Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 December 2025 – Wednesday, 10 December 2025
Tuesday, 23 December 2025, Tuesday, 21 April 2026 – Thursday 23 April 2026
Tuesday, 26 May 2026 – Wednesday, 27 May 2026

Virtual Hearing

Name of Registrant:	**Lisa Samazie**
NMC PIN:	17I0472S
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing, Level 1 (8 November 2021)
Relevant Location:	Lanarkshire
Type of case:	Misconduct
Panel members:	Farrah Jaura (Chair, Lay member) Emma Quinn (Registrant member) Joanne Morgan (Lay member)
Legal Assessor:	Michael Bell (1 – 10 December 2025, 23 December 2025) Nina Ellin KC (21 – 23 April 2026, 26 – 27 May 2026)
Hearings Coordinator:	Zahra Khan (1 – 10 December 2025, 23 December 2025) Eric Dulle (4 December 2025 only) Stanley Udealor (21 – 23 April 2026, 26 – 27 May 2026)
Nursing and Midwifery Council:	Represented by Sahara Fergus-Simms, Case Presenter Represented by James Edenborough, Case Presenter (23 December 2025 only, for hand down)

Mrs Samazie:	Present and represented by Khaled Hussain-Dupré from Sequentus
Facts proved by admission:	Charges 1a, 1b, 1c (i), 1c (iii), 4a, 4c, 4d, 4e, and 5
No case to answer:	Charges 1c (ii) and 4b
Facts proved:	Charges 3 and 6
Facts not proved:	Charges 2, 7(i), 7(ii), 8 and 9
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 weeks) with a review**
Interim order:	**No order**

Details of charge (unamended)

That you, a registered nurse:

1. On 10 February 2022:

    a) Gave the wrong immunisation to an unknown child.
    b) Incorrectly documented it on the SIRS sheet.
    c) Failed to:
        i) Check the SIRS sheet against the electronic records.
        ii) Check the red book.
        iii) Ask the child's parent if they had any vaccinations in the last 4 weeks.

2. On 26 October 2022 gave an unknown child the MMR vaccine when the parent requested the child not to have it.

3. On 8 February 2023 failed to perform the necessary checks regarding vaccinations.

4. On 26 April 2023:

    a) Gave Child C two pre-school vaccines four weeks apart.
    b) Told the mother of Child C at charge 4a) 'well he's well immunised isn't he' or words to that effect.
    c) Failed to check the red book and/or carry out the required checks of the child referenced at charge 4a).
    d) Failed to report the error made at charge 4a).
    e) Your conduct at charge 4d) was dishonest in that you were attempting to conceal the error made.

5. On 21 June 2023 incorrectly documented a vaccine given to an unknown child on the electronic system.

6. During an internal investigation on 20 June 2023 when discussing the error at charge 4 said ‘I’ve never done this before, I always do checks’ or words to that effect.

7. Your conduct at charge 6 was dishonest in that you knew you had made errors of a similar nature previously.

8. During internal investigation meetings between 20 June 2023 and 31 August 2023 provided inconsistent accounts of your practice.

9. Your conduct at charge 8 was dishonest in that you intended to mislead on the fact that you were not carrying out the required checks.

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

Background

You were referred to the NMC on 21 November 2023 by NHS Lanarkshire, where you were employed as a Staff Nurse within the health visiting team. The charges arose from a series of incidents between February 2022 and June 2023 concerning your immunisation practice, record-keeping, communication with parents, and your conduct during an internal investigation.

On 10 February 2022, it was alleged that you immunised a child without completing the required pre-immunisation checks. As a result, the child was immunised twice. It was recorded that you marked the vaccine as ‘*given in error’*, but the SIRS sheet had been altered to show a ‘*third’* immunisation when the child had actually received a second immunisation. It was alleged that you did not check the SIRS system against the electronic

record, nor carry out the required checks of the red book and parental history, which would have shown that the child had already been vaccinated 18 days earlier.

On 26 October 2022, it was alleged that you administered the MMR vaccine to a child whose parent had not consented to that immunisation. It was stated in the witness evidence that when the parent asked what vaccine had been given, you confirmed that it was the MMR, despite the parent having only consented to the 4-in-1 vaccine. It was alleged that you did not undertake the necessary verbal checks with the parent prior to administering the vaccine.

On 8 February 2023, it was alleged that you conducted an immunisation clinic without checking the IT system, resulting in two recording-of-care errors. It was stated that the computer had not been switched on, preventing verification of the child's electronic immunisation history. Concerns were raised by a colleague (Beth Dempster) who reported that you had only checked the red book and search schedule and were about to bring the next child into the clinic without documenting the previous immunisation. You were removed from the clinic, and the matter was later investigated.

On 26 April 2023, it was alleged that you again immunised a child without carrying out the required pre-immunisation checks, resulting in the child being immunised twice within a four-week period. It was stated that you did not report the error at the time, and witness evidence suggested that you responded '*flippantly*' when the parent later queried the duplication. The SIRS sheet had been incorrectly documented as a *'#2'*, which led to the child being recalled unnecessarily.

On 21 June 2023, it was alleged that you incorrectly documented a vaccine administered to a child on the electronic system. Although the correct vaccine was given and accurately

recorded in the red book, the electronic entry was incorrect as you had ticked the wrong box on the SIRS sheet.

In addition to the clinical concerns, it was alleged that there were issues relating to your honesty during the employer's investigation. During meetings held on 20 June 2023, 27 July 2023, and 31 August 2023, you were asked repeatedly about the events on 8 February 2023. It was alleged that you gave inconsistent accounts regarding whether the computer and system were functioning, and whether you had been able to complete the required checks. These discrepancies form the basis of the charges relating to dishonesty.

Decision and reasons on application to amend the charge

At the close of the NMC's case, having heard the witnesses called, the panel heard an application made by Ms Fergus-Simms, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 4(b) and 7 as follows:

4. On 26 April 2023:

b) ~~Told the mother of Child C at charge 4a) 'well he's well immunised isn't he' or words to that effect~~. **In relation to a/the child who had been given two pre-school vaccines, four weeks apart charge 4a) remarked "well he's well immunised isn't he" or words to that effect, in a flippant manner.**

7. Your conduct at charge 6 was dishonest in that ~~you knew you had made errors of a similar nature previously~~**:**

i) You knew that what you had said was untrue.

ii) You intended to mislead the person conducting the investigation.

In relation to charge 4(b), Ms Fergus-Simms submitted that the proposed amendment arose following the evidence of Ms Mulholland, which clarified to whom the comment was

allegedly made. Ms Fergus-Simms submitted that, although the charge as originally drafted referred to the mother of Child C, Ms Mulholland's evidence indicated that the comment was made to a friend of the mother, rather than directly to the mother herself.

Ms Fergus-Simms acknowledged that the wording of the original charge may have been drafted on the assumption that the comment was made to the mother of Child C. However, she submitted that the proposed amendment did not alter the substance or nature of the allegation, namely that a flippant comment was made in relation to the child's immunisation status. She submitted that the amendment merely clarified the identity of the person to whom the comment was made and did not cause any injustice to you. On that basis, she invited the panel to allow the amendment.

In relation to charge 7, Ms Fergus-Simms submitted that the proposed amendment was intended to clarify the basis upon which dishonesty was alleged. She submitted that, as originally drafted, the charge asserted dishonesty but did not specify why the conduct was dishonest. The amended wording brought the charge into line with the structure of other dishonesty allegations, including charge 9, by specifying that you knew what you had said was untrue and intended to mislead the investigator.

Ms Fergus-Simms submitted that the proposed amendment was based on the existing evidence already available to you, introduced no new factual allegations, and caused no prejudice. She submitted that allowing the amendment would be in the interests of justice.

The panel heard submissions from Mr Hussain-Dupré. In relation to charge 4(b), Mr Hussain-Dupré submitted that the proposed wording referred to remarks made '*in relation to a/the child,*' whereas Ms Mulholland's original statement appeared to assume that the comment was made directly to the child's mother. He submitted that, if the comment was now alleged to have been made to a friend of the mother, the panel would need to consider whether the amended wording sufficiently and clearly linked the comment to Child C, or whether it constituted an indirect reference.

Mr Hussain-Dupré submitted that clarity was required to ensure that the panel would be able to give sufficient reasons at later stages, including any half-time submission and findings on facts. While he accepted that there was a need to address the issue identified, he invited the panel to consider carefully whether the proposed wording was sufficiently precise to avoid difficulty at later stages.

In relation to charge 7, Mr Hussain-Dupré confirmed that you did not oppose the proposed amendment. He agreed that the amendment clarified the allegation of dishonesty and brought the charge into line with the drafting of other dishonesty allegations.

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

Charge 4(b)

In relation to charge 4(b), the panel determined that the proposed amendment did not provide additional clarity or proper specification to the allegation. The panel was of the view that the amendment did not arise from direct evidence and, at best, relied on hearsay. In these circumstances, the panel concluded that there was no proper evidential basis upon which to amend the charge.

The panel therefore determined that it was not appropriate to allow the amendment to charge 4(b), and the application in respect of that charge was refused.

Charge 7

In relation to charge 7, the panel determined that the proposed amendment was based on the existing facts, introduced no new evidence, and served to clarify the basis upon which dishonesty was alleged. The panel considered that the amended wording provided clarity and accuracy and brought the charge into proper form. The panel was satisfied that allowing the amendment would cause no prejudice to you and no injustice to either party.

The panel therefore determined that permitting the amendment was in the interests of justice and granted the application to amend charge 7, as applied for.

