Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 10 June 2026 – Tuesday, 16 June 2026

Physical Meeting

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

Name of Registrant:	**Bernadett Kiralyne Kemenes**
NMC PIN:	09H0041C
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nurse - RN1 - 14 August 2009
Relevant Location:	East Lothian**,** Scotland
Type of case:	Misconduct
Panel members:	Michaela McAleer (Chair, Lay member) Patricia Ford (Registrant member) Chanelle Gibson-McGowan (Lay member)
Legal Assessor:	Cyrus Katrak (9 – 10 June 2026) Suzanne Palmer (11 – 16 June 2026)
Hearings Coordinator:	Petra Bernard
Facts proved:	Charges 1, 2b, 2c, 2d, 3a, 3b and 3c
Facts not proved:	Charge 2a
Fitness to practise:	Impaired
Sanction:	**Suspension order (3 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Kemenes' registered email address by secure email on 3 March 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations and that this meeting will be considered on or after 7 April 2026. The panel noted that Mrs Kemenes had been afforded ample opportunity to submit any documentation she wished the panel to consider in advance of the meeting.

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

Details of charge

'That you, a registered nurse:

1. On 28 October 2022, gave Resident E a dose of Tolterodine in the morning and at lunch time instead of in the morning and evening as prescribed.

2. On 5 February 2023:
    a. Did not administer prescribed antibiotics to Resident B;
    b. Administered one cap of Isosorbide to Resident D rather than two as required;
    c. Did not administer prescribed prednisolone to Resident D;
    d. Did not administer prescribed memantine to Resident F.

3. On or around 17 June 2023:
    a. Gave Resident A 32 units of insulin instead of 8 units as prescribed;

b. Retrospectively amended Resident A's medication records;
c. Your actions at 3.b. were dishonest in that you were attempting to conceal that you had made a medication error.

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

Background

The Nursing and Midwifery Council (NMC) received a referral on 21 June 2023 from the Clinical and Governance Nurse Manager, Janet Decourt (Ms Decourt) at iCare24 (the Agency), arising from a complaint made by the Home Manager, at Haddington Care Home (Home 1) in relation to concerns about Mrs Kemenes' practice. Mrs Kemenes was employed by the Agency and was working at Home 1 as a registered nurse. The allegations arise out of an incident on 17 June 2023 at the Home 1, where it is alleged that Mrs Kemenes had administered the wrong dose of insulin to Resident A, then attempted to amend the Medication Administration Record (MAR) chart to cover up her error.

A further concern was identified that at Rumbling Bridge Care Home (Home 2) on 5 February 2023, it is alleged that Mrs Kemenes allegedly made three medication errors relating to three patients.

Concerns were also raised in October 2022, that whilst working at Beechwood Park Care Home (Home 3), that Mrs Kemenes administered medication to a resident at the wrong time, which was only noticed when said resident asked for their tablet at teatime.

At a local disciplinary meeting held by the Agency on 3 July 2023, Mrs Kemenes admitted that she had administered the wrong dose to Resident A and changed the MAR chart. She was apologetic and remorseful for this.

After the incidents at Home 3 and Home 2, Mrs Kemenes completed reflections in line with the Agency's policy. However, after the incident at Home 1, all matters were referred to the NMC.

It is the NMC's understanding that Mrs Kemenes has not worked as a nurse since June 2023 and her current employment status is unknown.

Decision and reasons on facts

The panel first considered the NMC guidance CMT- 4 entitled 'Considering cases at meetings and hearings. The panel had regard to the proof of posting documentation where it is noted that Mrs Kemenes had engaged sporadically in proceedings and enquired about Agreed Removal (AR) from the register. Mrs Kemenes has not returned a completed Case Management Form (CMF) and raised no objection to her case proceeding as a meeting.

The panel determined that it is therefore right and proper in the circumstances to proceed with this case as a meeting.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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

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

- Janet Decourt (Ms Decourt): Clinical and Governance Nurse Manager at iCare24 (the Agency) and referrer of incident at Home 1, at the material time

- Morag Shea (Ms Shea): Senior Home Manager at Home 2, at the material time

- Karen Gillespie (Ms Gillespie): Deputy Manager at Home 3, at the material time

Before making any findings on the facts, the panel accepted the advice of the legal assessor, which included reference to *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [2017*]* UKSC 67 and a good character direction per NMC 'Guidance on health and character'.

The panel considered all the documentary evidence provided by the NMC including the respective witness statements of Ms Decourt dated 22 November 2024 and 14 January 2025, Ms Shea dated 5 November 2024 and Ms Gillespie dated 27 July 2025, as well as each of their corresponding documentation (exhibits).

