Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
12 – 22 October 2026
2, 5, 10 and 11 November 2026

10 George Street, Edinburgh, EH2 2PF
&
Virtual Hearing

Name of Registrant:	Michael Rotgans
NMC PIN:	02H0117O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adulting Nursing (Level 1) – 2 August 2002
Relevant Location:	Herefordshire
Type of case:	Misconduct
Panel members:	Michaela McAleer (Chair, Lay member) Karen Gardiner (Registrant member) Gary Trundell (Lay member)
Legal Assessor:	Graeme Henderson (12 – 22 October 2026) Robin Hay (2, 5, 10 and 11 November 2026)
Hearings Coordinator:	Catherine Blake (12 – 22 October 2026) Jumu Ahmed (2, 5, 10 and 11 November 2026)
Nursing and Midwifery Council:	Represented by Safeena Rashid, Case Presenter
Mr Rotgans:	Present and not represented in the hearing
Facts proved by admission:	Charges 3.3, 4.1 and 4.2
Facts proved:	Charges 2.1, 5.3 and 6
Facts not proved:	Charges 1, 2.2, 3.1, 3.2, 5.1, 5.2, 7.1 and 7.2
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**

Interim order:	**Interim suspension order (18 months)**
Final outcome:	**FTP impaired - suspension order**

Details of charge

That you a registered nurse:

1. On 18 May 2023, failed to have a witness present when disposing of medication. **[NOT PROVED]**

2. On 26 June 2023:

   2.1 Failed to label a syringe containing Midazolam. **[PROVED]**

   2.2 Incorrectly placed a syringe into your left breast pocket. **[NOT PROVED]**

3. On 7 July 2023, failed to:

   3.1 Have a witness present when disposing excess Midazolam. **[NOT PROVED]**

   3.2 Have a witness present when discarding the syringe into the sharps bin. **[NOT PROVED]**

   3.3 Use a denaturing product / gel pad when disposing excess Midazolam. **[PROVED BY ADMISSION]**

4. On 14 June 2024, failed to:

   4.1 Have a second nurse / person present when opening the controlled a cupboard. **[PROVED BY ADMISSION]**

   4.2 Have a second nurse / person present when handling controlled drugs after opening the controlled drugs cupboard. **[PROVED BY ADMISSION]**

5. On 14 June 2024, failed to:

5.1 Inform Colleague A as to how an ampoule of Midazolam 5mg had broken / smashed. **[NOT PROVED]**

5.2 Document in the controlled drugs book that an ampoule of Midazolam 5mg had been broken / smashed. **[NOT PROVED]**

5.3 Escalate / report to management that an ampoule of Midazolam 5mg had been broken / smashed. **[PROVED]**

6. Your actions in charges 5.1 and/or 5.2 and/or 5.3 were dishonest in that you sought to conceal how the Midazolam 5mg ampoule broke / smashed. **[PROVED]**

7. On or around 7 July 2023, incorrectly signed the controlled drugs register by signing as a the *'responsible person'* and *'witness'* in relation to the following entries:

7.1 Fentanyl 75mcg timed at 12.38. **[NOT PROVED]**

7.2 Midazolam 1mg timed at 16.20. **[NOT PROVED]**

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

Background

The charges arose while you were employed by InHealth Limited ('InHealth') as a mobile cardiac nurse. You had been this role since 9 August 2021. This involved working with portable units that were moved from hospital to hospital when contracts were completed. This role involved working across the UK and could include working in the north of Scotland at the start of a week and finish in the south of England by the end of that week. Therefore, large distances were travelled by InHealth staff and each destination had local policies that may be subtly different.

Between 2 and 10 July 2023, complaints were received in relation to three incidents at two different workplaces, Worthing Hospital and St Peter's Hospital:

- On 18 May 2023, you allegedly disposed of a controlled drug prior to completion of a procedure, and out of sight of a witness rather than using the sharps bin closest to you where a witness could have easily seen your actions.
- On 26 June 2023, you were allegedly witnessed drawing 2mls of Midazolam into an unlabelled syringe before allegedly placing the syringe in your pocket rather than placing the syringe into a dish with the other drugs.
- On 7 July 2023, you allegedly did not have a witness present when disposing of excess Midazolam and disposed of it improperly.

As part of a local investigation into these incidents, it was also found, upon review of the controlled drugs book, that you had incorrectly signed as both the responsible person and witness on more than one occasion. Your actions were found to be in breach of InHealth's management of controlled drugs standard operating procedure. A disciplinary procedure was undertaken following which you were issued with a final written warning on 21 September 2023.

A further issue arose on 14 June 2024 in relation to your work at Hereford County Hospital (Hereford Hospital). Following investigation into two unaccounted for ampoules of Midazolam, it was found that you had accidentally broken these, but had failed to report both breakages and obtain witnesses. You were subsequently suspended on 18 June 2024.

A disciplinary hearing was held on 18 July 2024. By email letter dated 29 July 2024 you were dismissed by InHealth.

Nature of the hearing

Following your dismissal you moved to New Zealand. Despite the fact that you live in New Zealand the NMC decided not to list this case as a virtual hearing. The NMC was well aware that you would not be able to travel to the UK. None of the witnesses were scheduled to attend the hearing in person. There was no obvious advantage in

holding a hearing with the panel sitting in Edinburgh when all of the witnesses and you (a Registrant Litigant in person) were attending remotely.

Armed with the knowledge that there was a 12-hour time difference there ought to have been adjustments made to take into account the fact that, if normal hours were kept you would be starting a hearing at 9:00pm and concluding at 5:30am.

The panel bore in mind that you were becoming increasingly tired and curtailed the hearing whenever it seemed obvious that you would struggle to cope with further testimony being adduced.
This had a knock-on effect with witnesses who had to be rescheduled at short notice.

Decision and reasons on application to adjourn for one day

[PRIVATE].

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made full admissions to charges 3.3, 4.1 and 4.2.

The panel therefore finds these proved in their entirety, by way of your admissions.

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

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

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

- Jodene Da Silveira: Registered nurse at St Peter's Hospital at the time of the charges

- Patricia Laws: Colleague A/Registered nurse at Hereford Hospital at the time of the charges

- Nkululeko Nxumalo: Lead Nurse and Education Lead at InHealth at the time of the charges

- Laura Kendall: Operations Manager at InHealth at the time of the charges

- Joanna Oddie: Clinical Quality Nurse Specialist at InHealth

- Shelly Best: Mobile Cardiac Nurse at InHealth at the time of the charges

The panel heard live evidence from the following witness called on your behalf:

- Rachel Fernback: Registered nurse

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. He referred to *R (Dutta) v GMC* [2020] EWHC 1974 (Admin) and reminded the panel that the proper approach to making findings in fact was to base factual findings on inferences drawn from documentary evidence and known or

probable facts. He reminded the panel a witness, however honest, rarely persuades a judge that his present recollection is preferable to that which was taken down in writing immediately after the incident occurred.

It considered the witness and documentary evidence provided by both the NMC and you. Although there was some evidence of what was before your disciplinary hearings the panel was not tasked to conduct a review of these hearings. The only relevance this material had was for the panel to consider what was said by various witnesses during the investigation and the contemporaneous documentary evidence that was obtained.