Details of charge (as amended)

That you, a registered nurse:

1. On 10 February 2022:

    a) Gave the wrong immunisation to an unknown child.
    b) Incorrectly documented it on the SIRS sheet.
    c) Failed to:
        i) Check the SIRS sheet against the electronic records.
        ii) Check the red book.
        iii) Ask the child's parent if they had any vaccinations in the last 4 weeks.

2. On 26 October 2022 gave an unknown child the MMR vaccine when the parent requested the child not to have it.

3. On 8 February 2023 failed to perform the necessary checks regarding vaccinations.

4. On 26 April 2023:

    a) Gave Child C two pre-school vaccines four weeks apart.
    b) Told the mother of Child C at charge 4a) 'well he's well immunised isn't he' or words to that effect.
    c) Failed to check the red book and/or carry out the required checks of the child referenced at charge 4a).

d) Failed to report the error made at charge 4a).

e) Your conduct at charge 4d) was dishonest in that you were attempting to conceal the error made.

5. On 21 June 2023 incorrectly documented a vaccine given to an unknown child on the electronic system.

6. During an internal investigation on 20 June 2023 when discussing the error at charge 4 said “I’ve never done this before, I always do checks” or words to that effect.

7. Your conduct at charge 6 was dishonest in that:

i) You knew that what you had said was untrue.

ii) You intended to mislead the person conducting the investigation.

8. During internal investigation meetings between 20 June 2023 and 31 August 2023 provided inconsistent accounts of your practice.

9. Your conduct at charge 8 was dishonest in that you intended to mislead on the fact that you were not carrying out the required checks.

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

Submissions on application of no case to answer

Mr Hussain-Dupré’s submissions

Mr Hussain-Dupré made an application under Rules 24(7) and 24(8), submitting that, having heard the NMC’s case, insufficient evidence has been presented. He submitted that you therefore had no case to answer on one or more of the charges.

Mr Hussain-Dupré submitted that the burden of proof rests with the NMC throughout the fact-finding stage and that it must prove its case on the balance of probabilities, namely what is more likely than not. Mr Hussain-Dupré referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 which outlines the two-limb test applicable to submissions of no case to answer. He submitted that:

- Under limb one, the panel must consider whether there is any evidence upon which the facts alleged could be proved.
- Under limb two, where there is some evidence, the panel must consider whether that evidence is so tenuous, vague or weak that it cannot properly support a finding of fact proven, even when taken at its highest.

Mr Hussain-Dupré submitted that the panel may consider one or both limbs when determining whether there is a case to answer in respect of each individual charge.

Mr Hussain-Dupré further submitted that, although you have not yet put your case, the panel is entitled at the half-time stage to consider evidence already advanced by the NMC which might amount to a putative defence or alternative explanation that undermines the NMC's case.

Mr Hussain-Dupré also relied upon *R (Husband) v General Dental Council* [2019] EWHC 2210 (Admin), submitting that it is open to a panel to conclude at the half-time stage that, even if a charge were found proved, it could not amount to misconduct, in which case there would be no case to answer. He submitted that this approach is consistent with Rule 24(8).

Charge 1(c)(ii)

In relation to charge 1(c)(ii), Mr Hussain-Dupré submitted that the wording of the charge alleged that you had '*failed to*' check the Red Book, which denoted both an obligation and

an omission. He submitted that the NMC must therefore prove that such an obligation arose, which would require evidence that the parents had brought the Red Book to the consultation.

Mr Hussain-Dupré submitted that the panel heard evidence from Ms Mulholland and Ms Dempster that parents frequently forget to bring the Red Book when attending immunisation appointments. He submitted that Ms Care was only able to confirm that the Red Book was present when she later visited the family at home and was unable to offer any evidence as to whether it was present on 10 February 2022.

In the absence of confirmation that the Red Book was present at the relevant appointment, Mr Hussain-Dupré submitted that this charge could not be made out and that there was therefore no case to answer.

Charge 2

In relation to charge 2, Mr Hussain-Dupré submitted that the alleged incident occurred on 26 October 2022 and that none of the witnesses had contemporaneous knowledge of the event.

Mr Hussain-Dupré submitted that Ms Mulholland accepted in her evidence that she was not in post at the time and that her understanding of the incident was derived from the Datix report. He noted that the Datix was submitted on the same day as the incident and appeared to have been completed by you yourself. He drew the panel's attention to the description field of the Datix, which was written in the first person and stated that you had asked the mother whether she still wished to proceed and that the mother had confirmed that she wanted both vaccinations.

By contrast, Mr Hussain-Dupré submitted that the NMC relied upon notes of a local investigation meeting held on 20 June 2023, several months later. He noted that these

notes were not signed by you to confirm their accuracy and nonetheless still suggested that you believed consent had been given.

Mr Hussain-Dupré submitted that both accounts pointed to a potential miscommunication, but that the evidence demonstrated that you believed that consent had been given, and that the Datix specifically recorded that the mother had confirmed that she wished the MMR to be administered.

Mr Hussain-Dupré submitted that, in the absence of evidence from the mother, and given that Ms Mulholland's account relied entirely on the Datix, the evidence relied upon by the NMC was weak and tenuous, particularly on the issue of consent, and was in fact contradicted by the Datix itself. He emphasised that it was not for you to prove that consent had been given.

Mr Hussain-Dupré further submitted that Ms Mulholland had clarified in her oral evidence that the later concern was whether the consent was informed, due to a possible language barrier. However, he submitted that this was not reflected in the wording of the charge, which alleged that you administered the vaccination when the parent had requested that the child not receive it.

Mr Hussain-Dupré therefore submitted that a miscommunication or misunderstanding in the circumstances of this case could not amount to serious professional misconduct capable of leading to a finding of current impairment.

Charge 3

In relation to charge 3, Mr Hussain-Dupré submitted that the wording alleged that you had *'failed to perform the necessary checks'*, again denoting an obligation, an omission, and a requirement that the checks be '*necessary*'. He submitted that the burden rested with the NMC to prove all three elements.

Mr Hussain-Dupré referred to the evidence of Ms Dempster, who initially suggested that guidance on pre-vaccination checks could be found in the Green Book. He noted that the Green Book stated that consent must be obtained and suitability established but did not specify any particular checks or mandate a minimum set of checks.

Mr Hussain-Dupré relied upon the dictionary definition of '*necessary'* as meaning '*needed in order to achieve a particular result'*, submitting that the Green Book did not identify any specific checks as necessary to achieve that result.

Mr Hussain-Dupré submitted that Ms Dempster later accepted that neither the Green Book nor the Patient Group Directions specified any particular checks that must be undertaken.

Mr Hussain-Dupré further submitted that Ms Dempster's training note dated 1 February 2023 was not written until 12 February 2023, and that the Standard Operating Procedure relied upon was only authored in August 2024, approximately 18 months after the incident. He submitted that no participants had signed to confirm the contents of the alleged training and that no Trust-wide policy or guidance had been produced to establish MORSE as a necessary check.

Mr Hussain-Dupré submitted that the panel had also heard evidence that the Red Book was frequently unavailable and that Ms Mulholland herself had disagreed with the suggestion that clinics should not proceed unless all records were available. He further submitted that the SIRS schedule could also be out of date.

Mr Hussain-Dupré submitted that there was evidence of repeated computer failures in the immunisation room and that it was for the NMC to prove that you remained obliged to check MORSE even if the system was not operational.

Mr Hussain-Dupré drew the panel's attention to Ms Mulholland's evidence that, upon double-checking records, no errors were found, and the incident was described as a near miss.

Mr Hussain-Dupré further submitted that Ms Dempster had accepted that you did enter information onto MORSE and relied upon the student nurse's account confirming that the computer repeatedly shut down and required restarting.

Mr Hussain-Dupré submitted that logic dictated that you must have been using the computer if you were restarting it. He submitted that it was not in issue that you were checking the SIRS schedule and the Red Book.

Accordingly, Mr Hussain-Dupré submitted that there was insufficient evidence to establish that you failed to carry out the necessary checks.

Charge 4(b)

In relation to charge 4(b), Mr Hussain-Dupré submitted that the wording of the charge alleged that you made the comment to Child C's mother.

Mr Hussain-Dupré submitted that the panel heard evidence that the allegation was in fact made by a friend of the mother, who attended a later appointment with her own child. He submitted that Ms Mulholland had confirmed that it was a friend of Child C's mother who reported the alleged comment.

Mr Hussain-Dupré submitted that there was no contemporaneous documentary evidence to support this allegation and that the evidence amounted to hearsay, which could not be challenged.

Mr Hussain-Dupré further submitted that Ms Mulholland did not report that the friend of Child C's mother had described the comment as '*flippant*', and that this was merely Ms Mulholland's interpretation. He submitted that there was no evidence as to your state of knowledge.

Mr Hussain-Dupré submitted that, taken at its highest, the evidence was insufficient to establish this charge.

Charges 6 and 7

In relation to charges 6 and 7, Mr Hussain-Dupré submitted that the NMC relied upon investigatory meeting notes which were not signed by you and were advanced as hearsay. He submitted that none of the attendees at the meeting had been called to give evidence and that the accuracy of the notes could not be tested.

Mr Hussain-Dupré submitted that you had previously completed a Datix, had discussed mistakes with managers, and had provided a reflective account prior to the investigation meeting.

Mr Hussain-Dupré drew the panel's attention to the meeting notes which suggested that the investigator had already sent you information relating to the Datix reports. He submitted that this demonstrated that the investigator was already aware of the February 2022 incident and that you could not have misled someone who was already in possession of the relevant information.

