

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Order Review Meeting  
Wednesday, 20 May 2026**

Virtual Meeting

**Name of Registrant:** Angel Brown

**NMC PIN:** 19F0024W

**Part(s) of the register:** Registered Nurse - Adult  
Sub part 1  
RNA: adult nurse, level 1 (15 August 2019)

**Relevant Location:** Newport

**Type of case:** Lack of competence and Misconduct

**Panel members:** Angela Kell (Chair, lay member)  
Karen Gardiner (Registrant member)  
Saiqa Shaffi (Lay member)

**Legal Assessor:** Trevor Jones

**Hearings Coordinator:** Ifeoma Okere

**Order being reviewed:** Suspension order (12 months)

**Fitness to practise:** Impaired

**Outcome:** **Suspension order (6 months) to come into effect on  
11 July 2026 in accordance with Article 30 (1)**

## **Decision and reasons on service of Notice of Meeting**

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Mrs Brown's registered email address by secure email on 13 April 2026.

The panel took into account that the Notice of Meeting provided details of the review that the review meeting would be held no sooner than 18 May 2026 and inviting Mrs Brown to provide any written evidence seven days before this date.

The panel accepted the advice of the legal assessor.

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

## **Decision and reasons on review of the current order**

The panel decided to impose a suspension order for a period of six months. This order will come into effect at the end of 11 July 2026 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a substantive suspension order originally imposed by a panel of the Fitness to Practise Committee on 12 June 2024 for a period of 12 months.

The order was first reviewed on 24 June 2025. On that occasion, the reviewing panel determined that Mrs Brown's fitness to practise remained impaired and imposed a further suspension order for a period of 12 months.

The current order is due to expire at the end of 11 July 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

*‘1a) On 4 March 2020, you were unable to explain the difference in oxygen delivery between a facemask and nasal cannula.*

*1b) On 4 March 2020, you did not administer one or more doses of Terlipressin to Patient A, as prescribed.*

*2a(i) On 7 March 2020, after Patient B’s insulin infusion was stopped/gliclazide had been administered, you did not check/record Patient B’s blood glucose level on one or more occasion at 2 hour intervals.*

*2a(ii) On 7 March 2020, after Patient B’s insulin infusion was stopped/gliclazide had been administered, you did not check/record Patient B’s blood glucose level between 10:11 and 19:00.*

*2b) On 7 March 2020, you administered gliclazide at 18:00 to Patient B, without checking/recording Patient B’s blood glucose level.*

*2c) On 7 March 2020, you failed to recognise Patient B’s deterioration/hypoglycaemia.*

*3a) On 15 June 2020, you left the bedside area of an unknown patient who was desaturating/when their alarm was going off, to obtain some gauze/syringes.*

*3b) On 15 June 2020, you did not set an alarm limit for the unknown patient.*

*3c) On 15 June 2020, you did not adequately assess the unknown patient’s condition/monitor before walking away.*

*4a) On 17 June 2020, you inappropriately silenced a desaturating patient’s monitor alarm.*

*4b) On 17 June 2020, you did not assess the desaturating patient.*

*4c) On 17 June 2020, you did not check the patient's equipment.*

*4d) On 17 June 2020, you did not set an alarm limit for the desaturating patient.*

*5a(i) On 29 June 2020, you did not know how to set up a transducer.*

*5a(ii) On 29 June 2020, you did not know what landmark the transducer should be placed on.*

*5b) On 29 June 2020, you did not know how a nasal high flow machine worked.*

*5c) On 29 June 2020, you did not know the local nasogastric feeding protocol.*

*6a) On 24 June 2020, you selected the wrong bag of NG feed for an unknown patient.*

*6b) On 24 June 2020, you were unable to demonstrate an understanding of how to return nasogastric aspirate.*

*7a) On 25 June 2020, you were unable to demonstrate an understanding of knowing when a patient needs an Arterial Blood Gas analysis.*

*7b) On 25 June 2020, you were unable to demonstrate an understanding of a cuff leak's link to low ETCO<sub>2</sub>.*

*8a(i) On 1 July 2020, you failed to treat an unknown patient's low mean arterial pressure in that you did not consider adjusting the noradrenaline rate.*

*8a(ii) On 1 July 2020, you failed to treat an unknown patient's low mean arterial pressure in that you did not escalate the low pressure to the nurse in charge.*

*8b) On 1 July 2020, you incorrectly recorded that an unknown patient's breathing mode was on a mandatory set rate.*

