Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 11 November – Wednesday, 19 November 2025
Tuesday, 7 April – Friday, 10 April 2026

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

Friday, 26 June 2026

Virtual Hearing

Name of Registrant:	**Mandy June Jilley**
NMC PIN:	85Y3702E
Part(s) of the register:	RN5 Registered Nurse Sub Part 1 Learning disabilities- level 1 – (20 November 1988)
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, Lay member) Elaine Whitton (Registrant member) Sally Bourner (Lay member)
Legal Assessor:	Natalie Byrne (11 – 19 November 2025) Charlotte Mitchell-Dunn (7 – 10 April 2026 and 26 June 2026)
Hearings Coordinator:	Eleanor Wills (11 – 19 November 2025) Nicola Nicolaou (7 – 10 April 2026 and 26 June 2026)
Nursing and Midwifery Council:	Represented by Maham Malik, Case Presenter (11 – 19 November 2025, and 7 – 10 April 2026) Iwona Boesche (26 June 2026)
Ms Jilley:	Present and not represented at the hearing (11 – 19 November 2025 and 7 – 10 April 2026) Not present and not represented at the hearing

	(26 June 2026)
Facts proved:	Charges 1a(iii), 1b, 2a(ii)(a), 2a(ii)(b), 2b(i), 2b(ii), 3a, 3b, 4a, 4b, 5a(i), 5a(ii), 5a(iii), and 5b
Facts not proved:	Charges 1a(i), 1a(ii), 2a(i)(a), 2a(i)(b), 2a(i)(c), 2a(i)(d), and 2a(i)(e)
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reason on application for a postponement

At the outset of the hearing, you made an application under Rule 32 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to postpone the hearing.

You provided the following timeline of events. You informed the panel that, on 16 May 2025, your legal representatives at the time suddenly, and in your opinion unfairly, withdrew from acting for you. You stated that you had previously been represented since 2020 and had been instructed by your representative to not contact the Nursing and Midwifery Council (NMC). You submitted that you contacted your NMC Case Officer to ask questions about the process. You stated that your representative at the time withdrew, having been forwarded your correspondence with the NMC by your NMC Case Officer, without your knowledge or permission.

You stated that on 28 July 2025 you made a Subject Access Request (SAR) to the NMC in respect of these emails with your NMC Case Officer. Further you filed a formal complaint against your NMC Case Officer.

You submitted that you have been extremely proactive regarding your case management since May 2025. You stated that the concerns relating to Kitnocks Nursing Home ('Kitnocks') arose in 2020 and further allegations relating to Uplands Hospital ('Uplands') were added in 2022. You submitted that you have been under investigation for over five years, during which time the allegations have changed against you. You informed the panel that you have not been subject to an interim order, but you stated that you have not been able to obtain employment as a Registered Nurse, due to having to disclose to prospective employers that you are subject to an NMC investigation.

You informed the panel that you have made four SARs, two to Uplands and two to Kitnocks, on 9 October 2025 and 7 November 2025. You submitted that you have applied for copies of your own records in relation to patient documentation and incident reports.

You submitted that your SARs are complex, and you are unsure as to the length of time it would take to receive the requested documentation.

You informed the panel that on 13 October 2025 you had a case conference with the NMC, at which time you did not have access to the NMC's documentation for your case. You submitted that at this case conference you asked for the allegations against you to be reframed. You stated that the wording was unfair, in that you are not able to properly respond to the charges. You submitted that there was no discussion regarding your request.

You informed the panel that on 6 November 2025 you had a preliminary hearing, during which you applied for a postponement of the substantive hearing. Your application was refused.

You therefore requested that today's panel postpone the substantive hearing to allow you time to receive the requested documentation, which is the subject of the SARs. You submitted that you are at disadvantage as you do not have access to your records and documentation from your employer to support your case. You submitted that the panel does not have all the relevant information before it to consider this case.

Ms Malik, on behalf of the NMC, opposed the application to postpone the hearing. She submitted that the allegations date back to 2020 and there is a public interest in the expeditious disposal of the case. Ms Malik submitted that there has been proper and extensive case management. There was a case conference on 13 October 2025 and a preliminary hearing on 6 November 2025, during which your previous application to postpone the substantive hearing was refused.

Ms Malik acknowledged that you are unrepresented and that your previous representation came off record on 16 May 2025. Ms Malik submitted that you are not applying for a postponement on the basis of seeking alternative representation. She submitted that your application to postpone has been made on the basis that you are awaiting receipt of

documentation, having made SARs on 9 October 2025 and 7 November 2025. She submitted that you have had sufficient opportunity to gather evidence in advance of the substantive hearing and have not made any disclosure requests to the NMC.

Additionally, Ms Malik submitted that you are currently unable to confirm the required length of any postponement if granted. She submitted that to postpone this case on the first day of the substantive hearing would not be in the interests of justice.

Ms Malik therefore invited the panel to refuse your application to postpone the hearing.

The panel accepted the advice of the legal assessor who referred the panel to Rule 32 and the NMC guidance titled *'When we postpone or adjourn hearings'* reference *'CMT-11'*, last updated 13 January 2023. The legal assessor also referred the panel to the case of *CPS v Picton* [2006] EWHC 1108 (Admin).

The panel took into account that you have been aware of all the allegations for at least three years, albeit the wording of the allegations may have changed. The panel noted that you have previously had the benefit of legal representation. The panel acknowledged that you have been unrepresented since 16 May 2025, approximately six months. The panel noted that you are not requesting a postponement on the basis of seeking alternative representation.

The panel took into account that you were served the Notice of Hearing on 8 October 2025; you participated in a case conference on 13 October 2025 and attended a preliminary hearing on 6 November 2025.

The panel had regard to the fact that you stated that you made the SAR requests to Uplands and Kitnocks on 9 October 2025 and 7 November 2025. The panel took into account that you are requesting your records in relation to patient documentation and incident reports. Having had regard to all the documentation already before it the panel

was unclear as to the extent the requested documentation would assist in the consideration of your case.

The panel determined that you have had sufficient time to explore whether further documentation was available to support your case, having been aware of all the allegations for at least three years, and having been aware that you were no longer represented since May 2025. In reaching this decision the panel took into account that you made the SARs on 9 October 2025 and 7 November 2025 and determined that these requests were made at a late stage in proceedings. The panel concluded that it is in the public interest to consider this case expeditiously in order to ensure that the public is protected and to maintain confidence in the profession and the NMC as the regulator. The panel was satisfied that it had sufficient evidence before it to fully explore the concerns and make a decision.

The panel noted that the length of the postponement applied for is unknown, due to your submission that you are currently awaiting communication from Uplands and Kitnocks. The panel had regard to the potential inconvenience to witnesses who also may be unable to attend a hearing at a later date.

The panel determined that it was also in your interest that this hearing should proceed given that you have been subject to ongoing NMC proceedings for approximately five years and have stated that due to the investigation you have been unable to obtain employment as a registered nurse. The panel noted that you are unrepresented, however it took into account that you will have the opportunity to challenge the NMC's evidence in due course.

In all the circumstances the panel decided to refuse your application to postpone the substantive hearing. The panel determined that no injustice would be caused to either party and it was in the interests of justice to proceed with the hearing.

Decision and reasons on first application to amend the charges

The panel heard an application made by Ms Malik to amend the wording of the stem of charge 2b.

The proposed amendment was to insert the words *'you incorrectly'* before the word *'stated'*. It was submitted by Ms Malik that the proposed amendment would provide clarity.

> *"That you, a registered nurse:*
>
> *2. Whilst working as a senior nurse at Kitnocks Nursing Home:*
>
> *…*
>
> *b. In response to an investigation in relation into the events in charges 2(a)(i) and 2(a)(ii),* ***you incorrectly*** *stated:*
>
> *…*
>
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

The panel heard submissions from you. You did not object to the amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity.

Decision and reasons on second application to amend the charges

During Virgina Beacham's witness evidence, the panel of its own volition, proposed to amend charge 1b, in order to provide clarity.

The proposed amendment was to insert the words *'dated 13 May 2019, 17:00'* after the words *'Patient A's record'*.

> *"That you, a registered nurse:*
>
> *1. Whilst working at Uplands Hospital as the nurse in charge:*
>
> *…*
>
> *b. On 14 May 2019, did not clearly state that the entry made in Patient A's record,* ***dated 13 May 2019, 17:00*** *was made retrospectively*
>
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

The panel heard submissions from Ms Malik and you in respect of the proposed amendment. Neither party objected to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, to ensure clarity.

Decision and reasons on third application to amend the charges

During your evidence, Ms Malik proposed to amend charge 2a(i), to more accurately reflect the evidence. Ms Malik submitted that the application was being made at this

late stage due to the fact that the NMC had not previously had sight of the evidence in respect of your shift pattern between 15 and 20 December 2019.

The proposed amendment was to remove the word *'On'* and insert the words *'Between 15 and'* before *'20 December 2019'.*

> *"That you, a registered nurse:*
>
> *2. Whilst working as a senior nurse at Kitnocks Nursing Home:*
>
> *a. In relation to Patient B:*
>
> *i. ~~On~~* ***Between 15 and*** *20 December 2019, did not take appropriate action to treat Patient B's grade 2 pressure sore, in that:*
>
> *….*
>
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

You objected to the application. You submitted that the application was made at a very late stage and the NMC has previously had the opportunity to request your shift pattern in advance of the substantive hearing.

The panel accepted the advice of the legal assessor and had regard to Rule 28. The legal assessor referred the panel to the case of *The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Jozi* [2015] EWHC 764 (Admin).

The panel noted that you prepared your case in relation to the charges as originally drafted. However, the panel noted that the NMC has presented its case in respect of your actions or lack thereof, between 15 and 20 December 2025 in relation to charge 2a(i). Furthermore, the panel took into account that the witnesses have been questioned by Ms Malik and yourself in relation to your actions or lack thereof, between 15 and 20 December 2025 in relation to charge 2a(i).

The panel took into account that it is in the interests of justice that the charge adequately reflects the real mischief of the case. The panel noted that this application does come at a late stage and that the NMC has the burden of proof and should have obtained the evidence in respect of your shift pattern between 15 and 20 December 2019, in advance of the hearing.

However, the panel determined in all the circumstances that such an amendment was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed, in that the case had been presented and witnesses questioned by both you and Ms Malik in respect of your actions or lack thereof, between 15 and 20 December 2025 in relation to charge 2a(i). It was therefore appropriate to allow the amendment, to more accurately reflect the evidence.

Decision and reasons on fourth application to amend the charges

At the conclusion of your evidence, the panel of its own volition, proposed to amend charge 4b.

The proposed amendment was to replace the word *'On'* with the word *'By'* and insert the word *'had'* before the word *'only'.*

"That you, a registered nurse:

4. Between November 2019 and January 2020:

…

*b. ~~On~~ **By** 21 December 2019 regarding the admission of an unknown patient, **had** only completed 14 of the 425 questions on the admission questionnaire*

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

The panel heard submissions from Ms Malik who agreed with the proposed amendment.

You submitted that the proposed amendment widens the scope of the charge, and it is procedurally unfair.

The panel accepted the advice of the legal assessor and had regard to Rule 28. The legal assessor referred the panel to the case of *The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Jozi* [2015] EWHC 764 (Admin).

The panel noted that you prepared your case in relation to the charges as originally drafted. However, the panel took into account that the NMC has presented its case in respect of your actions in the lead up to 21 December 2019 in relation to charge 4b. The panel also noted that the stem of charge 4 states *'Between November 2019 and January 2020'*. Furthermore, the panel took into account that the witnesses have been questioned by Ms Malik and yourself in relation to your actions concerning care plans in the weeks leading up to 21 December 2019 in relation to charge 4b.

The panel took into account that it is in the interests of justice that the charge adequately reflects the real mischief of the case. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed, in that the stem of the charge states *'Between November 2019 and January 2020'* and the case has been presented and witnesses questioned by both you and Ms Malik in respect of your actions in the weeks leading up to 21 December 2019, in relation to charge 4b. It was therefore appropriate to allow the amendment, to more accurately reflect the evidence and provide clarity.

Details of charges (as amended)

That you, a Registered Nurse:

1. Whilst working at Uplands Hospital as the nurse in charge:
    a. On 13 May 2019:
        i. Did not countersign [Lauren Sheperd's] incident report
        ii. Did not make the necessary amendments to [Lauren Sheperd's] incident report to ensure its accuracy
        iii. Provided insufficient detail in relation to the entry made at 20:00 in Patient A's notes
    b. On 14 May 2019, did not clearly state that the entry made in Patient A's record, dated 13 May 2019, 17:00 was made retrospectively

2. Whilst working as a senior nurse at Kitnocks Nursing Home:
    a. In relation to Patient B:
        i. Between 15 and 20 December 2019, did not take appropriate action to treat Patient B's grade 2 pressure sore, in that:
            a) You did not ensure that Patient B was given an air mattress
            b) You did not arrange offloading for Patient B
            c) You did not ensure that a repositioning chart was in place
            d) You did not ensure that Patient B's calorie intake was increased
            e) You did not ensure that daily monitoring was put in place
        ii. On 21 December 2019:
            a) Did not update the NEWS2 chart with a score after taking Patient B's observations
            b) Did not call an ambulance in response to Patient B's condition deteriorating
    b. In response to an investigation in relation into the events in charges 2(a)(i) and 2(a)(ii), you incorrectly stated:
        i. You had no knowledge of Patient B's pressure sore
        ii. You had called an ambulance but got an engaged tone

3. Your actions at charges 2(b)(i) and 2(b)(ii) were dishonest, in that
    a. You knew these statements to be untrue
    b. You sought to avoid blame for your failings in patient care

4. Between November 2019 and January 2020:
    a. Did not complete and update care plans for patients
    b. By 21 December 2019 regarding the admission of an unknown patient, had only completed 14 of the 425 questions on the admission questionnaire

5. In relation to Patient C:
    a. Administered Olanzapine at the wrong time, being:
        i. 14:00 on 31 December 2019
        ii. 16:00 on 1 January 2020
        iii. 17:30 on 4 January 2020
    b. Did not seek medical advice from a General Practitioner for your actions at charge 5a.

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

Background

The NMC received a referral on 11 March 2020 by the General Manager at Cornerstone Health Ltd. You were allegedly involved in a series of incidents at Kitnocks during your time working there.