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

Charge 1

That you, a registered nurse:

1. On 28 October 2022, gave Resident E a dose of Tolterodine in the morning and at lunch time instead of in the morning and evening as prescribed.

This charge is found proved.

The panel took into account all the documentary evidence before it, including the witness statements of Ms Decourt and Ms Gillespie.

Ms Decourt's witness statement includes:

> *'...I became aware of a complaint submitted by Karen Gillespie, Deputy Manager at Beechwood Care Home on 2 November 2022. My understanding is that, on 28 October 2022, Mrs Kemenes gave Resident E a dose of Tolterodine, which is used to treat symptoms of an overactive bladder, such as incontinence (loss of bladder control) or a frequent need to urinate at the wrong time. Mrs Kemenes gave the dose in the morning and at lunch time instead of in the morning and evening...'.*

Ms Gillespie's witness statement includes:

> *'Bernadette did not overdose or underdose the resident. The medication error was in relation to timing. It was not a missed dose.*
>
> *...*
>
> *The resident did not experience any ill-effect from medication being administered at the wrong time. A set of vital observations were recommended to be carried out by a GP. Social Work were informed as an Adult Protection form was sent, and no further action was taken. A safeguarding report was not required.'*

The panel had regard to an email dated 2 November 2022 from Ms Gillespie at Home 3, stating that Ms Kemenes had self-reported the incident to the Agency:

> *'It's been brought to my attention that when Bernadette Kemenes was at Beechwood Park on Friday 28/10/22 she made a medication administration error when giving a resident their Tolterodine. The resident is prescribed this medication in the morning and at teatime, however, Bernadette gave a dose in the morning and at lunch time. So effectively, the resident wasn't over or under dosed. Medication was given at the wrong time. This caused some [PRIVATE] to the resident who asked at teatime where her small white tablet was. This is when the error was noticed by Bernadette herself. Bernadette then reported error to a Team Leader on duty who advised with reporting and recording processes.'*

The panel considered that there is no explanation from Mrs Kemenes before it in relation to this incident. The panel took into account that Mrs Kemenes had self-

reported the incident to her Team Leader. Further, there is clear, cogent and consistent evidence from reliable sources that she gave Resident E a dose of Tolterodine in the morning and at lunch time, instead of in the morning and evening as prescribed. The panel therefore finds this charge proved.

Charge 2a

2. On 5 February 2023:
a. Did not administer prescribed antibiotics to Resident B;

This charge is found NOT proved

In reaching its decision the panel took into account the respective witness statements of Ms Decourt and Ms Shea and Resident B's MAR chart.

Ms Decourt in her witness statement states:

'My understanding is that, on 5 February 2023, Mrs Kemenes had four medication administration incidents:
• Mrs Kemenes failed to give an antibiotic to Resident B...'

Ms Shea's witness statement states:

'On 5 February 2023, Resident B was not administered with the antibiotic, Nitrofurantoin, which they were meant to have around breakfast time between 8:00 and 10:00 and then another one at tea time, between 17:00 – 19:00 but this was not documented in the MAR chart. Mrs Kemenes had not signed for the medication indicating that the medication was given.'

I was not in the Home on 5 February 2023 as it was a Sunday and I became aware of the incident on 6 February 2023. I cannot recall whether I saw the MAR chart or one of the nurses notified me but it showed that the medication had not been given.'

The panel examined the MAR chart for the alleged omission to give antibiotics on 5 February 2023. The panel was of the view that the MAR chart evidence was unclear and inconclusive. It showed confusing overwritten dates and the omission to administer the antibiotic appeared more than likely to relate to 6 February 2023, not the 5 February 2023.

The panel took account of the morning and evening entries on the MAR chart on 5 February 2023, where it also records the number of tablets remaining in the pack, which makes it more likely than not that the antibiotic in question was administered on 5 February 2023. The panel noted that there was not an entry for administration of the antibiotic on 6 February 2023, however this charge relates to 5 February 2023.

The panel had regard to Mrs Kemenes' reflective account dated 8 February 2023. She mentions an antibiotic error, however it referred to a different antibiotic (doxycycline), than the one shown on the MAR chart. The antibiotic listed in evidence (nitrofurantoin) did not match what Mrs Kemenes had admitted to, therefore her admission does not align with this charge.

The panel took account that Mrs Kemenes apparently made admissions to a number of other medication errors made on 5 February 2023, however none concern this drug.

The panel therefore determined that because of mismatched drug names and unclear dates on the MAR chart, there is insufficient reliable evidence to support this charge that on 5 February 2023 Mrs Kemenes did not administer prescribed antibiotics to Resident B. The panel therefore finds this charge not proved.

