Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 2 – Friday 6 March 2026
Monday 9 – Friday 13 March 2026
Monday 16 – Friday 19 March 2026

Virtual Hearing

Name of Registrant:	Hazel Claire Pitches
NMC PIN:	21A3766E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (October 2021)
Relevant Location:	Kent
Type of case:	Misconduct and Lack of competence
Panel members:	Pamela Johal (Chair, lay member) Fay Jackson (Lay member) Rebecca Aylward (Registrant member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mrs Pitcher:	Present and represented by Gerard McGettigan instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1.1.1, 1.1.2, 1.2.1, 1.2.3, 1.3.1, 1.3.2, 1.4.1, 1.5.1, 1.6.2, 1.6.5, 1.6.6, 2.1.1, 2.1.2, 2.1.4, 2.1.5, 3, 8.2, 8.3, 8.4, 8.5, 12.2, 12.3, 12.5, 14.1, 14.2, 14.3.1, 14.3.2, 15.1, and 15.2
No case to answer:	Charges 5 and 6
Facts proved:	Charges 1.2.2, 1.6.1, 1.6.3, 1.6.4, 2.1.3, 5, 6,

	7.1, 7.2, 8.1, 9, 10, 11, 12.1, 12.4 and 13
Facts not proved:	Charge 4
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months – with review)**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Mr Kabasinskas on behalf of the Nursing and Midwifery Council (NMC) made a joint application for parts of this hearing to be held in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr McGettigan addressed the panel on your behalf. He confirmed that this is indeed a joint application [PRIVATE].

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

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas on behalf of the NMC, to amend the wording of charges 5 and 6.

The proposed amendment was as follows:

"[PRIVATE]"

Mr Kabasinskas reminded the panel that Rule 28 allowed amendments at any stage before findings of fact had been made. He emphasised that you had been given notice of the proposed amendments that morning, that the amendments did not alter the gravamen of the charges, and that no new evidence or material was being introduced. He submitted that the amendments were fair, did not constitute an ambush, and would not prejudice you, and therefore invited the panel to allow the NMC's application.

Mr McGettigan addressed the panel and confirmed that he had considered the proposed amendments under Rule 28. He stated that he could not identify any reasonable objection to the amendments. He submitted that, on a pragmatic basis, the amendments could be made without causing injustice, as his instructions indicated that the substance of the case remained the same despite the amendments. He concluded by confirming that he had no issue with the application.

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

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

Details of charge (as amended)

That you, between 1 November 2021 and 18 March 2022 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 Nurse in that:

Whilst employed at Maidstone and Tunbridge Wells NHS Trust:

1. Having failed a Medicines Assessment on 5 November 2021, were unable to complete drug calculations, with or without prompting:

1.1 On 17 November 2021 relating to:

1.1.1 Converting differing units of weight.

1.1.2 Working out the amount of solution that should be drawn.

1.2 On 24 November 2021 relating to:

1.2.1 Size of units being used.

1.2.2 When to applying the NHS formula.

1.2.3 Working out mls/hr required from a total volume.

1.3 On 25 November 2021 relating to:

1.3.1 The correct method to approach when answering a question.

1.3.2 Working out mls/hr required from a total volume.

1.4 On 2 December 2021 relating to:

1.4.1 Understanding mls/mg

1.5 On 21 February 2022 relating to:

1.5.1 Identifying the correct units to use mistaking grams for micrograms.

1.6 On 17 March 2022 during a practical assessment:

1.6.1 Required prompting to calculate how many millilitres of a drug to withdraw.

1.6.2 Required prompting to use a smaller syringe.

1.6.3 Required prompting to attach a label to the infusion bag.

1.6.4 Required prompting and explaining on how to calculate the infusion rate, and/or how much drug would be received after 15 minutes.

1.6.5 Required prompting and support to calculate how much Frusemide was required for the dose.

1.6.6 Was unable to calculate the minimum infusion rate for Frusemide and/or how the hourly infusion rate could be calculated.

2. On 10 January 2022, during a mock assessment:

2.1.1 Did not always verbalise the 5 R's when administering medication.

2.1.2 Having been informed that there were errors within drug charts, were unable to locate all of the errors.

2.1.3 Attempted to administer Sumatriptan to the wrong patient.

2.1.4 Did not identify that Amlodipine was a Calcium Channel Blocker (CCB).

2.1.5 Attempted to administer a CCB to a patient.

That you a registered nurse:

Whilst employed at Kent Community Foundation Trust ('Trust');

3. On or around 20 April 2022 stated to Colleague A, words to the effect of that you had, *'no knowledge of the NMC referral'.*

4. Your declaration in charge 3 was dishonest in that you knew at the time of

making the declaration that you had been referred to the NMC by Maidstone and Tunbridge Wells NHS Trust.

5. [PRIVATE].

6. [PRIVATE].

Whilst employed at Silver Springs Care Home:

7. Failed to follow Resident A's MAR chart regime by:

   7.1 Administering 12 units of Lantus Insulin to Resident A at 17.10 on 24 August 2023.

   7.2 Administering 12 units of Lantus Insulin to Resident A at 18.20 on 26 August 2023.

8. On 24 August 2023, failed to document in Resident A's daily notes and/or handover sheet:

   8.1 The reason why you did not follow Resident A's MAR chart regime for the administration of Lantus Insulin.

   8.2 A plan of care for Resident A to ensure that blood glucose levels were monitored after the administration of Lantus Insulin at 17.10.

   8.3 That Resident A's glucose levels were monitored and/or documented after 17.10.

   8.4 That you sought advice from a GP before administering Lantus Insulin at 17.10.

   8.5 That Lantus Insulin was administered to Resident A at 17.10.

9. On 24 August 2023, failed to monitor and/or ensure that Resident A's blood glucose levels were monitored after 17.10.

10. On 26 August 2023, failed to seek medical or professional advice prior to administering 12 units of Lantus Insulin to Resident A at 18.20.

11. On 26 August 2023 failed to document in Resident A's MAR chart that you had administered 12 units of Lantus Insulin to Resident A.

12. On 26 August 2023, failed to document in Resident A's daily notes and/or handover sheet:

    12.1 The reason why you did not follow Resident A's MAR chart regime for the administration of Lantus Insulin.

    12.2 A plan of care for Resident A to ensure that blood glucose levels were monitored after the administration of Lantus Insulin at 18.20.

    12.3 That Resident A's glucose levels were monitored and/or documented after 18.20.

    12.4 The reason why you had not sought advice from a GP before administering Lantus Insulin at 18.20.

    12.5 That Lantus Insulin was administered to Resident A at 18.20.

13. On 26 August 2023, failed to monitor and/or ensure that Resident A's blood glucose levels were monitored after 18.20.

Whilst employed at L'Hermitage Care Home:

14. On or around 21 May 2024:

    14.1 Failed to administer 5mg Morphine Sulphate to Resident B.

    14.2 Incorrectly documented in Resident B's MAR chart indicating that you had administered 5mg Morphine Sulphate to them.

    14.3 Having incorrectly documented that you had administered 5mg Morphine Sulphate to Resident B, failed to:

    14.3.1 Have someone witness the administration of the medication.

14.3.2 Have someone sign the MAR chart indicating that they witnessed the medication being administered to Resident B.

15. On or around 3 June 2024;

15.1 Left medication on Resident C's bedside table.

15.2 Incorrectly signed Resident C's MAR chart indicating that they had taken their medication when they had not.

And in light of the above your fitness to practise is impaired by reason of your lack of competence in respect of charges 1 and 2 and by reason of your misconduct in respect of charges 3 to 15.

Background

You qualified as a registered nurse and undertook a series of Band 5 nursing roles in both acute and community settings, followed by positions within care home environments. Across those roles, concerns were raised by successive employers in relation to your ability to safely undertake medication-related responsibilities without supervision.

The earliest concerns arose during your employment at Maidstone and Tunbridge Wells NHS Trust between November 2021 and March 2022. As a newly employed Band 5 nurse, you were required to complete a Medicines Management Assessment. It is alleged that you failed that assessment and, despite receiving support and further opportunities to demonstrate competence, were unable to consistently perform core drug calculations required for safe clinical practice. The allegations include difficulties with unit conversions, infusion rate calculations, volume calculations, and application of standard formulae used in clinical settings. It is further alleged that during both mock and practical assessments you required prompting in order to complete tasks involving intravenous medications and infusion pumps, and that you were unable to demonstrate an appropriate level of independent clinical judgement in relation to medication safety. Additional concerns are said to have arisen in relation to the safe administration process, including the identification of errors on drug charts and patient checks.

In March 2022 you were referred to the NMC and during your subsequent employment with Kent Community Foundation Trust (the Trust), it is alleged that you stated to a colleague that you had no knowledge of the referral to the NMC. [PRIVATE]. These allegations give rise to issues of candour and integrity.

Further concerns were later raised during your employment at Silver Springs Care Home (the Home) in August 2023. It is alleged that on two occasions you administered Lantus insulin to a diabetic resident outside the prescribed MAR chart regime, without seeking appropriate medical advice, and failed to document the administration and subsequent monitoring appropriately. It is also alleged that you did not ensure adequate

post-administration blood glucose monitoring. These matters are said to have had the potential to place a vulnerable resident at risk of harm.

In May and June 2024, during your employment at L'Hermitage Care Home (L'Hermitage), additional medication-related concerns were identified. It is alleged that you failed to administer a prescribed dose of morphine sulphate to a resident but recorded that it had been given, and that you did not comply with controlled drug procedures requiring witnessing and countersigning. A further allegation concerns leaving medication at a resident's bedside and signing the medication administration record to indicate that it had been taken when it had not. These allegations raise concerns about medication security, accuracy of record-keeping, and professional accountability.

Taken together, the allegations are said to present a pattern of concerns relating to medicines management, drug calculation competence, documentation accuracy, adherence to prescribed regimes, and professional candour. It is alleged that these matters demonstrate that you failed to meet the standards of knowledge, skill and judgement required to practise safely without supervision, and in some respects acted dishonestly and without integrity.

Decision and reasons on application to admit hearsay evidence

Mr Kabasinskas informed the panel that he would be making three applications under Rule 31 concerning the admissibility of evidence. Two applications related to hearsay evidence, and one concerned the introduction of a new exhibit.

The first application concerned paragraph 36 of Witness 6's witness statement. Mr Kabasinskas submitted that this paragraph contained hearsay evidence, namely an account of a conversation between Witness 6 and an unidentified nurse. He reminded the panel that Rule 31 provides that evidence is admissible if it is relevant and fair, even if such evidence would not be admissible in criminal or civil proceedings. He referred the panel to the NMC guidance document DMA-6 on hearsay evidence, emphasising that hearsay is not inadmissible merely because it is hearsay, although the panel must consider relevance and fairness.

On relevance, Mr Kabasinskas submitted that paragraph 36 was relevant as it related to a number of charges, particularly those concerning the alleged administration of insulin. He argued that the conversation formed part of the background information that prompted Witness 6 to initiate the internal investigation. It was therefore relevant to explain how the concerns came to light.

On fairness, he referred to case law, including the case of R (Bonhoeffer) v GMC [2012] IRLR 37, for the principle that there is no inherent right to cross-examine witnesses in regulatory proceedings, and Thorneycroft v NMC [2014] EWHC 1565 (Admin), which provides guidance on the approach to hearsay evidence. He submitted that admissibility is not a routine matter and that the panel must weigh competing factors, including whether the evidence is sole or decisive, whether there are other means of testing its reliability, and the seriousness of the charges.

Mr Kabasinskas argued that the hearsay evidence in paragraph 36 was not sole or decisive in relation to the relevant charges. It was background information explaining

the initiation of the investigation, and the panel would also have other documentary evidence and witness testimony, including from Witness 6, which could be tested in cross-examination. Although the nurse could not be identified, Witness 6 could be questioned about the content of the paragraph.

In relation to the nurse's non-attendance, Mr Kabasinskas stated that Witness 6 could not recall the nurse's name and, therefore, the NMC could not take steps to identify or secure the nurse's attendance. He emphasised that this was not new evidence; the paragraph had always formed part of Witness 6's statement, and the registrant had long been aware of the NMC's position.

While acknowledging that the charges were serious, he submitted that they were not at the most serious end of the spectrum. Some aspects of misconduct at Silver Springs Care Home had been admitted.

In conclusion, Mr Kabasinskas submitted that, given the relevance of the paragraph, the fact that it was not sole or decisive evidence, and the availability of other means to test its reliability, it would be fair to admit paragraph 36 into evidence.

In response, Mr McGettigan opposed the application to admit paragraph 36 of Witness 6's statement. He submitted that the paragraph contained explicit hearsay from an unidentified and unnamed nurse and argued that contrary to the NMC's position, the evidence could properly be regarded as decisive in relation to certain charges, particularly charges 7, 10.1 and 11.

Mr McGettigan explained that part of your case on those charges is that the MAR chart was not being used on the relevant days. Instead, a sliding scale document had allegedly been placed at the front of the file, with the MAR chart turned around and placed behind it. According to your position, the sliding scale was the operative document intended to be followed.

Mr McGettigan submitted that the hearsay reference in paragraph 36 to a failure to adhere to the resident's MAR chart amounted to adverse evidence on a central and disputed issue. He emphasised that the unnamed nurse would not be available to clarify precisely what was said or what wording was used, nor could she be questioned about the alleged use of the sliding scale. As such, you would be unable to challenge the substance of the allegation directly.

Mr McGettigan further submitted that there was a clear challenge to the content of the hearsay evidence, particularly on the MAR chart issue. Turning to the *Thorneycroft* criteria, he argued there was no good and cogent reason provided for the nurse's non-attendance, and no evidence that reasonable steps had been taken to identify or secure her attendance. He rejected the suggestion that the matter ended simply because Witness 6 could not recall the nurse's name. In his submission, reasonable steps could and should have been taken to identify the nurse, for example by checking rotas for the relevant day, making enquiries of staff members, or asking the employer to assist. While such steps might not have succeeded, none had been attempted.

Mr McGettigan acknowledged that the charges were less serious than those involving dishonesty or integrity but maintained that allegations relating to patient care and clinical decision-making were nonetheless serious for you.

Finally, Mr McGettigan submitted that the evidence was not demonstrably reliable. The panel had no information about the nurse, her role, or the circumstances in which the comment was made. He argued that questioning the recipient of the hearsay was not equivalent to testing the evidence of the original source.

