenzie told the panel that you were *'doing everything right'*.

In cross-examination, when asked to explain why you said Ms Duncan-McKenzie would 'call you out' you said *'[Ms Duncan-McKenzie] had been told to do that'* and that this was due to Ms Morris, who *'started to get Black people on board'*.

In response to panel questions, you stated that you knew what a handover was and acknowledged that communicating key information was important. You also said that this is a transferable skill that you had used previously in other settings. You said that no one told you there were issues with your handovers.

The panel considered Ms Duncan-McKenzie to be a reliable witness. In respect of this sub-charge, the panel took account of all of Ms Duncan-McKenzie's evidence and determined it to be consistent and cogent throughout. Her live evidence was corroborated by contemporaneous documentation and was not undermined by cross examination. The panel determined that Ms Duncan-McKenzie's assessment was objective and balanced, and there was no reason to disbelieve her evidence. The panel preferred this contemporaneous record of Ms Duncan-McKenzie outlining in detail the events on shift,

which was consistent with her oral evidence. The panel also did not accept your assertion that Ms Morris had gotten Ms Duncan-McKenzie ‘on board’ in targeting you.

Accordingly, the panel accepted the evidence of Ms Duncan-McKenzie and found this sub-charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant’s ability to practise safely and effectively without restriction.

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Mr Malik referred the panel to the case of *Calhaem v General Medical Council* [2007] EWHC 2606 Admin, which sets out that when considering whether allegations represent deficient professional performance, so as to impair a practitioner's fitness to practice, their standard of performance must be unacceptably low, and represent a fair sample of their work. Mr Malik referred the panel to NMC's Guidance at FtP-2b on cases concerning a lack of competence, and submitted that this reinforces that a lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of work, which could put patients at risk.

Mr Malik summarised the panel's findings on facts, and submitted that a considerable amount of the charges found proved are serious and concern your practice in the areas of patient assessment, medication administration, time management, documentation/record-keeping, and communication. He noted numerous instances of drug administration errors, which had the potential to cause serious harm to patients. In particular, he noted that it was found you intended to attach an IV line containing air bubbles to a patient's central line, which carries with it the potential of fatality.

Mr Malik noted the panel also found failures to provide a competent, effective handover when you had a professional duty to do so. In respect of communication, Mr Malik submitted that it has been found that you failed to use correct medical language and terminology and failed to name correct basic medical equipment.

Mr Malik invited the panel to take the view that the charges found proved amount to a lack of competence.

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.

Mr Malik identified the specific, relevant standards where your actions amounted to a lack of competence. He submitted that the following sections of the Code had been breached: 1.2, 1.4, 7.1, 8.2, 8.3, 8.6, 10.1, 10.2, 13.1, 13.3, 18.1, 18.3, and 20.1.

Mr Malik submitted that all the charges found proved show an unacceptably low standard of performance. He submitted that the facts found proved show that you failed to deliver the fundamentals of care on more than one occasion due to lack of skills, knowledge and judgment, and these clinical aspects in which you failed relate to fundamental aspects of nursing practice.

Mr Malik submitted that these breaches of the Code amount to a lack of competence and that lack of competence in any area of nursing practice puts patients at risk, whether that be from record keeping, communication, assessment of patients, medication, administration or time management. He submitted your lack of competence affected your ability to practice safely and this exposed residents and patients in your care to a very serious risk of harm.

Ms Bennet submitted that the panel must consider the findings taken together are a fair and representative picture of your practice.

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 referred to the decision of Mrs Justice Cox, and her reference to Dame Janet Smith's “test”. He submitted that, while there is no evidence of patient harm, your actions exposed patients to an unwarranted risk of harm. He submitted that, in the absence of full insight and remediation, the risk of repetition and future harm remains.

Mr Malik submitted that your actions brought the nursing profession into disrepute, and that you have breached fundamental tenets of the nursing profession.

Mr Malik submitted that there is a continuing risk to public protection and the wider public interest due to you not being able to demonstrate safe practice.

Mr Malik noted that you have not provided a detailed reflection, nor any evidence of steps you have taken to strengthen your practice. On this basis, he submitted that a finding of impairment is necessary to uphold professional standards, avoid undermining public confidence and trust in the nursing profession and the NMC as regulator.

Ms Bennet accepted that the findings are serious, and noted that there have been no allegations of harm, abuse or dishonesty in this case. She submitted there are no allegations of deliberate harm, and that the concerns in this case are not attitudinal. She submitted that while this does not mitigate the seriousness, it is relevant to current impairment.