*8c) On 1 July 2020, you failed to escalate an unknown patient's Acute Respiratory Distress Syndrome.*

*9) On 2 July 2020, on one or more occasion, you failed to conduct patient observations for an unknown patient.*

*10a(i) On 8 July 2020, you failed to demonstrate an understanding of ventilator alarms.*

*10a(ii) On 8 July 2020, you failed to demonstrate an understanding of subglottic suction.*

*10b(i) On 8 July 2020, on one or more occasion, you copied from previous shift recordings for WAASP.*

*10b(ii) On 8 July 2020, on one or more occasion, you copied from previous shift recordings for Waterlow.*

*10c) On 8 July 2020, on one or more occasion, you disturbed an unknown patient from sleeping.*

*11) On 13 July 2020, you were unaware of what equipment was needed for extubation.*

*12a) On 10 August 2020, you administered Patient C's hydrocortisone later than prescribed.*

12b) On 10 August 2020, you incorrectly administered hydrocortisone to Patient C orally/via NG without ensuring the necessary changes had been made on the prescription/drug chart.

12c) On 10 August 2020, you failed to order Patient C's hydrocortisone from the pharmacy.

13a) On 10 September 2020, during your Objective Structured Clinical Examination, you did not complete one or more safety checks.

13b(i) After being informed that Patient D's Clonidine infusion had been changed, you did not check the pump adequately.

13b(ii) After being informed that Patient D's Clonidine infusion had been changed, you did not recalculate the dose of Clonidine.

13b(iii) After being informed that Patient D's Clonidine infusion had been changed, you incorrectly documented the same dose of Clonidine prior to the changed infusion rate.

13c) On 10 September 2020, you failed to demonstrate an understanding of anaphylaxis.

13d) On one or more occasion, you did not check Patient D's pump on an hourly basis/regularly.

14) On one or more occasion, you were unable to calculate the correct rate of administration of a fluid bolus/Hartmann's.

15) You failed to complete an Informal Capability Process which commenced on 15 June 2020.

16a) On 12 November 2020, you attempted to place Patient E on a sedation hold when it was inappropriate to do so/prior to going on your break.

16b) *On 12 November 2020, you attempted to stop Patient E's Propofol when it was inappropriate to do so.*

16c(i) *On 12 November 2020, you extubated Patient E when it was inappropriate to do so, in that you did not restart the Propofol as advised.*

16c(ii) *On 12 November 2020, you extubated Patient E when it was inappropriate to do so, in that you did not bring over the emergency airway trolley.*

16c(iii) *On 12 November 2020, you extubated Patient E when it was inappropriate to do so, in that you did not titrate sedation, as advised.*

16d) *On 12 November 2020, you inaccurately informed one or more colleague/s that Patient E was for extubation.*

17) *On 26 November 2020, you failed your calculations test.*

18a) *Around 30 December 2020, you were unable to carry out a correct furosemide calculation.*

18b) *Around 30 December 2020, you were unable to provide correct information to an operator when asked to put out a cardiac arrest call.*

19) *You failed to complete a Formal Capability Process which commenced on 9 November 2020.*

20a) *On one or more occasion, you attempted to replace/clean a tracheostomy device alone.*

20b) *On one or more occasion, you inappropriately requested an X-ray for one patient, whilst another patient in the next bed required a tracheostomy procedure.*

21) *Around July 2021, you were unable to adequately complete your probation period at Spire Healthcare.*

22a) *Between 30 August 2023 and 4 September 2023, you applied for a role as a nurse in a hospital through an agency, MPS Healthcare.*

22b) *Between 30 August 2023 and 4 September 2023, you interviewed for a role as a nurse in a hospital through an agency, MPS Healthcare.'*

The first reviewing panel determined the following with regard to impairment:

*'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 Mrs Brown's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Brown's actions amounted to breaches of the Code. Specifically:*

*'1 Treat people as individuals and uphold their dignity*

*To achieve this, you must:*

*1.2 make sure you deliver the fundamentals of care effectively*

*6 Always practise in line with the best available evidence*

*To achieve this, you must:*

*6.2 maintain the knowledge and skills you need for safe and effective practice*

*8 Work co-operatively*

*To achieve this, you must:*

*8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

*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*

9 *Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues*

*To achieve this, you must:*

9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

10 *Keep clear and accurate records relevant to your practice*

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

*To achieve this, you must:*

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

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

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*

*To achieve this, you must, as appropriate:*

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

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

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

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

*To achieve this, you must:*

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

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*

20 *Uphold the reputation of your profession at all times*

*To achieve this, you must:*

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

23 *Cooperate with all investigations and audits*

*This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.*

*To achieve this, you must:*

23.3 *tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'*

*The panel bore in mind, when reaching its decision, that Mrs Brown 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 considered each of the charges in turn as to whether Mrs Brown's nursing practice met the standards of the reasonable average Band 5 registered nurse.*