Mr Hussain-Dupré submitted that there was no evidence that you sought to mislead the investigator or used the words alleged.

Charges 8 and 9

In relation to charges 8 and 9, Mr Hussain-Dupré reiterated that the meeting notes relied upon were unsigned hearsay and related to events that had occurred months earlier.

Mr Hussain-Dupré submitted that any inconsistencies regarding MORSE or computer use could be explained by technical difficulties, the passage of time, or the manner in which questions were put to you.

Mr Hussain-Dupré submitted that the burden rested with the NMC to prove that any inconsistencies were deliberate and designed to mislead, and that no such evidence had been presented.

Conclusion

Mr Hussain-Dupré submitted that the panel had insufficient evidence before it and was therefore invited to find that there was no case to answer on one or more of the charges.

Ms Fergus-Simms' submissions

Ms Fergus-Simms confirmed that she agreed that the panel must apply the test in *Galbraith* when considering whether there was a case to answer.

Charge 1(c)(ii)

In relation to charge 1(c)(ii), Ms Fergus-Simms submitted that it was correct that Ms Care confirmed that the child's Red Book was present when she visited the family at home. Ms Fergus-Simms submitted that the panel was entitled to draw an inference that the Red Book was therefore in existence and available on 10 February 2022 and should have been requested and checked by you. Ms Fergus-Simms submitted that the failure to check the Red Book had contributed to the error.

Charge 2

In relation to charge 2, Ms Fergus-Simms submitted that Ms Mulholland had given evidence that her information derived from both you and the Datix entry. Ms Fergus-Simms referred to Ms Mulholland's evidence that, on 26 October 2022, you administered the MMR vaccine to a child and that the child's mother became upset as the vaccination

was said to have been given against her wishes, in circumstances where the mother had only wanted the '*four-in-one'* vaccine.

Ms Fergus-Simms submitted that the issue raised by you as to *'consent'* was a matter of semantics. She submitted that the wording of the charge, namely that the parent requested the child not to have the MMR, was substantively the same as an allegation that the parent did not consent. She submitted that any attempt to draw a distinction between the drafting of the charge and the concept of consent was artificial, and that the panel would understand the meaning of the allegation.

Ms Fergus-Simms further referred the panel to the investigation record which recorded questions put to you on 20 June 2023 about the Datix raised in October 2022 and the allegation that the mother had said she did not want the child to have the MMR. Ms Fergus-Simms submitted that, in the notes, you recalled that the mother did not speak English, that a phone translation tool was used, that the mother was "*OK"* for the four-in-one but "*not for the MMR*", and that you "*thought she'd said yes to them all*". Ms Fergus-Simms submitted that, on your own account, this amounted to a concession that there had been a misunderstanding and that you had proceeded on an incorrect understanding.

Ms Fergus-Simms submitted that the panel had heard evidence about the availability and purpose of Language Line and the need for clear communication in circumstances involving language barriers, in order to ensure informed consent. She submitted that it was inconceivable that a phone translation tool could properly replace an interpreter when obtaining consent for a vaccination. She invited the panel to use its own experience in assessing the limitations of such translation tools.

Ms Fergus-Simms submitted that the incident at charge 2 fell within the same "*genus*" as the other concerns, namely failures relating to appropriate checks and safeguards. She submitted that there was no policy in place providing for the use of phone translation tools as a means to obtain informed consent in these circumstances. Ms Fergus-Simms

submitted that the allegation was capable of amounting to misconduct and that there was sufficient evidence for the charge to proceed.

Charge 3

In relation to charge 3, Ms Fergus-Simms submitted that Ms Dempster had given clear evidence that, at a training session held on 1 February 2023, nurses were advised of the checks they were required to complete. Ms Fergus-Simms submitted that, although Ms Dempster had accepted that there were no written guidelines, the NMC relied upon the training session as the benchmark. Ms Fergus-Simms submitted that the charge did not allege breach of any written policy and that not all policies or standards are necessarily documented in writing.

Ms Fergus-Simms submitted that the training pre-dated the incident of 8 February 2023 and constituted the operative standard for the clinic. She further submitted that while later documentation existed, including a Standard Operating Procedure authored on 6 August 2024, Ms Dempster had clarified that her training remained the standard referred to for new nurses working in that clinic.

Ms Fergus-Simms submitted that the Green Book and PGDs were general documents concerning record-keeping and did not detract from the central point that the clinic operated on specific processes and safety checks conveyed through training. She submitted that it was inconceivable that you would not have known the importance of MORSE, and that failure to check MORSE could lead to children being recalled or immunised twice.

Ms Fergus-Simms submitted that further support for the contents and quality of the training was found in the investigation notes. She referred to the account that the training had covered immunisations and process safety checks, including the requirement to have MORSE open and to complete checks. She submitted that Ms Mulholland described the

safety checks as including confirming the correct child's identity details and checking MORSE to verify prior immunisations and ensure vaccines were not duplicated.

Ms Fergus-Simms submitted that the wording of charge 3 referred to a failure to perform *'the necessary checks'* and did not require the NMC to prove the existence of a written policy. She submitted that it would be a dangerous position for a nurse to rely upon the absence of a written policy when there had been training addressing the specific checks required. Ms Fergus-Simms submitted that, on the evidence before the panel, there was sufficient evidence for the charge to proceed.

Charge 4(b)

In relation to charge 4(b), Ms Fergus-Simms acknowledged the panel's earlier decision not to permit amendment of that charge. She submitted that, notwithstanding who the comment was made to, the panel may consider that the comment was *'flippant'*. However, she accepted that, without the amendment, the issue would be a matter for the panel to determine on the wording as drafted.

Charges 6 and 7

In relation to charges 6 and 7, Ms Fergus-Simms submitted that the notes of the internal investigation meeting of 20 June 2023 were before the panel. She accepted that the notes were hearsay because the authors and attendees had not been called. However, she submitted that there was no dispute that an investigation took place and that the notes were business documents generated during the investigation process.

Ms Fergus-Simms submitted that each set of investigation notes contained an introductory statement inviting attendees to raise objections to the contents. She submitted that, although it was not your burden to prove anything, it was relevant that no material challenge had been made over a significant period of time to suggest that the notes were inaccurate, nor had any alternative account been provided.

Ms Fergus-Simms submitted that, in the investigation, you were recorded as stating words to the effect that you had "*never done this before*" and that you "*always*" did checks. Ms Fergus-Simms submitted that, given your subsequent admissions that errors had occurred and pre-dated that meeting, the recorded statement was untrue. Ms Fergus-Simms submitted that the only reasonable interpretation was that the statement was designed to minimise and mislead the investigation, and that there was therefore sufficient evidence for charges 6 and 7 to proceed such that you could be required to answer the allegation.

Ms Fergus-Simms addressed the point advanced that Datix reports had been sent to you before the meeting. She submitted that this did not preclude an attempt to mislead, particularly where the questions related to events including 8 February 2023, and where your account and position about MORSE and the clinic events later formed part of the disputed narrative.

Charges 8 and 9

In relation to charges 8 and 9, Ms Fergus-Simms submitted that the NMC relied upon investigation meetings on 20 June, 27 July, and 31 August 2023, and that the alleged inconsistencies were clearly set out in the exhibits. She submitted that the inconsistencies centred on whether MORSE and the computer were working on 8 February 2023, and whether you had checked MORSE.

Ms Fergus-Simms submitted that the investigator's questions recorded that, following further investigation, it had been said that the computer was on and working and that MORSE was working. She submitted that this could be cross-referenced with Ms Mulholland's account that the computer was working fine when she used it.

Ms Fergus-Simms submitted that your account shifted over time from stating that MORSE was not working to asserting that she did use it but that the computer kept switching off.

She also referred to evidence that records were input into the system that same day, which, in her submission, supported the proposition that the system was working.

Ms Fergus-Simms submitted that whether the computer was temperamental was ultimately a matter for the panel. However, the investigation material provided sufficient evidence of inconsistent accounts and a false impression being given, and that this was capable of supporting the dishonesty allegations. She submitted that it would not be appropriate to dismiss those charges at the half-time stage without requiring you to answer what you meant by your statements and how your account developed over time.

Conclusion

In conclusion, Ms Fergus-Simms submitted that, save for the issues the panel would need to determine regarding charge 4(b) on the wording as drafted, there was sufficient evidence for the charges to proceed. She invited the panel to find that you had a case to answer.

The panel's decision and reasons on application of no case to answer

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel had regard to the principles set out in *Galbraith*. The panel was mindful that it must consider whether there was evidence upon which the facts alleged could be proved and, if so, whether that evidence, taken at its highest, was such that a properly directed panel could make findings of fact proved. The panel further reminded itself that it must not make findings of fact at this stage.

Charge 1(c)(ii)

The panel noted that this was a charge alleging a failure, which required the NMC to establish both that the red book was available and that you failed to check it.

The panel considered the evidence relied upon by the NMC, including the witness evidence that referred to standard practice and the evidence of Ms Care, who stated that the incident occurred before she commenced her role and that "*standard procedure would be to check*" the red book. The panel noted that this evidence described general practice only and did not address whether the red book was in fact present at the relevant appointment or whether you failed to check it.

The panel further noted that there was no evidence from the child's parent, nor any contemporaneous documentation confirming that the red book was present on 10 February 2022. While the NMC relied upon the fact that the red book was present at a later visit by Ms Care, the panel determined that it would be unsafe and unfair to draw an inference that the red book was present at the earlier appointment, particularly given the seriousness of the allegation and the fact that this was a failure-based charge.