Ms Bennet asked the panel to consider the distinction between historical risk and current impairment. She submitted that it is a question for the panel whether the facts found proved demonstrate a continued and unmanaged risk.

Ms Bennet submitted that the concerns in this case are capable of being remedied. She noted that you are not currently working as a registered nurse, and have not provided a recent reflection. However, Ms Bennet submitted that this does not mean that you are incapable of remediation. She informed the panel that you most recently worked as an HCA, and no concerns were raised in respect of your practice. Ms Bennet submitted that

the most recent workplace evidence available is positive, and your current insight is supported by your reflections, your additional learning, and your willingness to return to practice. Ms Bennet confirmed to the panel that it should consider the training, reflections, case studies, clinical feedback forms and testimonials submitted by the RCN, as well as your most recent witness statement.

The panel accepted the advice of the legal assessor.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***7 Communicate clearly***
> *To achieve this, you must:*
>
> *7.1 use terms that people in your care, colleagues and the public can understand*

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code'

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel was satisfied that the NMC has provided a fair sample of examples from your practice upon which the panel could base its decision. The panel took into account the overwhelming number of sub-charges in the appendix, and noted of the charges proved that they occurred at numerous different times, while you were working at two different trusts and across three different practice areas. The panel reviewed the facts found proved holistically and was satisfied that the examples before it provided a detailed picture representative of your practice.

The panel was concerned by the repeated failures in patient assessment, medication administration, time management, documentation/record-keeping, and communication as reported by numerous different supervisors, assessors, and practice educators over a significant period of time. The panel noted these are fundamental areas of nursing practice, and that your conduct at numerous charges placed patients at risk of serious harm. The panel took into account that the concerns with your practice persisted despite extended induction periods, formal support plans, supervised practice and regular feedback. The panel noted that the facts found proved include many failure charges where it is assessed you had a professional duty to undertake tasks correctly and did not.

In these circumstances, the panel was satisfied this demonstrates unacceptably low standards of performance for a registered nurse and determined that you demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, your fitness to practise is currently impaired. The panel reminded itself that a finding of lack of competence does not automatically result in a finding of current impairment.

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. To justify that trust, nurses 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) …'

The panel found that the deficiencies identified had the potential to place patients at unwarranted risk of physical harm as a result of your lack of competence.

In respect of patient assessment, the panel has found numerous instances of incomplete risk assessments, as well as an inability to define a patient's airway status, an inability to identify a normal blood pressure reading, and an unfamiliarity with full ABG test results and the Glasgow Coma Score. The panel was satisfied that these areas are fundamental to nursing practice, and incompetence in these areas had the potential to cause serious harm to patients.

In respect of medication administration, the panel has found numerous failures in the calculation, administration and understanding of medication. The panel was most concerned by the evidence that it has heard regarding your intent to attach an IV line containing air bubbles into a patient's central line, given the potential of fatality. The panel was satisfied that incorrect administration and calculation of medication can cause serious physical harm to patients who may receive the incorrect dosages of important medication as a result of your lack of competence.

In respect of time management, the panel noted the evidence it has seen, and the charges proved, that you took an excessive amount of time to complete medication rounds and that you struggled to prioritise your workload and required repeated prompting from colleagues. The panel was satisfied that prolonged drug rounds had the potential to cause physical harm to patients who may be impacted on by a delay receiving subsequent medication. The panel also considered that these deficiencies in time management required intervention by your colleagues, and that this unduly impacted on their workloads, which could have the effect of detracting their attention from patients in their care.

In respect of documentation/record-keeping, the panel noted it has found failures in completing observations, care plans, relevant clinical documentation and a risk assessment, and nursing notes related to discharge. The panel was satisfied that inadequate or incorrect records had the potential to cause real harm to patients as it affects the continuity between shifts, evaluation of treatment and ongoing care provided to the patient.

In respect of communication, the panel noted it has found failures in the use of professional medical language and terminology, including the correct names of equipment, and providing effective handovers. The panel was satisfied that consistent use of correct and professional language is fundamental in the delivery of safe and effective care of patients. The panel also determined that being unable to communicate the care requirements to colleagues in a standard format at handover had the potential to cause harm to patients.

The panel considered that patient assessment, medication administration, time management, documentation/record-keeping, and communication are core clinical skills. It was satisfied, on the whole, that continuous, categorical and sustained deficiencies in these fundamental areas of nursing practice brought the nursing profession reputation into disrepute.