Charge 2b

> 2. On 5 February 2023:
> b. Administered one cap of Isosorbide to Resident D rather than two as required;

The charge is found proved

In reaching its decision the panel took into account the respective witness statements of Ms Decourt and Ms Shea and Resident D's MAR chart.

Ms Decourt's witness statement states:

> *'My understanding is that, on 5 February 2023, Mrs Kemenes had four medication administration incidents:*
> ...
> • *Mrs Kemenes gave Resident D one cap of nitrate rather than the two prescribed. (The Agency were are unable to locate a copy of this MAR chart despite extensive searches)'*

The panel had regard to the completed Complaints Form dated 5 February 2023 from Ms Shea which states *'...prescribed a nitrate 2 tablets am but was only given 1...'.*

Ms Shea's witness statement states:

> *'Resident D had angina which they were prescribed two caps of nitrate. I cannot confirm Resident D's nitrate prescription as I am unable locate the copy of his MAR chart for this but I forwarded a copy to iCare24. The prescribed frequency and timing for the nitrate administration are unknown to me due to the lack of access to the MAR chart. They were prone to chest infections, Chronic Obstructive Pulmonary Disease ("COPD"), and asthma. Mrs Kemenes failed to administer the two caps of nitrate to Resident D. According to the complaint form and Mrs Kemenes' reflective statement, one capsule of nitrate was administered instead of the prescribed two, which, if specified in the complaint, I can confirm this as correct.'*

Mrs Kemenes in her Reflective Account dated 9 February 2023 describes how only one tablet was available and that one cap was given instead of two. She also states there was *'only 1 left on the trolley, unable to locate more stock...'*.

The panel determined that Mrs Kemenes was aware that there was insufficient medication available to her at the time to administer to Resident D, yet still went ahead and administered the incorrect dose. The panel considered her reflective piece dated 8 February 2023 where she wrote *'Isosorbide – 1 caps given instead of 2'.* The panel determined that Mrs Kemenes acknowledges her own error in proximate terms to this alleged incident. The panel therefore finds this charge proved.

Charge 2c

2. On 5 February 2023:
c. Did not administer prescribed prednisolone to Resident D;

This charge is found proved

In reaching its decision the panel took into account the respective witness statements of Ms Decourt and Ms Shea and Resident D's MAR chart.

Ms Decourt in her witness statement states:

'My understanding is that, on 5 February 2023, Mrs Kemenes had four medication administration incidents:
...
• Mrs Kemenes failed to give prednisolone to Resident D.'

Ms Shea's witness statement states:

'On 5 February 2023, Mrs Kemenes did not administer Resident D's prednisolone which was a steroid and they were prescribed six tablets daily for two days in the morning.
...
As above, the incident was discovered on Monday morning (6 February 2024) upon checking Resident D's MAR chart which Mrs Kemenes left blank. I became

aware that the medication was not dispensed because Ms Kemenes was the nurse on shift and taking charge of the floor and dispensing medication.'

The panel examined the MAR chart for Resident D and noted that the entry for the morning of 5 February 2023 was left blank in contrast to the other days.

The panel noted that Mrs Kemenes' reflective piece dated 8 February 2023 states that the prednisolone *'...was not administered in the morning...'.*

The panel was satisfied that all of the evidence before it in relation to this charge is consistent and supports the allegation. The panel therefore determined that Mrs Kemenes did not administer the prescribed prednisolone to Resident D and found this charge proved.

Charge 2d

2. On 5 February 2023:
d. Did not administer prescribed memantine to Resident F.

This charge is found proved

In reaching its decision the panel took into account the respective witness statements of Ms Decourt and Ms Shea and Resident F's MAR chart.

Ms Shea in her witness statement states:

'Resident F had been at the Home since June 2020 and they were prescribed 20mg of memantine for depression. However memantine is a medicine used for dementia, to treat memory loss which is one of the main symptoms of dementia. It is also used to treat the symptoms of Alzheimer's disease. This was not administered by Mrs Kemenes on 5 February 2023. It should have been administered in the morning, either once or twice daily.'

...

As above, the incident was discovered on Monday morning (6 February 2023) upon checking Resident F's MAR chart which Ms Kemenes left blank. As above, I knew it was Mrs Kemenes because the medication was not dispensed when she was the nurse on shift and was in charge of the floor and dispensing medication.'

Ms Decourt in her witness statement states:

'My understanding is that, on 5 February 2023, Mrs Kemenes had four medication administration incidents:

...

- *Mrs Kemenes failed to give Alzheimer's medication to Resident C* [Resident F]*...'*

The panel had regard to Mrs Kemenes' reflective piece of 8 February 2023 she states *'mementine...not administered in the morning'.* The panel was of the view that Mrs Kemenes accepts and identifies the specific drug she had omitted to administer.