The panel noted that there had been an opportunity for the NMC to obtain evidence from the child's family addressing whether the red book was present, but no such evidence had been adduced.

Accordingly, the panel concluded that there was insufficient evidence upon which a properly directed panel could find charge 1(c)(ii) proved.

The panel therefore found that there was no case to answer in respect of charge 1(c)(ii).

Charge 2

The panel noted that Ms Care accepted that she was not present at the incident and that her understanding was derived from the Datix report and subsequent investigation material. The panel also noted that there was no witness evidence from the child's mother.

However, the panel considered the Datix dated 26 October 2022, and the internal investigation notes dated 20 June 2023, which recorded your own account of the incident.

During the internal investigation interview, you were asked:

> *'There was a Datix raised in October 2022 when you gave an immunisation and the mum had said no she didn't want her child to have it, can you talk me through?'*

You responded:

> *'I remember this, mum didn't speak English, I think she was Polish, I had to type into the phone to translate. Mum said ok, not for the MMR but for the 4 in 1, but I thought she'd said yes to them all. When I went to do the second injection mum said no and was being aggressive and rude so I called the Health Visitor in and she explained. We never give just 1 jag, I had already explained but she started shouting and wasn't happy'.*

The panel considered that this account constituted some evidence that, at some point, the parent expressed that she did not want the MMR vaccine to be administered. The panel further noted that this charge concerned a drug administration error, which was serious in nature.

The panel was not satisfied that this was a case where, taken at its highest, the evidence could not support a finding of fact proved.

Accordingly, the panel found that there was a case to answer on facts in respect of charge 2.

In relation to Mr Hussain-Dupré's submission that, if found proved, charge 2 could not amount to misconduct, the panel followed the approach set out in the cases of *R (Husband)* and *Woods v GMC* [2002] EWHC 1484 (Admin) and considered whether there was a real prospect of serious professional misconduct being established.

The panel determined that giving a child an MMR vaccine when a parent had requested the child not to have it, on its own, gave rise to a real prospect to serious misconduct being established. Further, the panel considered that the actions alleged in charge 2 were of the same genus as the other alleged clinical failures and looked at in totality if also found proved, gave rise to a real prospect of serious professional misconduct being established.

The panel therefore concluded that there was also a case to answer in respect of impairment in relation to charge 2.

Charge 3

The panel considered the evidence relating to training, professional standards, and observed practice.

The panel noted the training notes dated 1 February 2023, which set out the checks required to be undertaken by nurses conducting immunisation clinics. The panel was satisfied that this evidence was capable of establishing a professional obligation on you to carry out those checks.

The panel also considered the evidence of Ms Dempster, who provided direct observation evidence of your practice on 8 February 2023. In her witness statement dated 2 April 2025, Ms Dempster stated:

> *'… Before Lisa administered the vaccine the only checks she did was to look at the child's red book and the SIRS schedule, she did not put*

the child's CHI into MORSE to look at previous immunisations which would inform Lisa of all other previous immunisations administered, confirming correct dates and spaces between each immunisation and would confirm what is on SIRS schedule is correct…'.

The panel further noted your account within the internal investigation notes dated 20 June 2023, where you described your usual preparation for clinics, including checking MORSE. The panel considered that this evidence, taken at its highest, was capable of supporting an allegation that the necessary checks were not carried out on the date in question.

The panel concluded that there was sufficient evidence upon which a properly directed panel could find charge 3 proved. Accordingly, the panel found that there was a case to answer in respect of charge 3.

Charge 4(b)

The panel considered the oral and documentary evidence relating to this charge. The panel noted that the evidence from Ms Mulholland was that, if the comment was made at all, it was made to the friend of Child C's mother, rather than to the mother herself.

The panel noted that the wording of the charge was specific and alleged that the comment was made to the mother of Child C. The panel determined that this discrepancy was material.

The panel concluded that, even taken at its highest, the evidence did not support the charge as drafted. As the identity of the person to whom the comment was allegedly made was incorrect, the charge could not properly be left to be answered.

Accordingly, the panel found that there was no case to answer in respect of charge 4(b).

Charge 6

The panel acknowledged the submission that this evidence was hearsay and had not been tested by calling the authors of the investigation notes. However, the panel reminded itself that hearsay evidence is admissible in these proceedings and that the issue at this stage was whether there was some evidence, not the weight to be attached to it.

The panel had regard to the internal investigation notes dated 20 June 2023, including the passages relied upon by the NMC, and considered that, taken at its highest, the evidence was capable of establishing that the statement alleged at charge 6 was made.

Accordingly, the panel found that there was a case to answer in respect of charge 6.

Charge 7

Given that the panel found that there was a case to answer in respect of charge 6, it followed that there was also a case to answer in respect of charge 7.

The panel considered that the evidence relied upon by the NMC was capable of supporting the dishonesty allegation, subject to full consideration at the facts stage.

Accordingly, the panel found that there was a case to answer in respect of charge 7.

Charge 8

The panel considered the investigation material dated 20 June, 27 July and 31 August 2023, including the interview extracts. The panel noted the recorded inconsistencies relating to whether MORSE and the computer were working on 8 February 2023, including your account that:

‘It was switching on but then off again, I tried going onto MORSE and I was checking and updating but the computer would switch off…’.

The panel determined that there were apparent inconsistencies within the investigation material that required exploration and could not properly be resolved at this stage.

Accordingly, the panel found that there was a case to answer in respect of charge 8.

Charge 9

This charge is dependent upon charge 8. Given the panel’s findings that there was a case to answer in respect of charge 8, the panel found that there was also a case to answer in respect of charge 9.

Adjournment

Prior to the hearing adjourning on 10 December 2025 (due to lack of time), the panel accepted the advice of the legal assessor and considered its obligation under Rule 32(5) as to whether it was necessary to impose an interim order at this stage of the proceedings.

The panel was informed by Ms Fergus-Simms that an interim order is already in place. As you are already subject to an interim order, the panel did not impose one on 10 December 2025.

This case will next resume for one day on 23 December 2025 when the panel will amend and hand down its determination. The case will then resume again on 21 April 2026.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Hussain-Dupre, who informed the panel that you made full admissions to charges 1a, 1b, 1c (i), 1c (iii), 4a, 4c, 4d, 4e, and 5

The panel therefore finds charges 1a, 1b, 1c (i), 1c (iii), 4a, 4c, 4d, 4e, and 5 proved in their entirety, by way of your admissions.

In reaching its decision on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Fergus-Simms and submissions from Mr Hussain-Dupre.

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 evidence from the following witnesses called on behalf of the NMC:

- Eileen Mulholland: Team Leader at [PRIVATE] employed by NHS Lanarkshire at the time of the incidents.

- Elaine Care: Health Visitor at [PRIVATE] employed by NHS Lanarkshire at the time of the incidents.

- Beth Dempster: Health Visitor at [PRIVATE] employed by NHS Lanarkshire at the time of the incidents.

The panel also heard evidence from you under oath.

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

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

Charge 2

2. On 26 October 2022 gave an unknown child the MMR vaccine when the parent requested the child not to have it

This charge is found NOT proved.

The panel took into account that Ms Mulholland stated in her witness statement that:

> *'This was when Ms Samazie gave an MMR vaccination to a child. The child's mother asked what she had given, and Ms Samazie said the MMR. This went against the wishes of the parent for their child to have it. The mother of the child was very upset. It wouldn't have harmed the child as the child was due to have it, but it went against the mothers wishes. She was only consenting to the 4 in 1 and not the MMR vaccination.'*

The panel took account of the investigation meeting notes dated 20 June 2023 in which it was reported that, when asked about the alleged incident on 26 October 2022, you stated:

> *'I remember this, mum didn't speak English, I think she was Polish, I had to type into the phone to translate. Mum said ok, not for the MMR but for the 4 in 1, but I thought she'd said yes to them all. When I went to do the second injection mum said no and was being aggressive and*

rude so I called the Health Visitor in and she explained. We never give just 1 jag, I had already explained but she started shouting and wasn't happy.'

The panel had sight of the Datix incident report (Datix) dated 26 October 2022 in which a similar account as contained in the investigation meeting notes was reported.

The panel took into consideration that although you accepted that you gave the unknown child the MMR vaccine, you denied the allegation that the parent requested the child not to have it prior to administering. You stated in your defence statement that:

'From our original interaction using the app, I had understood that the mother had given consent for both the 4-in-1 vaccination and the MMR. I gave the MMR vaccine to a child because the mother had given her consent to go ahead.

I am absolutely sure that the mother did not actively request that the child not be given the MMR as I would never force a vaccine on a child if a parent does not agree.'

The panel noted that there was no dispute that you had administered the MMR vaccine to the unknown child and that there was a language barrier between you and the mother at the time of the alleged incident.

The panel considered that Ms Mulholland was not a direct witness to the alleged incident as she did not start her post until January 2023. The panel noted that the only contemporaneous evidence was contained in the Datix dated 26 October 2022. The panel concluded that the Datix was in the very least co-authored by yourself as it was written in the first person and you were the named reporter on the Datix. In oral evidence, when questioned by the panel, you were unable to confirm this as it occurred a long time ago.

The panel further noted that the NMC did not present any direct evidence that indicated that the mother had requested, prior to the administration of the MMR vaccine to her child, that the child should not have it. The panel was of the view that you believed that consent had been given by the mother for the MMR vaccine to be administered. The panel further noted that due to language barriers, it was reasonable to infer that there may have been miscommunication as to whether the mother wanted the MMR vaccine to be administered to her child. However, you believed that consent had been given.