The panel next considered the fundamental tenets of the nursing profession being the ability to practise effectively, preserve safety, promote professionalism and trust, and prioritise people. The panel took a holistic view of the charges found proved and was satisfied that your lack of competence has breached these fundamental tenets.

Regarding insight, the panel noted that it has not been provided with any recent reflections from you addressing the findings made by this panel. The reflections and case studies that the panel has seen were prepared a number of years ago. The panel accepted at the time that you had undertaken some learning and reflection in areas including medication administration, communication, record keeping and patient assessment. These reflective accounts contained within your bundle were prepared prior to the panel's findings on the facts, and do not provide an indication of your current levels of insight into the charges found proved, nor any practical changes resulting from this insight. The panel considered these historical reflections to be predominantly descriptive, lacking analysis and application to practice, and therefore they provide limited assistance when assessing your current level of insight into the deficiencies found proved.

The panel also considered your more recent witness statement dated 15 April 2025, and that it largely attributes the concerns underpinning the charges to discrimination, excessive scrutiny, witness unreliability and institutional failings. The panel noted what you have told it regarding the context of these charges, and that you believe you were subject to disproportionate scrutiny due to discrimination.

The panel also took account of the NMC Guidance on context at FtP-12, in particular commitment three to carefully consider evidence of discrimination, victimisation, bullying or harassment. The panel accepted that you genuinely believe that aspects of your treatment within the workplace were influenced by discrimination and that these experiences form part of your lived experience. While the panel carefully considered those submissions, it found limited evidence within the witness statement demonstrating acceptance of the clinical deficiencies found proved or recognition of the risks those deficiencies had the potential to create for patients.

The panel note Ms Bennet indicated your main evidence for insight should be assessed on the historical reflections and that the panel was to treat your witness statement cautiously and to see evidence you presented related to discrimination as background context and not primary evidence.

Accordingly, the panel was not satisfied that you currently demonstrate full insight into the lack of competence found proved. The panel assessed your current insight as limited.

In its consideration of whether you have taken steps to strengthen your practice, the panel has not seen any evidence of your current practice. It noted you are not currently working in a clinical environment. The panel noted the evidence you have provided is in relation to what appears to be mandatory training you completed at the last trust you worked for. The panel also considered that you have undertaken some targeted training and produced case studies relevant to some areas of nursing competence. The panel noted this material is historical and the panel considered that the material provided lacked specific analysis. The panel has not seen any information as to how this training has been consolidated into your most recent clinical practice.

The panel bore in mind that you most recently worked in a clinical environment as an HCA and accepted that the feedback from that role was generally positive. The panel accepted that this evidence demonstrates an ability to work safely within the scope of that role. However, the panel considered that it provides only limited assistance in determining whether the deficiencies identified in relation to registered nursing practice have been fully remediated. The panel therefore attached limited weight to this evidence when assessing your current competence as a registered nurse.

The panel also considered the positive testimonials you have submitted, and that there is a recurrent theme attesting to your kindness and compassion. However, the panel determined that these testimonials were ultimately general in nature, did not provide detail into your clinical practice as a registered nurse in the areas of concern, and often related

to historical working relationships that pre-dated the charges. The panel has not been provided with any recent testimonials. Accordingly, the panel could not place significant weight on these testimonials.

The panel accepted that the concerns identified are capable of remediation, however, the panel was not satisfied that the concerns have been sufficiently addressed. It noted that the concerns occurred at two different trusts and three clinical areas, and persisted despite additional support being provided for a significant period of time. The panel has not seen evidence of sufficient insight or remediation. Whilst some evidence of learning and training was provided, the panel was not provided with objective evidence demonstrating sustained safe practice as a registered nurse. The panel therefore concluded that there remains a risk of repetition.

The panel therefore decided 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. In reaching this decision the panel bore in mind the need for the public to trust nurses to practise safely, effectively and autonomously. The panel considered that the charges found proved are serious, based on significant and sustained deficiencies in fundamental, core areas of nursing. The panel was satisfied that your lack of competence could seriously impact public confidence in the profession, and that a fully informed member of the public would expect regulatory action in such circumstances. The panel therefore determined that a finding of current impairment is in the public interest to declare and uphold proper professional standards.