*In relation to charge 1a, the panel was of the view that it is reasonable for a Band 5 nurse in ICU to know the difference in oxygen delivery between a facemask and nasal cannula. The panel bore in mind the potential for harm in not knowing the difference between the two methods to ensure patients*

*are appropriately supported with breathing in different circumstances. The panel was satisfied that Mrs Brown's lack of knowledge in this area amounted to a lack of competence.*

*The panel considered charge 1b. The panel noted the potential for serious harm to Patient A in not receiving their prescribed doses of Terlipressin. The panel noted that Mrs Brown did not provide a reason as to why she did not administer this medication to the patient. The panel was of the view that it was reasonable for a Band 5 nurse to understand a medication chart or to seek guidance before deciding whether to administer prescribed medication to a patient. The panel was satisfied that Mrs Brown's failure to administer this medication amounted to a lack of competence.*

*The panel next considered charge 2. It noted significant and potential harm to Patient B as a result of Mrs Brown's conduct found proved in the charge. Actual harm was caused to the patient in that they experienced a hypoglycaemic episode and the panel was of the view that the level of harm was only mitigated by the doctor's interventions. However, it considered that it was reasonable for a Band 5 nurse to check and record the patient's blood glucose level, before administering gliclazide and to recognise when a patient has deteriorated or is hypoglycaemic. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel had regard to charge 3. It noted the potential for serious harm to the patient. It considered that it is reasonable for a Band 5 nurse to attend to a patient who is desaturating when their alarm is going off rather than leave a patient's bed space to obtain non urgent supplies, in this case gauzes or syringes. The panel heard that setting of alarm limits for patients in ICU is a fundamental part of nursing care. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*Regarding charge 4, the panel considered that the patient was at a very serious risk of harm. The panel noted that the patient's oxygen level was very low at 60%. It noted that Mrs Brown was only caring for one patient at*

*the material time. The panel noted that the supervisor had intervened, and so no actual harm was caused to the patient. The panel was of the view that it is reasonable for a Band 5 nurse to respond to an alarm of a desaturating patient's monitor rather than silencing it and to ensure that the patient's equipment is checked. The setting of appropriate alarm limits is a fundamental part of nursing care particularly for a patient who was known to desaturate. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*In respect of charge 5, the panel was of the view that these were areas which were fundamental to the care in the ICU. The panel considered that Mrs Brown was working in the ICU at the material time and that in this environment she would not be expected to work with this equipment without some training or instruction. The panel noted the supernumerary periods Mrs Brown worked under and determined that it was more likely than not, that these were areas that she should have known about. The panel considered the risk of potential harm to the patient which was mitigated by the response of Mrs Brown's supervisor. The panel considered that it was reasonable for a Band 5 nurse in ICU to know how to set up a transducer, what landmark the transducer should be placed on, how a nasal high flow machine works and to know the local nasogastric feeding protocol. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel took into account its findings at charge 6. The panel bore in mind the potential risk of harm of Mrs Brown's actions in this charge. The panel considered that it was reasonable for a Band 5 nurse in ICU to know the appropriate NG feed to provide to a patient and to demonstrate an understanding of what to do with nasogastric aspirate. The panel was of the view that this is fundamental to the care in the ICU. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel considered its findings of charge 7. It noted that it was observed that Mrs Brown did not know why she was conducting ABGs and it*

*appeared that she did not understand the equipment to identify a cuff leak. The panel noted the risk of harm to patients was lower in this charge. The panel was of the view that it is reasonable for a Band 5 nurse to demonstrate an understanding of when a patient needs an Arterial Blood Gas analysis and to establish a cuff leak link to low ETCO<sub>2</sub>. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel had regard to its findings of charge 8a and the potential risk of harm to the patient. It noted the risk of harm to a patient if a low mean arterial pressure is not treated. The panel noted that there were a number of ways in which Mrs Brown could have escalated this situation due to the presence of the doctors, nurse in charge and floating nurse on the ward. The panel was of the view that it is reasonable for a Band 5 nurse to treat a patient's low mean arterial pressure by considering adjusting the noradrenaline rate and escalate it to the nurse in charge. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*In relation to charge 8b, the panel bore in mind the potential harm to the patient if a nurse is not able to read the breathing equipment correctly. The panel was of the view that it is reasonable for a Band 5 nurse in ICU to correctly record a patient's breathing mode. It was of the view that this is fundamental to the care in the ICU. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*In respect of charge 8c the panel took into consideration the potential for serious harm to the patient. The panel was of the view that it is reasonable for a Band 5 nurse in ICU to be able to appropriately escalate a patient who is displaying Acute Respiratory Distress Syndrome. It was of the view that this is fundamental to the care in the ICU. The panel noted that there were a number of ways in which Mrs Brown could have escalated this situation due to the presence of the doctors, nurse in charge and floating nurse on*