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

Charge 1

> *'That you, a registered nurse, on 18 May 2023, failed to have a witness present when disposing of medication.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Shelly Best, Nkululeko Nxumalo, and you. This included InHealth's 'Local Policy for the Storage, Administration and Disposal of Controlled Drugs (CDs)' (Worthing CD Policy), and the informal investigation call notes with Ms Best dated 11 July 2023.

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to have a witness present when disposing of medication.

Although the charge does not reference the site of the incident, the panel considered the evidence of Mr Nxumalo that this incident occurred at Worthing Hospital. The

panel noted that it has been accepted by you that you were working at Worthing Hospital at the time of the charge.

The panel therefore considered the following from InHealth's Worthing CD Policy which was applicable to your work at Worthing Hospital:

> ***'Discarding Used Controlled Drug Ampoules***
> *At the end of the procedure, two registered professionals, one of which must be a*
> *InHealth RN will:*
> - *Witness and check the amount of CD (fluid) remaining in the syringe.*
> - *Witness the squirting of the remaining CD fluid (less than 5mls) into the sharps bin containing a absorbent gel pad/sachet. Any remaining CD fluid greater than 5mls must be discarded using an absorbent gel pad/sachet or denaturing kit rendering it irretrievable.*
> - *Sign the CD register.'*

On this basis, the panel was satisfied that you had a duty to ensure there was a witness present when disposing of medication.

The panel next considered the following from Ms Best's written statement:

> *'I remember seeing Michael stooped over the sharps bin. Ordinarily, you'd lean over it. It was a tall sharps bin, but it was not in my view with his position as I was at the foot end of the table and the bin was at the head end and blocked. Normally, a nurse would reach in and push the excess drugs into the sharps and drop the syringe into the bin. It puzzled me why Michael would stoop over it and hide the disposal.'*

However, the panel also noted the following from the informal investigation call notes with Ms Best dated 11 July 2023:

'Did you sign for the disposal of this CD despite your concerns about its disposal?

SB reports that she trusted that MJR had disposed of the drug as he stated he had. She did not witness the drug go into the sharps bin.'

The panel did not have the benefit of seeing this entry in the controlled drugs book.

During oral evidence, and in response to panel questions, Ms Best could not clarify why she signed as a witness when the medication was allegedly disposed of out of her view.

The panel was also concerned that Ms Best did not make a contemporaneous complaint regarding this issue. The issue was only raised after the events that form charge 2.

The panel then considered your own evidence that the disposal occurred in a room with other people in it, and that you announced you were discarding the medication before doing so. You said you believed you had appropriately disposed of the medication.

The panel found it difficult to accept your oral evidence as a credible or reliable recollection of events. When you were first asked about this allegation it was on 11 July 2023. You were asked to comment on a routine procedure which took place some 8 weeks before. You were asked whether the witness (Ms Best) had oversight of the disposal. You were not provided with any documents that may have assisted in jogging your memory. The panel found it credible that you were unable to remember when asked about what was alleged. The panel was unable to accept that you were able to provide confident, detailed evidence as time went on.

The panel noted that both you and Ms Best confirmed that other people were present at the time but did not have the benefit of hearing from any of these other people who may have witnessed the disposal. The panel noted Ms Best's oral evidence and that she could not recall her attention being drawn to the disposal but was clear that the disposal was hidden.

The panel also bore in mind the following from Ms Best's statement:

> '*I have limited recollection of the incidents, so I will be referring to my original accounts of the incidents, which I will exhibit throughout my statement.'*

The panel determined that there are two different recollections of this incident from you and Ms Best. The panel was not satisfied with the reliability of your recollection, nor Ms Best's, in relation to this charge. The panel could not confidently accept, on the evidence before it, that either version of events was reliable, therefore it was not satisfied that it could find that you failed to ensure the disposal of the medication was witnessed.

The panel decided that the NMC had failed to discharge its burden of proof for this charge, and therefore found it not proved.

Charge 2.1

> *'That you, a registered nurse, on 26 January 2023:*
>
> *2.1 Failed to label a syringe containing Midazolam.'*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Best and you. This included InHealth's 'Standard Operating Procedure for the Management of Controlled Drugs at St Peter's Hospital' (St Peter's CD Policy).

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to label the syringe.

Although the charge does not reference the site of the incident, the panel noted that it has been accepted by you that you were working at St Peter's Hospital at the time of the charge.

The panel therefore considered the following from InHealth's St Peter's CD Policy, which was applicable to your work at St Peter's Hospital:

> ***'9.1. Checking and Preparing a Controlled Drug for Patient Administration***
> *Two InHealth RNs or one InHealth RN and one other registered health professional will:*
>
> - *Check/count all stocked ampoules of the required CD prior to the removal of one*
> - *ampoule for administration.*
> - *Check the ampoule dose, name and expiry date*
> - *Witness the CD preparation*
> - *Witness the labelling of the prepared CD*
> - *Prior to administration, check the CD medicine against the prescription in the patient's medicine chart or ICP to confirm the patients name, hospital number and date of birth (against the patient's name band), dose required, route and frequency.*
> - *Witness the administration of the prepared CD'*

On this basis, the panel was satisfied that you had a duty to label a syringe containing Midazolam prior to administration to the patient.

In oral evidence you accept that you administered Midazolam in an unlabelled syringe. You said that this was because there were no stickers readily available, you did not declare this out loud, rather you stated that you did not want to distract from the procedure. You stated that in order to put the patient first you prioritised administration of the Midazolam and then labelled the syringe appropriately after the fact.

While you provided an explanation for your reasons for not labelling it, the panel considered that this does not go to the charge. The panel was satisfied on the evidence before it that you failed to label a syringe containing Midazolam, and accordingly found this charge proved.

Whether this constitutes misconduct is to be determined at a later stage.

Charge 2.2

'That you, a registered nurse, on 26 January 2023:
2.2 Incorrectly placed a syringe into your left breast pocket.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Shelly Best and you.

The panel paid close attention to the wording of the charge and bore in mind the use of the word 'incorrectly'. The panel was satisfied that in order for this charge to be found proved you must have placed a syringe in the left breast pocket of a lead apron, and that this was an incorrect thing to do.

The panel noted the following from Ms Best's statement:

'I observed a syringe sticking out of his lead pocket when he turned around. Michael was unaware that the syringe end was visibly sticking out of his pocket. I saw him occasionally pushing the syringe further into his lead pocket using the side of his arm during the procedure. I had the impression that it was the Midazolam because it was the tail end of a 5ml syringe which appeared to be in use, and not a Posiflush 10ml syringe. This, however, is unusual; keeping an IV drug being administered during the procedure in your lead pocket is an unusual place to place an in-use syringe. I can't confirm that it was definitely the Midazolam (in-use) syringe as it was only the end of the

syringe I saw in his lead pocket, and I was not able to see whether the syringe had liquid in it.'

The panel considered your evidence that storing syringes and/or ampoules of emergency drugs for ease of access is part of your usual clinical practice. It also heard from you that you would never put syringes containing controlled drugs into this pocket as they need to be visible to all clinicians throughout the procedure.

The panel has seen no evidence as to the contents of the syringe, nor has it been provided with any reliable evidence that keeping a syringe in the pocket of the lead jacket is an incorrect thing to do.

Accordingly, the panel found this charge not proved.

Charge 3.1

'That you, a registered nurse, on 7 July 2023 failed to:
3.1 Have a witness present when disposing excess Midazolam.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Jodene Da Silveira, Nkululeko Nxumalo and you. This included InHealth's St Peter's CD Policy and the controlled drugs log for 7 July 2023.