In this regard, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 2 not proved.

Charge 3

3. On 8 February 2023 failed to perform the necessary checks regarding vaccinations

This charge is found proved.

The panel took into account that Ms Dempster stated in her witness statement that:

> *'On 8 February 2023, the day of the incident, Lisa was running an immunisation clinic… Before Lisa administered the vaccine the only checks she did was to look at the child's red book and the SIRS schedule, she did not put the child's CHI into MORSE to look at previous immunisations which would inform Lisa of all other previous immunisations administered, confirming correct dates and spaces between each immunisation and would confirm what is on SIRS schedule is correct…. I then returned to the clinic and took Lisa to another room, where I explained that I was removing her from the clinic due to concerns about her practice. Lisa was unhappy with this decision.*

The panel took into consideration that you denied the allegation. It noted that you stated in your defence statement that:

> *'On 8 February 2023, I was having issues with the computer in the room where the vaccinations are given. The computer was working intermittently, so I was using it, but there were times it kept on switching itself off by itself. That day I had a student with me. So whilst I was trying to use MORSE, the problem with the computer meant that I could not use the system all the time. I confirm that there were children whose records I did check and update using the system.*
>
> *When the Beth, the Health Visitor came in, I tried to explain this to her.*
>
> *I understand from the evidence that has been presented to me that the student confirmed to Eileen Mulholland that the computer had not been working…. During the training* (on 1 February 2023)*, it was not explained to me that we needed to complete the documentation (including on the computer) after each and every immunisation.*
>
> *At the time, I did not know that I should not run a clinic if I did not have computer access. Or that I needed to report the computer not working to someone. I carried out the other checks, including the SIRS schedule, the patient letter and Red Book to ensure that the correct immunisations were being given to the right child. When the computer was working I was using MORSE, so for some patients there were records, but could not do so it the computer had shut itself down.'*

The panel noted that Ms Dempster confirmed in her oral evidence that the necessary checks were checking the child's red book, the SIRS schedule and MORSE. She highlighted that MORSE was a digital recordkeeping system through which the nurse was

expected to utilise to check the child's personal details, medical records and immunisation history. Ms Dempster stated that no vaccinations should be conducted without the necessary check on MORSE and where there is any technical difficulty in accessing it, the nurse should either use another platform such as a laptop or move to another clinical room to access MORSE.

The panel considered whether you had a duty to perform the necessary checks regarding vaccinations. Although there was no documentary protocol on the necessary checks to be performed, the panel took into account that you had completed an immunisation training session on 1 February 2023 (seven days before the alleged incident). The panel had sight of the Training Sheet, and it noted that training session covered the necessary checks to be performed regarding vaccinations and these included checking the SIRS schedule and MORSE. The panel took into consideration that it was reported that you had highlighted checking MORSE as part of the necessary checks to be performed regarding vaccinations, in the investigation meeting notes dated 20 June 2023. You also reiterated this in your reflective piece dated 4 August 2023. In this regard, the panel was satisfied that you had a duty to perform the necessary checks regarding vaccinations.

The panel considered that the only alleged failing was that you did not check MORSE as part of your necessary checks regarding vaccinations. It noted that you did not deny that you failed to check MORSE prior to conducting vaccinations however you stated that technical difficulties prevented you from accessing the system. The panel was of the view that even if there was a technical difficulty that affected your computer, it was expected that, as an experienced nurse who had completed the immunisation training, you should not have conducted the vaccinations without performing the necessary checks including checking MORSE. You should have used an alternative platform such as a laptop or moved to another clinical room to use its computer to access MORSE.

Having considered the evidence before it, the panel was satisfied that it was more likely than not, that on 8 February 2023, you failed to perform the necessary checks regarding vaccinations. The panel therefore found charge 3 proved.

Charge 6

6. During an internal investigation on 20 June 2023 when discussing the error at charge 4 said ‘I’ve never done this before, I always do checks’ or words to that effect

This charge is found proved.

The panel took into consideration that you denied the allegation. It noted that you stated in your defence statement that:

> *‘I do not recall exactly hat* (sic) *was said in the investigation meeting, but I do not agree that the words I used were that I had never made a mistake like that before. I did not have the February 2022 incident in my mind, I just wanted to get across that I had been completing the checks…’*

The panel had sight of the investigation meeting notes dated 20 June 2023 in which it was reported that you stated:

> *‘I was just scared, I was disappointed in myself, frustrated in myself, I was questioning myself, I‘ve never done this before, I always do checks…’*

The panel took into account that you confirmed during your oral evidence that the investigation meeting notes were sent to you although you stated that you did not sign them. The panel was of the view that you had the opportunity to read and challenge the account reported in the investigation meeting notes if you felt that it did not reflect your responses accurately. However, you did not do so.

Although, none of the other attendees at the investigation meeting dated 20 June 2023 had provided direct evidence in these proceedings, the panel considered that the investigation meeting note was a business record of a formal investigation meeting conducted by an independent panel and you had a trade union representative at the meeting. The panel therefore attached significant weight to the investigation meeting note dated 20 June 2023.

Having considered the evidence before it, the panel was satisfied that it was more likely than not, that during an internal investigation on 20 June 2023 when discussing the error at charge 4, you said '*I've never done this before, I always do checks'* or words to that effect. The panel therefore found charge 6 proved.

Charges 7 (i) and 7 (ii)

7. Your conduct at charge 6 was dishonest in that:
    i) You knew that what you had said was untrue.
    ii) You intended to mislead the person conducting the investigation

These charges are found NOT proved.

Having found charge 6 proved, the panel went on to consider whether your conduct in that charge was dishonest. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges, (DMA-8). It also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and

- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to charge 6, the panel took into account your evidence and the context of the incident.

The panel took into consideration that in explaining your conduct in charge 6, you stated in your defence statement that:

> *'*[PRIVATE] *I had a lot going through my mind and therefore answering some of the questions I was asked was difficult as I was trying to recall the details of the different incidents that were being referred to and because different dates were being mentioned. I tried to answer to the best of my knowledge, but fully accept that some of my answers may not have been properly thought through.'*

The panel also considered the totality of your statements before and after you made the comment in charge 6 during the internal investigation on 20 June 2023. The panel noted that in the investigation meeting note dated 20 June 2023, it was reported that you stated:

> *'I was just scared, I was disappointed in myself, frustrated in myself, I was questioning myself, I've never done this before, I always do checks. Being a parent myself I understand, I just shut down. I would never want to hurt anybody, I feel bad about it,* [PRIVATE] *I know where mum is coming from. I should have followed process. At that point I don't know what happened.'*

The panel was of the view that, when you made the comment in charge 6, you were reflecting on the incident in charge 4 by expressing disappointment in yourself and taking ownership of your conduct. The panel noted that the context of the incident and the totality of your comments did not demonstrate someone that intended to mislead the person conducting the investigation or make an untrue statement. The panel noted that it was reasonable to make such inference given that you knew that the investigating panel had the Datix reports from previous incidents and you did not seek to deny your conduct in relation to the incidents.

In applying the second limb, the panel was satisfied that your conduct would not be considered as dishonest by the standards of ordinary decent people.

In this regard, the panel was not satisfied that the NMC had discharged the burden of proof that when you made the comment in charge 6, you knew that it was untrue and intended to mislead the person conducting the investigation. The panel therefore found charges 7(i) and 7(ii) not proved.

Charge 8

8. During internal investigation meetings between 20 June 2023 and 31 August 2023 provided inconsistent accounts of your practice

This charge is found NOT proved.

The panel took into consideration that the NMC had stated that the '*inconsistent accounts'*, referred to in charge 8, related to the reasons you had provided during the internal investigation meetings for not conducting the necessary checks regarding vaccinations. This was when, on one occasion, you stated that you did not conduct the necessary check on MORSE because it was not working; on another occasion, you stated that the computer was working intermittently as it switched off sporadically; on another instance, you stated that the computer was not working.

The panel had sight of the investigation meeting notes dated 20 June 2023, 27 July 2023 and 31 August 2023 respectively. The panel noted that you had made those statements as alleged by the NMC during the investigation meetings, however, the panel was of the view that those statements did not represent an overall inconsistent account of your practice. The panel noted that an overview of your statements demonstrated that you had encountered technical difficulties in accessing MORSE to conduct the necessary checks regarding vaccinations at the time of the incident. The panel took into account that Ms Dempster, in her local statement dated 12 February 2023, stated that:

'James (the student nurse with you at the time of the incident) *also said the computer did seem to keep going off fully and Lisa had to re-start it however found it strange when writer accessed it and it worked.'*

The panel was of the view that the above statement confirmed that you had experienced some technical difficulties in accessing MORSE on the day of the incident. Although, you had made varying statements when explaining the incident, the panel took into account that in your defence statement, you stated:

'[PRIVATE]*. I had a lot going through my mind and therefore answering some of the questions I was asked was difficult as I was trying to recall the details of the different incidents that were being referred to and because different dates were being mentioned. I tried to answer to the best of my knowledge, but fully accept that some of my answers may not have been properly thought through.'*

The panel accepted your explanation for the varying statements you made during the internal investigation meetings, and it considered such variations to be trivial. In this regard, the panel determined that you had not provided inconsistent accounts of your practice. The panel was therefore not satisfied that the NMC had discharged the burden of proof. It therefore found charge 8 not proved.

Charge 9

9. Your conduct at charge 8 was dishonest in that you intended to mislead on the fact that you were not carrying out the required checks.