The panel examined the MAR chart for Resident F. It took account that there was a clear blank in the entry on the chart for administering the medication on 5 February 2023 in the morning as prescribed as well as the absence of an initial and number of remaining drugs in the pack.

The panel determined that Mrs Kemenes did not administer prescribed memantine to Resident F and therefore finds this charge proved.

In relation to the charge 3 the panel took account of the witness statement of Ms Decourt and the following corresponding documentation: Complaint Form from Home 1; Home 1 referral form to Health and Social Care; Duty of Candour email letter dated 26 June 2023 to Resident A's daughter; The Agency Investigatory Meeting dated 28 June 2023; local Disciplinary Hearing Notes dated 3 July 2023; Email to NMC dated 30 June 2023; Mrs Kemenes' reflective statement dated 31 July 2023 and Resident A's Insulin Administration charts.

Charge 3a

3. On or around 17 June 2023:
a. Gave Resident A 32 units of insulin instead of 8 units as prescribed;

This charge is found proved

In reaching this decision, the panel took into account of the above documentation.

Ms Decourt in her witness statement states:

> *'On 17 June 2023, Mrs Kemenes gave Resident A 32 units of insulin instead of eight. I became aware of this incident as it was reported as a complaint by Home Manager, Robert Krawcyzk, on 21 June 2023. On the complaint form, it is stated that Resident A had an overdose of insulin...'*

The panel had regard to Resident A's Insulin Injection Administration Charts which shows two separate charts for the morning (32 units) and afternoon (8 units) and Mrs Kemenes essentially worked from the wrong chart, leading to the error. Specifically, the panel noted that there was an entry on the morning chart recorded at 17:20 and no entry on the evening chart for that date.

The panel was of the view that on 17 June 2023 Mrs Kemenes administered 32 units of insulin instead of the prescribed 8 units to Resident A in error.

Mrs Kemenes wrote in her reflective piece:

> *'I was on shift on the 17/06/23 on 2nd floor. Team leader asked me to go to the ground floor and give the tea time insulin to one of his residents called [Resident A]. When I check the insulin administration chart, unfortunately I did not recognise that am and pm dose on different chart, and I did administer the*

morning dose instead of the team time dose. I accept my mistake and I am really sorry. I have learnt from my mistake.'

The panel took account of the Complaint Form from the Home Manager at Home 1, which states:

'2 Insulin recording charts AM and PM – Bernadette was not aware of this and only seen the AM sheet which is what she followed. Thus leading her to give the incorrect does.

The Mar chart shows insulin is due to be administered AM and PM but on the MAR chart does not highlight the dose to be administered. If the mar chart stated the dose that was to be administered this would further reduce the risk of administering the incorrect dose. Bernadette had read and signed on the mar chart that she had administered the insulin...'

On conclusion I feel this error could have been avoided had the MAR sheet been written clearly and the dose to be administered written.'

In the local investigatory meeting held on 28 June 2023, Mrs Kemenes said:

'Team leader came and asked me to go to his floor and give his tea time insulin. I open the mar chart and checked the mar chart-it didn't state what does [sic] *to be given just AM and PM, there was an insulin administration chart, different chart for morning and for tea team* [sic] *– I didn't notice there was 2 charts and followed the wrong one...'*

In Mrs Kemenes' Reflective Account she admitted the error describing it as a '*big mistake'.* The panel also took account that in the local Disciplinary Meeting held on 3 July 2023 Mrs Kemenes did not deny the allegation.

The panel determined that Mrs Kemenes' account was consistent with the documentary evidence and the pattern of entries on Resident A's Insulin Injection Administration

Charts.

The panel therefore determined that on the balance of probabilities, there is clear and consistent evidence, including Mrs Kemenes' own admission, that she administered 32 units of insulin to Resident A at the evening dose in error instead of 8 units as prescribed. The panel therefore finds this charge proved.

Charge 3b

3. On or around 17 June 2023:
b. Retrospectively amended Resident A's medication records;

This charge is found proved.

In reaching this decision the panel had regard to Ms Decourt's witness statement which states:

'On 17 June 2023, Mrs Kemenes gave Resident A 32 units of insulin instead of eight. I became aware of this incident as it was reported as a complaint by Home Manager, Robert Krawcyzk, on 21 June 2023. On the complaint form, it is stated that Resident A had an overdose of insulin, Mrs Kemenes falsified the records, and that she encouraged staff not to report the incident to NHS24 and external agencies.

...