- You allegedly failed to provide care or update the care plan for Patient B, who had a pressure sore. You later denied that you knew about the pressure sore, despite having seen a message on the CareDocs system sent by a colleague and subsequent entries in Patient B's daily notes.

- You allegedly inadequately assessed Patient B, when it was noticed that their condition has worsened, and failed to calculate and record their NEWS2 score.
- You allegedly failed to call an ambulance for Patient B, despite finding and recording that they had oxygen saturation levels of 80-82%. You later said that you did call an ambulance but heard an engaged tone
- You allegedly failed to update care plans for patients in your care
- You allegedly failed to complete the questionnaire for a new patient, only completing 14 of the 425 questions for this, delaying their care plan from being produced
- You allegedly administered medication to Patient C later than prescribed and failed to seek advice from a General Practitioner (GP) regarding this.

Concerns were also raised at your previous place of work, Uplands, as you allegedly failed to adequately and/or appropriately record, or countersign records for two incidents involving the restraint of Patient A in May 2019, when it was your responsibility to do so.

Decision and reasons on service of relevant documentation

During your oral evidence a query was raised by you, as to whether you have had sufficient opportunity to review the relevant documentation in advance of the hearing.

Ms Malik submitted that you were sent the documentation, in the form of the Case Examiners bundle, in April 2024, at which time you were represented. Ms Malik submitted that the evidence relied on by the NMC has remained substantively unchanged since April 2024.

Ms Malik submitted that you were then sent the draft hearing bundles for the substantive hearing on 22 April 2025, at which time you were represented. Your representative came off record on 16 May 2025. Ms Malik submitted that you accessed the documentation on 19 May 2025 sent by secure email.

Ms Malik submitted that on 8 October 2025 you were sent the Notice of Hearing and the charges, to your registered email address by secure email.

On 13 October 2025 you had a case conference meeting with the NMC, at which you raised you did not have access to the relevant documentation. Ms Mailk submitted that on 13 October 2025 you were resent the relevant documentation for the substantive hearing to your registered email address by secure email.

Ms Malik submitted that the NMC could not send the relevant documentation password protected, due to the size of the documentation. Ms Malik informed the panel that the relevant documentation was also sent to you via recorded delivery to your registered address.

On 17 October 2025 you confirmed you were able to access the relevant documentation by secure email.

Ms Malik submitted that you informed the NMC that on 18 October 2025, after a Royal Mail missed delivery card was posted, you applied to the Royal Mail for redelivery to your local Royal Mail post office. However, you stated that the documentation had not been delivered.

Ms Malik submitted that a preliminary hearing was held on 6 November 2025 which you attended, at which it was raised that you have had issues accessing the relevant documentation. It was determined that the NMC had made considerable efforts to assist with your access to the relevant documentation.

Ms Malik submitted that you have had sufficient opportunity in advance of the hearing to have access to the relevant documentation sent to you by secure email and by recorded delivery. She submitted that the NMC has complied with the requirements of Rules 11 and 34.

You confirmed that you have had access to the relevant documentation in advance of the hearing.

The panel accepted the advice of the legal assessor.

The panel had regard to the timeline of events in respect of service of the relevant documentation and the Notice of Hearing. The panel was satisfied that you have had sufficient opportunity in advance of the hearing to access the documentation and prepare your case. The panel was also satisfied that you have been served with the relevant documentation and the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on facts

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Jane Shaw: Clinical Manager at Kitnocks during the relevant time;

- Virgina Beacham: Deputy Manager at Uplands during the relevant time;

- Ovidiu Stoenescu: Senior Night Nurse at Kitnocks during the relevant time;

- Christopher Hayden: Telephony Manager at South Central Ambulance Service during the relevant time;

- Daniela Moldovan: Night Nurse at Kitnocks during the relevant time.

The panel also heard evidence from you under affirmation.

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

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

Charges 1a(i) and 1a(ii)

'That you, a Registered Nurse:

1. *Whilst working at Uplands Hospital as the nurse in charge:*
   a. *On 13 May 2019:*
      i. *Did not countersign [Lauren Sheperd's] incident report.*
      ii. *Did not make the necessary amendments to [Lauren Sheperd's] incident report to ensure its accuracy'*

These charges are found NOT proved.

In reaching this decision, the panel took into account Virginia Beacham's oral evidence and witness statement signed and dated 19 April 2024.

‘Mandy was the only nurse on shift at the time of the two incidents, so she would have been expected to write up a PSN regarding each incident, or to have at least checked and countersigned the PSNs written up by support staff. Mandy hadn’t been involved in the first of the two incidents, but had been present during the second incident, allowing [Lauren Sheperd] *to take the lead in the intervention.*

[…]

When asked about the PSN, Mandy said that [Lauren Sheperd] *had volunteered to write this up. She checked* [Lauren Sheperd’s] *PSN but said she didn’t countersign this because it wasn’t an accurate record of what had happened. If Mandy wasn’t happy with* [Lauren Sheperd’s] *report, she could have made amendments to this herself, as it was an electronic report.’*

The panel took into account the local investigation meeting notes dated 20 May 2019 and the following findings of facts within the corresponding investigation report completed by Virginia Beacham.

‘There is no countersignature from [you] *for the entry made by* [Lauren Sheperd] *relating to the events of the afternoon in her role as a nurse.*

[…]

In the meeting held with MJ and myself on 20th May 2019, MJ stated she had not been made aware of the incident at the time, and that she had not checked if the PSN or daily notes had been completed as ‘[Lauren Sheperd] *completed this, I didn’t countersign at this time.* [Lauren Sheperd] *said she would complete incident form, I think she completed the incident form as one with both incidents recorded.’ When asked by* [sic] *if she had checked the entry regarding the incident MJ replied “No she hadn’t.*

[…]

[Virginia Beacham] – *you did not countersign the entry made by* [Lauren Sheperd], *why was this?*

MJ: Because I didn't think it was a true of accurate record. I didn't know what would happen if I did sign it.'

The panel had regard to the two incident reports (PSNs), both PSNs were retrospectively completed by Sharon Wemyss.

The panel had regard to Lauren Sheperd's entry in Patient A's notes dated 13 May 2019. The panel noted that Lauren Sheperd's account referred to both incidents and was not countersigned.

Having had regard to all the evidence before it, the panel determined that the incident report as referred to in the charges, is the account provided by Lauren Sheperd in Patient A's notes dated 13 May 2019.

The panel took into account your oral evidence in which you stated that you had not been involved in the first incident, and you were not directly involved in the second incident. You stated that you did not witness the events which lead to the restraint of Patient A but came upon the incident when three support workers were already restraining Patient A. You stated that you kindly asked the support workers to stop restraining Patient A and subsequently you reported the incident to Virginia Beacham. You stated you were told by Virginia Beacham that Lauren Sheperd would complete the patient notes and incident report form. When questioned you stated that it was not normal practice to countersign patient notes and in any event, you did not witness the event, and you were not directly involved in the incident. You stated that you therefore did not countersign Lauren Sheperd's incident report or write your own account as you did not witness the full event,

but came upon the aftermath of the incident, at which point Patient A was restrained. You stated that you provided a full handover to the night staff.

The panel, having had regard to the PSNs and your oral evidence, was satisfied that you were on duty as the nurse in charge at the time, you were not involved in the first incident, however you were involved in the second incident, albeit only once Patient A had been restrained.

Having had regard to Patient A's notes and your oral evidence, the panel concluded that you did not countersign Lauren Sheperd's incident report. Further you did not make any amendments to the account to ensure its accuracy. In reaching this decision the panel took into account that you previously stated that you had not checked Lauren Sheperd's incident report.

The panel considered whether you had a duty as the nurse in charge on the shift, to countersign Lauren Sheperd's incident report or make necessary amendments to the account.

The panel took into account that there was no clear policy before it regarding your role and responsibilities at Uplands as the nurse in charge in relation to reporting incidents involving patients on your shift and having to countersign and/or amend colleagues' accounts. The panel also noted that in Patient A's notes there was no identifiable area which indicated that entries required a countersignature.

Having had regard to Virginia Beacham's oral evidence and witness statement the panel was satisfied that there was an expectation that, as the nurse in charge, you should have written up a PSN regarding each incident or at least checked and countersigned the PSNs written up by support staff and made any necessary amendments.

However, the panel took into account that you stated you reported the incident to Virginia Beacham, the Deputy Manager at Uplands at the time, who was senior to you. The panel

noted that Virginia Beacham was subsequently involved in the investigation of the incidents in relation to Patient A, having immediately reviewed the CCTV footage of the incident with Sharon Wemyss. Additionally, the panel took into account that Sharon Wemyss, the Registered Manager of Uplands, subsequently completed the PSNs for both incidents having apparently not been satisfied with Lauren Sheperd's account and having reviewed the CCTV footage.

The panel therefore concluded that, with Virginia Beacham and Sharon Wemyss reviewing the CCTV footage, there was confusion as to who was the senior member of staff overseeing these incidents. The panel concluded that it was reasonable for you to assume that it was not your responsibility to countersign or amend Lauren Sheperd's account. In reaching this decision the panel took into account that you were not involved in the first incident and not directly involved in the second incident, there was no clear policy stating you had an obligation to countersign or amend Lauren Sheperd's account and two more senior nurses were involved in the investigation and write up of the incidents.

The panel therefore determined that, on the balance of probabilities, charge 1a(i) and 1a(ii) are found not proved.

Charge 1a(iii)

'That you, a Registered Nurse:

1. *Whilst working at Uplands Hospital as the nurse in charge:*
   a. *On 13 May 2019:*

      …

      iii. Provided insufficient detail in relation to the entry made at 20:00 in Patient A's notes.'

This charge is found proved.

In reaching this decision, the panel took into account Virginia Beacham's oral evidence and witness statement signed and dated 19 April 2024.

> *'Mandy also had made a very brief record in Patient As daily notes at 8pm on 13 May, which mainly discussed the aftercare provided to* [Patient A] *following the first incident and only made limited reference to the incident itself* […] *I asked Mandy about this during our interview, and she said that she had let staff know about the incidents verbally during handover. This wasn't sufficient; there were a few patients to keep track of at the time, and staff can't be expected to remember everything that has recently happened with them, which is why it's important that staff have written notes to refer to.'*

The panel had regard to your entry in Patient A's notes dated 13 May 2019, 20:00, which appeared to give an overview of Patient A's food, drink and medication during the shift and in which the only reference to the incident was *'restrained earlier'*.

The panel had regard to the PSNs completed retrospectively by Sharon Wemyss. The panel noted that in relation to Patient A, the first incident occurred at 15:46 and the second incident at 16:38. The panel noted the PSN included an overview of the CCTV footage which evidenced that you were present during part of the second incident and would have witnessed the restraint of Patient A. You told the panel, in oral evidence, that restraint of a patient is a serious incident and only used as a last resort. The panel took into account that your entry in Patient A's notes was made some time after the incidents and provided no detail of the nature of the restraint, who was involved, and why it had occurred.

The panel took into account the local investigation meeting notes dated 20 May 2019 and the following findings of facts within the corresponding investigation report completed by Virginia Beacham.

> *'*[Virginia Beacham] – *your entry in the daily notes is brief and was made at 20:00 but there is no mention of the incident why was this?*

MJ – I gave a full handover to night staff.'

You stated in oral evidence that you had provided sufficient detail in your entry in Patient A's notes dated 13 May 2019, 20:00, and that you were not directly involved in the incident. You stated that you gave a full handover to the night staff. You stated that your entry at 17:00 on 13 May 2019 was a continuation of the same note.

The panel noted that the subject of the charge is in relation to your entry in Patient A's notes at 20:00 on 13 May 2019. The panel was of the view that your entry in Patient A's notes, at 20:00 on 13 May 2019, was insufficient, in that you were the nurse in charge at the time, and you only briefly referred to Patient A having been restrained earlier. A serious incident had occurred involving the restraint of a patient which the panel determined should have been recorded accordingly and in sufficient detail, explaining why the patient was restrained, how they were restrained and by whom, and that you had reported it to Virginia Beacham. The panel was not satisfied that your entry was sufficient in that you provided more detail in respect of Patient A's daily activities than you did about the incident.

The panel therefore determined that, on the balance of probabilities, charge 1a(iii) is found proved.

Charge 1b

'That you, a Registered Nurse:

1. *Whilst working at Uplands Hospital as the nurse in charge:*

…

   b. *On 14 May 2019, did not clearly state that the entry made in Patient A's record, dated 13 May 2019, 17:00 was made retrospectively.'*

This charge is found proved.

In reaching this decision, the panel took into account Virginia Beacham's oral evidence and witness statement signed and dated 19 April 2024.

> *'Mandy had made another entry regarding both incidents on 14 May, but her notes weren't indicated as having been made retrospectively* […] *It is important that all patient notes, including ones made retrospectively, are made as clear as possible to ensure that staff have an accurate clinical picture of the patients they are caring for. If they don't have this, this can involve clinical risks for the patients, as the staff caring for them won't be able to make fully informed decisions on the patients' behalf.'*

The panel had regard to your entry in Patient A's notes dated 13 May 2019, 17:00. The panel noted that your entry at 17:00 dated 13 May 2019 started with the word *'continued'* which was underlined and was not marked as a retrospective entry. The panel noted that your entry timed at 17:00 on 13 May 2019 predates your first entry timed at 20:00 on 13 May 2019.

The panel took into account the local investigation meeting notes dated 20 May 2019 and the following findings of facts within the corresponding investigation report completed by Virginia Beacham.

> *'*[Virginia Beacham] – *You then made entries in the daily notes dated 13/5/19 at 17:00 on the 14th May 2019, but you did not make it clear these were retrospective entries, why was this?*
>
> *MJ – 'Oh well',* [Sharon Wemyss] *said to leave a gap for her to write so I did.'*

You stated that you made an entry on Patient A's notes on 13 May 2019 before handover and had then left a gap in the notes as directed by Sharon Wemyss. You stated you then

continued your notes after said gap on the next page. When questioned you stated that you could not provide an explanation in respect of the different times of the entries on 13 May 2019, namely 20:00 and 17:00, but it may have been due to the fact they were completed at different times.