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to have a witness present when disposing of medication.

Although the charge does not reference the site of the incident, the panel considered the evidence of Ms Da Silveira that this incident occurred at St Peter's Hospital. The panel noted that it has been accepted by you that you were working at St Peter's Hospital at the time of the charge.

The panel therefore considered the following from InHealth's St Peter's CD Policy which was applicable to your work at St Peter's Hospital:

> ***'9.3. Checking and Discarding Used Controlled Drug Ampoules***
> *At the end of the procedure, two RNs, one of which must be an InHealth RN or one InHealth RN and one other registered health professional will:*
>
> - *Witness and check the amount of CD (fluid) remaining in the syringe.*
> - *Witness the squirting of the remaining CD fluid (less than 5mls) into the sharps bin.*
> - *Any remaining CD fluid greater than 5mls must be discarded using an absorbent gel pad or denaturing kit rendering it irretrievable.*
> - *Count the empty CD ampoules to ensure they correlate to the amount used/wasted*
> - *If only part of an ampoule is administered to the patient, both the amount administered, and the amount wasted must be recorded in the CD register.*
> - *Sign the CD register.'*

On this basis, the panel was satisfied that you had a duty to ensure there was a witness present when disposing of medication.

The panel next considered the following from Ms Da Silveira's witness statement:

> *'I was working with Michael on 7 July 2023. I walked into theatre and saw that he was behind a blind spot; Michael was positioned in an area of the laboratory that is out of the field of view from whoever is in the control room and is behind the theatre screen. He was also out of the field of view of the operator, radiographer and scrub nurse, but from my angle I could clearly see him dispose of Midazolam, which is a controlled drug, into a syringe wrapper. The correct procedure for disposing of controlled drugs involves 2 nurses witnessing the drug being discarded into a sharps bin. The drug must be expelled out of the syringe*

and denatured. Instead, I witnessed Michael expel the Midazolam into the wrapper and discard of the syringe in the sharps bin.

'When Michael saw me, after having expelled the drug into the wrapper, I said "let me take that wrapper for you"; this is when he acknowledged that I was there. He was very surprised and began acting very defensive. He initially said, "no, no let me do it". However, I insisted and told him he appeared to be busy whereas I could be witnessed by another nurse, Shelly Best ("Shelly"), who was scrubbing in. The wrapper and contents were disposed of in the sharps bin and witnessed by Shelly.'

However, the panel bore in mind the evidence it has seen of the controlled drugs book and the entry from 7 July 2023. It noted that, despite Ms Da Silveira's intervention in relation to the disposal of Midazolam, there is no record of Ms Da Silveira signing as either the witness or the responsible person on that date.

The panel determined that there are three different recollections of this incident from you, Ms Da Silveira and Ms Best. The panel could not confidently confirm, on the evidence before it, which one was correct and therefore was not satisfied with the evidence that you failed to ensure the disposal of the medication was witnessed.

The panel decided that the NMC had failed to discharge its burden of proof for this charge, and therefore found it not proved.

Charge 3.2

'That you, a registered nurse, on 7 July 2023 failed to:

3.2 Have a witness present when discarding the syringe into the sharps bin.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Jodene Da Silveira, Nkululeko Nxumalo and you. This included InHealth's St Peter's CD Policy.

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to discard the syringe into the sharps bin.

As above, the panel was satisfied that this incident occurred at St Peter's Hospital. The panel therefore the following from InHealth's St Peter's CD Policy:

> ***'9.3. Checking and Discarding Used Controlled Drug Ampoules***
> *At the end of the procedure, two RNs, one of which must be an InHealth RN or one InHealth RN and one other registered health professional will:*
> - *Witness and check the amount of CD (fluid) remaining in the syringe.*
> - *Witness the squirting of the remaining CD fluid (less than 5mls) into the sharps bin.*
> - *Any remaining CD fluid greater than 5mls must be discarded using an absorbent gel pad or denaturing kit rendering it irretrievable.*
> - *Count the empty CD ampoules to ensure they correlate to the amount used/wasted*
> - *If only part of an ampoule is administered to the patient, both the amount administered, and the amount wasted must be recorded in the CD register.*
> - *Sign the CD register.'*

The panel noted that there is no requirement for a syringe to be discarded into a sharps bin. It also bore in mind and accepted your oral evidence that syringes are not to be discarded into the sharps bin, and this is standard practice. The purpose of a sharps bin is to dispose of objects such as needles and ampules. An empty syringe is not a sharp.

The panel determined that you did not have a duty to dispose of the syringe into the sharps bin, and therefore found this charge not proved.

Charge 5.1

'That you, a registered nurse, on 14 June 2024 failed to:

5.1 Inform Colleague A as to how an ampoule of Midazolam 5mg had broken / smashed.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Patricia Laws and you. This included InHealth's 'Standard Operating Procedure for the Management of Controlled Drugs in the Angiography Suite, Hereford County Hospital' (Hereford CD Policy).

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to inform Colleague A, Patricia Laws, of how the ampoule was broken.

The panel had regard to InHealth's Hereford CD Policy and noted that there is nothing in the policy that requires Ms Laws to be informed of how a controlled drug ampoule was broken or smashed.

Accordingly, the panel decided there was no evidence before it that you had a duty to inform Ms Laws how an ampoule of Midazolam had broken. The panel therefore find this charge not proved.

Charge 5.2

'That you, a registered nurse, on 14 June 2024 failed to:

5.2 Document in the controlled drugs book that an ampoule of Midazolam 5mg had been broken / smashed.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Patricia Laws and you. This included Hereford CD Policy and the controlled drugs book.

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order for this charge to be found proved you must have had a duty to document in the controlled drugs book that an ampoule of Midazolam had been broken or smashed.

As above, the panel noted that there is nothing in the Hereford CD Policy that required you to document that an ampoule of Midazolam had been broken or smashed.

Accordingly, the panel decided there was no evidence before it that you had a duty to document in the controlled drugs book that an ampoule of Midazolam had been broken or smashed. The panel therefore find this charge not proved.

Charge 5.3

> *'That you, a registered nurse, on 14 June 2024 failed to:*
>
> *5.3 Escalate / report to management that an ampoule of Midazolam 5mg had been broken / smashed.'*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Patricia Laws, Joanna Oddie and you. This included Hereford CD Policy, the controlled drugs book, and the disciplinary hearing notes dated 18 July 2024.

The panel paid close attention to the wording of the charge and bore in mind the advice of the legal assessor regarding 'failure'. The panel was satisfied that in order

for this charge to be found proved you must have had a duty to escalate or report to management that an ampoule of Midazolam had been broken or smashed.

As above, the panel was satisfied that this incident occurred at Hereford Hospital. The panel therefore referred to the following from InHealth's CD Policy:

> ***'6.5 All InHealth Staff***
>
> - *Responsible for reading and following the requirements of this SOP.*
> - *…*
> - *Responsible for reporting any incidents, near miss or concerns to their line manager and via the Sentinel and Datix reporting system.'*

On this basis, the panel was satisfied that you had a duty to escalate or report to management that an ampoule of Midazolam had smashed.