As harm was caused to Resident A and he became unwell as he had an unstable blood sugar reading, paramedics had to review him in the Home. I became aware as I was given copies of the nursing notes recorded in his file. I do not have copies of these nursing notes. Haddington Care Home made a referral to Health and Social Care and they copied me in to the referral form and nursing notes. ... I am not aware of the outcome of the referral. On 26 June 2023, a duty of candour letter was sent to Resident A's daughter informing of the incident. I exhibit a copy of the email sent by Michelle Ferrey, Regional Support Manager.

...

On 28 June 2023, Ms Heather Martin, Clinical Nurse for ICare24 conducted a fact finding meeting with Mrs Kemenes and she made a recommendation for the matter to proceed to disciplinary action.

...

Mrs Kemenes denied that she encouraged staff not to report the incident and there were no witness statements provided to support this. Mrs Kemenes was very remorseful during the fact finding meeting.'

The panel took into account Resident A's Insulin Administration Chart and determined that it is clear that it has been amended, without any initials or explanation as to the reason for its amendment. The panel was of the view that it is evident that *'8 units'* and *'32 units'* are the relevant unit numbers and that the two doses are engaged in this charge. There is evidence of the number *'32'* being overwritten with *'08'* and then overwritten again with *'32'*. The panel noted that the amended chart appears to record *'32 units'* as the amount of insulin administered by Mrs Kemenes to Resident A.

It is not clear to the panel how the issue of falsification of records or retrospective amendment of records was discovered, nor did it have access to the nursing notes in Resident A's files. The panel has taken account of Mrs Kemenes' own evidence from the local investigatory meeting of 28 June 2023, that she changed the record in the morning in relation to Resident A and was remorseful for this.

Mrs Kemenes stated:

'I panicked, I don't know why I did it, I changed it in the morning when I went down stairs. Not sure what time at. I don't know why, it was a stupid decision'.

In Mrs Kemenes' Reflective Account of 1 July 2023 in her own handwriting she states:

'I have administered wrong dose of insulin, and I have tried to cover up my mistake. I should not try to cover, I should follow medication error policy. I made a big mistake by doing that, and I accept it.'

The panel considered the sequence of events and noted that Mrs Kemenes had said in the local Investigation Meeting that she became aware of the error on 18 June during handover she also contacted her Agency but the person she wanted to speak to was on annual leave as she wanted to inform the agency of the error.

The panel considered Mrs Kemenes' own admission to having retrospectively changed the record in the morning, found it to be genuine, consistent and not contradicted. The panel had particular regard to the local statement in where she admitted to changing the documentation and was remorseful. She said that she *'panicked'* and did not know why she did it, stating 'it was a *stupid decision*'. When Mrs Kemenes was specifically asked if she was aware of the seriousness of the allegation, she responded that she was '*aware that the mar chart is a legal document I don't know why I did it I regret what I did and I never wanted to harm the resident it was a big mistake...'.*

The panel determined that on the basis of Mrs Kemenes' admission, that on or around 17 June 2023, she did retrospectively amend Resident A's medication records. The panel therefore finds this charge proved.

Charge 3c

> 3. On or around 17 June 2023:
> c. Your actions at 3b. were dishonest in that you were attempting to conceal that you had made a medication error.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty as set out by Lord Hughes at paragraph 74 of *Ivey v Genting*. It relied upon its reasoning in charge 3b.

The panel had to determine what Mrs Kemenes' actual state of mind was as to the facts and decide whether her conduct with that state of mind would be considered dishonest by the standards of ordinary decent people.

The panel reminded itself that the test for dishonesty is a two-stage test.

First, the panel must determine, on the evidence, Mrs Kemenes' actual state of knowledge or belief as to the facts.

The panel considered Mrs Kemenes' admission that she tried to cover up the error once it was discovered, that she did not know why and just panicked, as well as her admissions to having retrospectively amended Resident A's medication record. The panel was of the view that Mrs Kemenes understood what she was doing, was in a state of panic and not sure why she did what she did, however she later admitted that she was trying to cover up the error. She said in her Reflective Account to the NMC dated 31 July 2023 that she was worried that she would be in *'big trouble'* for making an administration error.

Secondly, the panel must determine whether, in light of that state of mind, her conduct was dishonest by the standards of ordinary decent people. There is no requirement that Mrs Kemenes herself must have appreciated that her conduct was dishonest by those standards.

The panel determined that given Mrs Kemenes' experience and knowledge at the time, ordinary decent people would find her action of amending Resident A's medicines record, which she knew to be inaccurate, to be dishonest.

The panel therefore finds this charge proved.

Fitness to practise

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

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

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

Representations on misconduct and impairment

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

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

In written submissions provided to the panel, the NMC stated that it considered that Mrs Kemenes' conduct fell significantly short of what is expected of a registered nurse. Mrs Kemenes' actions between October 2022 and June 2023 involving administering incorrect dose of medication, omitting the administration of medication and dishonestly attempting to cover up her error are failings which amount to a significant departure from the fundamental principles of the Code. These principles include prioritising people, practising safely, preserving safety and promoting professionalism and trust in the profession.