The panel determined that your explanation was inconsistent with the evidence. In reaching this decision the panel took into account that your first entry on 13 May 2019 was timed at 20:00 and your second entry on 13 May 2019 was timed at 17:00 and the two entries did not flow as a continued narrative. If the entry was a continuation of your notes as indicated by you, then your second entry would not have been timed earlier than your first entry. Additionally, the panel noted that the second entry, timed at 17:00, referred to events which occurred after 17:00, namely events at 17:30, 18:15, and 20:00 on the same day. Furthermore, the panel had regard to the fact that prior to your entry at 17:00 dated 13 May 2019 there were two separate entries dated 14 May 2019 at 04:50 and 10:40/12:35. The panel therefore determined that your explanation provided was inherently implausible and therefore not credible.

The panel concluded that your entry dated 13 May 3019, 17:00 was more likely than not made on 14 May 2019 sometime after 12:35.

Having had regard to Virginia Beacham's evidence, the panel determined that you should have written up your entry before the end of your shift on 13 May 2019 and, if written the following day, it should have been marked as a retrospective entry.

The panel therefore determined that charge 1b is found proved on the balance of probabilities.

Charges 2a(i)(a), 2a(i)(b), 2a(i)(c), 2a(i)(d) and 2a(i)(e)

'That you, a Registered Nurse:

2. *Whilst working as a senior nurse at Kitnocks Nursing Home:*
    a. *In relation to Patient B:*
        i. *Between 15 and 20 December 2019, did not take appropriate action to treat Patient B's grade 2 pressure sore, in that:*
            a) *You did not ensure that Patient B was given an air mattress*
            b) *You did not arrange offloading for Patient B*
            c) *You did not ensure that a repositioning chart was in place*
            d) *You did not ensure that Patient B's calorie intake was increased*
            e) *You did not ensure that daily monitoring was put in place'*

These charges are found NOT proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

> *'On 15 December 2019, one of our patients,* [Patient B]*, was observed to have a grade 2 pressure sore on her heel. This was spotted by one of the nurses on the dayshift, who added a note about the pressure sore to CareDocs* […] *Information about the pressure sore was handed over to another nurse,* [Daniela Moldovan], *that evening, who took a picture of the wound.* [Daniela Moldovan] *handed over information about* [Patient B's] *pressure sore to Mandy the following morning* […]
>
> *On 20 December 2019, another nurse noticed that the pressure sore was black and necrotic. After receiving handover about the pressure sore, Mandy had failed to take any action to treat the issue. She wasn't the only nurse responsible for this, as a few nurses had failed to treat the pressure sore in the days in between, but she*

was the senior nurse, and had received instructions in handover directly from nurse who recorded the issue on CareDocs […] *Mandy should have ensured that the patient was given an air mattress, offloading was arranged (i.e. lifting the wounded foot so to relieve pressure on the heel), a repositioning chart was in place, calorie intake was increased and daily monitoring was put in place and provided a clear handover to next nurse* […]*'*

The panel took into consideration Daniela Moldovan's local statement dated 16 January 2020 in which she confirmed that she had been told by the day nurse, that Patient B had a pressure sore on her left heel which was found in the evening before handover. Daniela Moldovan stated she tried to take a picture in the evening, but one camera was not charged, and the other camera had a full memory. Daniela Moldovan therefore took the picture of the pressure sore in the morning on 16 December 2019, when the camera was charged. Daniela Moldovan stated that she informed the day nurse, you, of the pressure sore, on the morning of 16 December 2019, during handover.

The panel noted Kitnocks's Pressure Ulcer Management Policy and Procedure, last amended on 16 October 2019.

The panel had regard to Patient B's daily notes in relation to the care provided for their pressure sore, between 15 December 2019 and 20 December 2019 and had specific regard to the following entries:

- 15 December 2019, 16:25
    - General Observation: *'Pressure area found on left heel. Body map completed'* – Susan Fleet
- 15 December 2019, 19:24
    - Accident/Incident Form: *'Pressure sore found on left heel during P/C on the bed'* – Susan Fleet
- 15 December 2019, 19:39

    - Health Note: *'…a pressure sore grade 2 was noticed in this evening (see incident and body map) Cream applied, foot elevated. Added on GP list for tomorrow'* – Anemona Oprea
- 16 December 2019, 07:04
    - Photo Record (no photo provided) – Daniela Moldovan
- 17 December 2019, 11:01
    - Personal Care: *'Skin inspection: sore creamed'* – Diane Froggatt
- 17 December 2019, 19:12 and 19:26
    - Body Map Event: *'Area cleaned with saline, Dermol lotion applied as per Marchart.*' – Nicoleta Livanov
- 18 December 2019, 18:18
    - Personal Care: *'Skin Inspection: intack* [sic]*'* – Diane Froggatt
- 20 December 2019, 14:19
    - Telephone Call: *'Spoke with her daughter …informed her regarding* [Patient B's] *pressure sore (left heal); asked her to provide new shoes for* [Patient B]*'* – Nicoleta Livanov
- 20 December 2019, 14:30
    - Personal Care: *'Skin Inspection: Intact'* – Catherine Green
- 20 December 2019, 14:36
    - Photo Record: *'Caption: Left heel'* – Anemona Oprea
- 20 December 2019, 22:47
    - Bed Time: *'*[Patient B] *sleeping all ready* [sic] *in bed…reposition. She went back to sleep…'* – Agency 1 carer

The panel took into account that you made entries in Patient B's daily notes at 16:12 and 16:47 on 16 December 2019 and at 15:09 on 18 December 2019, which did not relate to their pressure sore. The panel therefore concluded that, it was more likely than not, that between 15 and 20 December 2019 you were involved in Patient B's care on 16 and 18 December 2019.

The panel took into consideration that between 15 and 20 December 2019, 14 other individuals participated in Patient B's care in addition to you.

The panel had regard to the local investigation report dated 23 December 2019 in which it was determined that there was no recorded evidence of any proactive steps that had been taken to prevent skin damage to Patient B. Further it was determined that Kitnocks contributed to Patient B's pressure ulcer forming and worsening.

The panel also noted that on 31 December 2019 you had a meeting with Jane Shaw which was, according to Jane Shaw, a formal probation meeting. The panel took into account that no concerns were raised at the *'formal probation meeting'* on 31 December 2019 regarding your care of Patient B's pressure sore.

The panel noted your oral evidence in which you stated that the pressure sore had been observed, recorded on the CareDocs and a Tissue Viability referral was subsequently made. You submitted that Nicoleta Livanov was the named nurse for Patient B's care, and you were not on duty at the time the pressure sore worsened. You stated that it was not your responsibility to provide care for Patient B's pressure sore.

The panel, having had regard to Jane Shaw's oral evidence and your own evidence, determined that Nicoleta Livanov was the named nurse for Patient B at the time, and you were a senior nurse. The panel noted that multiple other individuals were involved in Patient B's care and determined that, having had sight of the Investigation report dated 23 December 2019, there was a collective failing by Kitnocks to provide an appropriate level of care to Patient B. The panel therefore determined that it was not your sole responsibility to care for Patient B's pressure sore.

The panel concluded that between 15 and 20 December 2019 you did not have the sole responsibility to take appropriate action to treat Patient B's grade 2 pressure sore as a senior nurse at Kitnocks.

Accordingly, the panel found that charge 2a(i), in its entirety, was not proved.

Charge 2a(ii)(a)

'That you, a Registered Nurse:

2. Whilst working as a senior nurse at Kitnocks Nursing Home:

a. In relation to Patient B:

ii. On 21 December 2019:

a) Did not update the NEWS2 chart with a score after taking Patient B's observations.'

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

'On 21 December 2019, Mandy was looking after [Patient B] *again* […] *Mandy took down observations for* [Patient B] *but didn't update her NEWS2 chart and give a NEWS2 score.* [Patient B's] *observations included her oxygen saturation levels being at 80%, which is concerningly low* […] *Mandy was handing over to the night nurse* [Ovidiu Stoenescu]. *As soon as she told* [Ovidiu Stoenescu] *about* [Patient B's] *oxygen saturation levels, he immediately went to* [Patient B] *and undertook his own observations, giving* [Patient B] *a NEWS2 score of 8. A NEWS2 score of 8 indicated high risk of sepsis, meaning an ambulance needs to be called.'*

The panel took into consideration Ovidiu Stoenescu's oral evidence and witness statement signed and dated 5 June 2023.

'On 21 December 2019, I started my shift at 7.50pm and received handover from Mandy. Mandy told me during handover that she had taken observations for

[Patient B] *and that* [Patient B] *was poorly. I asked Mandy what* [Patient B's] *NEWS score was, but Mandy was unable to tell me.'*

The panel noted that Ovidiu Stoenescu's account was consistent with their contemporaneous statement and Patient B's daily notes for 21 December 2019, in that you informed Ovidiu Stoenescu during handover that Patient B was not very well, and you had taken observations. However, when asked you could not provide a NEWS2 score and informed Ovidiu Stoenescu that Patient B's oxygen saturation levels were 80-82%.

The panel had regard to Patient B's daily notes in relation to your entries on 21 December 2019:

- 21 December 2019, 20:14
    - Health Note: *'…Her feet and legs have been elevated* […] *Observations this evening, BP 99/54, Pulse 103, Sats varying 80-82%, Respirations 22. Repeat observations 15 minutes later, BP 104/53, Pulse 98, Stats varying 80-82%, Respirations 20. BM 7.6 mmol'* – You

- 21 December 2019, 20:54
    - Health Note: *'*[Patient B] *had a rapid deterioration just prior to hand-over and so I completed observations twice at this time, at 15 minute intervals. I then handed-over to the Night nurse on duty'* – You

The panel noted the Medical Emergency Policy and Procedure for Kitnocks, last amended 1 November 2019.

The panel took into account that on 24 December 2019 Jane Shaw spoke to you informally. Jane Shaw told the panel that they asked you about your understanding of the NEWS2 scoring system and you could not provide an answer, other than to refer to a laminated chart on the wall and then you subsequently became defensive. On 31 December 2019 there was another meeting with you and Jane Shaw which was,

according to Jane Shaw, a formal probation meeting. The panel took into account that one of the concerns raised was your failure to complete a NEWS2 score for Patient B. Jane Shaw stated that she showed you in detail how to use the NEWS2 score system, during this probationary meeting, due to your apparent lack of understanding.

Having reviewed the event report provided in respect of your CareDocs entries, during your period of employment at Kitnocks, the panel noted that entries containing patient observations prior to 31 December 2019 did not contain NEWS2 scores. However, the two entries made on 1 January 2020 included NEWS2 scores. The panel determined that this was consistent with the evidence of Jane Shaw in that she showed you, in detail, how to use the NEWS2 score system on 31 December 2019.

The panel had regard to the hearing notes dated 30 January 2020 which were titled *'probation termination hearing notes'.* However, the panel determined that having had sight of the hearing notes and given that the hearing was dated 30 January 2020 and you were dismissed on 8 January 2020, the hearing notes were in fact regarding your local appeal hearing.

The panel took into account that during your local appeal hearing you were asked if you had completed NEWS2 paperwork, (in respect of Patient B), and you replied, *"you know I didn't".* You stated that you did the NEWS2 scoring for Patient B, in that you measured each of the individual parameters and included them in Patient B's CareDocs. You stated that you did not complete the NEWS2 paperwork but used a document on the wall in the office. You stated that it is easy to calculate, when you have been doing it for a long time, you can estimate it. Further you stated that it is not important to put the score down as anyone can do it, you would be more concerned if someone did not provide the individual parameters.

Your oral evidence was consistent with your account provided at your local appeal hearing and your entries in Patient B's daily notes, in that you were working on 21 December 2019, you undertook observations for Patient B due to their deterioration and then

provided a handover to the night nurse, Ovidiu Stoenescu. Additionally, you stated in your oral evidence that you had done the NEWS2 score calculation and recorded it in Patient B's paper file.

The panel noted that it did not have the NEWS2 chart or the paper file for Patient B. The panel took into account that although you recorded observations for Patient B on 21 December 2019 in their daily notes, you did not record their NEWS2 score. The panel had regard to the evidence of Witnesses 1 and 3 who were clear and consistent in that you had not recorded a NEWS2 score for Patient B in their NEWS2 chart. The panel also had regard to the oral evidence of Ovidiu Stoenescu, who was clear that when they asked you for a NEWS2 score for Patient B, you were not able to provide one.

In all the circumstances the panel determined that it was more likely than not that you did not update the NEWS2 chart with a score after taking Patient B's observations on 21 December 2019. In reaching this decision the panel had regard to the evidence of Ovidiu Stoenescu, the fact that during your probationary meeting on 31 December 2019 you demonstrated a lack of understanding around the NEWS2 scoring system, and during your appeal hearing and oral evidence you maintained that recording the individual parameters was more important than recording the NEWS2 score, which further demonstrated a lack of understanding.

Accordingly, the panel found charge 2a(ii)(a) proved.

Charge 2a(ii)(b)

'That you, a Registered Nurse:

2. Whilst working as a senior nurse at Kitnocks Nursing Home:

a. In relation to Patient B:

ii. On 21 December 2019:

…

b) *Did not call an ambulance in response to Patient B's condition deteriorating.'*

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

> *'Mandy was handing over to the night nurse* [Ovidiu Stoenescu]. *As soon as she told* [Ovidiu Stoenescu] *about* [Patient B's] *oxygen saturation levels, he immediately went to* [Patient B] *and undertook his own observations, giving* [Patient B] *a NEWS2 score of 8. A NEWS2 score of 8 indicated high risk of sepsis, meaning an ambulance needs to be called.* [Ovidiu Stoenescu] *contacted the ambulance services, and* [Patient B] *was collected by an ambulance that evening* […]
>
> *Mandy said that she had tried to call an ambulance for* [Patient B] *during the shift, but that she had heard an engaged tone* […] *If Mandy had called the emergency service and perceived an engaged tone, she should have hung up and tried again until she had gotten through, or she should have asked one of the other nurses for advice. Mandy also failed to document any of this in CareDocs. I believe that Mandy lied about calling an ambulance and made no attempt to do this.'*

The panel took into consideration Ovidiu Stoenescu's oral evidence and witness statement signed and dated 5 June 2023.

> *'*[…] *Mandy said during handover that she had tried calling either 111 or 999 (I don't recall which) for* [Patient B], *but there was an engaged tone. I wasn't there when she made this call, and I didn't hear the engaged tone that she said she heard.'*

The panel noted that Ovidiu Stoenescu's account was consistent with their contemporaneous statement and Patient B's daily notes for 21 December 2019, in that

you had not taken a NEWS2 score for Patient B. Upon handover, Ovidiu Stoenescu went and undertook observations for Patient B and calculated their NEWS2 score, and an ambulance was subsequently called.