The panel has seen no evidence of an incident being reported by you. The panel accepted the evidence of Mr Nxumalo who was present with the Lead Mobile Cardiographer when they opened the drugs cupboard on the morning of 17 June 2024 and discovered a discrepancy in the stock balances. At the time this discrepancy was escalated and a local investigation commenced. During this investigation photographs of this broken ampoule were taken and submitted as evidence. By reviewing this evidence, the panel was able to identify on the day in question there were two separate ampoules broken, one which was shown to Patricia Laws, and a second which you state in your evidence you were unaware of.

It is your evidence that you dropped a box of Midazolam ampoules and stepped on them accidentally. You said that you did not escalate to management nor complete an incident form because you did not realise that an ampoule in the box had smashed. You do not dispute that the ampoules in the box were broken.

You accepted that you ought to have escalated this incident, but it is your evidence that not doing so was an oversight and not a deliberate action.

In oral evidence you said that, as a nurse of 30 years' experience, you would be qualified to write a drugs policy. However, when questioned you could not explain to the panel why you did not fully check the contents of the box or the policy, nor escalate or report to management that there had been a near miss.

It is your evidence that, at the first instance, you could not remember all the details of the incident. However, prior to your disciplinary hearing, you said you were in possession of everything you needed to recall the events of 14 June 2024.

In the disciplinary hearing notes, you were asked about how the boxes fell onto the floor:

> *'JO – so it was up on the workbench?*
> *MR – it's a mobile trolley with drawers*
> *JO – ok you've taken everything out to try and get this piece of paper back in*
> *MR – yes, I'd taken everything out, then realised no one was going to be here until Monday, lets[sic] make it easy for the people on Monday and reorganise*
> *JO – so you're on your own, and you decide to reorganise the controlled drugs*
> *MR – yes, moving around controlled drugs. I know, that's why were here*
> *JO – so the drugs were on the trolley, it then fell off. So, you actually stepped on the box?*
> *MR – yes, it fell on the floor and as I stepped back, I stood on it. I opened the box and when I looked at the ampoules, the looked fully intact.*
> *JO – but it was so damaged how did you not see it*
> *MR – I looked at the top one, and it looked fine*
> *JO – so you stepped on a box of drugs. Can you tell me what you should have done?*
> *MR – I should have got Pat, documented it all correctly and raised a datex[sic]'*

However, in oral evidence you said Ms Laws had gone home, that the trolley had been locked away and that the reason for removing boxes was because she had put them in an unusual place in the cupboard. You did not mention that you had removed the boxes in order to put the piece of paper back. The panel accepted your

oral evidence that you had significant interaction with the box housing the broken ampoule, which included removing it from the cupboard, treading on it, and then ripping the side of the box off and placing this back in the controlled drugs cupboard.

The panel did not accept that you had provided an accurate picture of what went on when you were alone after Ms Laws had left the cath lab. The smashed ampoule would have leaked 5ml of fluid. You claim to have opened the box and not seen the breakage despite tearing off one end. The fact that you had stood on the box made it more likely that one or more ampoules were broken. The panel determined that it was more likely than not that you knew that an ampoule was broken.

Taking into account your acceptance that you ought to have reported this incident to management, the panel was satisfied that this charge is found proved.

Charge 6

> *'Your actions in charges 5.1 and/or 5.2 and/or 5.3 were dishonest in that you sought to conceal how the Midazolam 5mg ampoule broke / smashed.'*

This charge is found proved.

In reaching this decision the panel took in to account its decisions at charges 5.1, 5.2 and 5.3.

The panel bore in mind your evidence that, at the time, you did not know that the ampoules had been smashed after you accidentally stepped on the box. You maintain that you were not acting dishonestly and did not seek to conceal that the ampoule had broken. The panel did not accept this evidence. The panel bore in mind that you are of good character but considered that the facts and circumstances pointed towards it being inherently likely that you sought to conceal the breakage.

The panel began to consider what your state of mind was in the context of this charge and that at the time of the incident you had received a final written warning. Earlier in the day you also had not highlighted to a doctor that an ampoule of

Midazolam had broken. You then had to engage Ms Laws in the controlled drugs count and explain about the previous broken ampoule, after which she admonished you for having opened the cupboard without her being present.

At the time that the second ampoule was broken you informed the panel whilst tidying up for the day alone you identified a loose controlled drugs page on the floor. You went ahead and opened up the controlled drug cupboard again without a witness. This was not in line with policy.

There was therefore a strong motivation for you not to report the incident.

If you reported the incident your employers would find out about: your opening the cupboard twice without a witness; that you had already broken one ampoule and had broken another whilst handling CDs without a witness.

On the balance of probabilities, considering your admitted behaviour in light of the context of the incident, the panel was satisfied that it was highly plausible that your failure to report was to conceal that the ampoule was broken. It noted that your account of this incident has changed over time and concluded it was more likely than not that your actions at charge 5.3 were to conceal how the ampoule was broken and was therefore dishonest.

The panel considered whether in light of that state of mind your actions would be considered dishonest in the minds of ordinary decent people. It formed the view that your actions would be considered to be dishonest.

Accordingly, the panel found this charge proved.

Charge 7

> *'That you, a registered nurse, on or around 7 July 2023, incorrectly signed the controlled drugs register by signing as a the 'responsible person' and 'witness' in relation to the following entries:*
>
> *7.1 Fentanyl 75mcg timed at 12.38*

7.2 Midazolam 1mg timed at 16.20'

These charges are found NOT proved.

The panel noted that the evidence underpinning charges 7.1 and 7.2 is the same. It considered the issue of whether you had incorrectly signed in the round.

In reaching this decision, the panel took into account the oral and documentary evidence of Nkululeko Nxumalo, Shelly Best and you. This included InHealth's St Peter's CD Policy, and the controlled drugs register.

The panel paid close attention to the wording of the charge and bore in mind the use of the word 'incorrectly'. The panel was satisfied that in order for this charge to be found proved you must have signed both as the 'responsible person' and the 'witness' in the controlled drugs register, and that this was an incorrect thing to do.

The panel first considered the entries in the controlled drug book, and noted that your signature appears as both the responsible person and the witness on the dates and times in question, and for the controlled drugs as charged.

The panel also considered the following from Mr Nxumalo's statement:

> *'During the preliminary investigation, we looked at Michael's entries in the controlled drugs book. This was where it was seen that on at least 1 occasion he had written his name as the person carrying out the task and the person witnessing the task …'*

In oral evidence you also accepted that you signed in both columns.

The panel was satisfied that you signed the drugs register as both the responsible person and the witness. However, on both occasions, there was always another signature for the relevant entry.

However, regarding whether this was correct or not, the panel was not provided with any policy specifically stating that double signing is prohibited. The panel also considered the oral evidence of Mr Nxumalo, who was your line manager at the time. He stated that this double signing is '*not typical practice but I have seen it before*'. He also said that there could be a reason behind such an occurrence. On this basis, the panel considered that it did not have sufficient evidence to satisfy itself that your actions were incorrect in signing the controlled drugs register as both the responsible person and the witness.

Accordingly, these charges are found not proved.

Decision and reasons on interim order

As the hearing is going part-heard, the panel considered whether an interim order was necessary pursuant to Rule 32(5). It invited submissions from the parties.

Ms Rashid submitted that the NMC was not seeking an interim order. She submitted that this case has been ongoing for a long time, and that on 4 September 2026 a panel of the Fitness to Practise Committee revoked the interim order that had previously been in place. She also noted that you currently reside in New Zealand. Ms Rashid submitted that it was a decision for the panel whether an interim order was currently necessary.