In conclusion, Mr McGettigan submitted that admitting the paragraph would be unfair. Given its limited detail, lack of context, and the absence of any opportunity to challenge the source, he invited the Panel to redact paragraph 36 from its consideration.

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

The panel first considered relevance. It was satisfied that paragraph 36 is relevant, in that it relates to the circumstances surrounding the alleged administration of insulin and forms part of the background to the initiation of the investigation. It therefore meets the threshold requirement of relevance.

The panel then considered fairness, applying the guidance in DMA-6 and the principles identified in *Thorneycroft*.

The panel determined that there was no good or cogent reason before it to justify the non-attendance of the unidentified nurse. While it accepted that Witness 6 was unable to recall the nurse's name, the panel found that no reasonable steps had been taken to attempt to identify her. It considered that enquiries such as checking staff rotas or making other workplace enquiries could have been explored. Although the panel recognised that such steps might ultimately have proved unsuccessful, it attached weight to the fact that no attempts had been made.

The panel carefully considered whether the evidence was sole or decisive. It concluded that paragraph 36 is neither sole nor decisive evidence in respect of the relevant charges. There is other documentary and witness evidence before the panel relating to the administration of insulin, including MAR charts, blood glucose readings, investigation notes and your own account. The paragraph does not stand alone, nor does the panel consider that it is determinative of the issues in dispute.

The panel also considered your ability to test the evidence. It considered that while the unidentified nurse cannot be cross-examined, Witness 6 is available to give evidence and can be questioned about the circumstances in which the information was received

and recorded. The panel further noted that both parties have had prior disclosure of the full bundle of evidence.

In weighing these factors, the panel recognised that hearsay evidence is inherently less reliable than direct oral evidence. However, the Panel was satisfied that, in this case, admitting paragraph 36 would not render the proceedings unfair. The panel considered that any potential prejudice to you can be addressed by attaching such weight as it considers appropriate to the evidence when determining the facts.

Accordingly, the panel determined that paragraph 36 of Witness 6's witness statement is admissible under Rule 31. The Panel will bear in mind the nature of this evidence and the absence of the original source when assessing the weight to be attached to it at the fact-finding stage.

Decision and reasons on application to admit hearsay evidence

Mr Kabasinskas' second application concerned paragraph 14 of the statement of Witness 8. He reminded the panel that paragraph 14 referred to a conversation between Witness 8 and a tutor at Canterbury Christ Church University. He acknowledged that the paragraph contained an element of hearsay, insofar as it recounted what the tutor had told Witness 8.

Referring back to the principles governing hearsay evidence, Mr Kabasinskas submitted that this was not sole or decisive evidence in relation to the relevant charges. He emphasised that Witness 8 herself would be attending to give live evidence and could therefore be questioned about the contents of the paragraph. He suggested that the position might be different if the NMC were seeking to admit the statement in her absence, but that was not the case here.

Mr Kabasinskas submitted that the paragraph provided contextual or background information relating to charges 5 and 6, which concerned an alleged failure, on or before

18 April, to declare matters to the Trust. The conversation recorded in paragraph 14 took place on 20 April, and therefore post-dated the relevant period identified in the charge. [PRIVATE]. The paragraph was simply one conversation among others touching on that topic.

Mr Kabasinskas maintained that the hearsay element was not sole or decisive in establishing the charges. [PRIVATE].

Mr Kabasinskas highlighted that Witness 8's statement was dated February 2023 and had been served well in advance of this hearing. Although it had been indicated that witnesses were required to attend to give evidence, no specific challenge had been raised beforehand in relation to the tutor or any request made for the tutor's attendance.

In conclusion, Mr Kabasinskas submitted that although paragraph 14 contained an element of hearsay, it could be tested through questioning of Witness 8, was not sole or decisive evidence in relation to the charges, and its admission would not be unfair or prejudicial. He therefore invited the panel to admit the paragraph into evidence.

Mr McGettigan opposed the admission of the hearsay element contained within paragraph 14 of Witness 8's statement specifically the section beginning "The tutor informed me…" to the end of the paragraph. He began by referring the panel to Rule 31(1), emphasising that admissibility is subject to the overarching requirements of relevance and fairness. He also referred to the NMC guidance (DMA-6), highlighting that evidence may be unfair where it cannot be challenged, particularly where the person who gave the evidence cannot be questioned.

Turning to the authority of *Thorneycroft*, he reminded the panel that admission of hearsay from an absent witness is not a routine matter and requires a careful assessment of fairness. He stressed that whether evidence is sole or decisive is only one factor in a broader balancing exercise. He drew particular attention to the

importance of (i) a good and cogent reason for non-attendance and (ii) whether reasonable steps had been taken to secure attendance.

Applying those principles, Mr McGettigan submitted that paragraph 14 could amount to sole or decisive evidence in relation to charges 5 and 6, particularly charge 6. [PRIVATE]. [PRIVATE].

[PRIVATE].

[PRIVATE].

In relation to non-attendance, he argued there was no good or cogent reason provided. No explanation had been advanced, nor had the issue been explored. He placed particular emphasis on the absence of reasonable steps to secure the tutor's attendance. In his submission, the tutor's identity could have been ascertained with relative ease, contact made, and a statement obtained. He suggested that the university documentation may even have contained names. However, no efforts at all had been made. He rejected the suggestion that it was disproportionate to do so, arguing that hearsay was obvious on the face of the paragraph and that it was incumbent on the NMC to investigate the source properly.

On seriousness, he submitted that the charge engaged issues of integrity and therefore carried potentially serious consequences for your career.

Finally, returning to the question of reliability and testing, he argued that the panel could not be satisfied that the evidence was demonstrably reliable. The tutor was unnamed and unknown, and there was no information about their role or basis of knowledge. Nor, he submitted, was there any real means of testing the evidence. Questioning the recipient of the hearsay was not equivalent to cross-examining the original source.
In conclusion, Mr McGettigan submitted that admitting the paragraph would be unfair. Given the limited detail, lack of context, absence of any effort to identify the tutor, and

inability to challenge the source directly, he invited the panel to redact the hearsay element of paragraph 14 from its consideration.

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

The panel first considered relevance. The panel noted that the conversation took place on 20 April 2022, shortly after the period specified in the charge ("on or before 18 April 2022"). [PRIVATE]. Accordingly, the panel determined that the paragraph is relevant as contextual and background evidence.

The panel then considered fairness, applying the principles set out in DMA-6 and *Thorneycroft*.

The panel noted that no explanation had been provided as to why the tutor had not been identified or called as a witness, and that no evidence had been placed before it of any steps taken to secure their attendance. The panel considered that it was possible that the tutor may have been capable of identification through reasonable enquiries. It therefore found that no good or cogent reason for the tutor's non-attendance had been advanced.

The panel considered whether the evidence is sole or decisive. It concluded that the hearsay element of paragraph 14 is neither sole nor decisive in relation to charges 5 and 6. There is other documentary and witness evidence relevant to those charges, including university documentation and your own account. The paragraph constitutes one piece of evidence within a broader evidential picture.

The panel also considered the ability to test the evidence. While the tutor cannot be cross-examined, Witness 8 will give live evidence and can be questioned about the

circumstances of the conversation, what she was told, and her understanding of it. The panel acknowledged that questioning the recipient of hearsay is not equivalent to cross-examining the original source but considered that it nonetheless provides a meaningful opportunity to explore the evidence.

The panel carefully weighed the potential prejudice to you, particularly given that the charges engage issues which may have serious professional consequences. However, taking all factors into account - including relevance, the availability of live evidence from Witness 8, the fact that the evidence is not sole or decisive, and the panel's ability to attach appropriate weight - the panel concluded that admission of the paragraph would not render the proceedings unfair.

Accordingly, the panel determined that the hearsay element of paragraph 14 of Witness 8's statement is admissible under Rule 31. The panel will consider the nature of the evidence, including the absence of the original source, when determining the weight to attach to it at the fact-finding stage.

Decision and reasons on admissibility of interim order hearing determination

Mr Kabasinskas made a third application under Rule 31 to admit a further document into evidence. He indicated at the outset that the application related to charges 5 and 6 and referred the panel to a document which he explained comprised the written reasons from an interim order hearing which had taken place on 18 May 2022. The panel was provided with a redacted version of the document which only contained a summary of the submissions made on your behalf at that time. He confirmed that this was an application by the NMC to admit that document into evidence.

[PRIVATE].

[PRIVATE].

[PRIVATE].

In summary, Mr Kabasinskas submitted that the document was relevant to the live issues before the panel, was a formal and reliable record, had been appropriately redacted, and that its admission would be fair. He therefore invited the panel to admit the document into evidence under Rule 31.

Mr McGettigan indicated that he did not raise any substantive legal objection to the admissibility of the document. He acknowledged that the document was a published and publicly available decision, subject to privacy restrictions, and accepted that it could properly be admitted. However, he made submissions in relation to the weight to be attached to it, which he emphasised was ultimately a matter for the panel.

Mr McGettigan noted that the material relied upon related to part of an interim order decision dated 18 May 2022, and in particular to a summary of submissions made by counsel on behalf of you at that hearing. He stressed that the document did not record submissions made in your own words, nor did it constitute sworn evidence given by you. It was not a transcript or verbatim account of what was said at the hearing, and there were no quotation marks indicating precise wording.

Mr McGettigan further observed that, in his experience, interim order decisions typically contain summaries of the proceedings and do not provide a comprehensive or word-for-word account of all oral submissions made. What the panel had before it, therefore, was a summarised record rather than a full and exact record of the exchanges at the hearing.

Accordingly, while he accepted that the panel could consider the document and did not oppose its admission, he invited the panel to bear in mind the limited nature of the material when determining what weight, if any, should be attached to it in these proceedings.

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

The panel considered the NMC's application under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 to admit into evidence a document comprising the written reasons of an Interim Order Panel hearing dated 18 May 2022. The panel accepted the advice of the Legal Assessor. It reminded itself that, pursuant to Rule 31, it may admit any evidence it considers fair and relevant to the case before it.

At the outset of its consideration, the panel reminded itself that it has no knowledge of the outcome of the interim order hearing. The document before it indicates only that an interim order hearing took place. The panel does not know whether an order was made, and it has not been provided with any information as to the result. The panel has therefore taken care not to speculate in any way as to the outcome of those proceedings.

The panel's consideration is confined to the relevance and fairness of admitting the extract relied upon, in particular the passage at page 7 summarising submissions made on behalf of you.

[PRIVATE]. The panel therefore determined that the document is relevant to live issues in the present proceedings.

The panel considered whether admission of the document would be unfair or prejudicial to you.

It noted that the document is an official regulatory record of proceedings. Although it is a summary of submissions rather than a verbatim transcript, it forms part of a formal determination. The panel also noted that you were legally represented at the interim

order hearing and that the passage relied upon records submissions made on your behalf.

The panel carefully considered whether admitting the document would prejudice you. It concluded that it would not. The panel is not treating the document as determinative of any issue, nor is it relying on it as sole or decisive evidence. Rather, it forms part of the broader evidential picture.

The panel was satisfied that admitting the document does not compromise fairness and does not place you at an unfair disadvantage.

Accordingly, the panel determined that the paragraphs contained within the Interim Order document dated 18 May 2022 is admissible under Rule 31. The panel will determine the appropriate weight to attach to this document when considering the evidence as a whole at the fact-finding stage.

Decision and reasons on application of no case to answer

The panel considered an application from Mr McGettigan on your behalf that there is no case to answer in respect of charges 4, 5 and 6. This application was made under Rule 24(7).

Mr McGettigan provided the panel with written submissions, supplemented by oral submissions, which were as follows:

"1. "The following submissions are made respectfully seeking directions of the Committee that there is "no case to answer" with respect to some of the charges before the Committee, thus they should be dismissed at this juncture. It is indicated at the outset that the submissions relate to charges 4, 5 and 6.

2. The Committee will be aware of NMC Guidance on "Evidence" (DMA - 6, 9/6/25), which includes the following, within the heading of "no case to answer":

There may be situations where, at the close of our case, the nurse, midwife or nursing associate feels that we just haven't put forward enough evidence to mean they still have a case to answer.

There will be no case for a nurse, midwife or nursing associate to answer where, at the close of our case, there is:

1. no evidence

2. some evidence, but evidence which, when taken at its highest, could not properly result in a fact being found proved against the nurse, midwife or nursing associate, or the nurse, midwife or nursing associate's fitness to practise being found to be impaired.

The question of whether there is a case to answer turns entirely on our evidence. Evidence which might form part of the nurse, midwife or nursing associate's case will not be taken into account.

Where the strength or weakness of our evidence depends on the weight it should be given, a submission that there is no case to answer is likely to fail. That issue is best considered after all the evidence has been heard.

3. The aforementioned guidance borrows from the Judgment of R v Galbraith [1981] 1 WLR 1039, which remains the seminal Judgment regarding directions of "no case to answer" during criminal proceedings. It is submitted that the Galbraith Judgment is of value to the Committee when approaching the instant application. In particular, the Judgment includes:

How then should the judge approach a submission of 'no case'? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the Crown's evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. (b) Where however the Crown's evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. It follows that we think the second of the two schools of thought is to be preferred.

There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge.

Application to the charges in the instant case

Charge 4*: Your declaration in charge 1 was dishonest in that you knew at the time of*
making the declaration that you had been referred to the NMC by Maidstone and Tunbridge Wells NHS Trust.