The panel noted the Medical Emergency Policy and Procedure for Kitnocks, last amended 1 November 2019.

The panel had regard to Patient B's daily notes for 21 December 2019, in which there was no record of you having attempted to call an ambulance and failing to get past an engaged tone. The panel noted that you had made an entry at 20:14, stating that you had undertaken two sets of observations in a 15-minute interval, both showing *'Sats varying 80-82%'*. The panel noted the evidence of Jane Shaw, that saturation levels of this level would indicate a medical emergency.

The panel also noted the evidence of Jane Shaw who told the panel that phone records had been checked and there had been no evidence of an attempt to dial 999 or 111 at the time.

The panel took into account the local appeal hearing notes in which you stated that you had put the phone on speaker and you had told Ovidiu Stoenescu that you had been trying to contact an ambulance via 999 and 111 and that both the numbers were engaged. The panel noted that this was consistent with your oral evidence in which you stated that you had tried to call an ambulance by dialling both 999 and 111 and received an engaged tone to both numbers. You queried whether there was an issue with the phone lines at Kitnocks.

The panel took into account Christopher Hayden's oral evidence and witness statement signed and dated 26 January 2024 in which they provided an explanation as to the process of dialling 999 and 111 to call an ambulance. The panel took into account Christopher Hayden's evidence that to receive an engaged tone this would be reflective of an overload of calls to the 999 or 111 systems and would not occur due to any issue with

the Kitnocks phone lines. The panel had regard to fact that the likelihood of receiving an engaged tone when dialling either 999 or 111 would be extremely low in that it would involve a major event such as the Streptococcus A outbreak in late 2022/early 2023 and would be national news.

Having had regard to the fact that there was no record of you having made a call to the ambulance service in Patient B's daily notes, Ovidiu Stoenescu clearly and consistently denied having heard an engaged tone, and the extremely low likelihood of receiving an engaged tone from both 999 and 111, the panel determined that your explanation was inherently implausible and therefore not credible.

The panel therefore determined that it was more likely than not that you did not call an ambulance in response to Patient B's condition deteriorating on 21 December 2019.

Accordingly, the panel found charge 2a(ii)(b) proved.

Charge 2b(i)

'That you, a Registered Nurse:

2. Whilst working as a senior nurse at Kitnocks Nursing Home:

b. In response to an investigation in relation into the events in charges 2(a)(i) and 2(a)(ii), you incorrectly stated:

i. You had no knowledge of Patient B's pressure sore.'

This charge is found proved.

In reaching this decision, the panel took into account your local appeal application in which you stated that you had no knowledge of Patient B's pressure sore.

The panel had regard to the local appeal hearing notes, which contained a contemporaneous record of the appeal hearing. The panel took into account that during the appeal hearing you stated that you did not receive any information verbally in the handover but that you would have seen the message if it was on CareDocs. You stated that all the information was new to you and that you were previously not aware that Patient B was developing a pressure sore and stated that a pressure sore does not develop overnight.

The panel noted that no documentary evidence of a formal investigation into the events which led to your dismissal was before it, save for the investigation report of Jane Shaw. However, the panel noted that during the local appeal hearing, Jane Shaw stated that you had previously informed them that *"you had no knowledge of Patient B's pressure sore."* The panel noted Jane Shaw's oral evidence in which they stated they had an informal meeting with you on 24 December 2019, a more formal meeting on 31 December 2019, and a final meeting on 8 January 2020 during which you were dismissed. The panel concluded that it was more likely than not that this comment was made during one of these final meetings and maintained at the local appeal hearing by Jane Shaw.

The panel therefore determined that in response to an investigation in relation to the events in charges 2a(i) and 2a(ii), you had stated that you had no knowledge of Patient B's pressure sore.

The panel next considered whether you incorrectly stated that you had no knowledge of Patient B's pressure sore.

The panel took into consideration Daniela Moldovan's local statement dated 16 January 2020 in which she confirmed that she had been told by the day nurse that Patient B had a pressure sore on her left heel. Daniela Moldovan then took a photograph on the morning of 16 December 2019 of the pressure sore. Daniela Moldovan stated she informed the day nurse, you, of the sore.

The panel had regard to Daniela Moldovan's oral evidence and witness statement dated 27 February 2024, which corroborated her local statement.

The panel took into account Patient B's daily notes in relation to the pressure sore for 15 December 2019 until 21 December 2019 as previously outlined. The panel had regard to your entries in Patient B's daily notes at 16:12 and 16:47 on 16 December 2019, at 15:09 on 18 December 2019 and at 20:14, 20:33 and 20:54 on 21 December 2019.

The panel also took into account that during your oral evidence you stated that you did not remember being aware of Patient B's pressure sore, but if it was recorded in their daily notes, you would have been aware. You also referred to having repositioned Patient B, elevating their feet and having ordered them new boots.

The panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 May 2024 in which they stated that during the appeal hearing you denied receiving handover regarding the pressure sore and denied that you had seen the message on CareDocs. Jane Shaw stated that Kitnocks could see that you had in fact read the message on CareDocs regarding Patient B's pressure sore as there was a digital footprint feature.

The panel determined that your evidence was inconsistent in that you stated that you were unaware of Patient B's pressure sore and yet, according to your own evidence and Patient B's daily notes, you provided care for their pressure sore. The panel therefore preferred the clear and consistent account of Daniela Moldovan which was corroborated by Patient B's daily notes. The panel determined that it was more likely than not that once concerns were raised regarding the treatment of Patient B's pressure sore, you incorrectly claimed that you had no knowledge of the pressure sore to limit your involvement in Patient B's inadequate care which led to their clinical deterioration.

Accordingly, the panel found charge 2b(i) proved.

Charge 2b(ii)

'That you, a Registered Nurse:

2. Whilst working as a senior nurse at Kitnocks Nursing Home:

b. In response to an investigation in relation into the events in charges 2(a)(i) and 2(a)(ii), you incorrectly stated:

…

ii. You had called an ambulance but got an engaged tone.'

This charge is found proved.

In reaching this decision, the panel had regard to the local appeal hearing notes. The panel took into account that during the local appeal hearing you stated that you had put the phone on speaker, and you had told Ovidiu Stoenescu that you had been trying to contact an ambulance via 999 and 111 and that both the numbers were engaged. The panel also noted your oral evidence, where you consistently claimed to have dialled both 999 and 111 and got an engaged tone.

The panel therefore determined that in response to an investigation in relation to the events in charges 2a(i) and 2a(ii), you had stated that you had called an ambulance but got an engaged tone.

The panel next considered whether you incorrectly stated that you had called an ambulance but got an engaged tone.

The panel had regard to its previous findings at charge 2a(ii)(b), in that it determined that your explanation of having heard an engaged tone for both 999 and 111 was inherently implausible and therefore not credible. The panel had determined, in relation to charge 2a(ii)(b), that it was more likely than not that you did not call an ambulance in response to Patient B's condition deteriorating on 21 December 2019.

The panel concluded that it was more likely than not that you incorrectly stated that you had called an ambulance but got an engaged tone in order to cover up for your failure to call an ambulance in response to Patient B's condition deteriorating on 21 December 2019.

Accordingly, the panel found charge 2b(ii) proved.

Charges 3a and 3b

'That you, a Registered Nurse:

3. Your actions at charges 2(b)(i) and 2(b)(ii) were dishonest, in that
a. You knew these statements to be untrue
b. You sought to avoid blame for your failings in patient care.'

These charges are found proved.

In reaching this decision, the panel adopted in its approach the test for dishonesty laid out in the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67:

'What was the defendant's actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?'

The panel referred to the NMC guidance *'Making decisions on dishonesty charges and the professional duty of candour'* reference *'DMA-8',* last updated 6 May 2025.

The panel took account of its previous findings at charges 2b(i) and 2b(ii).

The panel had regard to the fact that it determined that it was more likely than not that once concerns were raised regarding the treatment of Patient B's pressure sore, you

incorrectly claimed that you had no knowledge of the pressure sore to limit your involvement in Patient B's inadequate care which led to their deterioration. Furthermore, the panel concluded that it was more likely than not that you incorrectly stated that you had called an ambulance but got an engaged tone in order to cover up for your failure to call an ambulance until prompted to do so by Ovidiu Stoenescu, in response to Patient B's condition deteriorating on 21 December 2019.

The panel therefore determined that you knowingly incorrectly stated that you had no knowledge of Patient B's pressure sore, and that you had called an ambulance but got an engaged tone; and knew these statements to be untrue. The panel concluded that, having had regard to all the evidence before it, you made these false statements in order to avoid blame for your failure to provide care to Patient B.

The panel determined that your conduct at charges 3a and 3b would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel found charges 3a and 3b proved.

Charge 4a

'That you, a Registered Nurse:

4. Between November 2019 and January 2020:

a. Did not complete and update care plans for patients.'

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

‘We received a lot of complaints from other staff at Kitnocks during Mandy’s time working there, relating to Mandy not completing care plans. When I looked into this, I found that Mandy hadn’t completed care plans for any of the patients who had stayed at Kitnocks since she started.’

The panel had regard to the fact that on 31 December 2019 there was a meeting with you and Jane Shaw which was, according to Jane Shaw, a formal probation meeting. The panel took into account that concerns were raised at the *‘formal probation meeting’* on 31 December 2019 regarding your failure to update care plans or complete assessments for the patient who was admitted on 21 November 2019.

The panel had regard to the appeal hearing notes during which you stated that you had completed care plans, but you had not used CareDocs before. You stated that you previously raised that you did not have sufficient knowledge about the patients to review their care plans and that the care plans you had reviewed were incorrect, so you were not willing to complete them.

The panel noted that this was consistent with your oral evidence in which you stated that you had no introduction to the CareDocs or admission process and did not understand the CareDocs system. However, you stated that you did complete and update your own care plans.

Furthermore, in your local appeal application, when responding to the allegation regarding the care plans, you made reference to power and internet failures on the evening of 5 January 2020, without any further context as to how this impeded your ability to complete and/or update care plans.

The panel took into account that you may have completed your own care plans for patients, however having had regard to your own evidence and the evidence of Jane Shaw, the panel was satisfied that there was clear and consistent evidence that you did

not complete and update care plans for patients in keeping with the standards expected by Kitnocks by use of the CareDocs system.

Accordingly, the panel found charge 4a proved.

Charge 4b

> *'That you, a Registered Nurse:*
>
> > *4. Between November 2019 and January 2020:*
> >
> > *....*
> >
> > *b. By 21 December 2019 regarding the admission for an unknown patient had only completed 14 of the 425 questions on the admission questionnaire.'*

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

> '[…] *For one patient, who had been admitted on 21 December 2019, Mandy had only completed 14 of the 425 questions, meaning this patient didn't have a care plan for the initial part of their stint at Kitnocks.'*

The panel had regard to the fact that on 31 December 2019 there was a meeting with you and Jane Shaw which was, according to Jane Shaw, a formal probation meeting. The panel took into account that concerns were raised at the *'formal probation meeting'* on 31 December 2019 regarding your failure to update care plans or complete assessments for the patient who was admitted on 21 November 2019.

The panel noted that there was some inconsistency regarding for which patient you failed to complete the admission questionnaire. Having heard Jane Shaw and yourself be questioned in oral evidence, the panel was satisfied that charge 4b related to your failure to complete the admission questionnaire for Patient B who was admitted on 21 November 2019.

The panel took into account your oral evidence in which you stated that Jane Shaw had asked you to make a start on the questionnaire for Patient B and it was your view that Nicoleta Livanov was to complete it, as the named nurse for Patient B. You stated that it was not your responsibility to complete the questionnaire.

The panel determined that you had oversight for Patient B and therefore it was your responsibility to ensure that the questionnaire had been completed in good time soon after their admission, and in any event, by 21 December 2019. The panel determined that there was no evidence before it to demonstrate that you had in fact followed up regarding the questionnaire and care plan with Nicoleta Livanov.

The panel took into account Patient B's daily notes from 15 December 2019 until 21 December 2019 which demonstrated that you were involved in Patient B's care.

The panel determined that having completed your induction by 26 November 2019, it was your responsibility as a senior nurse to ensure that the questionnaire had been completed, and a care plan produced by either completing it yourself or ensuring that it had been completed by Nicoleta Livanov.

Accordingly, the panel found charge 4b proved.

Charges 5a(i), 5a(ii), and 5a(iii)

'That you, a Registered Nurse:

5. In relation to Patient C:

a. Administered Olanzapine at the wrong time, being:

i. 14:00 on 31 December 2019

ii. 16:00 on 1 January 2020

iii. 17:30 on 4 January 2020.'

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's oral evidence and witness statement signed and dated 7 March 2024.

> *'*[Patient C] *required olanzapine at 8am and 10pm each day. Olanzapine is an antipsychotic medication. If this is given late, it can make a patient more likely to present as aggressive and difficult. If it is given early, it can put the patient at risk of overdose and make them very sleepy.*
>
> *I discovered in January that Mandy had given* [Patient C] *olanzapine at 2pm on 31 December 2019, 4pm on 1 January 2020 and 5:30pm on 4 January.'*

The panel had regard to Patient C's Medication Administration Record (MAR) for 31 December 2019, 1 January 2020, and 4 January 2020. The panel noted that Patient C's prescribed morning dose of Olanzapine 5mg tablets had been administered at 14:00 on 31 December 2019, 16:00 on 1 January 2020, and 17:30 on 4 January 2020. The panel took into account that in oral evidence you confirmed that this was your signature, and that you administered the medication to Patient C at these times.

The panel had regard to the Overarching Medication Policy and Procedure for Kitnocks last amended 8 May 2019.

The panel noted that you did not provide a clear response to this allegation during your local appeal hearing. The panel had regard to your oral evidence in which you stated that

it is not critical that medication is given at a specific time of day and that you took a person-centred approach. You stated that you did administer the medication at the times alleged, with the consent of Patient C, as that was their preference and you were acting in line with their mental health needs.

Having had sight of the MAR chart for Patient C, the panel was satisfied that the prescribed medication was to be administered at a specified time in the morning, and yet, by your own admission, you administered the medication at various different times, on three separate days, over a small period of time.