You provided a history of your interim order. You informed the panel that you are currently working full time as a District Nurse since early August 2026 in New Zealand with no concerns raised regarding your practice. You informed the panel that while you intend to return to the UK, this would likely not be for at least a year. You submitted that an interim order was not necessary.

The panel heard and accepted the advice of the legal assessor.

Having heard the submissions of the parties, and noting that the interim order was recently revoked, the panel decided not to impose an interim order.

The panel bore in mind its decisions on the facts and that many of the charges have now fallen away. The panel considered this impacts on the concerns around whether there is a pattern of behaviour. The panel also considered that you currently reside in New Zealand. In all the circumstances the panel was satisfied that it is extremely unlikely that you would return to work as a registered nurse in the UK before the hearing resumes and concludes. The panel was not satisfied than an order was necessary for the protection of the public. The high bar of public interest has not been met. Imposing such an order was not in your own interest.

Therefore, the panel was not satisfied there was a compelling reason to impose an interim order in this case.

That concludes this determination.

The hearing resumed on 2 November 2026.

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.

Case Presenter's submissions on misconduct and impairment

Ms Rashid submitted that those found proved, taken individually and together, amounted to misconduct. She said that misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances (*Roylance v GMC*). The conduct must be serious (*Nandi v GMC*), and there is no burden or standard of proof at this stage, and that it was a matter for the panel's judgment.

Ms Rashid referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and invited the panel to consider the conduct against the standards in the Code, bearing in mind that a breach of the Code does not automatically amount to misconduct.

Ms Rashid submitted that, in relation to record keeping and communication**,** the panel found that you did not appropriately record what had happened in relation to the second broken ampoule and left it to colleagues to discover after the weekend had passed. She submitted that accurate and timely records are fundamental to patient safety because colleagues rely on them to know what medication is available, where it is, and what had happened to it. Ms Rashid further submitted that this was a breach of paragraph 10 of the Code (keep clear and accurate records) and of paragraph 8 (work cooperatively), in particular 8.2, which refers to effective communication with colleagues.

In relation to duty of candour, Ms Rashid submitted that paragraph 14 of the Code is engaged. Paragraph 14 requires nurses to be open and candid. She said that she accepts that this breach did not occur in the course of administering medication to a patient. However, that it still concerned medication in a clinical setting. She submitted that medication that is unavailable or inappropriately stored can, potentially, disrupt the treatment of patients. She further submitted that the

seriousness of the breach lies in that potential for harm, and in the failure to be open with colleagues who needed to know.

In relation to upholding the reputation of the profession: Ms Rashid submitted that paragraph 20 was engaged; paragraph 20 requires nurses to uphold the reputation of the profession at all times. Paragraph 20.2 requires them to act with honesty and integrity, and to make sure their behaviour at all times justifies the public's trust in them and the profession. She submitted that there was a clear finding of dishonesty among the proved charges, and dishonesty is a serious concern. She further submitted that you had many opportunities to tell colleagues what had happened, including at SWARM meeting on 18 June 2024, but chose not to do so and maintained a false position. She submitted that this was not a single lapse or a momentary error, but a sustained failure to be honest over a period of time, in a setting where colleagues were relying on you.

Ms Rashid submitted that the charges found proved fall seriously short of the standards expected by fellow practitioners and therefore amount to misconduct.

Ms Rashid moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Rashid submitted that your fitness to practise is currently impaired. She submitted that, as with misconduct, impairment is not defined in legislation. She referred the panel to the NMC's guidance at DMA-1, which states that impairment means that a professional on the NMC's register cannot practise safely and effectively without restrictions.

Ms Rashid reminded the panel of the factors set out *Grant*. She referred the panel to the four questions to be considered: whether the registrant 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; whether he has in the past brought, and/or is liable in the future to bring, the profession into disrepute; whether he has in the past breached, and/or is liable in the future to breach, one of the fundamental tenets of the profession; and whether he has in the past acted dishonestly, and/or is liable in the future to act dishonestly.

Ms Rashid acknowledged that, up to the point of referral to the NMC, you had practised without any regulatory concerns. However, she highlighted the proved charges demonstrate you had now acted to put patients at unwarranted risk of harm and were likely to do so in the future due to your lack of insight and/or strengthened practice.

Ms Rashid accepted that, taken individually, the charges proved or found proved by way of admission might not amount to impairment. However, she submitted that your justification of your actions in not adhering to policy, particularly in relation to charge 2.1 (failing to label a syringe) and charge 4 indicated a potential attitudinal concern. She submitted that although you knew what the policies where you chose not to follow them.

Ms Rashid reminded the panel that there was a clear finding of dishonesty and submitted that dishonesty was a serious concern. She said that valuable resources were taken up investigating what had happened, which could have been avoided if you had told your colleagues the truth in the first place. She said that you had the opportunity to tell colleagues what had happened, including at SWARM meeting on 18 June 2024 and chose not to. Instead, you chose to maintain the position that you are unaware a second ampoule of Midazolam was smashed when the box fell from the cupboard at the end of the day when you were alone with this controlled drug cupboard open.

Ms Rashid submitted that your conduct during the incident currently demonstrated a lack of insight. She said that you did not take steps to rectify the dishonesty but instead chose to maintain it. She noted that you were working in New Zealand as a district nurse, but that you did not provide any information about any steps you had taken to strengthen your practice or to address the concerns. She further submitted

that, at the time of the charges, you were working as a senior nurse with little or no supervision and that you were trusted as a senior nurse. She submitted that the dishonesty related to medication, which was not something trivial.

Ms Rashid submitted that your fitness to practise is currently impaired on the ground of public protection, because of the risk you pose to the public as a result of your lack of insight and remediation. She also submitted that a finding of impairment was required to protect public confidence in the profession. She submitted that you were dealing with medication at the time and were dishonest in relation to its handling, and therefore the public confidence in the nursing profession would be undermined if a finding of impairment was not made.

Your submissions on misconduct and impairment

You submitted that your fitness to practise was not currently impaired.

You told the panel that you had practised for 30 years in the UK and New Zealand without concerns and no actual harm was caused to any patient.

In relation to dishonesty, you told the panel that your account had been consistent. You did not know the ampoule was broken when you locked the box in the safe, so you could not have recorded it or be dishonest about it. You said you had one opportunity to give your account before the disciplinary hearing, at the SWARM meeting, and you were suspended that evening with no further chance to restate your case. You submitted that your honesty and integrity had not been questioned before or since.

In relation to policy and communication**,** you accepted that you did not follow policy on labelling the syringe and on disposal, and that your communication fell short. You told the panel that no one raised these concerns with you for seven to eight weeks, so you had no opportunity to correct your practice. You submitted that your practice improved once you were aware of the concerns, and that you worked for over a year afterwards, with many colleagues, without any further concern being raised.

You submitted that the incident in Hereford was unique as expired controlled drugs had been in the safe for years, and you were working alone with no colleague or manager available. You said that it was an administrative task and not clinical care, and no patient was involved. You accepted that opening the safe and rearranging the boxes was your decision alone and that this was an error of judgement that you would not repeat or recommend to others.

You told the panel that you had reflected for two and a half years and admitted your practise had fallen short of the high standards you set for yourself. You stated that it was your practice to employ principles of safe practice and perhaps at times that meant not following the letter of the policy. You stated that there were always going to be subtle differences in nurses' practice and this would be dependent on context.