*the ward. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel next considered its finding in relation to charge 9. In this particular instance, the panel bore in mind that Mrs Brown was distracted by observing a procedure for the patient she was to monitor observations for. The panel considered the risk of harm and noted that the risk was limited in these circumstances, as there were other medical professionals with the patient and Mrs Brown's supervisor stepped in to assist with the observations. The panel was of the view that it is reasonable for a Band 5 to monitor patient observations and Mrs Brown was not acting appropriately as a member of the multi-disciplinary team because the other staff would not know the patient's status. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel took into account its findings of charge 10. The panel took into consideration the very serious risk of harm outlined by the conduct in these charges.*

*In respect of charge 10a, the panel was of the view that it is reasonable for a Band 5 to demonstrate an understanding of ventilator alarms. It was also of the view that it is reasonable for a Band 5 in ICU to demonstrate an understanding of subglottic suction. The panel bore in mind that subglottic suction is fundamental to care in the ICU.*

*In relation to charge 10b, the panel was of the view that it is reasonable for a Band 5 to be able to accurately record WAASP and Waterlow risk assessments in the patient's notes. The panel was of the view that accurately recording risk assessments is fundamental to nursing care. By copying recordings from previous shifts Mrs Brown has prevented herself and colleagues from determining if any intervention is required for the patients involved.*

*The panel was of the view that Mrs Brown's actions in this charge demonstrated an attitudinal concern as she sought to cover up her lack of knowledge and understanding in these areas.*

*Regarding charge 10c, the panel was of the view that it was reasonable for a Band 5 nurse to demonstrate basic care toward patients by informing the patient of any procedures that they may have to undertake for the patient's care, particularly whilst they are asleep.*

*The panel was satisfied that Mrs Brown's actions in charge 10 amounted to a lack of competence.*

*The panel next considered its finding in relation to charge 11 and the potential risk of harm to patients. The panel was of the view that it is reasonable for a Band 5 nurse to be aware that emergency equipment should be nearby while attempting extubation. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel had regard to its findings of charge 12. In respect of charge 12a, the panel was of the view that Mrs Brown's conduct in this charge demonstrated a low risk of potential harm to the patient and that the delay in administering the hydrocortisone to the patient was understandable in the circumstances. The panel found that this did not amount to a lack of competence.*

*In relation to charge 12b, the panel noted that Mrs Brown did not follow the right medication administration protocol despite being told what to do by her supervising nurse. The panel was of the view that this is fundamental to nursing care. The panel was of view that it is reasonable for a Band 5 nurse to ensure that the necessary changes are made on the prescription/drug chart when there is a change in the route for the delivery of medication. The panel noted that in these circumstances the risk of harm to the patient was low however this failing could carry a high risk of harm in other instances.*

*Regarding charge 12c, the panel was of the view that it is reasonable for a Band 5 nurse to order medication from the pharmacy. It noted that Mrs Brown was requested to order the hydrocortisone by her supervisor. The panel noted that the risk of harm in this instance was low as Mrs Brown's supervisor ordered the medication from the pharmacy.*

*The panel considered that Mrs Brown has demonstrated an attitudinal concern in respect of this charge, in that she did not act on instructions from her supervisor. The panel was satisfied that Mrs Brown's actions in charge 12b and 12c amount to a lack of competence.*

*In respect of charge 13a, it noted that the OSCE is a fundamental, formal, important exam for nursing practice. The panel noted the context of formal assessment of Mrs Brown's skills and the potential risk of harm by failing to complete one of the safety checks. The panel was of the view that it is reasonable for a Band 5 nurse to complete all safety checks as required during their OSCE.*

*In relation to charge 13b, the panel had regard to its findings and the risk of serious harm to the patient. The panel was of the view that it is reasonable for a Band 5 nurse after being informed that a patient's clonidine infusion had been changed to check the pump, recalculate the dose of clonidine and record the revised dose of clonidine.*