The panel therefore determined that you more likely than not administered Olanzapine to Patient C at the wrong time.

Accordingly, the panel found charges 5a(i), 5a(ii), and 5a(iii) proved.

Charge 5b

'That you, a Registered Nurse:

5. In relation to Patient C:

…

b. Did not seek medical advice from a General Practitioner for your actions at charge 5a.'

This charge is found proved.

In reaching this decision, the panel took into account Jane Shaw's witness statement signed and dated 7 March 2024.

'There are some situations where delaying medication administration is unavoidable, especially when things are busy in the home, but in this situation, the

nurse should seek advice from the GP in terms of whether this is likely to have a significant impact on the patient's health, and what can be done to reduce this risk.

[…] *I was very concerned that Mandy didn't seek advice from the GP when she administered their medication so late, even when she had done so on three separate dates.'*

The panel had regard to the fact that this was corroborated by Jane Shaw's oral evidence in which she stated that it was not protocol to give medication late without first contacting the GP, and that prescribed medication should be given at the specified time on the MAR chart.

The panel had regard to the Overarching Medication Policy and Procedure for Kitnocks last amended 8 May 2019.

The panel took into consideration the MAR chart for Patient C which clearly stated that the medication should be administered at breakfast time in the morning.

The panel concluded that, given the large variation between the prescribed administration time and the time you actually administered the medication, as well as the number of occasions you varied the medication administration time in a short period of time, you should have sought medical advice from a GP. In reaching this decision the panel had regard to its previous findings at charge 5a and determined that your explanation provided, in that you were taking a person-centred approach, was not sufficient to alter medication times, as this is a prescribed drug and to alter prescribed medication times is not within your scope of practice.

Accordingly, the panel found charge 5b proved.

Decision and reasons on interim order

Having adjourned the substantive hearing, as the current listing period has concluded, Ms Malik applied for an interim suspension order for 18 months.

In reaching its decision, the panel considered the documentation before it, together with submissions by Ms Malik and you. The panel accepted the advice of the legal assessor and took account of the guidance issued by the NMC to panels considering interim orders and the appropriate test as set out at Article 31 of the 'Nursing and Midwifery Order 2001' (the Order). 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.

Ms Malik submitted that an interim suspension order is necessary on the grounds of public protection and also in the wider public interest. She submitted that there is cogent evidence of the concerns and referred the panel to the facts found proved.

Ms Malik submitted that the facts found proved related to:

- Record keeping, including not completing and/or updating care plans;
- Patient care, in that you failed to respond to a deteriorating patient who required emergency intervention;
- Medication administration;
- Dishonesty, which was directly linked to your clinical practice.

Ms Malik submitted that no actual harm was caused, however there was a real risk of harm to patients, colleagues, and the wider public. Ms Malik submitted that you have not provided any evidence of insight into your mistakes or dishonesty. Furthermore, you have not demonstrated any evidence of remediation or remorse. Ms Malik submitted that the panel cannot be satisfied that your conduct would not be repeated in the future. She submitted that there is a risk of repetition, and an interim order is necessary in order to protect the public.

Ms Malik submitted that there would be serious damage to public confidence in the profession if you were allowed to practise unrestricted. She submitted that the public would be shocked to learn that a registered nurse who posed a risk of harm to patients and who had acted dishonestly would be allowed to practice unrestricted.

Ms Malik therefore invited the panel to impose an interim suspension order for period of 18 months. She submitted that 18 months is required in order to protect the public and address the public interest concerns previously identified, until your substantive hearing has concluded. Ms Malik acknowledged that your substantive hearing is provisionally listed to resume in April 2026 but submitted that 18 months would provide a safeguard in the event, for whatever reason, your substantive hearing did not conclude.

You submitted that an interim order was not necessary and strongly refuted the NMC's submissions.

You submitted that since 2020, when the concerns arose, you have had no restrictions on your practice. You informed the panel that you have had a number of interviews for roles as a registered nurse but, having disclosed that you are subject to NMC proceedings to prospective employers, you have not been able to secure a job.

You submitted that an interim order, in practise, makes no difference in that you cannot currently secure a clinical role and therefore you present no risk.

You submitted that the NMC is seeking an interim suspension order on the basis of the findings of facts made during the substantive hearing. You submitted that you do not think that the panel's determination accurately reflects your evidence or submissions. Furthermore, you submitted that the NMC's witnesses were, in your opinion, not credible and were dishonest under oath/affirmation.

You submitted that an interim order is not in your own interest. You do not present a risk to the public nor is it in the public interest for an interim order to be imposed. You submitted

that if it were in the public interest, an interim order would have been imposed 5/6 years ago, when the concerns first arose.

You submitted that the length of time the NMC are applying for the interim order to be imposed is unfair, in that it is based on listing availability.

You invited the panel to not impose an interim suspension order. You submitted that an interim suspension order would negatively impact your finances, reputation, and career.

The panel accepted the advice of legal assessor who referred to the case of *NMC v Persand* [2023] EWHC 3356 (Admin).

The panel had regard to its finding on facts and had regard to the nature and seriousness of the facts found proved. The panel was of the view that the facts found proved are serious and wide-ranging involving:

- Record keeping, in that you failed to make appropriate and/or accurate patient notes and complete/update care plans;
- Patient care, in that you failed to care for a deteriorating patient and contact emergency services;
- Dishonesty, which was directly linked to your clinical practice;
- Medication administration, in that you acted outside of your scope of practice.

The panel determined that, given the serious and wide-ranging nature of the facts found proved, involving both clinical concerns and findings of dishonesty, there was a real risk of harm to patients, colleagues, and the wider public.

The panel took into account that these concerns arose in 2020, and you have not practised as a registered nurse since having been dismissed from Kitnocks. The panel took into consideration that there was no evidence before it of any strengthening of practice, remediation, insight, or remorse. The panel noted that you have a right to dispute

the allegations against you. However, having now made detailed finding on facts, the panel determined that there is a risk of repetition and consequentially a real risk of harm, at this time, given the serious and wide-ranging nature of the facts found proved and the lack of any evidence of insight or remediation. The panel therefore concluded that an interim order is necessary on the ground of public protection.

The panel also determined that an interim order is otherwise in the public interest. The panel was of the view that the public's trust and confidence in the profession and the NMC would be undermined if you were allowed to practice unrestricted at this time, given the serious and wide-ranging nature of the facts found proved.

The panel next considered an interim conditions of practice order and in all the circumstances determined that such an order would be insufficient to protect the public and to meet the wider public interest considerations of this case.

The panel was not satisfied that an interim conditions of practice order could be formulated which would be relevant, proportionate, workable and measurable given the facts proved which involved serious and wide-ranging clinical concerns as well as findings of dishonesty, which were directly linked to your clinical practice. The panel noted that dishonesty can be indicative of attitudinal concerns. The panel determined that an interim conditions of practice order would not be appropriate or proportionate given the nature of the facts found proved and in light of the lack of insight and remediation.

The panel was satisfied that, in the particular circumstances of this case, an interim suspension order is appropriate and proportionate. It has decided to make this interim suspension order for a period of 18 months. In reaching this decision the panel noted that the resuming substantive hearing has been provisionally listed for April 2026, at which time, if the substantive hearing concludes, the interim order will cease to exist.

The panel has noted that this interim order will prevent you from working as a registered nurse and, as a consequence, you may be caused financial hardship, and it may impact

your career and reputation. However, in applying the principle of proportionality, the panel determined that, in any event, the need to protect the public and the wider public interest outweighed your interest in this regard.

Unless your case has already been concluded or there has been a material change of circumstances, a panel will review the interim suspension order at a review meeting within the next six months and every six months thereafter. The reviewing panel will be invited by the NMC to confirm the interim suspension order at this meeting, and you will be notified of the panel's decision in writing following that meeting.

Where there has been a material change of circumstances that might mean that the order should be revoked or replaced, or there has been a request for an early review, a panel will review the interim order at a hearing which you will be invited to attend in person, send a representative on your behalf or submit written representations for the panel to consider. At any such review hearing the reviewing panel may revoke the interim order, it may confirm the interim suspension order, or it may replace it with an interim conditions of practice order.

The panel decided to make an interim suspension order for a period of 18 months.

Upon resuming, the panel was of the view that it would be assisted by:

- Your continued engagement with the NMC and proceedings;
- Any character references or testimonials from past or current employers for any paid or unpaid employment;
- A detailed reflective piece relating to the facts found proved;
- Any evidence of strengthening of practice, for example any relevant training undertaken.

This will be confirmed to you in writing.

The hearing resumed on Tuesday, 7 April 2026.

Decision and reasons on application for the panel to recuse itself

At the outset of the resumed hearing, you confirmed that you wished to put a document before the panel entitled “Formal Complaint to the NMC on FtP Hearing Decision”. You were informed in discussions with the legal assessor that this was not a forum in which you could raise complaints or appeal the panel’s previous decision. However, you confirmed that you wished to provide the document to the panel in any event.

Within the document, there are several points raised by you in respect of your dissatisfaction with the panel’s decision making, and the hearing process. In addition to this, you raised the issue of bias. The panel’s function is not to review the issues raised in respect of its own decision making or the hearing process. However, on the basis that the issue of bias was raised, the panel considered an application for its recusal.

You addressed the panel in respect of recusal. You referred to the concerns you had raised within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026 which, you said, contains examples of where the panel has been biased. You said that there may be overlapping bias in regard to the NMC’s management of your case, and the panel’s conduct throughout the hearing. You said that your evidence has been ignored and discounted, and was not acknowledged by the panel when making its decision on facts.

Ms Malik submitted that the NMC is neutral on the position of recusal. She submitted that it is a decision for the panel to consider, however, the NMC did not see any cause for concern in conduct, or in the panel’s decision. Ms Malik submitted that there are a number of references to bias in your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, and that those references seem to be framed in terms of a challenge to the panel’s decision on facts. Ms Malik submitted that you continue to dispute the findings on the facts, and also that there was bias on how the decisions were made.

In response to Ms Malik's submission, you said that you were not challenging the finding of fact, but that the facts have not been found. You stated that your evidence has been ignored, discounted, and not acknowledged by the panel.

The panel accepted the advice of the legal assessor who made reference to the cases of *Porter v Magill* [2001] UKHL 67; [2002] 2 AC 357, *Locabail (UK) Ltd v Bayfield Properties* [2000] IRLR 96, *R v Sussex Justices ex parte McCarthy* [1924] 1 KB 256, *Helow v Secretary of State for the Home Department* [2008] UKHL 62; [2008] 1 WLR 2416, *Medicaments and Related Classes of Goods* (No.2) [2001] 1 WLR 700, *Ameyaw v McGoldrick* [2020] EWHC 1787 (QB), *Dobbs v Tridos Bank NV* [2005] EWCA Civ 468 and *Suleman v General Optical Council* [2023] EWHC 2110 (Admin).

The panel systematically reviewed your document entitled "Formal Complaint to the NMC on FtP Hearing Decision", dated 5 April 2026. It noted that you raised numerous separate concerns, however, it was careful to specifically focus on issues that alleged, or could potentially allege bias on the part of the panel, given its role in this hearing.

The panel read the entirety of your Formal Complaint to the NMC on FtP Hearing Decision which contained complaints concerning the decision-making process of the panel at the facts stage, and allegations of behavioural issues and bias by the panel. The panel first considered whether by virtue of having been provided with this complaint document, it could create a potential for the panel to be biased. The panel considered itself to be an experienced and professional panel and by virtue of this fact, it considered that knowledge of your complaint would not impact its decision-making processes in this hearing. The panel recognised that you have full discretion to raise complaints about the Fitness to Practise process and the panel's conduct in separate proceedings before the High Court. The panel considered that these issues raised in your complaint are not for this panel to determine. The panel reminded itself of the advice given in respect of the case of *Dobbs v Tridos Bank* and noted the importance of not simply recusing itself on the basis that it had knowledge of criticisms raised against it.

The panel went on to consider paragraphs 1 – 18 of your Formal Complaint to the NMC on FtP Hearing Decision in order to identify and consider any specific issues of alleged bias.

In relation to paragraphs 1, 2, 3, 4, 5, 6, 9, 10, 11, 13, and 18, while the panel noted that you raised complaints regarding its decision-making at the fact-finding stage, it considered that there were no specific issues of bias raised within these paragraphs and therefore, the issues raised within these paragraphs were not relevant to your application for recusal. The panel noted that these concerns are matters that you may wish to raise after the conclusion of this hearing, through the appropriate appeal process.

The panel considered paragraph 7 within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, in which you stated:

> *'*[…] *The chair panel member showed bias, prejudice and unfair process by preventing me from asking the male witness to read a short paragraph from my appeal document in the NMC bundle. She refused to explain her refusal for him to do this, and this denied me the opportunity to cross-examine him on a very critical part of an allegation. This may also indicate discriminatory conduct on her part.'*

The panel considered the transcript from the previous hearing dates, specifically 12 November 2025:

> *'*[…] [THE REGISTRANT] *Q. Have you seen my document in the bundle? It's at the end. It's called 'Appeal application', and it is as page – 3*
>
> *A. I can't hear you, Mandy. Can you speak a bit louder, please?*
>
> *THE REGISTRANT: One second.*
>
> *THE CHAIR: And we'll also need a page number, Mandy.*

THE REGISTRANT: I'm just getting it. If you go to page 184, the top number. It's at the very end of the bundle.

THE CHAIR: He may not have – we're going to put it on the screen for you.

THE REGISTRANT: So the page number is – bear with me.

THE WITNESS: So what am I looking for?

THE CHAIR: If you look at the screen – we're not sure which page –

THE REGISTRANT: 187.

THE CHAIR: 187, please.

THE WITNESS: Okay.

THE REGISTRANT: Have you read this page prior to today?

THE WITNESS: No.

THE CHAIR: Is there a question about this page, or is it just whether he'd read it?

THE REGISTRANT: I'm just writing notes. Sorry, I have to write at the same time.

THE WITNESS: Yeah, I'm waiting for the question.