[PRIVATE]. You said that you had fully disclosed these proceedings to the Nursing Council of New Zealand, which granted you a practising certificate without restriction. You were working in New Zealand, and testimonials from your current Manager and Preceptor of improvement in your practice. You explained to the panel that as a result of a review at the High Court where you gave evidence that there was no need for an interim order as you were not working in the U.K., the most recent interim order had been revoked on 4 September 2026.

[PRIVATE].

You told the panel that you intended to return to the UK in 12 to 18 months' time [PRIVATE]. You submitted that the risk of repetition was low, and that impairment was not required to protect the public or the public interest.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory*

Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

In coming to its decision, the panel had regard to the case of *Roylance* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

The panel considered each of the charges found proved separately in order to decide whether they amounted to misconduct. In doing so, it had regard to the following provisions of the Code.

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

> ***8 Work co-operatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

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:

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

18.4 take all steps to keep medicines stored securely

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times …

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that your conduct fell seriously short of the standards expected of a registered nurse.

Charge 2(1)

The panel found that you had failed to label Midazolam before administration. The panel accepted that there was a requirement to label it, and that your failure to do so fell short of the standards expected of a registered nurse. It accepted that labelling requirements exist to protect patient safety and that this was poor, and indeed unsafe, practice, and noted that you have accepted this. The panel also heard from other nurses who said they would have labelled the medication before administering it.

However, the panel did not consider that the departure was sufficiently serious to amount to misconduct. It had regard to the following:

- this was a single occurrence in a single case, and there was no evidence of a repeated pattern of unlabelled medication;
- the period during which the medication was unlabelled was short. There was evidence that an orange label for Midazolam was found in the sharps bin at the end of the procedure, and that the medication, whilst not labelled at the point of administration, was labelled shortly after when you sourced a new supply of stickers;
- the panel heard and accepted that you were carrying out multiple procedures that day, working under the authority of the doctor, and were seeking to relieve the patient's agitation as early as possible. In addition, you were also being observed by another professional, and no witness suggested that this was part of a pattern.

The panel decided that, applying the ordinary meaning of the word, while other registered nurses might regard what happened as out with usual process, they would not regard it as misconduct due to the circumstances at the time. The panel therefore concluded that the facts found proved in charge 2(1) did not amount to misconduct.

Charge 3(3)

The panel reviewed the hospital policy in place at the time. The policy required a denaturing device to be utilised only when volumes of the drug were above 5ml. the drug being discarded was supplied as 2.5mls therefore there was no duty that required use of a denaturing product. The panel noted your admission in relation to this charge but based upon the policy did not make a finding of misconduct.

Charges 4(1) and 4(2)

The panel found that you had opened the controlled drugs cupboard and handled controlled drugs while alone. The panel considered that this was a clear breach of the Trust’s policy on handling-controlled drugs. The panel noted the requirement that two registered professionals to be present when handling controlled drugs and when opening the cupboard. Indeed, when Ms Laws supported you earlier in the day to

count controlled drugs, she had admonished you because you had accessed the controlled drug cupboard unaccompanied and removed the contents in advance of her arrival. During oral testimony both Ms Laws and you confirmed this account. Therefore, the panel was convinced that you were aware of your obligation to always have two registered professionals present when checking controlled drugs.

Although the NMC does not set stand-alone standards for controlled drugs, paragraph 18 of the Code, provides principles which apply to the safe handling of medicines. The panel found that, by taking the controlled drugs out and returning them to storage, you were storing them and were responsible for doing so securely.

The panel noted that the hospital's policy references the Misuse of Drugs Act 1971. The panel found that the policy was based on that legislation, which forms part of basic nurse training. Further, the panel accepted the principle that nothing is done alone with controlled drugs is a fundamental tenet of nursing. The policies exist because of the risks of misuse associated with controlled drugs.

The panel also took account of the fact that you accepted, in your oral submissions and in response to panel questions, that your actions in opening the controlled drugs cupboard and handling controlled drugs alone amounted to misconduct.

The panel concluded that your actions fell seriously short of the conduct and standards expected of a registered nurse, and that the facts found proved in charges 4(1) and 4(2) amounted to misconduct. The panel was satisfied that the breaches engaged the legislative framework and national guidance on controlled drugs, rather than a matter of mere local practice, and was therefore serious. The panel found that you opened the cupboard alone on two separate occasions on the same day and that the second occurrence took place after you were professionally challenged by Ms Laws. It was evident to the panel that other practitioners would find your actions to amount to misconduct in the circumstances.

Charge 5(3)

In finding this charge proved, the panel does not accept your continued protestations that you were unaware of the second broken ampoule at the end of the day on 14 June 2024. During a local disciplinary investigation, and during oral evidence to this panel, you explained that an unopened box of Midazolam had fallen and you had inadvertently stood on it. When you lifted the box, you reported you had a cursory glance inside and noted no damaged ampoules. You subsequently tore the end of the box off and placed the box into the controlled drug cupboard. You informed the panel the rationale for this act was to help colleagues coming to work next week to easily identify the in-date drugs from the expired drugs in the drugs cupboard. However, the panel did not accept this as plausible given that there were two shelves within the cupboard with one being used solely for expired drugs and one for in date drugs and these drugs had been stored in the cupboard in this way for almost six years. Furthermore, no other witnesses stated that this was ordinary practice to tear off the side of a box that had the expiry date and the batch number on, to indicate that it was in date. The panel found that policy required this whole event to be deemed a near miss, warranting escalation and a clinical incident report.

The panel had regard to section 11 of the Hospital policy, which provides that:

> *'Should a discrepancy occur during a drug count in the controlled drug register the following process and investigation must take place:*
>
> - *Two separate InHealth RNs or one InHealth RN and one other health professional to recount.*
> - *Complete a Sentinel incident report'*

The failings in your actions that day constituted a number of breaches of your duty and amounted to serious misconduct.

Charge 6

The panel recalled its findings on dishonesty and relied on the reasons given for finding the charge proved, and on the context in which they arose, including that you were already subject to a final warning at the time.

The panel was mindful that honesty is a fundamental tenet of the nursing profession. It had regard to the guidance 'Making decisions on dishonesty charges and the professional duty of candour' (Reference: FtP-2a-iii, Last Updated 31/07/2026):

> '[…] *Why does dishonesty matter?*
> *We take concerns that a professional has been dishonest very seriously. This is because everybody should be able to trust the people providing them with care* […]'

Dishonesty is a serious matter because it is of the highest importance that the public are able to trust nurses. The panel was satisfied that this conduct was serious and in these circumstances it amounted to misconduct.

The panel therefore found that:

- the facts found proved in charges 2(1) and 3(3) did not amount to misconduct;
- the facts found proved in charges 4(1) and 4(2) amounted to serious misconduct, given the legislative framework and national guidance on controlled drugs, rather than as suggested by you as some minor deviation in practice;
- the facts found proved in charge 5(3) amounted to serious misconduct, for the reasons set out above; and
- the facts found proved in charge 6 amounted to serious misconduct.

Decision and reasons on impairment

Having found that the facts found proved in charges 4(1), 4(2), 5(3) and 6 amounted to serious misconduct, the panel next decided whether, as a result, your fitness to practise is currently impaired. Whether a nurse's fitness to practise is impaired is a matter for the panel's own judgement.

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

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

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

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

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

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

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

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

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

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

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

The panel determined that limbs (b), (c) and (d) of the *test* were engaged.