*Regarding charge 13c, the panel bore in mind the risk of potential harm to the patient. It was of the view that it is reasonable for a Band 5 nurse to demonstrate an understanding of anaphylaxis.*

*The panel took into consideration to its findings at charge 13d. It took into consideration Mrs Brown's apparent lack of understanding of the need to check the equipment. The panel had regard to the potential risk of harm of not checking the patient's equipment. The panel was of the view that it is reasonable for a Band 5 nurse to check the patient's pump as directed (in this instance, on an hourly basis / regularly).*

*The panel was satisfied that Mrs Brown's actions in charge 13 amounted to a lack of competence.*

*The panel considered its findings at charge 14 and the real risk of serious harm which arises from this charge. The panel bore in mind that Mrs Brown was trained on undertaking calculations. The panel was of the view that it is reasonable for a Band 5 nurse to calculate the correct rate of administration of a fluid bolus/Hartmans. The panel was of the view that this is a fundamental nursing skill. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel took into account its findings of charge 16 and that there was actual harm caused to the patient. The panel bore in mind that Mrs Brown ignored instructions provided to her and failed to take the necessary precautions and put her colleagues at risk by giving them inaccurate information. The panel was of the view that it is reasonable for a Band 5 nurse to know when it is appropriate to place a patient on sedation hold, when to stop a patient's propofol, when to extubate a patient (specifically following advice, ensuring the emergency airway trolley is available and titrating the sedation as advised) and accurately informing colleagues when a patient is ready for extubation. The panel considered that Mrs Brown has demonstrated an attitudinal concern in respect of this charge in that she did not act on instructions from her supervisor. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel considered its findings at charge 17. The panel bore in mind the potential risk of serious harm which arises from this charge in failing to calculate medicine doses correctly and not being able to perform this skill in practice. The panel was of the view that it is reasonable for a Band 5 nurse who has received appropriate training and support to pass their calculations test. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*Regarding charge 18a, the panel was of the view that it is reasonable for a Band 5 nurse to carry out a correct furosemide calculation as this is a fundamental nursing skill. The panel noted that there is a risk of harm to patients if calculations are not completed correctly.*

*In respect of charge 18b, the panel considered its findings and that it did not have specific details in relation to this charge. However, the panel considered the potential for serious harm to the patient due to the emergency nature of cardiac arrest calls. The panel was of the view that it is reasonable for a Band 5 nurse to provide correct information to an operator when asked to put out a cardiac arrest call to ensure that the right support is in place for the patient.*

*The panel was satisfied that Mrs Brown's actions in charge 18 amounted to a lack of competence.*

*The panel had regard to its findings at charge 19. The panel bore in mind that it did not know all the reasons as to why Mrs Brown resigned from the Health Board however, it noted that Mrs Brown was informed that she would be referred to the NMC due to the Health Boards concerns regarding the potential risk of harm she posed to patients if she were to practise as a nurse unsupervised elsewhere. The panel was of the view that it is reasonable for a Band 5 nurse to complete their Formal Capability Process to ensure they have the required basic and fundamental skills for nursing. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*In respect of charge 20a, the panel bore in mind that there was a high risk of harm to the patient and that it heard witness evidence which described these incidents as 'potentially catastrophic'. The panel bore in mind that Mrs Brown received advice about the risk of replacing or cleaning a tracheostomy device alone from her supervisor and considered that Mrs Brown demonstrated an attitudinal concern by disregarding this advice. The panel was of the view that it is reasonable for a Band 5 nurse to understand*

*that attempting to replace or clean a tracheostomy device must be done with another colleague. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*In relation to charge 20b, the panel was of the view that it was reasonable for a Band 5 nurse to understand the wider picture in assessing the needs of all patients on a ward and to provide the appropriate care. The panel was of the view that Mrs Brown's actions in requesting an x-ray for her patient without consulting her colleagues was inconsiderate toward her colleagues and adjacent patients. The panel considered the risk of harm in this instance had been mitigated by the radiographer who had asked staff and surrounding patients to be moved. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel took into consideration its findings of charge 21. It noted that Mrs Brown failed to meet the sufficient standard required to pass her probation period at Spire Healthcare. The panel was of the view that it is reasonable, having received appropriate training and support, for a Band 5 nurse to pass their probation period. The panel was satisfied that Mrs Brown's actions in this charge amounted to a lack of competence.*