This charge is found NOT proved

Having found charge 8 not proved, the panel determined that charge 9 was not proved as a direct consequence of its decision on charge 8.

Fitness to practise

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

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

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

Submissions on misconduct

Ms Fergus-Simms referred the panel to Article 22 of the Nursing and Midwifery order 2021. She submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code) are engaged in this case and have been breached. They are sections 1.1, 1.2, 1.4, 4.1, 4.2, 6.2, 18.1, 18.2, 18.3, 20.1, and 20.2.

Ms Fergus-Simms submitted that the Code set out the professional standards of practice and behaviour for nurses, midwives and nursing associates. She invited the panel to find that all the charges found proved amount to misconduct.

Mr Hussain-Dupre submitted that in terms of whether the charges found proved amount to misconduct, you are neutral on all but one charge. He submitted that your conduct in charge 6 did not amount to serious professional misconduct on the basis of the panel's findings on facts and the contextual factors at the time of the incident [PRIVATE]. He asserted that your conduct in charge 6 would not be considered deplorable by fellow professionals.

Submissions on impairment

Ms Fergus-Simms referred the panel to the NMC Guidance on Impairment (DMA-1). She submitted that, in considering impairment, the panel should consider the test formulated by Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, c and d of the *Grant* test are engaged in this case when looking at past conduct, and also when looking forward to the future.

Ms Fergus-Simms invited the panel to consider the context of the errors and the conduct involved, particularly, the personal factors, professional work environment and culture at the time of the incidents. She submitted that a key question to be considered is whether it is highly unlikely that the conduct will be repeated. She asserted that it is highly likely that the concerns will be repeated unless you are given more time to strengthen your practice and reflect further on the concerns.

Ms Fergus-Simms submitted that a consideration of the public interest will require the Fitness to Practice Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and maintain public confidence in the profession. In upholding proper professional standards and conduct and maintaining public confidence, the Fitness to Practice Committee will need to consider whether the concern is easy to put right. Ms Fergus-Simms submitted that although you have undertaken relevant training in the areas of concern, there are types of concerns that are

so serious that even if a professional addresses the behaviour, a finding of impairment is required to uphold proper professional standards, and to maintain public confidence in the profession. She argued that your dishonest conduct and lack of duty of candour falls within this category.

Ms Fergus-Simms submitted that a key question to be asked is, would the ordinary man, having heard the admissions made and the mistakes outlined by the witnesses, supported by documentary evidence, entrust their child without any concern or question to you? She submitted that the answer is in the negative and therefore impairment must be found on public interest grounds. She referred the panel to the judgement of Sir Anthony Clark in *General Medical Council v Meadow* [2007] QB 462 (Admin) where he stated that the purpose of the fitness to practice proceedings is not to punish the practitioner for past mistakes, but to protect the public against acts and omissions of those who are not fit to practise.

Ms Fergus-Simms referred the panel to your impairment bundle and highlighted that it was stated in the Supported Improvement Plan that there were a number of areas that required improvement in your practice. She submitted that your reflection on your training on duty of candour showed limited information on the importance of honesty and integrity and it did not provide insight on the risk of harm your conduct posed to patients. She noted that you had further provided an undated reflective statement which provides more insight into the concerns, but the panel should take into account that this updated reflective statement was not provided at the last sitting of these proceedings and it is undated.

Ms Fergus-Simms highlighted that the Supported Improvement Plan stated that you need to gain more experience in administering year three and year four vaccines. She therefore submitted that there are still further areas of learning in relation to vaccines and immunisations for you to undertake. She therefore invited the panel to find your fitness to practise remains impaired on both grounds of public interest and public protection.

Mr Hussain-Dupre referred the panel to your impairment bundle, your reflective accounts and defence statement. He noted that the NMC had highlighted that there was no evidence of unsupervised practice, however, he submitted that you are currently under an interim conditions of practice order which restricts you from conducting vaccinations without supervision and therefore it was not possible to provide such evidence until the interim order was revoked. He highlighted that you have now moved from NHS Lanarkshire Motherwell to NHS Lanarkshire Airdrie where you have been provided with adequate support to strengthen your nursing practice. He submitted that your impairment bundle contains consistent positive feedback that you have received whilst working at NHS Lanarkshire Airdrie (your current employer).

Mr Hussain-Dupre submitted that the reflective accounts were not dated because they were prepared in the past for interim order hearings and they have now been assembled into a bundle for the purpose of the substantive hearing.

Mr Hussain-Dupre submitted that you acknowledge that although there was no actual harm caused, your failing posed a risk of harm to patients. He highlighted that impairment is considered as of today and there was extensive evidence of a registrant who is complying with her conditions, who had moved to a different team and is now receiving consistently positive feedback about her performance. He asserted that it would not be fair to penalise you at this stage for not having completed something that you are not permitted to do given the interim conditions of practice order.

Mr Hussain-Dupre submitted that you have demonstrated sufficient insight into the concerns, you have understood what went wrong and the factors that contributed to your conduct. He asserted that you have remediated the concerns and therefore, there is a low risk of repetition. He submitted that none of the clinical concerns suggest attitudinal issues nor a staunch refusal to follow the rules. He argued that, through your supervised practice, you have now demonstrated the consistency and ability to understand the rules and comply with them. He submitted that a finding of impairment is not required on the ground of public protection.

Mr Hussain-Dupre noted that you had made admissions to your dishonest conduct, and you had accepted that you tried to conceal your medication error. He stated that this may elevate the seriousness of the dishonesty concern, and the panel may decide that the public interest is engaged. He however submitted that you have received mentoring, support and training, particularly on the duty of candour, in the past three years. He submitted that you understand the seriousness of your dishonesty and its impact on patients and their families. He highlighted that you have been straightforward in your engagement with these proceedings and the fitness to practise process. He argued that given that other allegations of dishonesty were not found proved, this indicated that you are not prone to repeated dishonesty to serve your own interest. He therefore invited the panel to find that your dishonest conduct is highly unlikely to be repeated.

In conclusion, Mr Hussain-Dupre submitted that if the panel is minded to find impairment on the grounds of public interest on the basis of your dishonesty, it should also indicate the level of seriousness of your dishonest conduct on the spectrum of dishonesty.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel determined that your actions amounted to a breach of the Code. Specifically, the following sections of the Code:

'Prioritise people

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

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

Practise 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*

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:

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

Preserve safety

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

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

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

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

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

To achieve this, you must:

18.1 *prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*

18.3 *make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines*

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

To achieve this, you must:

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

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*

Promote professionalism and trust

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Charges 1a and 4a

The panel was of the view that your repeated medication errors, in which you had administered the wrong immunisation to an unknown child and given Child C two pre-school vaccines four weeks apart, demonstrated carelessness towards the administration of medication and your duty of care towards them. The panel noted that it was likely that such medication errors would have been prevented if you had conducted the necessary checks regarding vaccinations.

Although there was no evidence of actual harm, the panel determined that your medication errors posed a risk of harm to the unknown child and Child C given their

vulnerable nature. Your conduct may have also caused distress to the parents of the respective children.

The panel therefore determined that your conduct fell short of the standard of nursing care expected from a registered nurse and amounted to a breach of your fundamental duty of care to the children. Consequently, the panel determined that your actions in charges 1a and 4a were sufficiently serious and amounted to misconduct.

Charges 1b and 5

The panel took into account that you had incorrectly documented a medication error and also incorrectly documented a vaccine given to an unknown child.

The panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession. It noted that your conduct would have deprived your colleagues and the appropriate health professionals from being appraised with the relevant information pertaining to your medication error to an unknown child and the appropriate vaccine administered to the other unknown child. The panel determined that this could have had a consequent impact on the unknown children's continuity of care and therefore posed a risk of harm to them.

The panel therefore determined that your actions amounted to a serious failure in a fundamental aspect of nursing practice. The panel concluded that your actions in charges 1b and 5 were sufficiently serious to amount to misconduct.

Charges 1c (i), 1c (iii), 3 and 4c

The panel took into consideration that you failed to conduct the necessary checks regarding vaccinations on more than one occasion. The panel was of the view that your failings demonstrate a pattern of behaviour which suggests a careless disregard for NHS Lanarkshire's procedures and checks regarding vaccinations.

The panel noted that these checks were necessary to guarantee the safety of children during vaccinations and mitigate actual or potential harm. The panel therefore determined that your failure to conduct those checks placed children under your care at risk of harm. The panel noted that it was likely that the medication errors as outlined in charges 1a and 4a would have been prevented if you had conducted the necessary checks regarding vaccinations.

The panel determined that your conduct amounted to a failure to uphold the standards of the nursing profession. Consequently, the panel concluded that your failings in charges 1c (i), 1c (iii), 3 and 4c were sufficiently serious to amount to misconduct.

Charges 4d and 4e

The panel took into consideration that you failed to report the medication error and you also failed to document that a medication error had occurred on the appropriate records. The panel noted that you attempted to conceal your medication error by recording on the SIRS sheet that you had given the vaccination on 29 March 2023 rather than on 26 April 2023. Although you stated that your dishonest conduct was out of panic and the fear of being judged upon, the panel was of the view that this did not diminish your duty of candour to report any medication error appropriately.

The panel was of the view that your failure to report the medication error placed Child C at risk of harm as the appropriate health professionals would have been deprived of the relevant information relating to the medication error. This would not have enabled them to promptly assess the risk of harm to Child C and decide on necessary steps to minimise any risk or ongoing harm from the medication error. The panel also noted that it was part of your duty of candour to disclose the medication error and to document the incident, but you failed to do so as Ms Mulholland stated that the medication error only came to light when the parent of Child C made a formal complaint.