The NMC identified the following specific, relevant standards in the Code where in its view, Mrs Kemenes' actions amounted to misconduct: 1.2, 7.4, 10.2, 10.3, 14.1, 14.2, 14.3, 18.1, 19.1, 20.1, 20.2, 20.3 and 20.8.

The NMC submits that Mrs Kemenes' fitness to practise is impaired. It referred the panel to on NMC guidance on 'Impairment' Reference: DMA-1 guidance, the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)* and the questions outlined by Dame Janet Smith in the Fifith Report from the Shipman Inquiry (as endorsed in Grant).

> *1. has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
> *2. has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
> *3. has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
> *4. has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.*

It is the submission of the NMC that questions 1 – 4 can be answered in the affirmative in this case.

The NMC submit, in reference to the Shipman report that Mrs Kemenes' conduct creates concerns around patient safety, public confidence, professional standards, and dishonesty.

The NMC submits that Mrs Kemenes made repeated medication errors affecting several residents, including an insulin overdose that caused actual harm to Resident A. It also alleges that Mrs Kemenes dishonestly altered medication records to conceal the error, creating further risk because other professionals could not accurately assess Resident A's medication needs.

The NMC submit that Mrs Kemenes' conduct has brought the nursing profession into disrepute, breached fundamental tenets of nursing, and involved dishonesty. While some admissions and reflections were provided, the NMC consider the insight insufficient and say there is no evidence of meaningful remediation, training, or strengthened practice. It therefore submits there remains a risk of repetition.

The NMC submit that a finding of impairment is required on both public protection and public interest grounds, to protect patients, uphold professional standards, and maintain public confidence in the nursing profession.

The NMC reminded the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

The NMC invited the panel to find Mrs Kemenes' fitness to practise impaired on the ground of public protection and in the public interest.

The panel accepted the advice of the legal assessor. This included reference to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and Dame Janet Smith's test as set out in the Fifth Report from the Shipman Inquiry.

Decision and reasons on misconduct

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

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

‘1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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:

10.2 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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

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 considered each of the charges found proved and was of the view that Mrs Kemenes' actions amounted to conduct which fell below the standards expected of a registered nurse.

Charge 1

The panel determined that this incident was an error however was not sufficiently serious to amount to misconduct. The panel was of the view that Mrs Kemenes identified the mistake herself on the same day, reported it, took appropriate swift action and subsequently followed correct procedures to ensure no detrimental effect occurred to Resident E.

The panel took into account that the risk assessment conducted by the Home recorded the incident as minor, with no harm or real risk to the patient, noting that the medication was simply given at the wrong time. The panel further noted that other external safeguarding bodies did not pursue the matter further.

The panel determined that Mrs Kemenes' overall response demonstrated insight and remedial action meaning the situation did not amount to a serious departure from professional standards or misconduct. The panel was of the view that, in this regard, Mrs Kemenes' actions did not fall seriously short of the conduct and standards expected of a nurse and did not amount to misconduct.

Charges 2b, 2c and 2d

The panel considered that the incidents in charge 2 occurred during one shift, involving three proven medication errors affecting two residents. The panel took account that the

Home Manager at Home 1 assessed each error as serious due to the risks associated with the medications. The panel considered the multiple errors and the overall context and concluded that Mrs Kemenes' conduct met the threshold for serious misconduct.

The panel determined that Mrs Kemenes' conduct was sufficiently serious to amount to misconduct, primarily due to her failure to follow up appropriately, particularly knowing that she did not have sufficient medication to give the correct dose and then not acting on that. The panel determined that this lack of follow-up care increased the risk to residents' safety, elevating the seriousness of her errors beyond isolated mistakes.

Charge 3a, 3b and 3c

The panel was of the view that an average nurse would understand the serious consequences of administering the wrong dose of insulin. The panel took account that Resident A suffered actual harm from the overdose of insulin. The panel acknowledged that prior to the administration of the insulin, Mrs Kemenes attempted to act correctly, including checking with a manager about a second signature, but used the wrong chart (morning instead of evening), making the mistake understandable.

The panel determined that on its own, the medication error may not have met the misconduct threshold, however when combined with her retrospective and dishonest amendment of Resident A's medical records, the threshold was clearly met. The panel determined that, even though the error was by then identified enabling increased monitoring, altering Resident A's medical records was dishonest and could have caused confusion to other medical professionals, impacting on Resident A's ongoing care. The panel determined that Mrs Kemenes' actions in this regard were sufficiently serious to amount to misconduct.