1. *This charge relates back to charge 3, which for ease of reference includes, "On or around 20 April 2022 stated to Colleague A (Witness 8), words to the effect of that you had, 'no knowledge of the NMC referral'." Charge 3 has been accepted, on the basis that "words to the effect" of the above were said i.e. that the Registrant had indicated she had no knowledge of the NMC referral, meaning no prior knowledge of it (before being informed of it whilst on holiday on 6th April 2022).*

2. *Charge 4 alleges dishonesty in this regard, which is a serious allegation. The evidence matrix provided on behalf of the NMC indicates that the evidence for charge 4 (via charge 3) comes from Witness 8's statement (paragraph 15), [Witness 10]'s statement, and exhibits [Witness 10]/1 to [Witness 10]/5. [Witness 10]'s witness statement was read into evidence by agreement. The outworking of [Witness 10]'s witness statement and related exhibits is effectively to indicate that the Registrant was referred to the NMC on 30/3/22, made aware of this referral via email on 6th April 2022, and was on holiday until 18th April 2022.*

3. *Witness 8's witness statement, at paragraph 15 then includes (exhibit 3, page 45):*

Following this I spoke to Ms Pitches to ascertain how much she knew about the NMC investigation. ***Ms Pitches stated that she had no knowledge that she had been referred to the NMC****. This would been approximately the end of April or early May, as it was an informal conversation it was not recorded.*

4. *During chief - examination, Witness 8 did not add any detail to the above summary which spoke to any dishonesty on the part of the Registrant. During cross - examination, before this aspect was being probed, Witness 8 volunteered that the Registrant had (during the above conversation) indicated that, "they hadn't told her she'd been referred" or words to this effect. When asked who "they" were, Witness 8 confirmed that it was the Registrant's previous employer, that the Registrant had been talking about. Later in cross - examination, this aspect was revisited. It was put to Witness 8 that when the Registrant said she had "no knowledge that she had been referred to the NMC" she was conveying that she had no prior knowledge i.e. until she was told about it on holiday, she did not know the referral had actually been made. It was also suggested to Witness 8 that Ms Pitches was making this clear then to clarify why she had not disclosed the NMC referral at the time of the application and starting the job, because she had not been referred at that juncture, and Witness 8 was asked whether this explanation made sense (in the context of the conversation). Witness 8 answered (my note, subject to correction), "It does make sense."*

5. *In short, Witness 8 did not endeavour to advance any suggestion that the Registrant was being dishonest with the comment/s that she made and did not demur from the suggestion put to the contrary. There was no one else present, and there is no note or recording of the discussion. Witness 8 is the only witness that speaks to this conversation, and she has not actually alleged dishonesty, nor proffered any suggestion or explanation as to why the answer should be considered dishonest. In all those circumstances, it is submitted that there is no real evidence of dishonesty.*

6. *The Committee have also heard from Ms Witness 7, who indicated that during her discussion with the Registrant about the referral, the Registrant did not deny the existence of the referral, nor deny that she was aware of it (my note, subject to correction).*

7. *It is contended that there is no or insufficient evidence before the Committee of dishonesty on the part of the Registrant, in light of the evidence the Committee has now heard.*

8. *On the basis of the above, it is submitted in the first instance, that there is no evidence to support charge 4 (ground 1). Where the Committee do not accept this argument, it is submitted in the alternative, that the evidence now presented, taken at its highest, could not properly result in the charge being proved (ground 2). It is contended that the wording of the charge, considered alongside the evidence the Panel has now heard, means that the evidence is tenuous, inherently weak and vague, and/or inconsistent with other evidence, to such a degree, that it could not properly be found proved.*

Charges 5 and 6 *[PRIVATE].*

9. *For ease of reference, charges 5 and 6 include (as amended):*

   [PRIVATE]

10. *[PRIVATE].*

11. *[PRIVATE].*

12. [PRIVATE].

13. [PRIVATE].

14. [PRIVATE].

15. [PRIVATE].

16. [PRIVATE].

Conclusion

17. It is submitted that careful consideration should be given to each of the aforementioned charges. The Committee are respectfully urged to direct "no case to answer" with respect to the charges identified, on the grounds summarised above."

Mr Kabasinskas began by directing the panel to the NMC guidance on no case to answer applications. He also referred to and outlined the test as set out in R v Galbraith.

Mr Kabasinskas emphasised that at this stage the panel is concerned only with the sufficiency of evidence, not with determining which version of events is more probable. The question is whether, on the evidence already presented, the panel could properly draw the inference that the facts alleged have been proved.

Turning to Charge 4, which includes an allegation of dishonesty, Mr Kabasinskas submitted that the panel would ultimately be required to determine whether you acted dishonestly when stating that you had no knowledge of the NMC referral. He outlined the legal test for dishonesty derived from Ivey v Genting Casinos 2017 UKSC 67. Under that test, the panel must first determine the actual state of knowledge or belief as to the

relevant facts (a subjective assessment). The reasonableness of that belief may be evidentially relevant but is not a requirement. Once the registrant's state of mind is established, the panel must then determine whether the conduct was dishonest according to the objective standards of ordinary decent people.

Mr Kabasinskas also referred the panel to the NMC guidance document "Making Decisions on Dishonesty Charges and Professional Duty of Candour." The guidance indicates that the panel must consider the surrounding circumstances and what the registrant knew or believed at the time. Evidence about expectations placed on the registrant in the relevant circumstances may also be relevant. However, the registrant's own views about standards of honesty in society are not relevant. The ultimate determination of dishonesty is for the panel, not for witnesses.

Applying the Galbraith test to Charge 4, Mr Kabasinskas submitted that there was clearly evidence capable of supporting the allegation. He submitted that you had admitted saying words to the effect that you had no knowledge of the NMC referral during a conversation with colleague Witness 8 on or around 20 April 2022. He noted that the admission to having said the words was unequivocal and not subject to qualification.

In addition, he relied on evidence from Witness 1, who stated in his witness statement that on 17 March 2022 he was present at a meeting in which you were informed that an NMC referral would be made due to ongoing concerns. Mr Kabasinskas submitted that this evidence was not challenged. He further referred the panel to documentary evidence within the exhibit bundle showing that you received an email from the NMC on 6 April 2022 confirming receipt of a referral from your former employer. He highlighted that you responded to that email on the same date.

Mr Kabasinskas also referred to the witness statement of Witness 8, who maintained her account of the relevant conversation and did not depart from the contents of her statement when giving evidence. Mr Kabasinskas submitted that this body of evidence

was sufficient to defeat the submission under the first limb of Galbraith, as there was clearly evidence capable of supporting the allegation.

In relation to the second limb of Galbraith, he submitted that the evidence could not properly be characterised as weak, tenuous, or inherently inconsistent. Rather, any dispute about what the registrant meant by her statement, or how it should be interpreted, would require the panel to assess the reliability of the witnesses and the registrant's explanation. Those are matters squarely within the panel's role as fact - finders.

Mr Kabasinskas addressed your suggested explanation that you meant she had not been told about the referral by her previous employer. He submitted that there was evidence contradicting this suggestion, including Witness 1's account of the meeting in which the referral was discussed. He also noted that Witness 8's evidence did not support the interpretation advanced by you. In his submission, these matters reinforced that the issue was one of factual evaluation for the panel rather than a basis for stopping the case.

Mr Kabasinskas also cited the case of McLennan v General Medical Council, which held that when assessing sufficiency of evidence in cases involving dishonesty, a tribunal should disregard explanations advanced before evidence is given. Such explanations may later be rejected or may not remain live once the evidence has been heard. He submitted that this authority clarifies that a tribunal is not required to accept or fully consider alternative explanations at the no case to answer stage.

Accordingly, he submitted that the NMC's case on dishonesty falls within the Galbraith exception where the strength or weakness of the evidence depends on the panel's assessment of witness reliability and credibility. For that reason, the case should proceed.

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

Mr Kabasinskas submitted that this evidence was clearly sufficient to establish a caste to answer. In relation to the second limb under Galbraith, he argued that the strength or weakness of the evidence again depended on the panel's view of the witnesses and the weight to be attached to documentary evidence, which are matters for the panel to determine.

Finally, he addressed Charge 6, [PRIVATE]. He referred the panel to the authority of Wingate and Evans v SRA and SRA v Malins 2018 EWCA Civ 366, which distinguishes dishonesty from lack of integrity and explains that integrity is a broader concept reflecting the ethical standards expected of professionals.

He submitted that the starting point for assessing integrity is the NMC Code, which sets out obligations including maintaining knowledge and skills for safe practice, sharing information to reduce risk, taking account of personal limitations, and acting with honesty and integrity at all times.

[PRIVATE].

Mr Kabasinskas submitted that the panel could reasonably infer that this omission was for your own benefit in securing the role and therefore amounted to evidence of a lack of integrity.

In closing, Mr Kabasinskas invited the panel to reject the no case to answer submission and proceed to the next stage of the hearing.

Mr McGettigan responded briefly to the submissions made on behalf of the NMC. He first addressed the reference to paragraph 69 of Witness 1's witness statement. He submitted that there is an important distinction between a referral being likely or intended to be made and a referral having been made. In his submission, your obligations arise more clearly once a referral has actually been made. Accordingly, he maintained that when it was suggested to Witness 8 that you did not know you had been referred to the NMC, that position could still be correct. His point was that awareness of the possibility of a referral is not the same as knowledge that a referral has in fact been made.

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

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

The panel had regard to the principles set out in R v Galbraith. It reminded itself that the test to be applied is whether there is evidence upon which a properly directed panel could find the charge proved. If there is no evidence capable of supporting a charge, the

case must be stopped. Where there is some evidence, the panel must consider whether that evidence, taken at its highest, could properly support a finding that the charge is proved. At this stage the panel must consider only the evidence presented by the NMC and must not evaluate the strength of any explanation that you may later provide. The panel also reminded itself that where the strength or weakness of the evidence depends upon issues of credibility, reliability or interpretation which are properly matters for determination after all the evidence has been heard, the submission is unlikely to succeed.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts of charges 4, 5 and 6 proved and whether you had a case to answer.

Charge 4

The panel noted that charge 4 alleges that your declaration as set out in charge 3 was dishonest in that you knew at the time of making it that you had been referred to the NMC by Maidstone and Tunbridge Wells NHS Trust.

The panel considered the evidence relied upon by the NMC in support of this allegation. This included the witness evidence of Witness 8, in particular paragraph 15 of her statement, in which she records that you stated that you had no knowledge that you had been referred to the NMC. The panel also considered the evidence that you had in fact been referred to the NMC by Maidstone and Tunbridge Wells NHS Trust on 30 March 2022. The panel further considered documentary evidence indicating that you were notified of the referral by email on 6 April 2022 while you were on holiday. The panel also noted evidence suggesting that you responded to correspondence relating to the referral, and that the conversation described by Witness 8 occurred later in April 2022, by which time you would have already been served notice of the referral.

The panel reminded itself that at this stage it must consider the evidence at its highest and must not engage in an assessment of competing explanations or evaluate the strength of any potential defence that you may later advance.

Taking into account the evidence presented thus far, the panel determined that there is sufficient evidence capable of supporting the allegation. In those circumstances, the panel was of the view that there is sufficient evidence to support the charge and therefore you have a case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charges 5 and 6

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

The panel carefully considered whether the evidence relied upon by the NMC was capable of establishing that factual premise of the charge. [PRIVATE].

Accordingly, there is no evidence upon which a properly directed panel could find charge 5 proved.

As Charge 6 is dependent upon the factual premise set out in Charge 5, the panel determined that it cannot properly proceed if Charge 5 cannot be established.

Applying the principles set out in R v Galbraith, the panel therefore determined that the submission of no case to answer succeeds in respect of Charges 5 and 6. Those charges are accordingly dismissed at this stage.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr McGettigan who informed the panel that you made admissions to charges 1.1.1, 1.1.2, 1.2.1, 1.2.3, 1.3.1, 1.3.2, 1.4.1, 1.5.1, 1.6.2, 1.6.5, 1.6.6, 2.1.1, 2.1.2, 2.1.4, 2.1.5, 3, 8.2, 8.3, 8.4, 8.5, 12.2, 12.3, 12.5, 14.1, 14.2, 14.3.1, 14.3.2, 15.1, and 15.2.

The panel therefore finds charges 1.1.1, 1.1.2, 1.2.1, 1.2.3, 1.3.1, 1.3.2, 1.4.1, 1.5.1, 1.6.2, 1.6.5, 1.6.6, 2.1.1, 2.1.2, 2.1.4, 2.1.5, 3, 8.2, 8.3, 8.4, 8.5, 12.2, 12.3, 12.5, 14.1, 14.2, 14.3.1, 14.3.2, 15.1, and 15.2 proved, by way of your admissions.

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

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:

- Witness 1: Practice Development Nurse, Acute Assessment Unit;

	Maidstone and Tunbridge Wells NHS Trust
• Witness 2:	Practice Development Nurse, Maidstone Hospital; Maidstone and Tunbridge Wells NHS Trust
• Witness 3:	Clinical Skills Facilitator, Maidstone Hospital; Maidstone and Tunbridge Wells NHS Trust
• Witness 4:	General Manager, L'Hermitage Care Home Inc Beaumont Villa
• Witness 5:	Senior Sister, Acute Assessment Unit - Maidstone Hospital; Maidstone and Tunbridge Wells NHS Trust
• Witness 6:	Clinical Deputy Manager, Silver Springs Care Home
• Witness 7:	District Nurse Team Leader Specialist Practitioner, Kent Community Health NHS Foundation Trust
• Witness 8:	Primary Care Nurse Lead, Kent Community Health NHS Foundation Trust
• Witness 9:	General Manager, Barchester Healthcare

The panel also heard evidence from you under oath.

The panel also took into account your good character and the bundle provided on your behalf which contained in summary personal reflections, certificates of learning and training and positive testimonials.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 1

1. Having failed a Medicines Assessment on 5 November 2021, were unable to complete drug calculations, with or without prompting:

1.2 On 24 November 2021 relating to:

1.2.2 When to applying the NHS formula.

This charge is found proved.

The panel considered the documentary and oral evidence relating to the medicines support session on 24 November 2021.

The panel had regard to the written statement of Witness 1 in which he stated:

"On 5 November 2021, I received an email from […] Practice Development Nurse which said that Ms Pitches did not get 100 per cent in the drug calculation theory assessment (Paper B) […]

Nurses are expected to pass this assessment on their first attempt. The pass mark is 100 per cent. […]

The questions on the assessment are considered core knowledge that I expect all nurses, even those newly qualified, to be able to answer. […]

Ms Pitches was able to use the NHS formula that we discussed in the last meeting when prompted and was able to come up with the right answer most of the time. However, Ms Pitches tried to apply this formula in cases where it was not appropriate. It appeared that Ms Pitches when it should and should not be used and that she did not fully understand the point of why we use the formula. We went through the formula again, and I advised Ms Pitches to write the formula at the top of every page before she starts any paper."

The panel also considered Witness 1's oral evidence. During questioning, he accepted that you were sometimes able to apply the NHS formula correctly. However, he explained that on a number of occasions you attempted to apply the formula in situations where it was not appropriate to do so. In his view, this indicated that you did not consistently understand when the formula should be applied.

The panel then considered your evidence. You stated that you understood the NHS formula but sometimes needed reminding where to begin. You explained that when prompted you were able to carry out the calculation correctly.

The panel accepted that you were at times able to apply the NHS formula correctly. However, the panel considered that the key issue in this charge is not solely whether you could perform the calculation once prompted, but also whether you demonstrated an adequate understanding of when it was appropriate to apply the NHS formula.