*The panel concluded that Mrs Brown's practice was below the standard that one would expect of the average registered Band 5 nurse acting in Mrs Brown's role. In all the circumstances, the panel determined that Mrs Brown's performance demonstrated a lack of competence.*

*The panel also appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered Mrs Brown's conduct in charge 22 and took into consideration that Mrs Brown subject to an undertaking from her professional regulator to ensure that her nursing practice was monitored and safe. However, Mrs Brown attempted to breach those restrictions imposed by the undertaking. The panel therefore determined that Mrs Brown's conduct, as found proved in charge 22, was sufficiently serious to amount to misconduct.*

*The panel found that Mrs Brown's actions did fall seriously short of the standards expected of a nurse and that her conduct in charge 22 amounted to misconduct.*

### **Decision and reasons on impairment**

*The panel next went on to decide if as a result of Mrs Brown's lack of competence and misconduct, her fitness to practise is currently impaired.*

*In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:*

*'The question that will help decide whether a professional's fitness to practise is impaired is:*

*"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

*If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

*'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

*professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) ...'*

*The panel found limbs a, b and c of Dame Janet Smith's "test" engaged in this case.*

*The panel found that patients were put at a real risk of significant harm as a result of Mrs Brown's lack of competence and misconduct. Mrs Brown's lack of competence and misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.*

*Regarding insight, the panel considered that Mrs Brown has limited insight. It took into consideration the reflective statements Mrs Brown completed during her employment at the Health Board in relation to the lack of*

*competency charges found proved. It noted that she was showed some remorse for her conduct. However, it bore in mind that Mrs Brown sought to blame others for some of her mistakes and did not reflect on the impact her actions had on her colleagues. Further, she did not reflect on how her actions impacted the reputation of the profession and members of the public. It noted that Mrs Brown demonstrated limited insight in her reflective statements however, she repeated her mistakes and so it did not appear that her reflections turned into positive changes in her practice.*

*The panel was satisfied that the lack of competence charges in this case could potentially be capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Brown has taken steps to strengthen her practice in relation to the lack of competence charges. The panel took into account the evidence of progress Mrs Brown supplied from her employment at Nuffield Health including two references, completing training in a number of relevant areas and obtaining positive feedback. However, the panel had received no recent evidence of her practice as the most recent documents were from February 2023. Therefore, the panel was not satisfied that Mrs Brown has demonstrated a consistent period of applying the knowledge from her training to her nursing practice without any concerns raised. The panel took into consideration that it had no information about Mrs Brown's current insight or nursing practice apart from her misconduct, found proved, in charge 22.*

*The panel was satisfied that the misconduct in this case is difficult to address. It noted that the misconduct underlying charge 22 was related to Mrs Brown's attitude and integrity, the panel did not accept that she had misunderstood the undertakings and therefore she had withheld information from a potential employer. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Brown has taken steps to strengthen her practice in relation to this charge. The panel took into account that it had no recent information from Mrs Brown regarding her*

*insight, remorse or any evidence of strengthened practice in relation to her actions as outlined in the charge.*

*The panel concluded that there is a real risk of repetition as it could not be satisfied that Mrs Brown's behaviour, in both the lack of competence and misconduct charges, would not be repeated in the future.*

*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. It considered that public confidence in the profession would be undermined, the reputation of the nursing profession and the NMC as a regulator would be damaged, given the requirement to declare and uphold proper standards, if a finding of impairment were not made in this case. The panel was of the view that an informed member of the public would be concerned to learn that a registered nurse with the findings found proved in this case was allowed to practise unrestricted. The panel therefore also finds Mrs Brown's fitness to practise impaired on the grounds of public interest.*

*Having regard to all of the above, the panel was satisfied that Mrs Brown's fitness to practise is currently impaired.'*

The first reviewing panel determined the following with regard to sanction:

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

*The panel took into account the following aggravating features:*

- Mrs Brown has demonstrated limited insight in relation to the lack of competence failings and no insight into the misconduct charge.*
- Mrs Brown's lack of competence demonstrates a pattern of behaviour over a long period of time.*
- Mrs Brown's failings caused actual harm to some patients and was otherwise a serious risk of harm to patients.*
- Mrs Brown has demonstrated a lack of competence over a long period of time despite having supportive employers who invested significant time and resources into improving her practice.*

*The panel also took into account the following mitigating features:*

- Mrs Brown has demonstrated some evidence of strengthening practice through her reflective statements, relevant training courses, the two character references she has provided and positive feedback from colleagues and patients.*
- At the material time of the concerns identified, Mrs Brown was a newly qualified Band 5 nurse working in a specialist area of practice.*