In light of the above, the panel found that Mrs Kemenes' actions in relation to charges 2 and 3 did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel went on to decide if as a result of the misconduct, Mrs Kemenes' 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/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

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

The panel found each of the above four limbs to be applicable in this case.

The panel determined that residents were put at risk as a result of Mrs Kemenes' misconduct. The panel decided that Mrs Kemenes' misconduct had breached the fundamental tenets of the nursing profession, in particular to act with honesty and integrity and to prioritise patient care, and therefore brought it into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty to be extremely serious.

The panel considered the following factors as set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin):

- Is the behaviour easily remediable?
- Has it already been remedied?
- Is it highly unlikely to be repeated?

The panel was of the view that with further support and training Mrs Kemenes'

behaviour is remediable in relation to the medication administration errors. However the panel determined that due to a lack of significant strengthening of practice for drug administration, there remains a risk of repetition of drug administration errors until she receives the right training and support. In relation to the medication administration failings, the panel therefore concluded that Mrs Kemenes' fitness to practise is currently impaired on public protection grounds.

Regarding insight, the panel considered Mrs Kemenes made admissions and has demonstrated an understanding of how her actions put the residents at a risk of harm. Mrs Kemenes has demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. Mrs Kemenes has apologised for her misconduct however the panel was not satisfied that she has sufficiently demonstrated how she would handle [PRIVATE] differently in the future, to avoid making similar errors.

The panel carefully considered the evidence before it in determining whether or not Mrs Kemenes has taken steps to strengthen her practice. The panel noted that Mrs Kemenes has she not practised as a nurse since June 2023 and has not yet demonstrated any strengthening of her nursing practice.

The panel took into account the training Mrs Kemenes has undertaken (which pre-dated the relevant incidents) and the three reflective accounts written by her addressing her misconduct. In this regard, panel considered that each time there were drug errors and omitted medication, Mrs Kemenes recognised the risk of harm, but only after the fact and without much foresight. However, the panel determined that this it is aspect of the misconduct moving forward could be addressed with stringent employer supervision, training and further reflection to ensure similar errors are not repeated. However, the panel decided that a finding of impairment is necessary on the grounds of public protection in relation to the drug administration errors.

Turning to the dishonesty finding, the panel considered Mrs Kemenes' reflective pieces and noted that she took full responsibility for her actions and stated that she had learnt from her mistakes. She recognised that her actions would have resulted in a loss of

trust in her by patients, patients' relatives and colleagues, and a lot of trust in the profession as a whole. The panel took account that there is no other evidence before it of Mrs Kemenes acting dishonestly throughout her career. Ms Decourt in her statement commented positively that Mrs Kemenes usually acted honestly. The panel was therefore of the view that this incident of dishonesty was out of character and the subsequent proceedings will have taught Mrs Kemenes a significant lesson, and it therefore appeared highly unlikely that Mrs Kemenes would attempt to falsify clinical records in the future.

The panel bore in mind 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 did not consider that the medication errors involved in charges 2 and 3a required a finding of current impairment on wider public interest grounds. They took place on two shifts and in some instances were understandable errors, capable of being remedied. Although there remains a risk of repetition, and therefore the panel has found impairment on public protection grounds, it did not consider that these drug administration errors were sufficiently serious to require a finding of impairment on the wider public interest grounds.

The panel determined, however, that a finding of impairment on public interest grounds is required in relation to Mrs Kemenes' dishonesty in amending a resident's medical records in an attempt to conceal that she had made a medication error. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case in relation to the dishonesty, to maintain proper standards and maintain public confidence in the profession and the NMC as its regulatory body. The panel therefore also finds Mrs Kemenes' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Kemenes' fitness to practise is currently impaired:

- In relation to the medication errors (charges 2 and 3a), on public protection grounds alone
- In relation to the dishonesty (charges 3b and 3c) on public interest grounds alone

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of three months. The effect of this order is that the NMC register will show that Mrs Kemenes' registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor which included reference to the NMC guidance on sanctions.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 3 March 2026 the NMC had advised Mrs Kemenes that it would seek the imposition of a six-month suspension order with a review if it found her fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Kemenes' fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to

be punitive in its effect, may have such consequences. The panel had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which caused a resident to suffer actual harm
- Conduct which had the potential of putting people at unwarranted risk of suffering harm
- A pattern of repeated medication errors

The panel also took into account the following mitigating features:

- No evidence of any other concerns
- Early admissions to some of the facts
- Some evidence of insight
- Personal mitigation of [PRIVATE]