The panel placed significant weight on the evidence of Witness 1, who observed your performance during the support session. His evidence was clear that although you could sometimes reach the correct answer after prompting, you attempted to apply the formula in situations where it was not applicable. The panel considered that this demonstrated a lack of consistent understanding of the underlying principle governing the use of the formula.

The panel also took into account that the pass mark required for medicines calculations was 100 per cent for all qualified registered nurses. The panel considered that this requirement reflects the critical importance of accuracy and understanding in drug calculations in clinical practice, where errors can have serious consequences for patient safety.

Taking all of the evidence into account, the panel was satisfied that on 24 November 2021, in relation to the charge that you were unable to complete drug calculations, with or without prompting, you demonstrated difficulty in recognising when the NHS formula should be applied. Accordingly, the panel finds charge 1.2.2 proved.

Charge 1.6.1

1. Having failed a Medicines Assessment on 5 November 2021, were unable to complete drug calculations, with or without prompting:

1.6 On 17 March 2022 during a practical assessment:

1.6.1 Required prompting to calculate how many millilitres of a drug to withdraw.

This charge is found proved.

The panel considered all the evidence, including contemporaneous documentation, written statements, and oral testimony.

The panel had regard to the Practice Development Report completed by Clinical Skills Facilitator, Witness 3, on the same day as the assessment on 17 March 2022. The panel noted that this was a contemporaneous record and therefore attached significant weight to it. In that report, Witness 3 recorded:

> *"Hazel required support and prompting to calculate how many millilitres of the drug to withdraw. She then attempted to withdraw 3.4mls into a 10ml syringe, resulting in an error before I suggested that this is impossible to do accurately in a large syringe, and that she needed to use a smaller syringe to draw 0.4 mls. Hazel then did this."*

The panel also considered the oral evidence of Witness 3, who explained the nature of the exercise and stated that she would expect a newly qualified nurse to be able to complete such a calculation independently. In her written statement, Witness 3 stated:

> *"We started the paper on the first question, which was marked out of a total of five. The first question involved a dosage of drug to be administered over a given time and the correct rate of administration. The second part of that question was also to work out how much of a drug would have been provided if the administration was stopped after fifteen minutes.*
> *I had to explain how to calculate the amount of a drug that had been*

administered to a patient to Ms Pitches. When I asked Ms Pitches to explain her process to understand where she may be making errors in this question I could not follow her thought process as she did not even seem to be using the correct numbers prior to us explaining the questions. Rather, she would use randomly selected numbers in the question provided."

The panel further had regard to the evidence of Witness 2, who observed the practical assessment in her capacity as Clinical Skills Facilitator and confirmed the accuracy of the contemporaneous report. In her written statement, Witness 2 stated:

"On 17 March 2022, Witness 3 and I met with Ms Pitches to assess her drug calculations. This is a practical assessment with a focus on testing knowledge and the practice of an individual that is made up of three questions. The questions in this assessment ranged from those which could be considered easy to those more complex, however I expected a registered nurse who has been on a ward and with the Trust for several months to be able to complete the questions with ease. The questions involved several stages and were made up of a mix of drug calculations and administering medication by setting up the relevant machine and IV lines.

As this assessment was conducted on her last day with the Trust it, it was not mandatory for her to complete this assessment. […]

Ms Pitches took approximately one hour to complete the assessment. This is far above the time in which a nurse, newly qualified or otherwise, should have taken to complete the assessment. I expected Ms Pitches to complete each of the drug calculations within the assessment within approximately five to seven minutes, this would also be a generous allowance. Ms Pitches did not have any issues

when it came to preparing an IV line, although it was basic expectation this could be completed, only when it came to calculations did she begin to struggle. “

The panel also considered the written statement of Witness 1, which described your ongoing difficulties with drug calculations. He stated:

“Ms Pitches really struggled with working out how many mls/hr any fluid would be given when given the total amount of fluid and total timescale. For example, 1000L over four hours is 250mls/hr. I tried to explain this to Ms Pitches using bars that I have drawn to represent the total fluid and splitting it up into equal sections for each hour it is over so that Ms Pitches can see that it needs to be divided up into the amount of hours. I tried showing Ms Pitches a bag of fluid and doing it with the bag but this did not really help at all. I tried rather than using numbers, using words, such as half, quarter or a third which Ms Pitches comprehended much better. This was only practical in large and equally divisible portions and was not practical in practice.”

The panel took into account your evidence, in which you stated that you had limited recollection of this part of the assessment and believed it was a practice exercise rather than a formal assessment. The panel did not consider this misunderstanding altered the facts, as the assessment was clearly conducted as a practical evaluation and you participated voluntarily on your final day of placement.

Having considered all the evidence, the panel was satisfied that during the practical assessment on 17 March 2022 you required prompting to calculate how many millilitres of a drug to withdraw. Your difficulty in performing this calculation demonstrates that you were unable to complete this aspect of drug calculations independently. Accordingly, the panel finds charge 1.6.1 proved.

Charge 1.6.3

1. Having failed a Medicines Assessment on 5 November 2021, were unable to complete drug calculations, with or without prompting:

1.6 On 17 March 2022 during a practical assessment:

1.6.3 Required prompting to attach a label to the infusion bag.

This charge is found proved.

The panel again considered the Practice Development Report completed by Witness 3 on 17 March 2022. In that report, Witness 3 recorded:

> *"I prompted Hazel to attach a label to the infusion bag. Hazel was able to correctly prime a giving set and also to load the giving set into the infusion pump. Prompting and explanation was needed for Hazel to calculate the infusion rate. Hazel also needed explanation and support to calculate how much of the drug would have been received after 15 minutes at the calculated rate."*

The panel also considered Witness 3's oral evidence, in which she confirmed that you required prompting before you attached the label to the infusion bag.

The panel took into account your evidence, in which you stated that you understood what needed to be done but required reassurance and prompting during the exercise. The panel acknowledged that you may have understood the task once prompted. However, the charge specifically concerns whether prompting was required, and the evidence clearly shows that you did not attach the label independently and only did so after receiving prompting from Witness 3.

Having considered all the evidence, the panel was satisfied that during the practical assessment on 17 March 2022, you required prompting to attach a label to the infusion bag. Accordingly, the panel finds Particular 1.6.3 proved.

Charge 1.6.4

1. Having failed a Medicines Assessment on 5 November 2021, were unable to complete drug calculations, with or without prompting:

1.6 On 17 March 2022 during a practical assessment:

> 1.6.4 Required prompting and explaining on how to calculate the infusion rate, and/or how much drug would be received after 15 minutes.

This charge is found proved.

The panel considered the contemporaneous Practice Development Report completed by Witness 3 on 17 March 2022. The report records that:

> *"Hazel was able to correctly prime a giving set and also to load the giving set into the infusion pump. Prompting and explanation was needed for Hazel to calculate the infusion rate. Hazel also needed explanation and support to calculate how much of the drug would have been received after 15 minutes at the calculated rate."*

The panel also considered Witness 3's written statement which records:

> *"Ms Pitches seemed to find this question difficult to understand as there was a large amount of information contained within the question. Ms Pitches required help to understand the question and what calculations to carry out in order to get to the answer. I asked what the danger was in relation to giving the drug,*

Furosemide, at the incorrect rate of infusion. Ms Pitches did not seem to grasp that if it exceeded the rate of 4mg/ml, it could make the patient deaf if it was administered too quickly. Furosemide is provided for high blood pressure, hypertension and a build up of fluid in the body"

During her oral evidence Witness 3 maintained that you found the question difficult to understand and required guidance to identify what calculations were required and to complete them correctly.

The panel further considered the evidence of Witness 2, who observed the assessment. She confirmed that you struggled with more complex calculations and that a registered nurse would normally be expected to complete such questions independently. Her observations reinforce Witness 3's account.

The panel took into account your own evidence. You acknowledged that you required explanation or support to complete the calculation. You stated that once the process was explained you could perform the calculation. The panel interpreted this as an admission that prompting and guidance were necessary.

Having considered all the evidence, the panel was satisfied that during the practical assessment on 17 March 2022, you required prompting and explanation to calculate the infusion rate and to determine how much drug would be delivered after 15 minutes. This demonstrates that you were unable to perform these calculations independently. Accordingly, the panel finds charge 1.6.4 proved.

Charge 2.1.3

2. On 10 January 2022, during a mock assessment:

2.1.3 Attempted to administer Sumatriptan to the wrong patient.

This charge is found proved.

The panel considered the evidence relating to the mock assessment conducted on 10 January 2022.

The panel had regard to the Summary of Development Session with Practice Development Nurse dated 10 January 2022, completed by Witness 1. In that record, Witness 1 documented:

> *"Two patients had similar names with the same date of birth and different hospital numbers. I gave Hazel the drug chart of one of the patients but put the wristband of the other patient on the dummy. This was in the hope that Hazel would identify that this was not the correct drug chart/patient. One of the patients had received sumatriptan already. Hazel knew that sumatriptan is prescribed for migraines and asked the patient if they needed anything for their migraine, the patient responded "no, I don't have a headache, I don't know what you are talking about". Hazel did not pick up that this was not the correct patient. Hazel's patient identification and wristband check was not sufficient and Hazel administered medication to the wrong patient."*

The panel also considered Witness 1's written statement, in which he stated:

> *Ms Pitches was going to administer drugs, such as Sumatriptan, to the patient as two purposely had similar names. Ms Pitches confused the patients and went to administer the medication to the opposite patients. This would have caused harm to patients if in a real scenario as patients would have been administered medication that was not required and would not have been administered they did require.*

In his oral evidence, Witness 1 confirmed that his recollection of the events was consistent with what he had recorded contemporaneously. He explained that the scenario had been designed to test patient identification processes and that the Registrant offered medication for a migraine to a patient who did not suffer from migraines because she had confused the two patients.

During your evidence, you denied attempting to administer the medication. You stated that the scenario did not make sense to you and that you had picked up the drug only to look at it, asserting that you had no intention of giving it to the patient.

The panel considered the credibility and reliability of the evidence before it. The panel attached significant weight to Witness 1's contemporaneous written record, which was completed immediately after the session. The panel also noted that his oral evidence was clear and consistent with the written documentation.

The panel did not find your account persuasive when weighed against the contemporaneous record and Witness 1's evidence. The panel concluded that you confused the patients during the scenario and attempted to administer Sumatriptan to the wrong patient. Accordingly, the panel finds Charge 2.1.3 proved.

Charge 4

That you a registered nurse:

Whilst employed at Kent Community Foundation Trust ('Trust');

4. Your declaration in charge 3 was dishonest in that you knew at the time of making the declaration that you had been referred to the NMC by Maidstone and Tunbridge Wells NHS Trust.

This charge is found NOT proved.

The panel considered the evidence relied upon by the NMC in support of this allegation. This included the witness statement of Witness 8, which stated:

> *"I spoke to Ms Pitches to ascertain how much she knew about the NMC investigation. Ms Pitches stated that she had no knowledge that she had been referred to the NMC. This would have been approximately the end of April or early May, as it was an informal conversation it was not recorded."*

The panel noted that you had been formally referred to the NMC on 30 March 2022 and that you were notified by email on 6 April 2022 while on holiday. Documentary evidence shows that you received and responded to that notification on the same date. The conversation described by Witness 8 occurred around 20 April 2022, postdating your acknowledgment of the referral.

The panel first considered the evidence from Witness 8. She stated that you said you had no knowledge of the NMC referral. However, the panel noted the conversation was informal, took place in a corridor or kitchen, was not contemporaneously recorded, and her witness statement was written approximately a year later. Witness 8 herself confirmed in cross-examination that she did not think you were attempting to hide anything and that your words could have been understood differently.

The panel considered your explanation. You stated that when you said you had "no knowledge" you meant that you had no prior knowledge of the referral before receiving the email on 6 April. You explained that you first became aware of the referral while on holiday and that your conversation with Witness 8 was intended to reflect this. The panel accepted that it was possible that the words you used in this conversation were said in the context of the wider explanation.

The panel also considered additional context: you returned to work around 18 April 2022 and stated that you informed colleagues of the referral. While there is no independent evidence confirming this, it does not undermine your explanation.

The panel applied the legal test for dishonesty, noting that dishonesty is a serious allegation and that the burden of proof rests with the NMC. To prove the charge, in the circumstance of this case, the panel would need to be satisfied that at the time you made the declaration you intended to mislead or to conceal the referral.

The panel recognised that only you and Witness 8 were present during the informal conversation, and the exact wording and meaning of your statement remain unclear. Witness 8 herself indicated she could understand your explanation and did not perceive any attempt to deceive.

After careful consideration, the panel concluded that your words may have been misunderstood or taken out of context and therefore cannot support a finding of dishonesty. The panel accepted your explanation that you were referring to and intending to put across was that you had no ‘prior’ knowledge of the referral before 6 April. Further, there was no evidence that you attempted to conceal the referral once you became aware of it.

Accordingly, the panel is not satisfied, that the NMC has proved to the balance of probabilities, that you acted dishonestly when using the words as set out in charge 3. Charge 4 is therefore not proved.

Charge 7

Whilst employed at Silver Springs Care Home:

7. Failed to follow Resident A’s MAR chart regime by:

7.1 Administering 12 units of Lantus Insulin to Resident A at 17.10 on 24 August 2023.

7.2 Administering 12 units of Lantus Insulin to Resident A at 18.20 on 26 August 2023.

These charges are found proved.

Whilst the panel considered each of these charges separately, they had been written up together as they arise out of similar circumstances.

The panel had regard to Witness 9's evidence which stated:

> *"I understand that Hazel gave a resident a different dosage of insulin to the amount prescribed. The resident required nursing care and was a long-term diabetic on insulin. The normal procedure is to follow the program prescribed by the GP, and if the program needed to be altered, then we would speak to the GP to get medical advice, or speak to another nurse or the Deputy Manager, who would have contacted the GP. However, Hazel altered the resident's regime, without any clinical reason, and without consulting the GP or seeking medical advice on that decision. One of the nurse brought the incident to my attention during our meeting about the residents."*

The panel noted that Witness 9, who confirmed that staff must follow MAR chart instructions exactly and that any deviation requires proper clinical authorisation from a GP, a diabetic nurse, or another qualified colleague. She explained that you altered Resident A's insulin regime without any clinical reason and without consulting a GP or another qualified staff member.

The panel had regard to an internal disciplinary investigation record which documented:

> *"Hazel has confirmed that she administered the medications at the times of 17:10 on 24 August and 18:20 on 26 August. The MAR chart has been signed by Hazel for tea time on 24 August. While the MAR chart clearly states 'AS PER DIABETIC CLINIC INSTRUCTIONS IN THE MORNING' [….]*

The blood glucose charge indicates the details of the sliding scale with AM indicated under the name of the insulin with additional note stating refer to MAR chart.