The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession. Your dishonesty was directly linked to patient care and your duties as a registered nurse. In being dishonest, it found you to have breached a fundamental tenet of the nursing profession. It noted that your dishonest conduct demonstrated a lack of accountability and transparency on your part. The panel considered your dishonest behaviour to be unprofessional and would be seen as deplorable by other members of the profession and the public. Therefore, the panel determined that your conduct in charges 4d and 4e were sufficiently serious to amount to misconduct.

Charge 6

The panel bore in mind that it had earlier determined that, when you made the comment in charge 6, you were reflecting on the incident in charge 4 by expressing disappointment in yourself and taking ownership of your conduct. The panel had also earlier noted that the context of the incident and the totality of your comments did not demonstrate dishonesty. In this regard, the panel determined that your conduct in charge 6 was not so serious as to amount to misconduct.

Consequently, having considered the proven charges individually and in totality, the panel determined that your actions in charges 1a, 1b, 1c (i), 1c (iii), 3, 4a, 4c, 4d, 4e and 5 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

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

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

The panel first considered whether any of the limbs of the Grant test were engaged as a result of your misconduct. The panel determined that your medication errors, inaccurate record-keeping and failures to conduct necessary checks regarding vaccinations placed vulnerable patients at unwarranted risk of harm.

The panel determined that your misconduct constituted a serious breach of fundamental tenets of the nursing profession in that you failed to prioritise people, practise effectively, preserve safety, and promote professionalism and trust. It determined that you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. The panel also found you to have acted dishonestly.

The panel therefore concluded that limbs a, b, c and d of the Grant test are engaged in respect of your past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) in which the Court addressed the issue of impairment with regard to the following three considerations:

a. *‘Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?’*

The panel first considered whether your misconduct is capable of being addressed. The panel was of the view that your misconduct with respect to medication errors, inaccurate recordkeeping and failures to conduct necessary checks regarding vaccinations could be addressed through a process of insightful reflections, retraining in the areas of concern and evidence of good practice. Therefore, the panel determined that it is capable of remediation.

In respect of your dishonest conduct, the panel noted that the NMC Guidance set out that dishonesty was generally difficult to address. The panel considered that whilst dishonesty can be difficult to address, there is a wide spectrum of dishonest behaviours and that the nature and extent of your dishonesty had to be considered with care.

The panel considered that your dishonesty was a deliberate breach of the professional duty of candour as you attempted to conceal your medication error. It noted that your dishonesty was related to your clinical practice and posed a risk of harm to Child C. However, the panel considered that your dishonesty was not pre-meditated but a spontaneous reaction to the medication error. Your dishonest conduct did not involve a misuse of power nor was there any tangible gain. It was not longstanding but a one-off incident and you had in the past shown an openness to reporting previous errors. There was also a context of you finding the work environment difficult and unsupportive at times. Having considered these factors, the panel found your dishonest conduct to be at the middle end of the spectrum of dishonesty. It determined that your dishonest conduct was not suggestive of deep-seated attitudinal concerns and that you had already made some efforts to reflect on your conduct and acknowledge what you had done was wrong.

The panel then went on to consider whether the concerns have been addressed and remediated. The panel took into account your reflective accounts, your oral evidence, your defence statement, your training certificates and your Supported Improvement Plan (SIP).

The panel also considered the context of the misconduct. It noted that you had alleged that you faced bullying, harassment and a lack of support at NHS Lanarkshire Motherwell, and that you felt isolated from the team there. Whilst the panel had not seen any evidence to support these assertions, it acknowledged that this was your perception and that you were able to contrast the working environment at the time these incidents took place with your current working environment which you have described as more supportive.

Regarding insight, the panel considered that you made admissions to some of the charges, shown genuine remorse and apologised for your failings. The panel was of the view that you have demonstrated some insight into the seriousness of your misconduct and the lessons you had learnt from the incidents. It noted that you had also reflected on how you would act differently if a similar situation should occur in the future or to prevent such a situation from re-occurring. The panel considered the opportunity that you have been able to move to a new working environment. This has supported your ability to reflect and demonstrate developing insight into how better working practices could support your ability to strengthen your practice and move into a position of unsupervised practice.

However, the panel considered that you have not yet demonstrated sufficient insight into the impact of your clinical failings and dishonesty on patients, their families, your colleagues, the nursing profession and the wider public. The panel therefore determined that your insight is still developing.

In considering whether you have strengthened your nursing practice, the panel considered your training certificates and your Supported Improvement Plan (SIP). The panel was of the view that although the training courses were relevant to the areas of concerns, there was no testimonial provided from your line manager or your current employer to

demonstrate how you have applied your training into your nursing practice or comment on your conduct and aptitude to resuming work as an independent registered nurse.

The panel was also concerned that the SIP was not co-signed and dated by you although there was a column requiring such action on the document. You had also not signed and dated your reflective statement. This raises concerns about your approach towards record-keeping and documentation in your practice.

In light of this, the panel was not satisfied that any of the concerns had been fully remediated nor that you had sufficiently strengthened your nursing practice. Accordingly, the panel determined that there is a risk of repetition, and limbs a, b, c and d of the *Grant* test are engaged in the future.

The panel therefore concluded 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 are 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 had regard to the serious nature of your misconduct and the public protection issues it had identified. It determined that public confidence in the profession, particularly as the misconduct involved dishonesty, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six weeks 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).

Submissions on sanction

Ms Fergus-Simms submitted that the most appropriate and proportionate sanction in this case is a 12-month suspension order with a review. She referred the panel to the NMC Guidance '*The purpose of and approach to sanctions'* (SAN-1) which confirms the purpose of the imposition of a sanction is to meet the NMC's overarching objective to protect the public. She highlighted that the NMC Guidance states that considerations in this regard include any risk the registrant might pose to those who use their services, the deterrent effect on other registrants, public confidence in the profession and in the regulatory process.

Ms Fergus-Simms submitted that taking no further action and a caution order would not be appropriate due to the elements of dishonesty and the lack of the duty of candour found in this case. She referred the panel to its previous findings on misconduct and impairment. She submitted that a suspension order with a review would address the public interest aspect of dishonesty, whilst also providing you with an opportunity to develop further insight.

Ms Fergus-Simms highlighted that you had provided an updated bundle which may have addressed some of the concerns raised by the panel in its earlier findings. She noted that a striking-off order would be disproportionate in this case given that the panel had earlier determined that there was no evidence of deep-seated attitudinal concerns and your misconduct was capable of remediation. She submitted that it was a matter for the panel to determine the appropriate weight to be given to the fact that you had completed all that is required to be competent moving forward.

Mr Hussain-Dupre highlighted that you had provided an updated bundle comprising details of the Supported Improvement Plan (completed recently on 20 May 2026) and various references from those who have been supervising you since you commenced employment at your current workplace. He submitted that, given the details contained in the updated bundle, the clinical concerns in this case have now been remediated. He asserted that the NMC would agree that an employer is usually best placed to actually determine whether or not remediation has in fact occurred and whether or not a registrant is competent to carry out the tasks that are assigned to them. He submitted that the residual matter, in terms of sanction in this case, was your dishonest conduct. He highlighted that you had admitted your dishonest conduct in charge 4e, but the panel did not find dishonesty in the remainder of the charges.

Mr Hussain-Dupre submitted that you have demonstrated sufficient insight into the concerns in this case, you have engaged fully with the NMC and these proceedings, you have complied with your interim conditions of practice order and there have been no further concerns raised about your nursing practice. He stated that you had highlighted in your most recent reflective statement that the interim conditions of practice order has restricted you from further strengthening your nursing practice. He submitted that a conditions of practice order, as a substantive sanction in this case, would be disproportionate and a one-year caution order would be the most appropriate and proportionate order to mark the seriousness of your dishonest conduct.

Mr Hussain-Dupre highlighted that although any dishonesty is serious, the panel had found that this was not a deep-seated attitudinal problem nor incapable of remediation. He therefore submitted that a caution order would satisfy the public protection issues in this case. He asserted that the dishonesty in this case was at the lower end of the scale, it occurred quite some time ago, and you have demonstrated sufficient insight into your dishonest conduct. He submitted that a caution order would sufficiently mark the public interest and upholding professional standards in the nursing profession.

Mr Hussain-Dupre submitted that, given the steps you have taken to remediate the concerns and that there have been no further concerns raised about your nursing practice, a suspension order would be wholly disproportionate in this case. He asserted that it would be wholly unfair and detrimental to your nursing practice if a 12-month suspension order, as proposed by the NMC, was imposed on your practice. He submitted that you would be deprived of the opportunity to further strengthen your nursing practice in a safe and secure working environment.

Mr Hussain-Dupre submitted that he agreed with the submissions of Ms. Fergus-Simms that a striking-off order would be wholly disproportionate in this case and that the dishonesty in this case would make a no further action inappropriate. He therefore invited the panel to impose a one-year caution order as the most appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

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.

Since the panel's decision on impairment in April 2026, it had now received a number of testimonials and a completed SIP as well as a further reflection from you. The panel concluded that its earlier concerns that there were no testimonials from your line manager or current employer and the fact that the SIP was not co-signed and dated by you, had now been addressed. The panel also noted that you had further addressed your learning and its application to your clinical practice in your most recent reflection. The panel was now satisfied that the clinical concerns had been remediated.

However, the panel remained of the view that your dishonest conduct had not yet been fully remediated. Although you touched upon the issue of dishonesty, the panel was of the view that the depth of your insight was still incomplete.