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

*It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues*

*identified, an order that does not restrict Mrs Brown's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mrs Brown's misconduct and lack of competence failings were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.*

*The panel next considered whether placing conditions of practice on Mrs Brown's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.*

*The panel bore in mind that it had no evidence before it that Mrs Brown was willing to respond positively to retraining as she had not engaged with this hearing. The panel was not satisfied, as a result of its findings at the impairment stage, that patients would not be put in danger either directly or indirectly, during the period that conditions were imposed on Mrs Brown's practice. The panel took into account that it has no evidence that Mrs Brown has demonstrated harmful deep-seated personality problems. However, the panel bore in mind that it has identified that Mrs Brown has demonstrated attitudinal concerns in her nursing practice, in that she did not adhere to instructions from her supervisors. The panel determined that there are identifiable areas Mrs Brown's practice which are in need of assessment and retraining and she had demonstrated a general lack of competence in her nursing practice. It noted that Mrs Brown was provided with supernumerary support and training from the Health Board and Spire Healthcare however this did not prevent the failings occurring in her practice.*

*The panel is of the view that there are no practical or workable conditions that could be formulated, given the wide-ranging areas of Mrs Brown's lack*

*of competence in this case and that any conditions of practice imposed would be tantamount to a suspension order. Furthermore, the panel concluded that the placing of conditions on Mrs Brown's registration would not adequately address the seriousness of the misconduct and would not protect the public.*

*The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel considered that the following factors from the SG in relation to a suspension order that are apparent in the circumstances of this case:*

- A single instance of misconduct but where a lesser sanction is not sufficient;*
- No evidence of repetition of behaviour since the incident;*
- In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

*The panel bore in mind that it has no evidence that Mrs Brown has demonstrated harmful deep-seated personality problems however it has identified that Mrs Brown has demonstrated attitudinal concerns in her nursing practice.*

*Whilst the panel has no evidence of repetition of the misconduct and lack of competence failings since the material incidents, the panel bore in mind that it has found that Mrs Brown has limited insight and there is a real risk of repetition.*

*The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation identified, the panel concluded that it would be disproportionate. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. It noted the seriousness of Mrs Brown's misconduct was suitable for a sanction of*

*suspension, due to the issues with integrity identified, but was not serious enough to warrant a striking off order. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Brown's case to impose a striking-off order.*

*The panel bore in mind that this case largely relates to Mrs Brown's wide-ranging lack of competence and that the panel did not have the sanction of striking off available to it, in respect of those charges, on this occasion.*

*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 Mrs Brown. 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 to provide Mrs Brown with the opportunity to address the lack of competence failings she has demonstrated in her practice.*

*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.'*

## **Decision and reasons on current impairment**

The panel has considered carefully whether Mrs Brown's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined

fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

In reaching its decision, the panel had regard to all of the documentation before it, including the NMC bundle. The panel noted that Mrs Brown had not provided any written representations for this review. In particular, she had not provided any reflective statement, evidence of professional development, testimonials, or any information regarding her intention to return to nursing.

The panel accepted the advice of the legal assessor. He reminded the panel that the findings of misconduct and lack of competence made at the substantive hearing could not be revisited. The panel's role at this review was to consider whether Mrs Brown had addressed the concerns identified previously and whether there remained a risk of repetition.

The panel bore in mind that its primary function is to protect patients and the wider public interest, which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance.

The panel noted that this is the second review of the substantive suspension order originally imposed by a Fitness to Practise Committee panel on 12 June 2024. The order was reviewed on 24 June 2025 and was continued. The current suspension order is due to expire at the end of 11 July 2026.

The panel noted that the previous reviewing panel had identified a number of matters that would assist any future reviewing panel, including:

- Mrs Brown's engagement with the NMC's fitness to practise process;
- Information regarding her intention to continue practising as a nurse;
- Evidence of professional development and strengthening of practice;

- A reflective statement demonstrating insight into the concerns and the impact of her actions on patients, colleagues, the public and the reputation of the nursing profession; and
- Testimonials from a line manager or supervisor detailing her current work practices.

The panel noted that, despite these matters being clearly set out for Mrs Brown, she had provided none of the requested information.

The panel considered whether Mrs Brown had developed insight. It noted that there was no evidence before it that she had reflected on the concerns, demonstrated an understanding of how her actions put patients at risk, or shown any understanding of the impact of her misconduct and lack of competence on colleagues, the public, or the reputation of the nursing profession.