On 24th August Hazel had made an entry '12 units given @17:10 H Pitches Hazel Pitches'

On 26th August Hazel has made and[sic] entry '12 units given @18:20pm omitted lunch time as not eaten'

The panel had regard to the MAR chart which clearly specified the prescribed insulin dose and the timing of administration and recorded that Lantus Insulin was to be administered in the morning as per the diabetic clinic instructions.

The panel noted that the MAR chart indicated that on 24 August 2023, this drug was administered at teatime.

The panel had regard to Resident A's Diabetes medication and dosage charge which noted entries recording administration of 12 units of insulin at 17:10 on 24 August 2023 and at 18:20 on 26 August 2023, which is inconsistent with the prescribed instructions.

You explained to the panel that you were confused by the sliding scale chart, which you believed stated "once daily," and that the resident had missed meals, so you delayed insulin to teatime to avoid hypoglycaemia. You also stated that you spoke with a GP visiting the home who allegedly approved the timing, but this advice was not documented.

On the evidence before it, the panel is satisfied that you administered insulin to Resident A at 17:10 on 24 August 2023 and at 18:20 on 26 August 2023 in a manner

that did not follow the prescribed MAR chart regime. Accordingly, charge 7.1 and 7.2 is found proved.

Charge 8

8. On 24 August 2023, failed to document in Resident A's daily notes and/or handover sheet:

8.1 The reason why you did not follow Resident A's MAR chart regime for the administration of Lantus Insulin.

This charge is found proved.

The panel noted that your job description explicitly placed a duty on you to "observe and carry out appropriate handovers to ensure the detail and accuracy of service user information being provided." The panel considered that this would include maintaining clear, accurate and detailed records of all care provided, including medication administration and the documentation of any deviations from prescribed regimens, including the rationale for such actions.

The panel had regard to an internal disciplinary investigation record which documented:

> *"The daily notes has a very basic entry that does not demonstrate any personalised care pertaining to Resident A these entries were made earlier in the day. There were no further entries to detail the blood glucose readings, what treatment was given, and the rationale for the treatment given.*
> *Hazel has not recorded in the care records, which in turn have not allowed others who have access to the care records have the correct and most up to date care of Resident A"*

The panel had regard to Resident A's daily notes which contained only basic entries and did not record any personalised care information. There were no entries detailing

blood glucose readings, the treatment given, or the rationale for deviating from the MAR chart. The care notes did not contain any explanation for the departure from the prescribed insulin regime.

Furthermore, you did not sign the MAR chart to record the administration of insulin. The panel noted that signing the MAR chart is a key element of accurate medication record keeping. Evidence from Witness 6 indicated that MAR charts must be used alongside the sliding scale chart, and that both records are required to provide a complete and legal account of medication administration.

Evidence from Witness 6 indicated that MAR charts must be used at all times alongside the sliding scale chart, meaning the two records should be used together rather than one replacing the other.

During your evidence you accepted that you should have recorded the rationale for having departed from the MAR chart regime. The panel considered your explanation that you believed the MAR chart was no longer in use after being turned over in the folder, and that no one had informed you that both the MAR chart and sliding scale chart needed to be used.

Having considered all the evidence, the panel was satisfied, on the balance of probabilities, that you failed to document the reason for deviating from Resident A's MAR chart regime and did not record the administration of insulin on the MAR chart. Accordingly, Charge 8.1 is found proved.

Charge 9

9. On 24 August 2023, failed to monitor and/or ensure that Resident A's blood glucose levels were monitored after 17.10.

This charge is found proved.

The panel considered the documentary evidence in relation to this incident which included the disciplinary report records that states:

> *"There is no evidence of a plan of care for Resident A in the daily records, or hand over records to stipulate what actions the nurse was taking to monitor the reaction of Resident A to the insulin administration. There is no evidence of further monitoring by staff nurse Hazel or of any measures put in place to increase the monitoring following the administration of the insulin.*
> *Hazel expressed in the investigation meeting that it is not her place to put a plan of care in place and this would be the GP, which is concerning as the plan of care was changed by Hazel with no follow up of monitoring of Resident A wellbeing."*

The panel also considered evidence regarding expected clinical practice following the administration of insulin. Evidence from Witness 6 showed that there was a duty on you to ensure that blood glucose levels should be monitored approximately two to three hours after insulin administration.

The panel noted that the insulin had been administered at 17:10. On that basis, the expected monitoring window would have been approximately 19:10 to 20:10. The panel noted that you remained on duty during part of this monitoring period, as she stated that your shift ended at 19:45.

The panel also considered the documentary records relating to Resident A. The panel noted that there was no recorded evidence that Resident A's blood glucose was checked during the relevant monitoring window, and there was no documentation indicating that the requirement for monitoring had been handed over to the next shift. There was also no entry within the handover documentation or daily records identifying the need for monitoring following the administration of insulin.

The panel therefore noted that the only contemporaneous record present was the entry confirming that the insulin had been administered at 17:10.

The panel then considered your oral evidence. You stated that you did not consider it necessary to check Resident A's blood glucose following the administration of insulin. You explained that you relied on your clinical judgement and monitored the resident by observing for signs of hypoglycaemia.

The panel noted that monitoring blood glucose levels after insulin administration is a preventative clinical measure, intended to detect potential problems before symptoms develop. Relying solely on observation of symptoms would mean reacting after deterioration had occurred, rather than proactively monitoring the resident's condition.

Based on the evidence before it, the panel was satisfied that on 24 August 2023 you failed to monitor and/or ensure that Resident A's blood glucose levels were monitored after 17.10. accordingly, charge 9 is found proved.

Charge 10

10. On 26 August 2023, failed to seek medical or professional advice prior to administering 12 units of Lantus Insulin to Resident A at 18.20.

This charge is found proved.

The panel considered the documentary and oral evidence relating to the administration of insulin to Resident A on 26 August 2023.

The panel had regard to the documentary evidence contained within the exhibit bundle, including the investigation report which recorded:

“Hazel has expressed both verbally in the meeting and in her witness stamen provided that she did not speak to a GP […] about administering resident A insulin on the evening of 24 August. Hael has expressed that the visit was not documented by the HP as it was not an official visit and resident A would be charged if it was. On 26 August 2023 Hazel administered the insulin again at the incorrect time, tis time she did not consult a GP or any other professional stating in the investigation meeting ‘After speaking to the GP previously I thought it would be OK’

The investigation report referenced your mitigation and indicated that you believed that advice you had previously obtained from a GP on 24 August could be relied upon when administering insulin on 26 August.

The panel then considered the oral evidence of Witness 6, who confirmed that the GP had been spoken to previously but that this occurred two days earlier and not on 26 August.

The panel also considered the evidence of Witness 9, who stated that, in the circumstances, there was a duty on you to consult the GP on the day that the medication was administered. Witness 9 was clear in her evidence that advice obtained previously could not simply be carried forward to a later date. She explained that if a nurse was unsure about administering insulin outside of the prescribed regime, they should either contact the GP for advice or consult another nurse on duty.

The panel then considered your explanation. You stated that you believed it was not necessary to contact the GP again on 26 August because you understood that advice had previously been given on 24 August. You therefore assumed that the same guidance continued to apply.

You also explained that on 26 August the resident had not eaten breakfast or lunch and that insulin was therefore administered later when the resident eventually ate. You

stated that you informed the night nurse and asked that the resident be monitored overnight.

The panel accepted that you believed you were acting appropriately. However, the panel considered that administering insulin outside of the prescribed regime required consultation with a GP or another appropriate healthcare professional at the time the decision was made.

The panel was satisfied that no medical or professional advice was sought on 26 August 2023 prior to the administration of insulin, and that reliance on advice obtained two days earlier was not appropriate clinical practice. Accordingly, the panel finds Charge 10 proved.

Charge 11

11. On 26 August 2023 failed to document in Resident A's MAR chart that you had administered 12 units of Lantus Insulin to Resident A.

This charge is found proved.

The panel considered the documentary evidence contained within the exhibit bundle, including the MAR chart for Resident A.

The panel noted that the MAR chart records medication administration for Resident A but contains no entry indicating that insulin was administered on 26 August 2023. In particular, there is no signature or record confirming that 12 units of Lantus insulin had been administered on that date.

The panel also noted that the MAR chart had been signed on other days both before and after the relevant date. The absence of any entry on 26 August therefore stood out as a clear omission.

The panel then considered your evidence during which you accepted that you should have signed the MAR chart after administering the insulin. The panel considered your explanation that you believed the MAR chart was no longer in use after being turned over in the folder, and that no one had informed you that both the MAR chart and sliding scale chart needed to be used.

The investigation record noted that the MAR chart is a legal document used to record the administration of medication, and that as a registered nurse you had a duty to properly document medication administration. It also records that during the discussion you stated that you did not realise that the chart had been turned over and questioned how you were supposed to know that it had been turned over.

You suggested during the investigation that the chart had not been consistently used or signed by others. However, the panel considered that this did not remove your individual professional responsibility to ensure that medication you administered was properly recorded.

The panel therefore determined that you administered 12 units of Lantus insulin to Resident A on 26 August 2023 but failed to record this administration in the MAR chart. Accordingly, this charge is found proved.

Charge 12.1 and 12.4

12. On 26 August 2023, failed to document in Resident A’s daily notes and/or handover sheet:

12.1 The reason why you did not follow Resident A’s MAR chart regime for the administration of Lantus Insulin.

12.4 The reason why you had not sought advice from a GP before administering Lantus Insulin at 18.20.

These charges are found proved.

Whilst the panel considered each of these charges separately, they had been written up together as they arise out of similar circumstances.

The panel also considered the written evidence of Witness 9, including her local witness statement dated 7 September 2023 which stated:

> *"I have been asked […] to provide a statement in regards to my conversation with Hazel, I can confirm that I asked Hazel if she had sought any medical advice or discussed with her colleague the administration of insulin on 26th August, Hazel replied no she had not."*

The panel first considered Charge 12.1, namely whether you documented the reason why you did not follow Resident A's MAR chart regime when administering Lantus insulin.

The panel noted that you administered insulin at a time that deviated from the prescribed MAR chart regime. The panel reviewed the resident's daily notes and the available handover documentation and found no record explaining the reason for the deviation.

You explained in your evidence that the resident had not eaten during the day and that insulin was therefore administered later in the evening once the resident had eaten. While the panel noted this explanation, it also noted that this reasoning was not recorded within the resident's daily notes, handover documentation, or care plan. You further stated that you believed the MAR chart had been turned over and appeared not to be in use and that you believed the sliding scale insulin chart had replaced the MAR

chart. The panel considered that, regardless of this belief, you had a professional obligation to document the clinical reasoning for administering medication outside the prescribed regime.

The panel then considered Charge 12.4, namely whether you documented the reason why you had not sought advice from a GP prior to administering insulin.

The panel had already determined under Charge 10 that you did not seek advice from a GP on 26 August before administering insulin.

The panel reviewed the daily notes and handover documentation and found no record explaining why medical advice had not been sought prior to administering insulin. You stated in your evidence that you believed it was not necessary to contact the GP again because you believed that advice provided on 24 August continued to apply. The panel did not accept that explanation as appropriate clinical practice. Reliance on advice obtained two days earlier did not remove your obligation to seek advice again when administering medication outside the prescribed regime.

The panel also noted that you stated during the hearing that you had verbally handed over the situation to the next nurse. However, the panel found no documentary evidence confirming that the deviation from the MAR chart regime or the lack of GP consultation had been recorded in the daily notes or handover documentation. Accordingly, the panel finds Charges 12.1 and 12.4 proved.

Charge 13

13. On 26 August 2023, failed to monitor and/or ensure that Resident A’s blood glucose levels were monitored after 18.20.

This charge is found proved.

The panel noted that this charge is closely linked to previous monitoring-related charges, with the primary distinction being the timing of the insulin administration relative to the handover period and the expected monitoring schedule.

The panel had regard to the disciplinary investigation report which stated:

> *"There is no evidence of a plan of care of care for Resident A in the daily records, or hand over records to stipulated what actions the nurse was taking to monitor the reaction of Resident A to the insulin administration. There is no evidence of further monitoring by staff nurse Hazel or of any measures put in place to increase the monitoring following the administration of the insulin. Hazel expressed in the investigation meeting that it is not her place to put a plan of care in place and this would be the GP, which is concerning as the plan of care was changed by Hazel with no follow up of monitoring of Resident A wellbeing."*

The panel noted that evidence from Witness 9 indicated that your rationale was that you had completed a verbal handover and left it to the night nurse to monitor. Witness 9 stated that a verbal handover alone is unacceptable and that a proper handover document should have been completed.

During your oral evidence, you reiterated that you believed monitoring was not necessary. The panel also noted that you said that you would have monitored for signs of hypoglycaemia rather than taking proactive blood glucose measurements.

The panel noted that despite there being a duty on you to monitor and/or ensure that Resident A's blood glucose levels were monitored you failed to do either.

Despite having completed relevant diabetes training, you maintained the view that monitoring was unnecessary.

On the evidence before it, the panel concluded that on 26 August 2023, you failed to monitor and/or ensure that Resident A's blood glucose levels were monitored after 18.20. Accordingly charge 13 is found 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 a lack of competence and/or 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 without restriction.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or 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 lack of competence and misconduct

Mr Kabasinskas, on behalf of the NMC, submitted that your fitness to practise is impaired by way of a lack of competence and misconduct.

Mr Kabasinskas highlighted that the NMC has defined a lack of competence as:

‘A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.’

Mr Kabasinskas reminded the panel that the appropriate benchmark was that of a reasonably competent Band 5 nurse, not a higher or more demanding standard.

Mr Kabasinskas referred the panel to Holton v General Medical Council [2006] EWHC 2960 (Admin), in particular paragraphs 74 and 75. Mr Kabasinskas submitted that it was irrelevant whether you had sufficient training; performance was judged objectively, and deficiencies were not excused by lack of training or education. Personal factors such as your education, training, or personality were not relevant to whether your performance was deficient, although such matters might later be relevant to remediation. By contrast, external factors such as workload pressures or lack of resources could be relevant when assessing performance in context.

Applying those principles, Mr Kabasinskas submitted that the facts found proved demonstrated that your competence fell below the standard expected of a Band 5 nurse. Mr Kabasinskas emphasised that the concerns related to medication administration, which was a fundamental nursing skill in any setting, and that your failings were numerous, varied, and wide-ranging.