The panel considered limbs (a) to (d) in turn in relation to your past conduct.
In relation to limb (a), the panel found your misconduct had not put patients at unwarranted risk of harm in the past. Limb (a) was therefore not engaged.

In relation to limbs (b) and (c), the panel found that your misconduct had in the past brought the profession into disrepute and breached fundamental tenets of the profession. The misconduct concerned controlled drugs for which stringent practice is required. You did not manage controlled drugs as you should have done and subsequently breached the policies that exist to keep patients, nurses and others safe. The panel heard that you had recognised in your oral submission that you had not met the standards you had set for yourself. The panel determined that you did not meet the standard required by your profession.

In relation to limb (d), the panel found that you had acted dishonestly in the past, as found proved in charge 6.

The panel then considered whether you are liable to repeat your conduct in the future.

In relation to limb a: risk to patients, the panel found no evidence of a present risk to patients.

The panel next considered limbs (a) and (b) in the future.

The panel heard that you are working in New Zealand, as a District Nurse; this may well be a completely different regulatory environment and clinical setting from that in which the concerns arose. Further, you have been in that role for only a few weeks. In regard to the testimonials provided, no reference is made to controlled drugs, and there is nothing to indicate that you do have access to such medication in your current role. [PRIVATE]. However, the panel did not find this information provided assurance that the risk of repetition was lower.

The panel did consider whether you have demonstrated insight and taken steps to remedy the concerns, but it found your insight, although developing, is currently limited.

The panel took into account your oral submissions in which you deflected responsibility onto others. You were not a newly qualified nurse but an experienced senior nurse. On one hand you stated to the panel that if you had been given feedback at the time of the incidents in 2023 you could have changed your practice accordingly. The panel found that your submissions was evidence of a lack of personal reflection in relation to daily practice which is a fundamental tenet of nursing.

Moreover, when feedback was provided on 14 June 2024 in relation to being admonished by Ms Laws for opening the controlled drugs cupboard alone, this had no effect on your conduct, despite your being subject to a final written warning for previous breaches of policy in relation to controlled drugs.

The panel was further concerned by your statement that policies are written for ideal situations, but in healthcare you are not in an ideal situation and that you have to adapt to the circumstances in which you find yourself. The panel accepted that

nurses must sometimes adapt, but not at the expense of policies designed to keep people safe and considered that this attitude carried a significant continuing risk.

The panel found that you had over emphasised your own high standards. The standards that matters are not yours but those set by your employer based upon national policy and legislation, and the professional standards enshrined in the NMC Code.

Although you did make some admissions and expressed some remorse, the panel found the remorse related more to the impact of these events on you rather than on your colleagues and the wider nursing profession.

The panel then considered limbs (d) of the test in the future.

The panel has found that you have recognised that you were dishonest. It was of the view that you have not addressed the impact of your conduct on public perception, on colleagues, on professionalism or on confidence in the profession.

The panel considered the recent testimonials provided by two registered nurses in New Zealand. One of whom does not currently work with you but did interview you for your current post. The other is your preceptor. It found them to be of limited assistance. The panel found that these indicated your ability to learn and develop openness to feedback, learning and improving your practice, and the panel considered that the content suggests some humility. The testimonials demonstrated your ability to explain to be honest about your referral to the NMC and to work as a nurse, and some understanding of the need to change. They did not, however, amount to evidence of strengthened practice, and the panel could not assess your practice as a district nurse in New Zealand on the basis of a few weeks in post. In light of the above, the panel lacked evidence of further development over a longer period of time and which explains your current practise in relation to the management of controlled drugs.

The panel heard your submissions in that your honesty had not been questioned in 24 years of nursing and that there had been no other concerns, including in your

current workplace. It took into account the explanations you gave for the length of time it took you to find work, and [PRIVATE].

The panel could not be confident that you would not engage in further dishonesty due to your lack of insight and reflection on the circumstances and how this impacted your behaviour.

The panel concluded that in light of your limited and fluctuating insight, the absence of strengthened practice and your attitude towards policy, the panel concluded that there remains a risk that you could breach fundamental tenets of the profession in the future and, as a result, bring the profession into disrepute.

The panel had regard to the case of *Cohen*:

- whether the concerns are easily remediable,
- whether they have in fact been remedied, and
- whether they are highly unlikely to be repeated.

The panel considered that the concerns are capable of being remedied, although dishonesty is more difficult to remedy. They have not, however, yet been remedied. The panel considered that your reflection was, at present, self-serving.

The panel was of the view that there were no public protection concerns, therefore it determined that a finding of impairment was not necessary on the grounds of public protection.

The panel therefore next considered the wider public interest.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

It had regard to the importance of maintaining public confidence in the profession and in the NMC as its regulator, and of declaring and upholding proper professional standards. The misconduct involved breaches in relation to the management of controlled drugs and also dishonesty. The public would find dishonesty in a nurse to be repugnant resulting in a loss of confidence. The panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made and therefore finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public interest only, and not on the ground of public protection.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Ms Rashid's submissions on sanction

In the Notice of Hearing, dated 2 September 2026, the NMC had advised you that it would seek the imposition of a 12-month suspension order with a review if it found your fitness to practise currently impaired.

Ms Rashid reminded the panel that it had found your misconduct to be serious. She submitted that the threshold for taking action in the public interest was a high one, and that the panel had already found that threshold met because of the seriousness of your misconduct. She submitted that any sanction had to be proportionate. Its aim was not to be punitive, although she accepted that some sanctions might have a punitive effect.

Ms Rashid submitted that, given the serious nature of your misconduct, there were no exceptional circumstances that would justify taking no action. She then submitted that the nature of your misconduct did not meet the criteria in the sanction's guidance (San 2-B) for a caution order. She said that a caution order might be suitable where a registrant had demonstrated significant insight, making repetition highly unlikely. She reminded the panel that it had found your insight to be developing but currently limited, and that there was limited evidence of strengthened practice.

Ms Rashid submitted that conditions of practice were not suitable in your case. She said they were not appropriate where there was evidence of deep-seated personality or attitudinal problems, and that proven dishonesty was more difficult to remediate through conditions. She also relied on the serious nature of your misconduct in support of that submission.

Ms Rashid therefore submitted that a suspension order was the appropriate sanction. She accepted that the impairment was very serious but submitted that it was not fundamentally incompatible with your continuing to be a registered professional. She submitted that a suspension order would satisfy the public interest, and that the NMC was seeking a 12-month suspension order, with a review.

In response to a question from the panel, referencing the guidance on 'Previous Interim Orders and their effects on length of sanction', Ms Rashid submitted that, in her view, the previous interim order did not affect the length of any final sanction.

Your submissions on sanction

You addressed the panel's question about the interim order. You acknowledged that Ms Rashid had said the interim order should not affect the length of a final sanction, because the facts had not been proven at the time. You submitted that you had been subject to an interim conditions of practice order for 18 months, the conditions of which were unworkable and therefore in effect amounted to a suspension.

You said that a further suspension was therefore unnecessary. If the panel considered suspension proportionate, you submitted that the time already served should be taken into account when setting its length.

You submitted that the panel had found no risk of harm to patients, and that the concern was the public interest. You submitted that the panel should start with the least restrictive sanction and work upwards. You asked the panel to impose no restriction. You accepted that sanctions were not meant to be punitive but said that, by their nature, they were.