THE REGISTRANT: Am I able to read it out, or is that not –

THE LEGAL ASSESSOR: I think it's on the screen so that the witness can be directed to certain paragraphs. I think, unless he indicates otherwise, he can probably read it himself. It's for you to just ask questions around the points you'd like –

THE REGISTRANT: It's only because he said he hasn't read it, so –

THE CHAIR: I'm wondering once we know what the questions are, we can then determine the relevance. Because obviously, the appeal came after, and this witness is giving evidence of what happened on that night. So I think we just need to know what your questions are concerning this, and then we can take him to the particular point. I don't think he needs to read your entire appeal. Which part in particular –

THE REGISTRANT: It's not my entire appeal. It's just the page regarding that night, and it's just the facts, as he hasn't read it.

THE WITNESS: Okay, what exactly do you want me to look, because I don't know exactly what you want me to be – where to look specifically.

THE CHAIR: Let's ask the question, and then we can give him time to read in case he needs to for the answer.

THE REGISTRANT: Okay. Do you agree that I phoned just before 8.00 p.m. on the 21st to explain that I was unable to attend handover because I had two residents who were unwell?

THE WITNESS: So do you want me to confirm what you have done before me to come there? Because I don't understand the question.

Q. Do you agree – did you get the message that I phoned just before 8.00 p.m. when you were in the handover room – I phoned from Swan unit to say I'm unable to come over just yet because I have two residents who are unwell.

A. I can't remember.

Q. You can't remember.

A. Even though I waited for you to come, if you had someone unwell in Swan wing, I need to wait for you to come in the handover, isn't it? I'm not going to go out from the handover and to go home to wait for you. So I was waiting, despite the fact that you came 7.30 or 8.00. I can't remember exactly what time you came. I can't remember if you called. I just – maybe you're right. I can't remember, but even though I was in the handover waiting for you, and in that handover, you were unable to tell me the NEWS score for [Patient B].

Q. Okay, going back to my question, this was at the start of your night shift, so you weren't in the process of going home.

A. So your question is, Mandy, please?

Q. You've already answered it. Thank you.

A. Okay, thank you.

Q. The next question, I went over to the handover to hand over the keys and give you a very brief handover sometime just after 8.00. Do you agree with that?

A. I can barely hear you, Mandy. Can you repeat, please? My laptop is on 100%, so –

THE CHAIR: [Ovidiu Stoenescu], *can I just check, do you hear me clearly when I speak?*

THE WITNESS: Very well, yes.

THE CHAIR: Thank you. I think you just need to project into the microphone –

THE REGISTRANT: I can't project any more. It's right up to – I can't. It's a change in microphone. It seems a bit of a coincidence.

THE CHAIR: [Ovidiu Stoenescu], *if I could just repeat the question. Mandy's asking, she says she went to hand you the keys just after 8.00. Do you agree with that?*

THE WITNESS: I can't remember. Probably, because in handover, when you are coming in handover, you are coming with your phone, with your keys, so yeah, probably, she gave me. What time, I can't remember exactly what time.

THE REGISTRANT: So I came over just after 8.00 to give you the keys and a brief handover. No phone. Do you agree that after that handover when I gave you the keys, when we were in the Swan office, do you remember that I asked you to listen to the landline phone, and I put it on speakerphone, and I said to you, 'Look. Watch. I'm going to dial 999, and I'm going to dial 111 and listen to the engaged tone'?

THE WITNESS: Sorry, Mandy. You came into the handover, and you already said that 'I tried to call 999, but the phone was engaged'.

Q. I'm talking about in the Swan office –

A. No, you didn't. I asked you to call 111 after I come back with new readings for [Patient B]. You didn't call 999, even though – even though let's say we have a problem with the landline, you can use your mobile phone. I used my mobile phone

many times and never no one told me you are banned or you are something because you use mobile to call 999 or 111. So even though the engaged tone was from the landline in Swan wing, you can use your mobile. Period. I'm sorry.

Q. So you're agreeing that there was an engaged tone with the landline.

A. I was not there. I didn't hear anything. You didn't show me. I don't know. But again, even though, next thing you will use your mobile.

Q. Can I just ask you to please answer my question? Because it's difficult – because I'm unrepresented, unfortunately, because I've got questions and we need to keep on track. So if that would be –

A. Sorry, can you be more specific, please?

THE LEGAL ASSESSOR: I'm just going to intervene for a second. There's just a couple of issues I think we need to keep an eye on. First thing, Mandy, does the witness need to have sight of the document that's on the screen, because it's been up there for some time now and I don't want it to cause confusion.

THE REGISTRANT: I wanted him to read it, but I'm not sure what the situation is regarding that.

THE CHAIR: He doesn't need to read it. I think it's a prompt for you. It's all part of your appeal. It may be a prompt for you to ask questions about whether – for example, whether he remembers about you taking the keys to the office and what time. It's a good prompt for you, for your points of your appeal, which may assist your cross-examination, but the appeal isn't part of his evidence or anything. So perhaps you use that as a prompt for yourself if you've got it.

THE REGISTRANT: It's not the appeal. It's just about the incident.

THE CHAIR: Well, you can still use it and put it to [Ovidiu Stoenescu], *but he doesn't need to read them.*

THE LEGAL ASSESSOR: If that's your case, Mandy, if you're stating that that document provides your version of events, then there is nothing to stop you from asking the witness questions in and around that document in the way that the Chair has indicated, for example, 'Do you agree that this happened? Do you disagree that this happened?' Just again, a further reminder, the witness is here to answer questions. So everything has to be worded as a question, and [Ovidiu Stoenescu], *if you could perhaps just listen to the question that is being asked and provide an answer to that question.*

THE WITNESS: Thank you, yeah.

THE LEGAL ASSESSOR: Okay. Mandy, are you ready to continue?'

The panel noted that the document that you were referring to was a 12-page appeal against a decision of Cornerstone Healthcare Group to dismiss you in January 2020. The panel considered that the above exchange concerns you asking questions to Ovidiu Stoenescu about your dismissal from Cornerstone Healthcare Group. The panel noted that, in the transcript, the Chair raised that once a question was asked by you, the witness would be able to be directed to the relevant part of this document, and would be given time to read. Having examined the transcript in relation to this exchange, the panel could not find evidence of the Chair refusing or preventing the witness from reading any part of the document.

The panel noted the advice provided by the legal assessor. It considered that a fair-minded observer, having considered the relevant facts, would not conclude that there was a real possibility that the panel Chair was consciously or subconsciously biased.

The panel then considered paragraph 8 within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, in which you stated:

> *'Failure by the panel to be honest and true in their conduct when I questioned them if they had read my only document in the bundle, an appeal at Kitnocks House. The panel's prolonged silent and shocked response indicated they had not. I reminded them I had not provided a witness statement nor a bundle and so this appeal in the NMC bundle was my only document, as they had not acknowledged or realised this fact. When I asked the panel chair if she had read it, she would not or could not answer. I explained it was a simple yes or no question. She tried a common tactic by trying to deflect from answering and to delay answering. I calmly said I thought she was lying after she tried to mumble to suggest she had. This was my only document which she refused to allow me to use during my cross-examination of the NMC witnesses. The panel never asked me any questions on this document.'*

The panel took into account the transcript from the previous hearing dates, specifically 19 November 2025:

> *'*[…] [THE REGISTRANT] *In that document are extracts, paragraphs related to the charges or the allegations against me. When I tried to ask the witness, the male nurse, to read one of those, to have it up onscreen, just a paragraph, I was told no, that was blocked. I get the impression – because there has been no reference to that document by anyone, not by the Case Presenter, not by the Panel, not by the Legal Assessor – it gives me the impression that no-one's actually even bothered to read it. Are you able to confirm you did read it?*
>
> *THE CHAIR: I can confirm that we've read the entirety of all the paperwork that was exhibited, the statement bundle, the entirety of the exhibit bundle. There were documents in that bundle – I'm not going to get into a debate here now –*
>
> *THE REGISTRANT: No, I just want a yes or no – yes, you have read it. Yes?*

THE CHAIR: – but I want to reassure you that even though some documents within that bundle didn't come up in oral evidence, in cross-examination or evidence-in-chief, they were still part of the bundle which we used as our reference material. They were evidence in the bundle had been agreed in advance. This was the bundle that had been provided to us. There were no applications to redact any of it that was received by us. So the entirety of that bundle was there.

THE REGISTRANT: There was no redaction. I just want to know, simply yes or no. 'Yes, we have read the appeal.

THE CHAIR: I want to reassure you, Mandy, as well, that with the witness, [Ovidiu Stoenescu], *the reason I asked you not for* [Ovidiu Stoenescu] *to read out a document was not to stop you using it in any sense. I said you could use that as your reference to ask questions. But it wasn't his evidence. It wasn't his statement he was reading. It was words that you'd written, which we all had sight of. There was no necessity for him to read it, but it was absolutely evidence that you could use, which you did use, to frame your questions for us.*

THE REGISTRANT: I've had to read evidence that I haven't written, and I think some of the others. I was happy to read it if he couldn't or wouldn't read it.

THE CHAIR: We're not going to get into a debate about that.

THE REGISTRANT: I don't want a debate. My question was simply, has the Panel read my –

THE CHAIR: Absolutely. I assure you, every page.

THE REGISTRANT: That's all I want to know, yes or no. It wasn't an invitation for any discussion. I just want to have that confirmed. There's two references to the very odd wording 'mischief' of this case in the document. What does that mean?

THE LEGAL ASSESSOR: Chair, I'm just going to interject because we seem to have gone slightly off-piste from the issue of an interim order here. Mandy, the Panel's determination is their decision. If you are unhappy with any aspect of that decision there is recourse away from these proceedings for you to challenge that decision. But the moment now, the time is not to pick apart the determination and point out things that you're perhaps not happy with. It's for you to address the Panel on the NMC's application for an interim order. If we could perhaps move on to that, please, Chair.'

The panel noted from the transcript that the Chair had confirmed that the panel had read the entirety of all paperwork that was exhibited. The panel considered that a fair-minded observer, having considered the relevant facts, would not conclude that there was a real possibility that the panel was consciously or subconsciously biased.

The panel then considered paragraph 12 within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, in which you stated:

'Failure by the case presenter and NMC panel, to ensure they were not biased or prejudiced in their conduct. They have shown during the hearing and then their published decision, they had used a one-sided and biased selective interpretation of the presented evidence and failed to provide explanations. They have repeatedly ignored my presented evidence. They dealt with each allegation and subheadings as separate and in isolation, instead of holistically and in factual context, which is evidence of unfair process and conduct by them.'

The panel noted that you gave no specific examples of bias within paragraph 12. The panel considered that the matters that you raised in this paragraph are matters relating to

your dissatisfaction with the panel's decision on facts which are not matters which can be considered by this panel. The panel considered that you may wish to raise such issues in an appeal, but that these are not matters of bias.

Regarding paragraph 14 within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, you stated:

> *'The failure or inability by the NMC panel and case presenter to identify their perceived identification with evidence of current risk to justify their decision on 19 November 2025 for an Interim Suspension Order of 18 months, at this adjourned part heard hearing. Their failure to provide any evidence of any risk assessment for this case and they have failed to provide a copy of a risk assessment to evidence the justification for their decision. This is backward thinking by the NMC panel and case presenter and an abuse of process after 6 years with no restrictions on my practice.'*

The panel noted that you gave no specific examples of bias within paragraph 14. The panel considered that the matters that you raised in this paragraph are matters relating to your dissatisfaction with the panel's decision to impose an interim order which is not a matter which can be considered by this panel. The panel considered that you may wish to raise such issues in an appeal, but that these are not matters of bias.

Regarding paragraphs 15, 16, and 17 within your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, you stated:

> *'The failure of the only registrant on the panel, to acknowledge at the hearing any of her limitations for this case. She is an adult/general nurse and is not qualified in mental health, learning disabilities or neurological conditions. If she is, then she should have informed the hearing about this. It was not appropriate nor part of a fair process to have a general nurse on the panel instead of a registered nurse in learning disabilities or mental health. She did not have the required knowledge and*

training to assess and make a judgement on all of the allegations regarding clinical mental health and learning disability practice and the complexities involved in this clinical work.

The chair panel member's demeanour was from the start, frequently dismissive, defensive and contemptuous, which did not ensure a fair process. At the start and during, her demeaner and attitude was judgemental and accusatory. She and the panel showed no evidence of critical thinking and no ability to evaluate evidence fairly. The panel failed to understand the clinical, ethical, legal and medical issues and complexities involved in this case. It seemed the chair was uninformed or uneducated on the issues. But I have some sympathy for the lay member, who should be supported by the panel registrant and chair on some decision making. My overriding impression was that the chair had already formed a judgment. I tested her basic ability to be able to understand another person's point of view and situation by briefly explaining about my journey to the hearing. She immediately responded defensively and with some hostility it seemed, by stating that the lay person has to travel from the north. But it was not a competition, and my expectation was for her to simply acknowledge my journey and perhaps also that this was an excessively delayed case of over 5 years and she understood the impact on my life. Also, as I was unrepresented, I was constantly hand-writing notes for 7 days and having to represent myself at the same time. Due to this I had repetitive stress pain in my hand and had to frequently shake and rest it. At no time did anyone on the panel simply acknowledged this and check if it was okay. I had to point this out to them to allow some extra time and still this resulted in silent and hard staring. The NMC case presenter made an absurd and inappropriate comment about this. I observed very odd and frequent responses from the panel, especially the chair of smirking at times which were incongruent to what was being discussed or presented. And at the end, when she stated the decision was for an Interim Suspension Order of 18 months and smiled and then smirked, which was inappropriate and odd communication.

This formal complaint also forms my reflective account of the hearing from the excessively delayed case of 6 years, as requested in the part heard written decision. My view is that healthcare is one of the most regulated environments and medical care requires real time judgements, adaptions and nuanced decision making in unpredictable situations, which I showed I had done competently and safely, in my clinical role in my presented evidence. And in my presented evidence, I showed I had complied with my code of conduct. It involves ethics, consent, and complex patient communication, as shown in a patient-centred approach which all healthcare professionals must use. Both of the NMC case presenters and the panel, showed their apparent ignorance and refusal to acknowledge this is a legally and medically or clinical safe principle. Without using this approach, the NMC code of conduct would not be complied with and unsafe and harmful practice can result causing harm to patients. Their apparent arrogant dismissiveness of this as some kind of 'fluffy' philosophy of care is very concerning. The panel and case presenter did not understand or refused to accept how clinical judgement is used to make decisions e.g. in the NEWS2 assessment, even after I carefully explained this tool and how and why it is not a substitute for clinical judgement and this resulted in their inadequate and it seemed irrational decision'

The panel considered that the criticisms raised in the above paragraphs, which could potentially amount to allegations of bias, were not supported by evidence or examples within the transcript. The panel considered that a fair-minded observer, having considered the relevant facts, would not conclude that there was a real possibility that the panel was consciously or subconsciously biased. The panel noted that the issues that you raised would be matters for an appeal or complaint before the appropriate forum, but are not matters which this panel can consider at this stage.