Mr Kabasinskas submitted that these failings occurred despite extensive support, including supervision, supported practice, action plans, and assessments.

Mr Kabasinskas then set out a three-stage approach to assessing lack of competence:

1. Whether you were made aware of the concerns,
2. Whether you were given an opportunity to improve,
3. Whether there was further assessment.

Mr Kabasinskas submitted that all three stages were satisfied. Mr Kabasinskas referred to the initial meeting on 5 November and numerous subsequent meetings as evidence that you were made aware of the concerns.

Mr Kabasinskas submitted that you were given multiple opportunities to improve, including tests and assessments relating to safe medication administration. Mr Kabasinskas further referred to evidence of reassessment, including the exercise on 17 March.

Mr Kabasinskas also referred to your employment history. Mr Kabasinskas submitted that after leaving your initial Trust, you were placed on an action plan at Kent Community Foundation Trust and were not signed off as competent in medication administration. Thereafter, at Silver Springs and at L'Hermitage Care Home, further medication errors occurred. Mr Kabasinskas acknowledged that there were periods of improvement but submitted that errors subsequently reappeared, demonstrating a pattern of ongoing incompetence.

Mr Kabasinskas therefore submitted that your practice fell below the standard expected of a registered nurse and that your actions and omissions demonstrated a lack of competence.

Turning to misconduct, Mr Kabasinskas submitted that this was a matter for the panel's judgment. He referred 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.'*

Mr Kabasinskas invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. He identified the specific, relevant standards where he said your actions amounted to misconduct.

In relation to charge 3, Mr Kabasinskas submitted that you used incorrect terminology and failed to communicate effectively. Mr Kabasinskas argued that clear communication was required under the Code and that your inaccurate wording in an important clinical context amounted to serious misconduct.

In relation to charge 7, Mr Kabasinskas submitted that you failed to follow the MAR chart and insulin administration regime for a patient. Mr Kabasinskas submitted that there was a system in place which you did not follow, and that this fell below the expected standard and amounted to misconduct.

In relation to charge 8, Mr Kabasinskas submitted that you failed to properly record relevant information, including why the MAR chart was not followed, the care plan, blood glucose monitoring, and advice from a GP. Mr Kabasinskas submitted that accurate and timely record-keeping was essential and that your failure amounted to misconduct.

In relation to charge 9, Mr Kabasinskas submitted that you failed to appropriately monitor blood glucose levels, particularly after administering insulin contrary to the prescribed regime. Mr Kabasinskas submitted that this posed a risk to patient safety and amounted to misconduct.

In relation to charge 10, Mr Kabasinskas submitted that you failed to seek appropriate medical or professional advice prior to administering medication. Mr Kabasinskas submitted that there was a duty to seek assistance from a doctor or diabetic nurse and that your failure amounted to misconduct.

In relation to charge 11, Mr Kabasinskas submitted that you failed to document the administration of insulin in the MAR chart, contrary to policy, and that this amounted to misconduct. Mr Kabasinskas submitted that charges 12 and 13 were similar in nature to earlier charges and that the same submissions applied.

Mr Kabasinskas further submitted that even if individual charges were not considered serious in isolation, the panel could consider them cumulatively, particularly as they related to the same patient and the same issue of medication administration.

In relation to charge 14, Mr Kabasinskas submitted that you failed to administer prescribed morphine, a strong pain relief medication, and incorrectly documented its administration. Mr Kabasinskas submitted that there was a clear duty to administer the medication and that your failure amounted to misconduct.

In relation to charge 15, Mr Kabasinskas submitted that you left medication unsecured and incorrectly signed the MAR chart, contrary to policy, and that this also amounted to misconduct. Mr Kabasinskas concluded on misconduct that your conduct across all charges fell below the standard expected of a registered nurse and amounted to misconduct.

Mr McGettigan referred the panel to NMC guidance on lack of competence. He highlighted that lack of competence would usually involve an unacceptably low standard of professional performance demonstrated over a sample of work and which could put patients at risk. He also emphasised that the guidance required consideration of the wider circumstances, including your overall practice and history, in order to determine whether concerns were confined to a particular area or were more general.

Mr McGettigan submitted, firstly, that all elements of charges 1 and 2 related to practice or simulated exercises, including written practice papers, a voluntary practice session, and a mock assessment using dummies. He observed that, aside from limited elements, the concerns were largely focused on drug calculations. He submitted that all of these matters arose within one workplace, your first role in nursing, during a period when you were probationary and supernumerary.

Mr McGettigan also highlighted that you worked part-time (two days per week) and were absent for approximately half of the four-month period in question. He submitted that the panel might consider whether this reduced your opportunity to learn and progress compared to others. In that context, Mr McGettigan submitted that the concerns related more to learning and development than to professional performance. He argued that, given the theoretical nature of the exercises and your supervised status, the matters would not have placed patients at risk.

Mr McGettigan submitted that the difficulties you experienced were largely confined to a specific area - drug calculations - rather than demonstrating a general lack of competence. He also pointed to evidence of effort and determination, including your attempts to obtain additional practice materials outside of work. He further submitted that, as a new nurse, you would only have been expected to reach a limited level of competence at that stage. While it appeared that you fell behind peers and required additional support, Mr McGettigan submitted that this must be considered in light of the limited time you were present in the workplace.

Mr McGettigan invited the panel to consider evidence from a prior learning plan, which indicated difficulties that may have affected your ability to complete written assessments.

In all the circumstances, Mr McGettigan submitted that, although there were areas requiring improvement, the panel might conclude that there was no general lack of competence, particularly when your experience and status at the time were taken into account.

Turning to misconduct, Mr McGettigan referred the panel to Remedy v GMC (2010), which set out principles for determining misconduct. He submitted that misconduct could arise either from serious failings in professional practice or from morally culpable or disgraceful conduct. Mr McGettigan submitted that this case fell, if at all, within the first category, and did not involve any morally culpable or disgraceful behaviour.

Mr McGettigan highlighted that matters such as record-keeping and communication, while part of professional practice, would usually fall within deficient performance rather than misconduct, unless the failings were sufficiently grave or involved gross negligence.

Mr McGettigan further referred to guidance that poor judgment alone does not amount to misconduct, although it may amount to deficient performance, and that actions taken in good faith for legitimate reasons, even if ill-judged, may not constitute misconduct. He reminded the panel of NMC guidance stating that not all breaches of the Code warrant regulatory action, and that only serious professional misconduct should be pursued.

In relation to charge 3, Mr McGettigan submitted that, in isolation and without charge 4, it amounted only to a statement or comment and lacked any accusatory element. Mr McGettigan submitted that it could not, in those circumstances, amount to misconduct.

In relation to charges 7.1 and 7.2, concerning failure to follow the MAR chart, Mr McGettigan acknowledged the panel's findings but highlighted that you had recorded entries on the MAR chart and made handwritten notes on the sliding scale document. Mr McGettigan emphasised that there was no evidence of harm, and that blood glucose readings did not raise concerns. He submitted that your actions were based on a clinical judgment at the time, in circumstances where the patient had not eaten. While that judgment may have been misconceived, he submitted that it was made in good faith and for legitimate reasons. Mr McGettigan submitted that the panel could conclude that the conduct amounted to negligence or poor decision-making but was not sufficiently serious to constitute misconduct.

In relation to charge 8, Mr McGettigan submitted that this concerned a failure to document matters properly. Mr McGettigan noted your evidence that you had provided a verbal handover and again emphasised the absence of harm. Mr McGettigan

submitted that this amounted to poor record-keeping, which the panel might consider as deficient performance rather than misconduct.

In relation to charge 9, concerning monitoring, Mr McGettigan acknowledged the panel's findings but again highlighted the absence of harm and submitted that the conduct could be characterised as negligent or poor decision-making, but not sufficiently serious to amount to misconduct.

In relation to charge 10, Mr McGettigan submitted that this involved a misjudgement in relying on earlier advice. Mr McGettigan noted that the panel had accepted that you believed you were acting appropriately. Mr McGettigan submitted that this supported a finding that your actions were taken in good faith and again may not reach the threshold for misconduct.

In relation to charge 11, Mr McGettigan submitted that this concerned failure to document in the MAR chart. Mr McGettigan pointed out that you had made entries in the sliding scale document and submitted that this again amounted to poor record-keeping, potentially falling short of misconduct.

In relation to charges 12 and 13, Mr McGettigan submitted that similar considerations applied, namely failures in documentation and monitoring, absence of harm, and conduct that could be characterised as negligent but not sufficiently serious.

In relation to charges 14 and 15, Mr McGettigan acknowledged that these were more serious. Mr McGettigan noted that you had accepted these matters, including pre-signing documentation, and acknowledged their unacceptability. Mr McGettigan accepted that these charges may be capable of amounting to misconduct but emphasised that this remained a matter for the panel.

Mr McGettigan also addressed the issue of cumulative misconduct, submitting that this case was not unusual and did not meet the high threshold suggested by case law for

cumulative findings. Mr McGettigan submitted that the panel should consider each charge individually.

Submissions on impairment

Mr Kabasinskas 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. He reminded the panel that the key question was whether you could currently practise safely and effectively.

Mr Kabasinskas reminded the panel of the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He made reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kabasinskas submitted that all three limbs of the Grant test were engaged.
In relation to limb A, Mr Kabasinskas submitted that although no actual harm had been proven, there was a clear potential for harm. Mr Kabasinskas referred to failures in insulin management, which could have resulted in serious illness, particularly given the vulnerability of the patient. Mr Kabasinskas also referred to the failure to administer morphine, which could have caused unnecessary pain, and to leaving medication unsecured, which created further risks.

In relation to limb B, Mr Kabasinskas submitted that your conduct had brought, or was liable to bring, the profession into disrepute.

In relation to limb C, Mr Kabasinskas submitted that safe medication administration was a fundamental tenet of the nursing profession, which you had breached.

Mr Kabasinskas referred the panel to *Nicholas Pillai v General Medical Council [2009] EWHC 1048 (Admin)* and *Amao v NMC [2014] EWHC 147 (Admin)*. He submitted that the panel could take into account your attitude and insight, distinguishing between insight into past misconduct and insight into the risk of recurrence.

Mr Kabasinskas emphasised that impairment was a forward-looking exercise and referred to Cohen v GMC, which set out three key considerations:

1. Whether the concerns were remediable,
2. Whether they had been remedied,
3. Whether they were unlikely to be repeated.

Mr Kabasinskas accepted that the concerns were, in principle, capable of being remedied, as they related to clinical practice issues such as medication errors and record-keeping. However, He submitted that the concerns had not been remedied.

Mr Kabasinskas referred to your reflections, including one dated 4 March 2026, and characterised them as superficial and generic, consisting largely of assertions that the conduct would not be repeated. Mr Kabasinskas submitted that your reflections did not adequately address the risks posed to patients or demonstrate full acceptance of responsibility.

Mr Kabasinskas further submitted that in your evidence you had attributed responsibility to others, including colleagues, systems such as MAR charts, and lack of support, rather than demonstrating full insight into your own role.
Mr Kabasinskas acknowledged that you had undertaken some training but submitted that such training had limitations and did not demonstrate sustained safe practice in a clinical environment.

In relation to the risk of repetition, Mr Kabasinskas invited the panel to consider the chronology of your employment. Mr Kabasinskas highlighted that at your first Trust you were not permitted to administer medication, at Kent Community Foundation Trust you

were not signed off as competent, and at subsequent care homes you continued to make medication errors, even after periods of improvement. He submitted that this demonstrated a pattern of repeated failings and a lack of lasting improvement, indicating a continuing risk of repetition.

Finally, in relation to public confidence, Mr Kabasinskas submitted that although the concerns were clinical in nature, they also demonstrated an attitudinal element, including a failure to recognise accountability and the importance of accuracy in patient safety. Mr Kabasinskas submitted that public confidence in the profession would be undermined if a finding of impairment were not made.

Mr McGettigan emphasised that the key question was whether you were currently able to practise safely and effectively, and that the assessment must be made at the date of the hearing, not at the time of the events.

Mr McGettigan highlighted that not every case of misconduct leads to impairment, particularly where there has been an isolated error of judgment and the risk of recurrence is low.

In relation to impairment by way of a lack of competence, Mr McGettigan submitted that the relevant period was a short timeframe of less than four and a half months early in your career, during your first role as a nurse. Mr McGettigan submitted that, even if competence had been lacking at that time, it should not lead to a finding of current impairment several years later.

In relation to misconduct, Mr McGettigan submitted that the panel could conclude that, even if misconduct were found, there was no current impairment. Mr McGettigan characterised the misconduct as falling towards the lower to middle end of the spectrum, and submitted that, viewed in the context of an otherwise unblemished record, your fitness to practise was not currently impaired.

Mr McGettigan highlighted a number of factors in support of that submission:

- The misconduct arose from a limited number of dates,
- There was no evidence of harm,
- You had accepted most of the charges,
- You had demonstrated remorse and regret, particularly in relation to charges 14 and 15,
- You had undertaken reflection and training,
- You had provided positive testimonials,
- You had shown a strong work ethic and determination.

Mr McGettigan also referred to your oral evidence, in which you explained what you had learned and how you would act differently in the future. Mr McGettigan submitted that you had demonstrated insight, including recognition of the risks and the importance of seeking support.

Mr McGettigan further submitted that there was no real risk of repetition, and that any such risk could safely be discounted.

In relation to the public component of impairment, Mr McGettigan submitted that the panel should consider all the circumstances, including the absence of harm, the context in which you were working, and your subsequent conduct. Mr McGettigan submitted that an informed member of the public would not necessarily consider a finding of impairment to be required, and that public confidence could be maintained through the regulatory process and findings already made.