The panel then considered whether Mrs Brown had taken steps to strengthen her practice. The panel noted that the most recent evidence of training and references had been provided in February 2023, prior to the substantive hearing in June 2024. There was no evidence of any further training, professional development, or safe practice since that time.

The panel also noted that Mrs Brown had not engaged with the NMC since the previous review and had provided no information regarding her current circumstances or whether she intends to return to nursing practice.

The panel determined that there has been no material change in Mrs Brown's circumstances since the previous review. The panel was not satisfied that Mrs Brown had addressed the concerns identified at the substantive hearing or that the risk of repetition had reduced.

The panel therefore determined that Mrs Brown remains liable to repeat matters of the kind found proved. It concluded that a finding of continuing impairment remains necessary on the grounds of public protection.

The panel also determined that a finding of continuing impairment is required on public interest grounds. The panel considered that a well-informed member of the public would

be concerned if a nurse with significant unresolved concerns relating to both misconduct and lack of competence, and who had failed to engage with the regulatory process, were permitted to practise without restriction. The panel concluded that a finding of impairment is necessary to maintain public confidence in the profession and to uphold proper standards of conduct and performance.

For these reasons, the panel finds that Mrs Brown's fitness to practise remains impaired.

### **Decision and reasons on sanction**

Having found Mrs Brown fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) last updated 28 January 2026 and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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

The panel next considered whether to make a caution order. The panel determined that a caution order would not restrict Mrs Brown's practice and would therefore be insufficient to protect the public and address the wider public interest.

The panel then considered whether a conditions of practice order would be appropriate.

The panel concluded that a conditions of practice order would not be workable or appropriate in this case. It noted that Mrs Brown had previously been subject to undertakings, which she breached. The panel also noted that the concerns were wide-ranging and related to both lack of competence and misconduct. In the absence of any engagement, insight, or evidence of remediation, the panel had no confidence that Mrs Brown would comply with any conditions imposed.

The panel then considered the imposition of a further period of suspension.

The panel noted that Mrs Brown qualified as a nurse in 2019 and that the concerns arose during the early stages of the COVID-19 pandemic when she was working in intensive care. The panel took into account the context in which the concerns arose. However, the panel also noted that Mrs Brown was supported through a comprehensive capability process by both her employer and her university, which she did not complete. She subsequently worked for another employer, who also identified concerns and attempted to support her.

The panel noted that previous panels had provided clear guidance as to the steps Mrs Brown could take to demonstrate remediation. Despite this, she had not engaged with the NMC and had provided no evidence of insight, strengthening of practice, or remediation.

The panel considered whether a striking-off order would be appropriate. However, the panel accepted the legal assessor's advice and referred to NMC Guidance REV-2a 'Standard reviews of substantive orders before they expire' last updated 30 August 2024. The panel noted that this case involves lack of competence, a striking-off order is not available until Mrs Brown has been continuously subject to a conditions of practice order or suspension order for a period of two years. That period has not yet elapsed.

The panel therefore concluded that a further suspension order is the only appropriate and proportionate sanction available. The panel determined that a further suspension order will continue to protect the public and satisfy the wider public interest, while giving Mrs Brown a further opportunity to engage with the NMC and provide evidence that she has addressed the concerns.

The panel considered the appropriate length of the order. It considered a period of three months but determined that this would be too short, particularly given the practicalities of arranging a further review. The panel concluded that a suspension order for a period of six months would be appropriate and proportionate. This period will allow sufficient time for a meaningful review and will provide Mrs Brown with a further opportunity to engage with the regulatory process should she choose to do so.

Accordingly, the panel determined to impose a suspension order for a period of six months.

This suspension order will take effect upon the expiry of the current suspension order, namely at the end of 11 July 2026, in accordance with Article 30(1) of the Nursing and Midwifery Order 2001.

Before the end of the period of suspension, another panel will review the order. At the review, the panel may revoke the order, confirm the order, or replace the order with another order, including a striking-off order if the relevant statutory criteria are met.

Any future panel reviewing this case would be assisted by:

- Mrs Brown's engagement with the NMC's fitness to practise process;
- Information regarding her intention to continue practising as a nurse;
- Evidence of professional development and strengthening of practice;
- A reflective statement demonstrating insight into the concerns and the impact of her actions on patients, colleagues, the public and the reputation of the nursing profession; and
- Testimonials from a line manager or supervisor, or from any current employment, detailing her current work practices.

This will be confirmed to Mrs Brown in writing.