The panel reminded itself of the advice given in respect of the case of *Dobbs v Tridos Bank* and noted the importance of not simply recusing itself on the basis that it had knowledge of criticisms raised against it.

Taking all of the above factors into account, the panel considered itself to be a professional panel able to fairly and objectively conduct the next stages of this hearing.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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, and without restriction.

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

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

Submissions on misconduct

Ms Malik invited the panel to take the view that the facts found proved amount to misconduct. Ms Malik referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code).

Ms Malik went through each charge found proved in turn and identified the specific, relevant standards where, in her submission, your actions amounted to misconduct. She made reference to the specific areas of the Code which the NMC says your conduct is said to have breached.

You told the panel that you do not intend to give evidence at this stage, save for the additional document you had already provided for this resumed hearing. In response to a question from the panel, you said that you had detailed training that you had undertaken over the last six years, but did not provide documentary evidence as you were not asked to do this prior to this resuming hearing and did not know that the panel needed them. Further, you said that employers do not provide character references and therefore you do not have any character references to provide to the panel.

Submissions on impairment

Ms 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).

Ms Malik submitted that your conduct was a pattern of problematic behaviour that occurred in two separate places of work, namely Kitnocks and Uplands between May and December 2019. She submitted that the facts found proved involved serious and wide-ranging concerns relating to your clinical practice and dishonest conduct. Ms Malik submitted that all limbs of the *Grant* test are engaged in this case. Ms Malik submitted that your conduct put patients and colleagues at a risk of harm. She submitted that you have breached fundamental tenets of the nursing profession and brought the profession into disrepute.

Ms Malik submitted that there is no evidence before the panel to indicate that you have demonstrated any insight into your misconduct, nor have you demonstrated that you are capable of learning from your misconduct. Ms Malik submitted that you continue to deny the facts in this case and that there is evidence of a deep-seated attitudinal concern. Ms

Malik referred the panel to the Continuing Professional Development (CPD) that you said you had completed, with the most recent being completed in June 2025. However, Ms Malik submitted that there is no documentary evidence of the completion of the CPD before the panel and therefore appropriate weight should be applied.

Ms Malik submitted that your misconduct was not an isolated incident, it was wide-ranging and spanned two different places of work. Ms Malik submitted that in the absence of any insight or evidence of steps taken to strengthen your practice, there is a risk of repetition and subsequent risk of harm to the public. Ms Malik invited the panel to find your fitness to practise currently impaired on the grounds of public protection and public interest.

In your submissions on misconduct and impairment, you said that you were shocked and appalled at the panel's failure to explain why it prefers the evidence of the NMC witnesses over your account of events. You said that the panel and Ms Malik have worked hand-in-hand and that the panel seems to accept whatever is said by Ms Malik. You said that the conduct of the panel and Ms Malik throughout this hearing is coming dangerously close to being detrimental to you.

You said that no test for dishonesty has been demonstrated by the panel or Ms Malik. You said that your concerns raised in your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026 have not been addressed by the panel.

You submitted that the panel and Ms Malik have ignored, discounted, and covered up your truthful evidence. You asked how a reasonable observer would expect you to reflect and demonstrate insight into something that you did not do. You said that it does not make a difference what you say and that Ms Malik has made damaging and untrue submissions about your conduct and your level of insight. You said that there is no evidence of deep-seated attitudinal issues regarding your practice and that you feel that you are being *"gaslighted".*

The legal assessor referred you to your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026, specifically where you outlined the CPD that you have completed. You were asked if you wanted to address the panel in terms of what you are currently doing to strengthen your practice.

You said that you have worked in many different roles including as a trainee pharmacy advisor, and a senior case officer for your local council. You said that you utilised your clinical skills and knowledge in these roles and that you received positive feedback from customers. You said that in your role as a trainee pharmacy advisor, you have completed documentation for patients, liaised with GP's, advised on contraindications, and advised on how to dispense and administer medication to patients. You said that in your role as a senior case officer, you wrote care plans and individual in-person assessments. You said that you completed additional mandatory training, including safeguarding training, and that this is renewed on a yearly basis. You said that there is no training that you need to complete this year as your mandatory training is not due to be renewed until the summer of 2026.

You said that you have good insight and self-awareness. You said that Ms Malik's submissions do not mean that there is evidence of a deep-seated attitudinal concern in relation to your conduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgements, including *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, *Nandi v GMC* [2004] EWHC 2317 (Admin), *Meadows v General Medical Council* [2007] 1 All ER 1, *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin), *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), and *Sawati v General Medical Council* [2022] EWHC 283.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***4 Act in the best interests of people at all times***
> *To achieve this, you must:*
> ***4.1** balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*
>
> ***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*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.2** maintain effective communication with colleagues*
> ***8.6** share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

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

***10.4** attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

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*

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

***15.2** arrange, wherever possible, for emergency care to be accessed and provided promptly*

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*

20.2 *act with honesty and integrity at all times,* […]*'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel took each charge in turn when deciding whether your actions amounted to misconduct.

With regard to Charge 1a(iii), the panel considered that you were the nurse in charge on the shift at the time. It had regard to its previous finding that:

> *'A serious incident had occurred involving the restraint of a patient which the panel determined should have been recorded accordingly and in sufficient detail, explaining why the patient was restrained, how they were restrained and by whom, and that you had reported it to Virginia Beacham. The panel was not satisfied that your entry was sufficient in that you provided more detail in respect of Patient A's daily activities than you did about the incident.'*

The panel determined that your actions at Charge 1a(iii) fell seriously short of the standards expected of a registered nurse and amounted to serious misconduct. Whilst you identified some contextual difficulties in your evidence in respect of your relationships with colleagues at Uplands, the panel considered that these were not relevant to the need to provide sufficient details in relation to patient notes. As such, the panel was not able to take this context into account. The panel found that your failing to record the restraint incident could have prevented other clinicians from having full knowledge of what had occurred and could have impacted future treatment decisions.

With regard to Charge 1b, the panel noted its previous finding that you did not clearly state that the entry regarding Patient A was made retrospectively. The panel had regard to Virginia Beacham's witness statement which stated:

> *'*[…] *It is important that all patient notes, including ones made retrospectively, are made as clear as possible to ensure that staff have an accurate clinical picture of*

the patients they are caring for. If they don't have this, this can involve clinical risks for the patients, as the staff caring for them won't be able to make fully informed decisions on the patients' behalf.'

Whilst you identified some contextual difficulties in your evidence in respect of your relationships with colleagues at Uplands, the panel considered that these were not relevant to the need to ensure clear and accurate patient records. The panel considered that providing clear and accurate entries in patient care notes is a fundamental aspect of nursing. It considered that your failure to clearly state that the entry regarding Patient A was made retrospectively was a serious departure of the standards expected of a registered nurse and resulted in potential confusion in understanding the care given to Patient A which could have impacted on subsequent care. The panel therefore found that your actions amounted to misconduct.

The panel considered the context at Kitnocks at the time of the following concerns. It noted your concerns that resulted in your whistleblowing complaint which you had raised separately to Kitnocks and the Care Quality Commission (CQC), and that you had experienced difficult working relationships at Kitnocks.

With regard to Charge 2a(ii)(a), the panel considered that the use of a NEWS2 scoring system is a fundamental and basic element of patient care to assess risk in an unwell or deteriorating patient and the tool is used to identify acute deterioration, including sepsis. The panel considered that a failure to calculate and act upon a patient's NEWS2 score creates a risk of harm to patients in creating a risk that colleagues may be unable to correctly identify any deterioration in the patient's health and take appropriate action. In this case, the panel noted that Patient A's NEWS2 score would have been 8, indicating a high risk of sepsis and requiring immediate treatment in a hospital. The panel considered that Patient A was put at a risk of harm as a result of your actions. Whilst you identified some contextual difficulties in your evidence in respect of your whistleblowing concerns at Kitnocks, the panel considered that these were not relevant to your failure to engage with

the NEWS2 scoring system. Your actions fell far below the standards expected of a registered nurse and amounted to misconduct.

With regard to Charge 2a(ii)(b), the panel noted its previous finding that you did not call an ambulance in response to Patient B's condition deteriorating. It previously stated:

> *'The panel noted that you had made an entry at 20:14, stating that you had undertaken two sets of observations in a 15-minute interval, both showing 'Sats varying 80-82%'. The panel noted the evidence of Jane Shaw, that saturation levels of this level would indicate a medical emergency.'*

The panel considered that your inaction, in that you failed to call an ambulance put Patient B at a risk of harm. The panel considered that a registered nurse should have recognised the need to call an ambulance immediately after identifying a deterioration in the extent of the patient's condition. Whilst you identified some contextual difficulties in your evidence in respect of your whistleblowing concerns at Kitnocks, the panel considered that these were not relevant to your failure to call an ambulance for Patient B. The panel considered that your action at Charge 2a(ii)(b) fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

With regard to Charges 2b(i) and 2b(ii), the panel determined that in and of itself, a failure by you to provide a correct response to an investigation does not amount to misconduct. However, the panel considered Charges 2b(i), 2b(ii), 3a, and 3b together. The panel found that your responses were untrue, and found that you made them in order to distance yourself from your failings in Patient B's care. You continue to maintain this dishonest position. The panel considered this dishonest conduct to fall seriously short of the standards expected of a registered nurse. Whilst you identified some contextual difficulties in your evidence in respect of your whistleblowing concerns at Kitnocks, the panel considered that these were not relevant to your failure to provide a correct response to an investigation. The panel considered that honesty and integrity are fundamentals of nursing

practice and by acting dishonestly, your actions at Charges 2b(i), 2b(ii), 3a, and 3b amounted to misconduct.

With regard to Charges 4a, and 4b, the panel previously found that whilst you had completed some care plans, they were not completed to the standards required by Kitnocks. Regarding the patient admission questionnaires, whilst the panel considered that it was your responsibility as a senior nurse to ensure that these questionnaires had been completed, it noted your position that there was a lack of clarity at Kitnocks in relation to who was responsible for completing the assessments. The panel noted that your actions in relation to these charges did not lead to an identified risk to patient care. The panel noted that you identified some contextual difficulties in your evidence in respect of your whistleblowing concerns at Kitnocks, the panel considered that these were not relevant to these charges, which the panel considered to be performance issues, rather than misconduct. The panel therefore considered that your actions at Charges 4a and 4b were not so serious as to amount to misconduct.

With regard to Charges 5a(i), 5a(ii), 5a(iii), and 5b the panel considered that you acted outside of your scope of practice by taking it upon yourself to change the medication times for Patient C without seeking medical advice from a GP. The panel considered that this put Patient C at risk of harm. The panel heard witness evidence from Jane Shaw that:

> *'*[Patient C] *required olanzapine at 8am and 10pm each day. Olanzapine is an antipsychotic medication. If this is given late, it can make a patient more likely to present as aggressive and difficult. If it is given early, it can put the patient at risk of overdose and make them very sleepy.* […]*'*

The panel noted your position that you were taking a patient-centred approach. However, the panel considered that you acted outside of your scope of practice, and consequently put Patient C at risk of harm. The panel noted that you identified some contextual difficulties in your evidence in respect of your whistleblowing concerns at Kitnocks, the panel considered that these were not relevant to the facts of this charge. The panel

considered that your actions fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

The panel found that your actions at charges 1a(iii), 1b, 2a(ii)(a), 2a(ii)(b), 2b(i), 2b(ii), 5a(i), 5a(ii), 5a(iii), and 5b did fall seriously short of the conduct and standards expected of a registered nurse. It considered that your actions in relation to these charges would be considered deplorable by another registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only*

whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel considered that, although there is no direct evidence before it to suggest that patients were harmed as a result of your misconduct, there was a significant risk of harm. It considered that Patient B's NEWS2 score was suggesting a significant deterioration which required urgent investigation and management in an acute hospital setting. Your failure to call an ambulance and your subsequent dishonest claim that you had called an

ambulance but received an engaged tone put Patient B at an unwarranted risk of harm in delaying hospital care. Regarding Patient C, the panel considered that your failure to follow prescribed instructions regarding the administration of olanzapine, without referring to a GP, put Patient C at a risk of harm due to delaying the administration of a prescribed dose of olanzapine for a number of hours on multiple occasions.

The panel considered that your misconduct individually and cumulatively had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It considered that the facts found proved in this case are wide-ranging and occurred across two different organisations over a number of months. The panel considered that you were an experienced nurse and often worked as the nurse in charge. The panel considered that the public would expect such an experienced nurse to deliver fundamental nursing practice effectively and safely and a failure to do so may damage public confidence in the nursing profession.

The panel considered that you had, in the past, acted dishonestly in respect of charges 3a and 3b.

The panel noted that the areas of concern were wide-ranging and fell into the broad categories of record keeping, medication administration, patient care, and dishonesty. It considered that some of the misconduct in this case is capable of being addressed. However, the panel was mindful that concerns of dishonesty may be more difficult to put right.

Having considered that the misconduct may be capable of being addressed, the panel then went on to consider what steps, if any, you have taken to address the concerns. The panel took into account your Formal Complaint to the NMC on FtP Hearing Decision, dated 5 April 2026 in which you listed the CPD that you have completed. Whilst the panel considered that there is no evidence, such as certification, before it to corroborate the training, it found no reason to dispute that you had undertaken it in the course of your employment. However, the absence of reflection demonstrating how the CPD learning

applies to, and strengthens practice, meant that the panel could not be satisfied that it was relevant to the concerns in this case. The panel also did not have evidence before it of any testimonials. You asserted that organisations do not give character references, but the panel considered that it would have been possible for you to have approached individuals within your different places of employment to attest to your character and work, but that you had not done so.

The panel noted the authority of *Sawati v General Medical Council* [2022] EWHC 283 (Admin). It considered that this was not a case where a primary factor of dishonesty was disputed as Charges 3a and 3b aggravate the primary allegations of Charges 2b(i) and 2b(ii) which are allegations of other misconduct which may or may not be honest. The panel noted that you did not wrongly implicate or blame others, or brand witnesses giving a different account as delusional or liars in respect of the dishonesty allegations in Charges 3a and 3b. The panel considered that it would not be fair to take into account your denial of the allegation in determining the level of your insight.