In conclusion, Mr McGettigan submitted that the panel could properly conclude that your fitness to practise was not currently impaired, either on public protection or public interest grounds, and that the matters giving rise to the charges did not justify a finding of current impairment in all the circumstances.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, Holton v General Medical Council [2006] EWHC 2960 (Admin), Cohen v GMC [2008] EWHC 581 (Admin), Ahmedsowida v GMC [2021] EWHC 3466 (Admin), CHRE v NMC and Grant [2011] EWHC 927 (Admin), Schodlok v GMC [2015] EWCA Civ 769 and Calhaem v GMC [2007] EWHC 2606 (Admin)

Decision and reasons on misconduct and lack of competence

When determining whether the facts found proved amount to a lack of competence and/or 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
1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence
6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

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

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

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

13 Recognise and work within the limits of your competence

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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

Lack of competence

In respect of charges 1 and 2, the panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel began by identifying the relevant timeframe for the allegations. The concerns relating to competence arose between November 2021 and March 2022, during the early stages of your first role as a newly qualified nurse. The panel took into account Witness 3's evidence which stated:

> *"The assessment took approximately an hour to complete with around twenty minutes or more needed for the first and last question looked at. We would typically expect nurses, including those newly qualified, to be able to complete these kinds of calculations in around five minutes each. At the time of the session Ms Pitches had been with the Trust for a number of months."*

The panel noted that this evidence demonstrated that your performance fell significantly below the level reasonably expected of a Band 5 registered nurse. The panel acknowledged that you were newly qualified, working under probationary conditions, and undertaking a supernumerary role. However, The panel was satisfied that the standard to be applied was that of a reasonable band 5 registered nurse. There was no lesser standard applicable by virtue of inexperience alone.

The panel was mindful that safe and effective administration of medicines is a fundamental and core component of nursing practice. This is not an advanced or specialist skill but a basic requirement expected from the point of qualification. As such, the panel determined that you should have been able to demonstrate competence in

drug calculations, dosage preparation, and associated clinical reasoning from the outset of your practice.

In considering Charge 1, The panel noted that it contained multiple sub-particulars, each identifying failures in drug calculation and medication-related tasks. The panel considered whether these matters represented isolated incidents or whether they constituted a fair sample of your work. The panel was satisfied that the evidence was sufficiently extensive, over multiple sessions and assessments spanning a 5-month period and this did represent a fair and representative sample of your work.

The panel found that the errors identified were not minor or peripheral. They included:

- Repeated inability to correctly perform fundamental drug calculations using standard formulae.
- Difficulty calculating appropriate dosages and inability to calculate minimum and hourly infusion rates.
- Errors in determining volumes to be drawn into a syringe.
- Poor understanding of appropriate equipment selection (for example, syringe size).
- A lack of logical or structured approach to solving calculation problems.

The panel considered that these were basic nursing skills requiring both technical knowledge and applied clinical reasoning. The repeated nature of the errors demonstrated not a momentary lapse, but a persistent inability to perform essential functions.

The panel further noted that these failures occurred across multiple supervised practice sessions and assessments. These were not high-pressure real-world emergencies but structured learning and evaluation environments designed to assess competence. The panel placed significant weight on the fact that, even with support, repetition, and opportunity for improvement, the same deficiencies persisted over time.

In relation to the argument that these were “practice” or “mock” scenarios, the panel rejected the suggestion that this reduced their significance. The purpose of such assessments was to determine whether you were competent to administer medication safely in a real clinical setting. The requirement was effectively one of complete accuracy, given the potential consequences of error in medication administration. The panel therefore considered that failure in these controlled environments was particularly concerning, as it indicated a risk of error in real patient care. The panel took account of Witness 1’s evidence which stated:

> *“If a nurse fails the original medicines management theory assessment, they are provided with the opportunity to resit the assessment, this usually occurs within one month. This however, was not the case for Ms Pitches as it was clear she lacked the required competencies needed to pass the assessment…*
> *I expected Ms Pitches to be able to do the unit conversions because any nurse that has a nursing degree should be able to know the different units and measurements as its fundamental aspect of the role taught…”*

[PRIVATE].

The panel further considered whether there had been sufficient support. It found that you had been provided with additional opportunities to practise, repeat assessments, and receive guidance. Despite this, the deficiencies continued. This reinforced the conclusion that the concerns were not attributable to a lack of opportunity, but rather to an underlying lack of competence.

In respect of Charge 2, the panel considered the failed mock assessment in conjunction with the wider pattern of failures. The panel placed particular weight on the fact that the assessment was designed to test readiness for safe medication administration in practice. The failure, including the attempted administration of the wrong drug and the inability to correctly identify and respond to a patient scenario, further demonstrated a lack of competence. Drawing these matters together, the panel concluded that your

performance fell below the standard expected of a reasonably competent registered nurse. The deficiencies related to fundamental aspects of nursing practice and the failures were repeated, sustained, and occurred over a meaningful period of time. The panel was satisfied that the evidence represented a fair sample of your work and the actions in charge 2 demonstrated a pattern of poor performance rather than isolated incidents. Accordingly, the panel was satisfied that the threshold for lack of competence was met. The panel determined that your professional performance during the relevant period demonstrated a sustained deficiency in core nursing skills.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was below the standard that one would expect of the average registered nurse acting in your role.

In all the circumstances, the panel determined that your performance as set out in charges 1 and 2 demonstrated a lack of competence.

Misconduct

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges individually and made the following findings:

The panel first considered Charge 3. The panel accepted that the wording of this charge, when viewed in isolation, amounted to no more than a statement or comment. The panel noted that it had originally been linked to a wider allegation of dishonesty which was not found proved by the panel. In those circumstances, the panel found that there was no remaining accusatory element capable of amounting to misconduct. Accordingly, the panel determined that Charge 3 did not amount to misconduct.

The panel considered Charges 7.1 and 7.2 separately but recognised that they arose from the same underlying circumstances, namely your failure to follow the MAR chart on

two occasions. The panel found that you had a clear professional duty to follow the MAR chart, which reflected the prescribing clinician's instructions. The panel rejected the suggestion that your actions could properly be characterised as an acceptable exercise of clinical judgment. While nurses are expected to exercise professional judgment, the panel determined that any deviation from a prescribed plan must be justified, documented, and undertaken in consultation with an appropriate colleague or medical professional. The panel was of the view that your actions created a real risk of harm to a vulnerable patient, particularly given the importance of timing in insulin administration and its direct impact on blood glucose levels. The panel noted that Witness 6's evidence was that:

> *"By Hazel failing to administer insulin to Resident A in accordance with her regime and the Homes medication policy, could have resulted in Resident A hypoing in the night, which would have resulted in her become seriously unwell, to the point where the resident could have become unconscious and/or had a fit"*

The panel also noted that your actions had wider implications, including creating a risk of hypoglycaemia and undermining the integrity of the prescribed care plan. The panel concluded that this was not a mere error of judgment but a serious departure from fundamental nursing standards. Accordingly, the panel determined that Charges 7.1 and 7.2 each amounted to serious misconduct.

The panel considered charges 8, 11, and 12, which related to failures in record-keeping and documentation, including daily notes, handover records, and entries on the MAR chart. Accurate and timely documentation is a fundamental aspect of nursing practice, essential for patient safety, continuity of care, and the ability of colleagues to provide safe care. The panel found that these failures created a clear risk to patients, as critical information - such as the administration of insulin, reasons for deviation from the care plan, and ongoing monitoring requirements - was not properly recorded. Colleagues were similarly placed at risk, being deprived of information necessary to continue safe care. The panel did not accept that verbal handovers, even if given, were sufficient in

these circumstances, particularly given the clinical significance of the events. Furthermore, the panel noted your explanations regarding limited documentation space and found that these demonstrated a failure to appreciate your professional responsibilities. The MAR chart, in particular, is a legal document and a vital component of safe medication administration; failure to complete it accurately undermines both patient safety and the legal requirements of practice. For these reasons, the panel concluded that the conduct in relation to Charges 8, 11, and 12 fell far short of expected standards and amounted to serious misconduct.

In relation to charges 9 and 13, the panel considered that monitoring following insulin administration was an essential aspect of your nursing duties. Having administered insulin outside the prescribed plan, the need for monitoring was heightened.
The panel determined that your failure to monitor created a significant risk of harm. The panel also noted that your oral evidence suggested that monitoring was only necessary if symptoms arose, which the panel found to be fundamentally flawed. Monitoring in such circumstances is preventative, not merely reactive. The panel concluded that this represented a serious breach of duty and amounted to serious misconduct.

Charge 10 concerned your failure to seek appropriate medical or professional advice. The panel considered Witness 9's evidence in respect of this charge which stated:

> *"The normal procedure is to follow the program prescribed by the GP, and if the program needed to be altered, then we would speak to the GP to get medical advice, or speak to another nurse or the Deputy Manager, who would have contacted the GP. However, Hazel altered the resident's regime, without any clinical reason, and without consulting the GP or seeking medical advice on that decision. Although no harm was caused to the resident, Hazel's action could have caused harm, especially if it was not picked up by others. Giving insulin to a resident whose blood sugar was low, it could have had serious implications and fatal consequences – there was a risk that the resident could have died.*

I had a conversation with Hazel about the incident. I asked her if she spoken with the GP or another nurse. She said that she didn't need to do so. Hazel did not seem to take the incident seriously."

The panel accepted that you had previously sought advice in general. However, the panel found that relying on earlier guidance without reassessing the patient's current condition was a falling short of what would be expected in the circumstances. The evidence before the panel showed that you independently altered a resident's insulin regime. This demonstrated a failure to fulfil your professional duty to seek up-to-date guidance when required. The panel noted that this failure placed the resident at risk of serious harm. The evidence illustrated that giving insulin to a patient not as prescribed could have led to severe or fatal consequences. Additionally, your explanation to the witness - that you did not need to consult anyone - demonstrated a disregard for established professional safeguards and the patient's safety. By failing to seek appropriate medical or professional advice, you departed significantly from the standards expected of a registered nurse. The panel concluded that this conduct represented a serious lapse in professional judgment. Accordingly, the panel determined that Charge 10 amounted to serious misconduct.

Charge 14 concerned your failure to administer a prescribed dose of morphine, your inaccurate recording of its administration, and your failure to ensure appropriate witnessing of a controlled drug. The panel considered the evidence you did not administer the prescribed dose of morphine; you recorded that the medication had been administered when it had not and you failed to obtain the required witness signature for a controlled drug. The panel noted that morphine is a controlled drug, subject to strict legal and professional safeguards. Failure to administer the medication had the potential to expose the patient to unnecessary pain, while recording it as given created a risk that further errors could occur, undermining the integrity of patient care. The failure to follow required witnessing procedures also compromised safeguards designed to prevent harm and ensure accountability.

The panel concluded that your actions represented a serious departure from the standards expected of a registered nurse. Charge 14 therefore amounted to serious misconduct.

Charge 15 concerned your handling and recording of medication at a patient's bedside. The panel noted Witness 4's evidence which stated:

> *"Leaving medication by a patient's bedside table is not line with the medicines management policy […]. Medications should not be left unattended but rather they need to be administered, then signed for on the MAR chart to show that it had been administered."*

The panel determined that by leaving medication unsecured you created a clear and unacceptable risk, including the potential for another patient to access it. Further, the panel determined that recording that the medication had been taken when it had not deprived colleagues of essential information needed to deliver safe and effective care. Proper storage and accurate recording of medication are fundamental to patient safety and professional practice. The panel concluded that these actions involved a serious breach of professional standards. Charge 15 therefore amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence and 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 make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

d) […].'

The panel determined that limbs a – c of the "test" are engaged in this case. The panel considered the evidence and found that your misconduct put patients at risk of serious harm. Your breaches of professional standards were wide-ranging and included failures in:

- medication administration, including insulin and controlled drugs;
- record-keeping, including inaccurate entries in MAR charts and handover notes;
- seeking appropriate medical and professional advice; and
- ensuring patient monitoring and safe care.

The panel noted that while your conduct did not result in actual harm, the potential for serious harm was evident. For example, administering insulin without proper monitoring, your failure to administer a prescribed dose of morphine, your inaccurate recording of its administration, your failure to ensure appropriate witnessing of a controlled drug and leaving drugs unsecured could have led to significant patient harm. The panel determined that these breaches represented serious departures from the standards expected of a registered nurse and were contrary to the fundamental tenets of the profession.

The panel also considered whether your actions brought, or were liable to bring, the profession into disrepute. The panel concluded that repeated failures in patient safety, governance, and accountability undermined confidence in the nursing profession and would do so if not addressed.

The panel considered the lack of competence elements of the case, which primarily related to failures in medication administration, record-keeping, and patient monitoring. These breaches demonstrated a recurring pattern of inadequate professional judgment, inconsistent adherence to care plans, and a failure to escalate or seek appropriate guidance when required. The panel concluded that by way of these failings, your nursing practice did place patients at risk of harm.

The panel carefully considered the evidence relating to your insight into your misconduct and lack of competence. While you have made some general statements acknowledging that errors occurred, the panel found that these did not demonstrate a meaningful understanding of the risks your actions posed to patients or the impact on colleagues and the wider profession. Your reflections were general in nature and frequently included justifications that the panel found concerning, such as claiming there was insufficient space to complete documentation. The panel found that your insight did not sufficiently demonstrate your detailed understanding of the specific risks arising from the misconduct and lack of competence found proved. Rather than accepting full accountability, you relied on these explanations to excuse or minimise your actions. The panel was of the view that your level of insight demonstrated that you continue to misunderstand the importance of timely monitoring and accurate documentation indicating that you have not fully grasped the potential consequences of your decisions. As a result, the panel concluded that you have not sufficiently reflected on your practice and that your insight is limited, which increases the risk that similar errors could occur in the future.

The panel carefully considered whether your conduct was capable of remediation, the steps you have taken to address the concerns identified, and the likelihood of repetition. It noted that you have undertaken additional training in diabetic care and related practice areas. However, the panel was not satisfied that this training fully addressed the deficits in practice or the risks arising from your prior actions. While some efforts have been made to improve your knowledge and skills, the panel found that these steps alone are insufficient to eliminate the risk of similar errors occurring in the future. The

panel was not satisfied that these steps alone, without the necessary level of clinical understanding and professional accountability, were sufficient to prevent recurrence.

For these reasons, the panel determined that there is a risk of repetition of the conduct found proved. The panel therefore decided that a finding of impairment is necessary on the grounds 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 determined that a finding of impairment on public interest grounds is required The seriousness and pattern of your lack of competence and misconduct, combined with insufficient accountability and understanding of professional responsibilities, means that a finding of impairment is required on public interest grounds. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired by way of your lack of competence and misconduct.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with a review. The effect of this order is that the NMC register will show that your 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.

Submissions on sanction

The panel had regard to the Notice of Hearing in which the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months if it found your fitness to practise currently impaired.

Mr Kabasinskas submitted that, before determining sanction, the panel should have regard to the NMC's guidance, The Purpose and Approach to Sanctions (SAN-1). He reminded the panel that the overarching objective of any sanction is the protection of the public, and that any outcome must be proportionate, meaning the least restrictive measure necessary to address the risk identified. He submitted that the panel must consider the reasons for impairment, together with all aggravating and mitigating factors, and weigh those factors in the round.