Accordingly, the panel determined that your fitness to practise is currently impaired by reason of lack of competence on public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Prior to hearing submissions on sanction the panel was informed that you were no longer represented in these proceedings. You advised you were content to proceed without representation, and the panel allowed you full opportunity to consider this. Thereafter you confirmed you were content to proceed unrepresented.

Mr Malik informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months, with a review, if it found your fitness to practise currently impaired. Mr Malik submitted that this position has not changed.

The panel also bore in mind your submissions that a suspension period was not necessary. You acknowledged that the charges are serious. You informed the panel of your work history in Ghana as a nurse and midwife in numerous practice areas. You also provided a brief background of this referral, including the local investigation at the Trust. You informed the panel you have never previously been referred to the NMC. You reiterated that you are passionate about nursing, and that you care deeply about the patients in your care.

You informed the panel that no concerns were raised in relation to your practice in the 12 years prior to these allegations whilst working at UBHW.

You invited the panel to impose no sanction. You said you have done a lot of reflection on the charges although you are not currently working in a clinical environment. You expressed a desire to return to nursing, especially in the practice areas in which the charges arose in order to establish your competence.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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:

- deficiencies in practice which had the potential to put people receiving care at unwarranted risk of harm
- lack of competence that occurred repeatedly over a prolonged period from 9 September 2019 until 9 February 2023, across two different trusts and three different practice areas, as formally assessed by a multitude of practice educators
- very limited insight and reflection which, at this time, appears to be in its early stages
- limited evidence of remediation and application of this knowledge

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the concerns in this case, and the public protection issues identified. 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 your actions were not at the lower end of the spectrum. It noted its previous finding that your actions posed a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that a caution order would be neither proportionate nor in the public interest.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. 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 was satisfied, this being a lack of competence case, that there are identifiable areas of your practice in need of assessment and retraining. The panel considered whether it has seen evidence of your potential and willingness to respond positively to retraining. The panel has noted your rejection of some of your formalised feedback from your educators previously, and an overreliance on any feedback that was positive. The panel noted that the deficiencies identified persisted despite prolonged supervision, mentoring, competency reviews and regular feedback from experienced senior colleagues. The panel also noted your position that at times identified ongoing standardised evaluation such as during induction periods, necessary to ensure patient safety, as a form of excessive scrutiny.

The panel noted that you have sought a 'volunteer supervised practice role' and made an enquiry in 2023 about completing a return to practise course, but the panel has seen no evidence that either of these have been confirmed.

The panel noted that you have provided some historical reflection and evidence of historical continued professional development, including evidence of some training in the areas of concern. However, the panel considered that your insight is very limited and appears to be in its early stages. The panel also considered the positive testimonials you have submitted on your behalf, and which spoke to your kindness, but noted these are also historical.

Notwithstanding your more recent efforts to provide the panel with more recent information, the panel was nonetheless concerned about your willingness to meaningfully engage with any conditions of practice given its findings as to your rejecting formal assessments that are critical of you, and seeking to over rely upon favourable feedback.

The panel noted that you were found to have shown a consistent and prolonged lack of competence in fundamental areas of nursing practice across three clinical areas and two

different trusts. The multitude of concerns across numerous practice areas raises serious concerns for public safety. In these circumstances, the panel were not satisfied that conditions of practice could be formulated that are workable in this case as any conditions would be so restrictive as to amount to suspension.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the concerns of this case and maintain public confidence.

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 a lack of competence is not fundamentally incompatible with a registered nurse remaining on the register. The panel noted your continued engagement in the fitness to practise process, and balancing all of the above factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel considered that this order is necessary to protect the public, 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 standards of competence and professional practice required of a registered nurse.

The panel determined that a suspension order for a period of 12 months, with a review, was appropriate in this case to mark the extent of the lack of competence.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

Any future panel reviewing this case would be assisted by:

- A detailed written reflective piece specifically addressing the findings of this panel.
- Evidence of professional development, including documentary evidence of relevant training courses completed in the relevant clinical areas (patient assessment, medication administration, time management, documentation/record-keeping, and communication) and application of this knowledge.
- Any other evidence demonstrating that the deficiencies identified by this panel have been addressed, and that safe and effective practice can be maintained. This may include up-to-date testimonials or character references from employers or line managers in any field.

This will be confirmed to you in writing.

Interim order

As the suspension 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 suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Malik. He invited the panel to impose an interim suspension order for a period of up to 18 months to allow time for any appeal to be resolved.

You did not make submissions in relation to an interim order.

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 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 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 allow time for any appeal to be lodged and resolved.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.