You told the panel that you had always been honest with the NMC and the New Zealand Nursing Council, and that you would report the panel's findings to them and to your employer. You said you did not know how they would respond, but that suspension would probably end your current employment in New Zealand. You submitted that this would remove your only real opportunity to demonstrate improved practice. You said that courses or work as a healthcare assistant would not give you that opportunity.

You accepted that the panel had found your insight to be limited. You said you did not dispute that your maintaining your account had been perceived as continuing dishonesty. You maintained your recollection that you had been unaware of the broken ampoule, but you said you respected the panel's finding and had reflected on it. You accepted that honesty is fundamental to the profession. You said that dishonesty findings were of concern to you, your colleagues and the public, and that they damaged the reputation of the profession and the NMC.

You relied on the testimonials from your colleagues in New Zealand, who spoke to your honesty and integrity. You accepted that the panel had given them limited

weight because they covered only a short period (a matter of weeks). You submitted that they nonetheless showed no concerns about your conduct since the events. You also submitted that no employer or regulator had previously questioned your honesty. You said that you had voluntarily disclosed the NMC investigation at interview, although you were not obliged to.

When asked about your management of controlled drugs as a District Nurse, you stated that District Nurses do not manage controlled drugs in New Zealand and that responsibility was restricted to hospice nurses for palliative patients. You went onto clarify that whilst District Nurses would not routinely have to change syringe driver contents which could include controlled drugs. Controlled drugs would be stored in a patient's home and as such a District Nurse would therefore have access to them.

In response to a panel question, you gave two examples of reporting incidents in your current role. The first was minor skin contact with scissors during a dressing, which you reported despite the patient's husband suggesting it was unnecessary. The second was a medication administration issue arising from an incorrect referral and an unwritten local policy, which you reported through an incident form. You submitted that both showed your commitment to transparency and maintaining accurate documentation. You also described the greater responsibility and trust involved in lone district nursing and said you were aware of it.

You submitted that ending your practice in New Zealand would not be proportionate, given that the panel had found no risk to patients.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Previous disciplinary findings – despite a final written warning which you had received in relation to your handling of controlled drugs, the panel determined that you failed to follow policy in relation to controlled drugs for the second time only weeks later, which indicates an attitudinal issue and lack of reflection and the ability to change practice
- Repeated removal of controlled drugs without a second registered professional even after being admonished on the same day for exactly that conduct
- Developing and fluctuating level of insight with regards to dishonesty
- Deliberate breaches of the Code
- Abuse of a position of trust

The panel found that your account in relation to the controlled drugs changed repeatedly and significantly. Whilst the panel appreciates that memories fade and develop it found that what you told the local investigation and this panel varied so significantly that a finding of dishonesty was required.

The panel found that there to be inconsistencies throughout your submissions which led to concerns of the reliability of your position.

The panel also took into account the following mitigating features:

- [PRIVATE].
- At the time of the misconduct, your working environment was not ideal, in that you were working very long hours, away from home, travelling 400 miles a week, and working in a number of different remote units which could have impacted your situational awareness. Furthermore, staffing levels at the workplace had been changed from having 2 registered nurses per list to one which added significant pressure to the running of the list and in particular the management of controlled drugs. This was corroborated by colleagues during oral testimony.
- Some admissions of the facts.
- Developing insight.

- Corporate sub-optimal management of expired controlled drugs providing latent conditions for error or misuse.
- Key evidence at both the local investigation and the NMC case was the SWARM huddle. You were the only staff member present at this huddle from the day in question. Ideally all staff involved in an event must contribute to a huddle in order to gain a full understanding of facts. You were sent the transcript which you told management had inaccurately recorded the events but by that time you were suspended and no edits were made. This therefore meant key evidence was relied upon that was not a full factual record of the events under review.
- Engaged with the local investigation.
- During your submissions on sanctions, you were able to provide the panel with two examples of near misses and what you had learnt from the events. The panel considered that you showed a willingness to put things right and be open despite your employer knowing you were under investigation with the NMC, which demonstrated a principle of good practice.
- Demonstrated integrity when disclosing the NMC proceedings to the New Zealand Nursing Council.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case which included dishonesty. The panel decided that it would not be proportionate in the public interest to take no further action.

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

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

A caution may be appropriate when any of the following factors are apparent (this list is not exhaustive):

- *significant evidence of re-training and reflection*
- *significant insight which makes repetition highly unlikely*
- *a sanction is necessary to uphold professional standards and public confidence in the profession, but the professional is able to practise safely and a more restrictive sanction would be disproportionate.'*

The panel found that your actions were not at the lower end of the spectrum as it included dishonesty. Moreover, it also found your reflection and insight to be limited and developing and that there remained a likelihood of repetition. It determined that it would not be appropriate in the public interest to impose a caution order.

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

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

The panel is of the view that there are no relevant, proportionate, workable or measurable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining, particularly as it included dishonesty and attitudinal concerns. The panel also noted that you are not currently practising in the U.K. and do not intend to return back to the U.K. in the next 2 years.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and meet the wider public interest.

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

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*

- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with you remaining on the register, and that a suspension order would satisfy the overarching objectives of the NMC. It took into account that despite the seriousness of your misconduct, you have engaged in the proceedings. Furthermore, the panel was of the view that a suspension order would give you an opportunity to develop insight into the misconduct and to take steps to address the concerns.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order. It determined that it would not be in the public interest to lose an otherwise good nurse from the register.

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

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

The panel imposed a suspension order having found your fitness to practise currently impaired in the public interest. The panel was satisfied that the suspension order will satisfy the public interest in this case and will maintain public confidence in the nursing profession as well as the NMC as the regulator. Further, the substantive order will declare and uphold proper professional standards.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct and meet the public interest.

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

Any future panel reviewing this case may be assisted by:

- A reflective piece on the impact of your misconduct on the nursing profession and colleagues;
- A reflective piece related to the impact on public perception of dishonesty in a nurse;
- A reflective piece related to the New Zealand Health and Disability System Safety Strategy – in particular how you can improve situational awareness to reduce risks of non-compliance with policy;
- [PRIVATE];
- Evidence of insight in relation to the dishonesty proved;
- Evidence of safe engagement with controlled drugs;
- Examples of your compliance with local policies in relation to controlled drugs and incident reporting;
- Evidence of your engagement with incident reviews including your reflections and learning as a result of these (for example a local equivalent of a SWARM huddle);
- Records of appraisals and performance reviews by line manager; and
- Testimonials in relation to your honesty and integrity.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Rashid. She invited the panel to impose the interim suspension order on the same factual and regulatory basis as the substantive suspension order.

In your submission, you said if there was no immediate danger to the public, as the panel had determined, but the panel had imposed a suspension order on the ground of public interest, and any order was not meant to have a punitive effect, then surely an interim order in place while the decision was under appeal would have a punitive effect. You argued that if your appeal succeeded and there was no immediate threat to the public, the interim order would have been purely punitive.

You told the panel that you are not currently in the U.K. so there is no immediate threat to the public. You said that any suspension in the U.K. has the potential to end your nursing career in New Zealand. In response to the panel's question, you said that this was under review by the Nursing Council.

Decision and reasons on interim order

The panel was satisfied that an interim order is in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its

decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential appeal period.

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

A professional can ask for the committee to review the interim order at any time if new information becomes available which is relevant to the order, as stated in Article 31 of the Order.

That concludes this determination.