Mr Kabasinskas referred the panel first to the aggravating features. He submitted that there was a clear risk of patient harm, emphasising that the absence of actual harm is less significant than the existence of risk, and reminding the panel that it had already made such a finding. He further submitted that your conduct was repetitive, taking place over a number of months and across multiple incidents. He identified a failure to prioritise vulnerable patients, noting that the patients concerned were particularly vulnerable. He also submitted that your failure to follow a prescribed insulin regime represented a serious departure from expected standards, rather than a mere error of judgment.

Mr Kabasinskas referred to the panel's determination in relation to insight highlighting that your reflections were general in nature, contained elements of justification, and failed to demonstrate a meaningful understanding of the risks your actions posed or the importance of appropriate monitoring and record-keeping. He argued that this lack of insight was significant, as it made it difficult for you to remediate and increased the risk of repetition.

In relation to mitigation, Mr Kabasinskas submitted that you were a newly qualified nurse at the relevant time and that there had been some admissions to the charges. However, he reminded the panel that personal mitigation is of less weight where public protection is the primary concern, and that the panel should assess the weight of factors rather than simply their number.

Mr Kabasinskas referred the panel to your employment history, submitting that it demonstrated a consistent pattern of concerns across multiple roles. He highlighted that you had failed to achieve required competencies, had been subject to restrictions in practice, and had continued to make medication errors despite training, supervision, and support. He submitted that there was no evidence of a sustained period of safe or effective practice.

Turning to the available sanctions, Mr Kabasinskas submitted that taking no further action would be inappropriate given the panel's findings of risk and the need to protect the public. He submitted that a caution order would also be unsuitable, as such an order is only appropriate where there is no ongoing risk and where the conduct is at the lower end of the spectrum, which he argued was not the case here.

Mr Kabasinskas then addressed a conditions of practice order. He acknowledged that there were identifiable areas for retraining, such as medication administration and record-keeping. However, he submitted that there was insufficient evidence that you would respond positively to retraining, noting that you had previously been given opportunities, training, and support but that concerns had persisted. He further

submitted that your lack of insight could not be effectively addressed or monitored through conditions, and that there remained a risk of harm and repetition even if conditions were imposed. On that basis, he submitted that a conditions of practice order would not be appropriate.

Mr Kabasinskas submitted that a suspension order was the appropriate and proportionate sanction. He proposed a period of 12 months' suspension with review, submitting that this would adequately protect the public while allowing you the opportunity to develop insight and reflect on your conduct. He noted that you had engaged with the fitness to practise process and had indicated a willingness to retrain and submitted that this suggested a possibility that you could return to safe practice in the future, although not at present.

Finally, Mr Kabasinskas referred the panel to the need to consider more serious sanctions, including striking off, but submitted that such a sanction would be disproportionate in this case. He concluded that a 12-month suspension order with review was the appropriate outcome, balancing the need to protect the public with the potential for future remediation.

Mr McGettigan provided the panel with written submissions which he supplemented with oral submissions. He submitted at the outset that the appropriate and proportionate sanction in this case is a conditions of practice order, and that you should not be subject to the more onerous sanctions of suspension or striking off. He indicated that his submissions were structured by reference to the NMC's guidance and focused on applying that guidance to the facts as found.

Turning first to aggravating factors, Mr McGettigan submitted that many of the suggested aggravating features were not engaged. He submitted that there was no abuse of a position of trust, and no deliberate conduct placing patients at risk of harm. While he acknowledged that the panel had found a risk of harm, he submitted that your actions were not deliberate and, in his submission, did not amount to recklessness

when considering both subjective and objective elements. He further submitted that there were no deliberate breaches of the Code and challenged the suggestion that there was a pattern of misconduct over time, arguing that the misconduct findings were limited to a small number of dates and incidents rather than being spread across your entire career. He emphasised that earlier matters related to lack of competence or confidence, rather than misconduct.

Mr McGettigan submitted that there were no previous regulatory findings, no dishonesty in your evidence, and noted that the dishonesty charges had been dismissed. He also highlighted your full engagement with the fitness to practise process, including attendance and giving evidence. In relation to insight, he accepted the panel's finding that your insight was limited but submitted that it was not absent. He also argued that the vulnerability of patients should not be overstated beyond the general vulnerability inherent in care home settings, and that there was no evidence of premeditated, predatory, or discriminatory behaviour.

Overall, Mr McGettigan submitted that very few aggravating factors were engaged, identifying only limited insight and, potentially, questions around recklessness, pattern of conduct, and vulnerability as matters for the panel's consideration. He also addressed the issue of your defence of the charges, submitting that it should not be treated as an aggravating factor. He emphasised that you were entitled to defend yourself, that the case did not involve being "caught in a lie" and that some charges were successfully contested. He characterised the issues as matters of interpretation and assessment of evidence, rather than dishonesty.

Turning to mitigation, Mr McGettigan submitted that a significant number of mitigating factors were present. He highlighted your early admissions to many of the charges, both during the hearing and in internal investigations. He submitted that you had expressed remorse and apology, and had made efforts to improve your practice, including seeking additional training and engaging in self-directed learning.

He further submitted that there had been periods of safe and professional practice, noting that you worked as a nurse for several years and that, in the absence of further charges, there must have been occasions where your practice was satisfactory. He referred to training courses completed, including those you sourced independently, and your efforts to keep your knowledge up to date, despite not being able to practise since 2024–2025.

Mr McGettigan also relied on personal mitigation, including periods of illness and stress, your family and financial circumstances, and the fact that you are a relatively inexperienced nurse, particularly at the time of the earlier incidents. He also referred to limitations in workplace support in certain roles. He submitted that, taken together, there is a high degree of mitigation in your case.

In relation to sanction, Mr McGettigan accepted that no action and a caution order would not be appropriate, given the panel's finding of impairment. He then submitted that a conditions of practice order is the perfect fit for this case. He referred the panel to the relevant guidance and submitted that multiple criteria for conditions are met. In particular, he submitted that there is no evidence of deep-seated attitudinal problems, that there are clearly identifiable areas for retraining (such as medication management and record-keeping), and that there is a realistic prospect of remediation. He argued that you have demonstrated a willingness to engage with training, pointing to past efforts and some evidence of improvement. He further submitted that conditions could adequately manage any risk, that they could be workable, measurable, and enforceable, and suggested examples such as supervision, targeted training, and regular reporting. He emphasised that you would be willing to comply with any conditions imposed.

Mr McGettigan also invited the panel to take into account that you have already been subject to an interim suspension order for a significant period and submitted that this should be reflected in the overall proportionality assessment and the length of any order.

In opposing a suspension order, Mr McGettigan submitted that such a sanction would be disproportionate. He argued that, while the case is serious, it is not at the most serious end of the spectrum and does not meet the threshold of being “very serious” as described in the guidance. He submitted that the risks identified can be managed by conditions, and that it is not necessary to remove you from practice to achieve public protection. He also submitted that public confidence would not be undermined by allowing you to practise under conditions, particularly given that you have already been out of practice for a substantial period. He emphasised that your risk of repetition is not significant, and that you have demonstrated some insight and remediation.

In relation to striking off, Mr McGettigan submitted that such a sanction would be wholly disproportionate, as your conduct is not fundamentally incompatible with remaining on the register. He noted that even the NMC did not seek such an outcome.

Finally, Mr McGettigan addressed proportionality in the round, highlighting the significant impact the proceedings have already had on you, including your inability to work as a nurse, financial hardship, and personal circumstances. He referred to your commitment to nursing, your desire to return to the profession, and the steps you have taken to improve.

In conclusion, Mr McGettigan urged the panel to impose a conditions of practice order of relatively short duration, with workable and targeted conditions. He submitted that such an order would adequately protect the public, address the identified risks, and give you a meaningful opportunity to remediate and return to safe practice, whereas a more restrictive sanction would be disproportionate in all the circumstances.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction

imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- conduct which put people receiving care at risk of suffering harm
- a pattern of a lack of competence and misconduct over a period of time
- Limited insight
- Failure to prioritise vulnerable patients

The panel also took into account the following mitigating features:

- early admission of the facts
- engagement with the NMC process, including attendance and meaningful participation during the hearings
- evidence of some remorse
- [PRIVATE].

The panel has borne in mind that the imposition of a sanction is not intended to be punitive, although it may have that effect, it is intended to protect the public, maintain public confidence in the profession, and uphold proper professional standards. The panel has applied the principle of imposing the least restrictive sanction that adequately addresses those objectives.

The panel determined that your misconduct and lack of competence are serious. Although no actual harm was caused, the panel has found that your actions created a real risk of serious harm to patients, particularly in relation to medication administration, monitoring, and clinical decision-making. The panel also found a continuing risk of repetition, driven by your limited insight and insufficient understanding of the seriousness of your failings.

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 determined that taking

no action would be neither proportionate nor sufficient to protect the public or address the wider public interest.

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

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

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that 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 your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*

- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel carefully considered whether a conditions of practice order would be appropriate and sufficient to address the concerns identified. However, the panel concluded that there are no proportionate, workable or measurable conditions that could be formulated in your case.

In reaching this conclusion, the panel had particular regard to your limited insight. You have not demonstrated a full understanding of the risks your actions posed to patients or how those risks could be addressed in practice. In the absence of sufficient insight, the panel could not be satisfied that you would be able to comply with conditions or meaningfully apply any learning in a clinical setting.

The panel also considered the breadth and nature of the concerns, which are wide-ranging and fundamental. These include deficiencies in medication administration, record-keeping, monitoring, and clinical judgement. The panel considered that these concerns did not arise from an isolated incident and related to core aspects of daily nursing practice. As such, any conditions would need to address multiple, interconnected areas of your practice at a very basic level. The panel concluded that this would require conditions of such breadth, intensity and scope that they would be overly onerous and impracticable to implement in a real clinical setting and therefore could not be said to be workable or proportionate.

Further, the panel was not satisfied that patient safety could be adequately protected through conditions. Even if stringent conditions were imposed, such as direct supervision in relation to medication administration, record keeping, monitoring and

wider clinical decision-making, the panel considered that the risk of harm would remain. The concerns are not confined to discrete or technical tasks but extend to your overall clinical reasoning and ability to practise safely and independently. In those circumstances, the level of oversight required would be so extensive and continuous that it would be unrealistic to sustain in practice and, in the panel's view, would not provide a reliable safeguard for patients. In addition, the panel concluded that any such conditions would be difficult to monitor and enforce and therefore would not provide reliable or effective protection to the public.

The panel further determined that imposing conditions in these circumstances would carry a real risk that you would not be able to comply successfully, given the extent of the concerns and the lack of a structured support framework. This would not be in the interests of public protection or your remediation.

Finally, the panel concluded that a condition of practice order would not adequately reflect the seriousness of the findings in this case. A fully informed member of the public would expect a more restrictive sanction in response to conduct that created a real risk of serious harm to patients.

For all of these reasons, the panel determined that a conditions of practice order would be insufficient to protect the public or to address the wider public interest.

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 was satisfied that in this case, the misconduct was not fundamentally incompatible with your remaining on the register. However, the panel considered that the concerns found proved are serious, wide-ranging, and go to the heart of safe and effective nursing practice, including fundamental deficiencies in medication administration, record-keeping, monitoring, and clinical judgement.

The panel determined that these matters are sufficiently serious to call into question your suitability to practise at this time. The concerns are not isolated and have occurred across more than one setting, indicating a broader deficit in safe clinical practice which requires a sustained period of reflection and remediation. The panel considered that you

have engaged with the regulatory process and have shown some willingness to improve. However, your insight remains limited and underdeveloped. A period of suspension will provide you with the necessary opportunity to reflect meaningfully on your failings, develop deeper insight, and take steps to address the deficiencies in your practice before returning to safe practice.

The panel concluded that the seriousness of your lack of competence and misconduct is such that allowing you to continue practising at this stage would undermine public confidence in the profession and in the regulatory process. A suspension order appropriately marks the gravity of the concerns and the importance of maintaining proper professional standards.

The panel carefully considered whether a striking-off order would be appropriate. However, it concluded that striking off would be disproportionate at this stage, particularly in light of your engagement with the proceedings and the possibility that the concerns may be remediable with time and reflection. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and the lack of competence. When determined the appropriate length of suspension, the panel

considered whether a shorter period would be sufficient. The panel determined that a shorter period would not provide you with adequate time to develop meaningful insight, undertake relevant training and demonstrate remediation. A period of 12 months is necessary to allow you sufficient time for reflection and structured remediation whilst not being disproportionate.

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

Any future panel reviewing this case would be assisted by:

- Your attendance and continued engagement at any future hearing
- Evidence of developed insight into your lack of competence and misconduct and its impact on patient safety;
- Evidence of relevant training or education, particularly in drug dosage calculation, medication management, record keeping, and clinical decision-making;
- A reflective account demonstrating how your insight has developed and the impact of any training or learning you have undertaken;
- Engagement in a healthcare-related environment, such as work in a supportive role, with feedback from supervisors;
- Any other steps you have taken to strengthen your professional practice and rebuild competence.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific

circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Kabasinskas submitted that the interim order will cease to have effect once the panel has made its decision on sanction, and that the substantive suspension order will only come into force after the 28-day appeal period. He noted that, during this period, you would otherwise be able to practise unrestricted unless an interim order is imposed. He applied for an interim order on both public protection and public interest grounds, relying on the panel's findings of a risk of repetition and the seriousness of the concerns identified. He further argued that allowing unrestricted practice during the appeal period would be inconsistent with the substantive suspension order and would undermine public confidence. He submitted that an interim suspension order is the only appropriate option, as conditions of practice would be incompatible with the substantive sanction. Finally, he submitted that an 18-month duration is proportionate given that, if an appeal is lodged, the matter may proceed to the High Court and take an uncertain length of time. He therefore invited the panel to impose an interim suspension order for 18 months.

Mr McGettigan indicated that he had no substantive submissions to make in relation to the imposition of an interim suspension order, given the panel's decision to impose a substantive suspension order. He suggested, however, that the panel may wish to consider whether an interim suspension order of 12 months would be more proportionate in the circumstances. He noted that, while an appeal process may take time, the duration of any interim order could be revisited if necessary.

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 due to the seriousness of the concerns found proved, the ongoing risk to patient safety, and the need to maintain public confidence in the profession while any appeal period is ongoing and any appeal, if lodged, is determined.

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

That concludes this determination.