The panel first considered taking no further action. It was mindful that it has found a risk of repetition, with associated risk of harm, in relation to the medication administration errors. It also considered that the dishonesty was too serious to warrant no further action. It concluded that it would neither protect the public nor be 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 Mrs Kemenes' dishonesty was not at the lower end of the spectrum of impairment and it found that there is a risk to patient and public safety in relation to the medication errors. The panel therefore determined that a sanction that does not restrict Mrs Kemenes' practise would not protect the public. A caution order would be insufficient to mark the dishonesty. The panel determined that it would neither protect the public nor be in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Kemenes' registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel considered that it would be possible to formulate relevant, proportionate and workable conditions if this case involved only the clinical failings in respect of medication administration. However, it considered that the dishonesty in this case, although one-off, spontaneous and unlikely to be repeated, was sufficiently serious in character, involving an attempt to cover up a clinical error, that a conditions of practice

order would be inadequate to mark the seriousness of the misconduct and satisfy the wider public interest considerations.

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

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel had regard to the NMC sanctions guidance 'Sanctions for the highest risk cases' Reference: SAN-4 (Last Updated 28/01/2026) and specifically noted the provisions within the guidance in relation to honesty. In particular it referred to the case of *Lusinga v NMC* [2017] EWHC 1458 (Admin) which states that *'not all dishonesty is equally serious'* and that dishonest conduct would generally be less serious in cases of:

- One-off incidents
- Spontaneous conduct
- Professionals who have behaved dishonestly can engage with the Committee to:
    - Show that they feel remorse
    - Recognise that they acted in a dishonest way
    - Explain, with evidence, how this will not happen again.

The panel was of the view that these factors were alive in Mrs Kemenes' case. It relied on the evidence in Mrs Kemenes' reflective statement of 31 July 2023 demonstrating remorse and acknowledging that she knew she had broken trust. The panel also bore in mind that this was an isolated incident of dishonesty which appeared to be out of character and at a time of [PRIVATE]. The panel also acknowledged the reference within the guidance to it being:

> *'...very unlikely that a sanction less than suspension will be proportionate to findings of dishonesty. Conditions of practice are unlikely to be an appropriate sanction, because dishonesty is an attitudinal concern which cannot easily be mitigated by conditions.'*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register, however there is a need to mark that it is unacceptable to amend a medical record in an attempt to conceal a medication error which could have had serious consequences for the resident.

In making this decision, the panel carefully considered the submissions of NMC in relation to the six-month with review suspension order sanction that it was seeking in

this case. The panel recognise that it is an attitudinal concern however determined that it is not deep-seated and unlikely to be repeated. The panel determined that Mrs Kemenes needs time to demonstrate how she would act differently to ensure she is able to conduct herself in a pressurised situation in future. The panel therefore decided that a three-month suspension order is the appropriate and proportionate sanction to mark the seriousness of the dishonesty and discharge the public interest element in this case.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Kemenes' case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a three-month suspension order would be the appropriate and proportionate sanction.

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

At the end of the period of suspension, another panel will review the order. At the review hearing/meeting the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective piece demonstrating further reflection on the incidents
- Evidence of private study or other remedial steps to strengthen practice
- References from any employment, whether in a healthcare setting or otherwise
- Training in relation to safe drug administration and record keeping
- Engagement with the next review hearing

This will be confirmed to Mrs Kemenes in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Kemenes' own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that the registrant's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registrant the NMC submitted that an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public in relation to the medication errors in this case. The panel determined that there is still an ongoing risk as Mrs Kemenes has not undertaken any further training, or apparently worked as a nurse, since June 2023 and therefore it has seen no evidence of improved

practice. Furthermore her current employment status is unknown. The panel therefore considered that the only way is to manage this is through interim conditions of practice.

The panel was mindful of its earlier findings that the dishonesty is unlikely to be repeated. It did not consider that the high threshold for imposing an interim order on wider public interest grounds is met.

The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The following interim conditions of practice order will be for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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

1. You must limit your nursing practice to one healthcare setting.

2. You must be supervised at all times for all drug administration by a registered nurse or a line manager who is fully trained and qualified in medication management and administration.

3. You must meet with your line manager or supervisor every month to discuss your record keeping, medication management and administration over the previous period.

4. You must work with your line manager to create a personal development plan (PDP). Your PDP must address the concerns

about:

- Safe management and administration of medication
- Record keeping
- How to report incidents and errors

5. You must send your case officer a report from your line manager or supervisor of prior to any review This report must show your progress towards achieving the aims set out in your PDP:

    - Safe management and administration of medication
    - Record keeping
    - How to report incidents and errors

6. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

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

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this interim conditions of practice order is for 18 months.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive suspension order 28 days after Mrs Kemenes is sent the decision of this hearing in writing.

That concludes this determination.