However, regarding insight, the panel considered that there is a consistent theme of avoiding responsibility relating to the behaviours found proved in this case. At the conclusion of the previous sitting of this hearing, the panel outlined some areas where it may assist you to demonstrate insight, specifically:

- *'Your continued engagement with the NMC and proceedings;*
- *Any character references or testimonials from past or current employers for any paid or unpaid employment;*
- *A detailed reflective piece relating to the facts found proved;*
- *Any evidence of strengthening of practice, for example any relevant training undertaken.'*

When asked if you had any evidence of reflection to provide to the panel, you maintained that you had already provided this to the panel in your additional documentation prepared prior to this resumed hearing, which included your Formal Complaint to the NMC on FtP

Hearing Decision, dated 5 April 2026. The panel found this document not to contain any reflections into the facts found proved, and your conduct, but instead contained complaints regarding this NMC hearing process, the actions of others, and your whistleblowing complaint previously submitted to other bodies. The panel did not find this document to be a reflection of your actions that led to the misconduct found proved.

The panel considered its above conclusions in respect of your CPD between 2020 and 2026 in the form of a list of course titles. The panel considered that in your oral submissions you were not able to demonstrate or highlight, despite prompting, how the CPD you have undertaken specifically addressed the concerns raised in this case and what, if anything, you have learnt that would prevent a risk of repetition of the current concerns.

The panel considered that you have not demonstrated an understanding of how your actions put patients at a risk of harm, nor have you demonstrated any understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel considered that you have not demonstrated how you would handle similar situations differently in the future.

The panel moved on to consider whether there was a risk of repetition of the misconduct identified. It considered that in the absence of any insight and reflection on the concerns in this case, there is a significant risk of repetition of similar concerns, and therefore there is also a risk of harm to the public. 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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that a well-informed member of the public would be shocked to learn that a registered nurse who had not demonstrated any reflection or insight into wide-ranging misconduct of the type found proved in this case were allowed to practise unrestricted. The panel considered that its finding in respect of dishonesty, and your refusal to take responsibility for your failings amounted to a deep-seated attitudinal issue. It considered that a finding of current impairment was necessary to protect the public, uphold proper standards of conduct and behaviour, and maintain public confidence in the nursing profession and the NMC as the regulator. The panel therefore also finds your fitness to practise impaired on the ground of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel considered this case very carefully and had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC and last updated on 28 January 2026.

Submissions on sanction

Ms Malik submitted that a striking off order was the appropriate and proportionate sanction given the seriousness of the misconduct. She identified the aggravating and mitigating features that the NMC says are present in this case.

Ms Malik submitted that patients were put at risk of harm on at least two occasions. She submitted that the charges found proved raise fundamental questions regarding your professionalism and are indicative of a deep-seated attitudinal concern. Ms Malik submitted that there is not a realistic prospect that you would develop insight after a period

of suspension. She submitted that there is no evidence before the panel of any willingness by you to develop your insight.

Ms Malik submitted that this is not a case where it would be realistic for you to return to unrestricted practice within one year. She submitted that public confidence in the nursing profession cannot be maintained through the imposition of a suspension order. She therefore submitted that a striking off order is the only appropriate and proportionate sanction in this case.

You said that you are attending this hearing unrepresented and that this is a significant detriment to your case. You said that if you had representation here, there would be a different outcome. You said that it is crucial in this situation to have a barrister with you to help you navigate the nuances of this fitness to practice hearing.

When addressing the panel on sanction, you referred the panel to the case of *Gilbert v General Medical Council* [2026] EWCA Civ 53. You said that you have not have the time to read this case law, but said that it may be beneficial for the panel when making its decision. You said that the finding of facts in this case is faulty, and that you cannot respond to a sanction on the facts when the facts are incorrect.

You said that you performed no risk of harm to Patient B by not calling an ambulance. You submitted that the on-call doctor agreed with your assessment. With regard to Patient C, you said that there was no error and no risk of harm by you administering the Olanzapine at a later time. You said that the medication was prescribed to be administered once daily, and that the patient was entitled to change the time in which they received their medication. You said that the administration of the Olanzapine was documented correctly on Patient C's MAR chart. You said that there is no evidence of dishonesty or *"covering up"* your actions. You said that you used your judgement when deciding if it was an appropriate time to give Patient C their medication.

You said that since 2020, the NMC have not provided a risk assessment to justify a burden of proof to uphold the sanction that they are intending to impose today. You said submitted that *"mitigation assumes wrongdoing"*. You said that you have been open and honest in what you have done. You said that you have been denied the opportunity to show strengthened practice as you cannot obtain employment due to being subject to unresolved NMC proceedings since 2020.

You said that you have managed to maintain your CPD and have managed to work in roles which have maintained your clinical knowledge and skills. You said that in your role as a trainee pharmacy advisor, you had face-to-face interactions with patients and helped manage queries. You said that you received good feedback from your line manager whilst working in this role. When addressing the panel regarding your role as a senior case officer, you completed tasks such as risk assessments and safeguarding of vulnerable service users. You told the panel that you also received positive feedback whilst you were working in this role.

You submitted that you have shown that there was no risk in 2020, and that there is no future risk. You told the panel that you have hard copies of your training certificates, and that you could send this to the NMC if needed. You said that it would be wrong of the NMC to decide that you should be blamed for not working as a registered nurse for the last six years. You said that this is a result of the delays of your case.

You submitted that similar situations will arise in the future when patients may prefer to take their medication at a different time, or that they may be unwell or asleep, and that you would take the same approach. You said that this is usual in mental health and learning disability nursing. You accepted that these are serious allegations and have had a detrimental effect on your nursing practice. You said that the way the allegations have been worded is wrong and misleading.

You submitted that there is no justification for a striking-off order. You said that if you had a representative, it would not have come to this stage and that the case would have been

handled differently. You said that there is no evidence of dishonesty, lack of insight, or future risk, and that the panel should decide to take no further action.

The panel accepted the advice of the legal assessor which included reference to the case of *Gilbert v GMC*.

The panel then retired to make its decision on sanction. There was insufficient time to conclude the hearing, and so the hearing went part heard. You were reminded that the interim suspension order imposed in November 2025 remains in place until the conclusion of this hearing.

The hearing resumed on Friday, 26 June 2026.

Decision and reasons on service of Notice of Hearing

The panel was informed on 26 June 2026 that Ms Jilley was not in attendance and that the Notice of Hearing letter had been sent to Ms Jilley's registered email address by secure email on 18 May 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and the venue of the hearing, and, amongst other things, information about Ms Jilley's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Jilley

The panel next considered whether it should proceed in the absence of Ms Jilley. It had regard to Rule 21 and heard the submissions of Ms Boesche who invited the panel to continue in the absence of Ms Jilley. She submitted that Ms Jilley had voluntarily absented herself.

Ms Boesche referred the panel to an email sent by Ms Jilley to the NMC Hearings Coordinator dated 26 June 2026 which stated:

> *'*[…] *It is for the reasons above, and due to the behaviour and misconduct of both the case presenter and panel chair, that I decline to attend the sanction hearing and this makes no legal difference to my submissions document and intended appeal.* […]*'*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Jilley. In reaching this decision, the panel has considered the submissions of Ms Boesche, the email from Ms Jilley dated 26 June 2026, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA

Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Jilley;
- Ms Jilley has stated in her email dated 26 June 2026 that she does not wish to attend the hearing today;
- There is no reason to suppose that adjourning would secure Ms Jilley's attendance at some future date;
- There is a strong public interest in the expeditious disposal of this case which has been ongoing since 2020; and
- It is in Ms Jilley's own interest that this hearing is concluded without further delay.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Jilley.

Additional documents produced by Ms Jilley during panel deliberations on sanction

The panel was informed at the start of this resuming hearing that Ms Jilley had provided the NMC with additional documentation to go before the panel before it hands down its decision on sanction. The documentation included Ms Jilley's further written submissions on the sanction stage, and numerous training certificates spanning 2019 – 2024.

Ms Boesche submitted that these documents do not assist the panel with any decisions on sanction, and that Ms Jilley's submissions instead focus on the NMC proceedings, and the behaviour of the panel and NMC Case Presenter. Ms Boesche submitted that the documents produced by Ms Jilley confirm her conduct throughout these proceedings.

The panel decided to admit these documents and consider them during its deliberations on sanction.

The panel noted that the training certificates provided by Ms Jilley for this stage of the hearing evidenced numerous and wide-ranging CPD undertaken between 2019 and 2024.

Whilst the panel noted that some of the training courses could be relevant to the concerns identified in this case, such as infection prevention and control, and telephone call handler training, it considered that a significant proportion of the training courses demonstrate Ms Jilley's compliance with mandatory organisational training. The panel considered that the new material did not evidence if, or how, Ms Jilley has applied, or could apply, this training and knowledge to her clinical practice, or to the specific behavioural concerns around her practice.

The panel also noted the following within Ms Jilley's written submissions on sanction:

> *'10 April 2026 – NMC panel gave their verbal sanction decision on FtP to me on this date, and I notified the panel at that time I would be appealing. This was before the formal sanction hearing on 26 June and before this FtP hearing had final completion.*
>
> […]
>
> *this particular panel and case presenter have decided on the very highest sanction possible, which is a strike off from the professional register.'*

The panel had not concluded its deliberations or handed down a determination on sanction. When the hearing adjourned on 10 April 2026, the panel confirmed that there would not be enough time to conclude the hearing, and that the hearing would need to be relisted. This is reflected in the transcript dated 10 April 2026.

Decision and reasons on sanction

Having found Ms Jilley's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Consistent theme of avoidance of responsibility
- Lack of insight and reflection into the misconduct found proved
- Conduct which recklessly put vulnerable people receiving care at risk of suffering harm
- A pattern of misconduct on a number of occasions
- Dishonest conduct which, whilst occurred in isolated incidents, was done to deliberately cover up where things had gone wrong and involving a direct risk to patients.

The panel also took into account the following mitigating features:

- Continuing to undertake roles in healthcare related settings
- Evidence of wide-ranging CPD undertaken between 2019 and 2024

The panel also considered Ms Jilley's assertion that she had performed well in her various healthcare related roles and that there had been no further concerns raised regarding her practice. However, the panel found that there was an absence of testimonials and no corroborative evidence, both during the hearing, and in the new documentation provided at this stage, of safe and effective practice

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

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

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

The panel considered that Ms Jilley's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Jilley's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case, which include an element of dishonesty which the panel found to be attitudinal in nature. The panel determined that the misconduct identified in this case was not something that can be addressed through retraining. Whilst the panel accepted that it was Ms Jilley's right to maintain her denial of the allegations found proved, it determined that Ms Jilley has not demonstrated any insight or willingness to reflect on, or address the core nature of the concerns identified which it found demonstrated deep-seated attitudinal concerns.

In Ms Jilley's verbal submissions on sanction, with regard to the administration of medication outside of times prescribed, she said:

> *"*[…] *I would use the same approach, even reflecting back, because the approach I used was the correct one. I work with the patient, I find out what their views are, I make a judgment* […] *it's not a case of what Jane has said, that you just have to follow what is on the MAR chart. The MAR chart has to be interpreted. You have to use your judgement* […]*"*

The panel found that Ms Jilley's focus is that of discontent in the Fitness to Practise process, rather than her reflection and insight into the misconduct found proved. In her written submissions on sanction, Ms Jilley stated:

> *'I will not be reflecting on this particular panel's and case presenter's version of the case. I have instead, reflected on the experience of the process, impact, learning, professional standards and any future aims.* […]*'*

The panel therefore concluded that the placing of conditions on Ms Jilley's registration could not adequately address the seriousness of this case and the clinical concerns, and so would not protect the public or maintain public confidence in the nursing profession.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The latest edition of the SG states that in considering a suspension order the panel should take into account a number of key factors the most relevant of which were:

- *is it realistic that the professional could return to unrestricted practice in the future, even if it is not appropriate for them to do so now?*
- *What would the registrant need to do in order to be fit to practise in the future? Is it realistic that they will be able to do this?*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered Ms Jilley's firm stance and concluded that it is highly unlikely that she will commit to addressing and developing insight into the clinical and attitudinal concerns identified. It further considered that it is not realistic to expect that Ms Jilley could return to unrestricted practice in the future due to the total absence of insight and her unwillingness to take personal responsibility and be accountable for her actions. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Jilley's actions is fundamentally incompatible with her remaining on the register.

The panel also noted the SG states that the sanction of suspension may be appropriate when:

> *'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.'*

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering a striking-off order, the panel had particular regard to SAN-3, *'Deciding between suspension and strike off'* in the recently revised SG and, in particular:

- *Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*

The panel also had careful regard to that part of the SG relating to striking off orders and noted that it had to consider the following:

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel considered that the charges found proved raised fundamental questions about Ms Jilley's honesty, professionalism, and safe practice. It found that there has been not only an absence of insight, but a refusal by Ms Jilley to consider reflecting on her practice. The panel reminded itself of its earlier considerations and conclusions on lesser sanctions in that Ms Jilley has focussed only on reflecting upon the Fitness to Practise process, and other matters at Uplands and Kitnocks that are not relevant to this hearing process and that she had no intention of reflecting on the findings of this panel.

The panel found that, whilst the misconduct could possibly be remediated with in-depth reflection, insight, and training, there was no realistic prospect that, following a period of suspension, Ms Jilley would have developed insight or strengthened her practice such that the risk she poses to patients will have reduced. The panel noted that this was a case that not only involved dishonesty, but also involved conduct which, at different times and in different places of employment, put patients at a risk of harm. As such, the panel considered that the public could not be protected, and that public confidence in the nursing profession could not be maintained if Ms Jilley was not removed from the register.

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

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

The panel directs the registrar to strike Ms Jilley off the register. The effect of this order is that the NMC register will show that Ms Jilley has been struck off the register.

This will be confirmed to Ms Jilley in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Jilley's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Boesche. She submitted that an interim order is necessary to protect the public, and is otherwise in the public interest. Ms Boesche invited the panel to impose an interim suspension order for a period of 18 months to allow time for any possible appeal.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that 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 possible appeal.

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

That concludes this determination.