The panel identified the following aggravating features:

- Your misconduct placed vulnerable children at risk of suffering harm.
- Your misconduct involved dishonesty and the deliberate breach of the duty of candour
- Your misconduct involved deliberate breaches of the Code.

The panel identified the following mitigating features:

- Early admission to some of the charges.
- You have shown genuine remorse and apologised for your actions.
- You have shown insight into your clinical failings, albeit your insight into your dishonesty is still developing.
- You have practised as a registered nurse under supervision since the incident without any further concerns.
- Evidence of steps taken to remediate some of the concerns through training courses in relevant areas of concern and the positive testimonials made on your behalf.

- You have kept up to date with your area of practice.

The panel first considered whether to take no action but concluded that this would be inappropriate and not proportionate in view of the seriousness of the case. It had earlier decided that there is a risk of repetition, that you breached fundamental tenets of the nursing profession, and that your misconduct would undermine the public confidence in the nursing profession if you were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel next considered a caution order. It carefully considered the submissions of Mr Hussain-Dupre in relation to the imposition of a caution order in this case and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b) 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 took into account that, at the resumption of the hearing on day 13, you had provided an updated and signed reflective statement, an updated SIP dated 20 May 2026 and several positive testimonials from your current employer. However, the panel noted that you have still not yet demonstrated sufficient insight into the impact of your dishonesty on patients, their families, your colleagues, the nursing profession and the wider public.

The panel noted that it had found your dishonest conduct to be a deliberate breach of the professional duty of candour, directly related to patient care and your dishonesty would be seen as deplorable by other members of the profession and the public. The panel was of

the view that a well-informed member of the public, aware of your dishonest conduct in this case, would be very concerned if you were permitted to practise as a registered nurse without restriction. The panel decided that your misconduct was not at the lower end of the spectrum. In view of its findings on misconduct and impairment, the seriousness of the case, the public protection and public interest considerations identified, the panel determined that an order that does not restrict your nursing practice, would not be appropriate nor proportionate in the circumstances. The panel therefore concluded that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be appropriate and proportionate. 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) in which the following factors on when a conditions of practice order may be appropriate are set out:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *….*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *…..*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel was of the view that although the clinical concerns in this case have been addressed through retraining, your dishonest conduct (though not deep-seated) is less easily addressed through retraining alone. The panel determined that a conditions of

practice order would not mark the seriousness of the dishonesty and address the public interest concerns in this case.

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) 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. The panel considered that the following list of circumstances applied in this case and make a suspension order an appropriate sanction:

- *'……*
- *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*
- *……*
- *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 of the view that although your dishonest conduct is attitudinal in nature, there was no evidence before it to indicate any harmful deep-seated attitudinal concerns in this case. It took into account that you have been practising as a registered nurse since the incidents occurred and there was no evidence of repetition of the concerns nor were there any further concerns raised about your nursing practice. It noted that you have actively engaged with the NMC and these proceedings.

The panel considered that you had demonstrated some developing insight into your misconduct, had apologised and shown remorse for your actions. It considered that you had taken steps to strengthen your nursing practice through relevant training courses in the areas of concern and presented evidence of good practice. The panel took into account that you had provided an updated and signed reflective statement; an updated SIP dated 20 May 2026 which you had co-signed and demonstrated that you are taking active steps to remediate the concerns. It was also provided with some recent positive references from senior staff members at your current workplace, where you had been employed since the incidents occurred. It noted that the length of time you were employed provided adequate time for staff to observe both your clinical practice and your character in relation to the issues of honesty and integrity.

However, the panel noted that you were yet to demonstrate sufficient insight into the severity and impact of your dishonest conduct on patients, their families, your colleagues, the nursing profession and the wider public. The panel had also found your misconduct to amount to a serious breach of the fundamental tenets of the nursing profession which brought the nursing profession into disrepute.

For completeness, the panel considered whether a striking-off order would be appropriate in this case and had regard to the following paragraphs of the SG (SAN-3e) with respect to imposing a striking-off order:

- *'Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

Taking account of all the evidence before it, including the evidence of your current good practice, the positive references, the steps you had taken to strengthen your nursing practice, and your developing insight; the panel concluded that a striking-off order would be disproportionate.

Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive and disproportionate in this case to impose a striking-off order. It was of the view that a striking-off order could deprive the public of an experienced nurse who has practised since the incidents occurred without any further concerns, has the potential to further reflect and strengthen her nursing practice as well as return to safe and effective practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Consequently, the panel was satisfied that, in this case, the misconduct is not fundamentally incompatible with remaining on the register and that public confidence in the nursing profession could be maintained if you were not removed from the register.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of six weeks with a review is necessary in order to provide you with an adequate opportunity to demonstrate

evidence of sufficient insight into your misconduct, and that your fitness to practise is no longer impaired.

The panel noted that it was clear from your most recent reflective statement that this process is already ongoing as you stated:

> *'…I fully recognise and accept the seriousness of the findings that were upheld, particularly in relation to failure to complete all required vaccination checks before administering immunisations.*
>
> *This process has made me think much more critically about accountability, professional judgement, and the importance of following procedures fully, even in difficult or pressured circumstances. I now understand more clearly that patient safety systems are in place for a reason and that even when there are practical difficulties, such as technical problems or time pressures, these cannot compromise safe practice.*'

In addition, the panel noted that you have practised safely and without any concern since the incidents occurred. As evidence of this, you have provided several testimonials from colleagues and managers that demonstrate your improved practice in four key areas: clinical competence, honesty, professionalism and your empathy towards patients.

The panel noted that your dishonest conduct arose from one incident rather than from a repeated pattern of dishonesty, and you have shown deep remorse for your actions. It was of the view that, now that you have openly acknowledged your dishonesty, a suspension period of six weeks with a review would be sufficient to allow for further reflection and remediation. The panel decided that a twelve-month suspension order would be excessively punitive and that such a long period of time may lead to a degradation of your clinical skills. In addition, the panel considered that a member of the public would deem a suspension order an appropriate mark of the seriousness of the misconduct but would

prefer to see a nurse, who has strengthened her practice, return to practice as soon as possible.

The panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse. The panel concluded that a period of six-week suspension with a review would be sufficient to uphold public confidence and mark the seriousness of your dishonest conduct.

The panel noted the hardship a suspension order will inevitably cause you, however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

Before 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:

- An updated reflective statement:
    a) demonstrating more in-depth insight into the gravity and impact of your dishonesty on patients, your colleagues, the nursing profession and the public.

    b) demonstrating more in-depth insight into the lessons you have learnt from the training courses you had undertaken, especially, on the duty of candour.

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.

Submissions on interim order

The panel took account of the submissions made by Ms Fergus-Simms. She submitted that given the panel's earlier decisions, an interim suspension order for a period of 18 months is necessary in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. She submitted that not to impose an interim suspension order would be inconsistent with the panel's earlier decisions. She submitted that any well-informed member of the public would be concerned if no interim order was imposed to restrict your nursing practice pending any appeal. In the circumstances, public confidence in the nursing profession would be seriously undermined given the panel's decisions on impairment and sanction.

Mr Hussain-Dupre noted that the panel had imposed a suspension order for a short period and it had clearly outlined the reasons for such a decision. He submitted that although you could manage a six-week period of absence from your current workplace, the imposition of an interim suspension order would effectively lead to the total of a ten-week suspension, which would likely lead to a dismissal from your current employment.

Mr Hussain-Dupre highlighted that, prior to the imposition of the substantive order, you have been subject to an interim conditions of practice order which you had been in full

compliance with. He submitted that in order to preserve the panel's six-week suspension order and to achieve the objective of providing you with the opportunity to reflect further on your dishonesty, an interim conditions of practice order would be both fair and just in the circumstances. He submitted that an interim conditions of practice order would satisfy the public interest elements identified by the panel in its earlier decisions. He highlighted that the panel had stated in its decision on sanction that it is in the public interest to not deprive the public of a practitioner who is capable of full remediation and demonstrating further insight. He submitted that the most appropriate and practical way to achieve these objectives would be to facilitate you still working as a registered nurse. He therefore invited the panel to impose an interim conditions of practice order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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 took into account that it had earlier stated in its decision on sanction that a suspension order for a period of six weeks with a review is necessary. This is to provide you with an adequate opportunity to demonstrate more in-depth insight into your misconduct and mark the seriousness of your dishonest conduct. Whilst there remains a risk of repetition, the panel noted that, since the incidents occurred, there have been no further concerns raised about your conduct. It also noted that your dishonesty was not deep-seated and arose from a single incident. Therefore, the panel considered any future risk to be low.

The panel balanced the low risk against the likely impact of imposing an interim order and considered that there was a real possibility that you could lose your employment which has been both supportive and constructive in your remediation. The purpose of the substantive order is to enable you to return to practice once you have demonstrated full

remediation and to mark the seriousness of the past misconduct. Any loss of employment at this stage would be disproportionate and it would defeat the intended purpose of the sanction.

The panel determined that public confidence and the reputation of the nursing profession and the NMC as regulator would not be undermined or damaged if an interim order is not imposed. It considered that the substantive order would satisfy the public interest in this case. The panel concluded that a reasonable and fully informed member of the public, aware of all of the information before the panel, would not be concerned if you were allowed to continue to practise without restrictions until the substantive order comes into effect.

Consequently, the panel did not find it necessary to make an interim order on the public protection ground nor is it otherwise in the public interest.

If no appeal is made, then the substantive suspension order would come into effect 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.