Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Thursday 12 November 2026

Virtual Hearing

Name of Registrant:	Penelope Claire Wright
NMC PIN:	83Y2406E
Part(s) of the register:	Registered Nurse – Sub Part 2 Adult Nursing (Level 2) – 06 August 1985 Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 24 September 1994 Renal Nursing (P136) – 09 August 1995
Relevant Location:	Nottinghamshire
Type of case:	Lack of competence
Panel members:	Serene Rollins (Chair, Lay member) Stacey Coxon (Registrant) David Anderson (Lay member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Andrea Lawrence
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Miss Wright:	Present and represented by Emily Kettell, instructed by Kings Chambers
Order being reviewed:	Suspension order (12 months – with review)
Fitness to practise:	Impaired
Outcome:	**Suspension order of 9 months to come into effect on 5 December 2026 in accordance with Article 30(1)**

Decision and reasons on review of the substantive order

The panel decided to extend the current suspension order for a period of 9 months.

This order will come into effect at the end of 9 December 2026 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 5 November 2025.

The current order is due to expire at the end of 9 December 2026.

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

That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a dialysis nurse in that you:

1. *Between 29 November 2021 and 1 November 2022 while subject to an action plan and/or informal capability process/informal performance improvement programme failed to meet the following objectives:*

   1.1. Delivery of Patient Care.
   1.2. Hand Hygiene and infection control.
   1.3. Waste segregation.
   1.4. Prioritising workload.
   1.5. Providing patient dialysis in accordance with individual dialysis prescription.
   1.6. Providing individual patient care.
   1.7. Treating colleagues with respect.
   1.8. Medication management.
   1.9. Safety checks.

2. *Between May 2022 and 16 November 2022 in respect of Patient 7:*
   2.1. On one or more occasion pulled/tugged their neck line.

2.2. On one or more occasion did not refrain from pulling/tugging their neck line after being told by them that it caused discomfort/pain.

2.3. On a date unknown inserted a swab into rather than around their neck line.

2.4. ….

3. ….:

3.1. ….

3.2. ….

3.3. ….

4. On 1 July 2022 failed to administer to Patient 14 Enoxaparin.

5. Between 3 November 2022 and 16 November 2022 while subject to a formal capability process/formal performance improvement plan you:

5.1. On 11 November 2022 in respect of Patient 2:

i. Did not prepare the dialysis machine prior to them attending.

ii. Delayed starting their dialysis treatment by over 50 minutes.

iii. Required to be prompted to remove air/aspirate the syringe/needle containing saline solution.

iv. Did not clamp their line when disconnecting them from the dialysis machine.

5.2. On 11 November 2022 in respect of Patient 3:

i. ...

ii. ...

c) On 11 November 2022 handled Patient 5's needle without wearing gloves.

d) On 11 November 2022 and/or 15 November 2022 in respect of an unknown patient/s:

i. Did not check the earth cable was connected properly their dialysis machine/s.

ii. Did not check bed brakes.

iii. ...
iv. Did not assess for oedema.
v. Did not check shortness of breath.
vi. Did not complete the pre-safety checks.
vii. Did not assess them for Covid-19 signs and/or symptoms.

e) On 11 November 2022 in respect of Patient 9:
i. Required to be prompted to remove their clothing to check their blood pressure.
ii. Failed to administer their Enoxaparin.
iii. Required to be prompted to sign their medication chart.

f) On 11 November 2022:
i. Did not clean the trolley containing equipment needed to connect patients to dialysis machines.
ii. Did not wash/disinfect your hands between patients and/or cleaning equipment.
iii. Failed to change gloves.
iv. Did not clean up blood left on the floor/bed from previous patient/s.

g) On 14 November 2022:
i. Were unaware that a dialysis machine was not priming.
ii. Did not identify that an unknown patient's arterial line was not connected properly to the dialysis machine.
iii. In respect of Patient 11;
(1) Struggled to insert their needle.
(2) Were unable to calculate their UFgoal.
iv. In respect of Patient 10 wrongly identified that they required their Diafer medication to be administered.
v. In respect Patient 13 did not read their prescription to identify the correct needle size for them.

h) On one or more occasion on dates set out in Schedule A:
i. Failed to dispose of clinical waste appropriately.

ii. ….

iii. Failed to use a new wipe to clean separate surfaces.

iv. Failed to clean your hands effectively.

v. Did not adhere to the 5 moments of hand hygiene

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

Schedule A

11 November 2022
14 November 2022
15 November 2022

The original panel determined the following with regard to impairment:

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

In this regard the panel considered the "test" of Mrs Justice Cox in the case of CHRE v NMC and Grant in reaching its decision. In paragraph 76, she said:

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

The panel found that vulnerable patients were put at risk of serious harm as a result of your lack of competence. The panel had already accepted the evidence

of Witness 1 who commented on how unsafe your practice was and how she was required to intervene to prevent patient harm.

The panel had regard to the complaints received from the patients. In their local complaint submitted to Clinic 2, Patient 4 referred to you:

'Causing mental health problems in patients because 3 of us in our bay panicked if we thought we might have [you] and even worried about it the night before and didn't want to go to dialysis'

Patient 2, in his complaint of 14 November 2022 referred to 'Grave concerns with regard to [your] professional ability' and stated:

'I believe that this feedback is critical as someone's life may well be in danger should these issues not be addressed as soon as possible...Something needs to be done because it's only a matter of time that someone less observant could have serious repercussions having been at the mercy of what can only be described as perilous care from [you]'

Patient 7, in her complaint to Clinic 2 in November 2022, stated:

'I feel she is a danger to patients and herself... She is looking after vuneral [sic] /sick people, our lives are in her hands and they are not safe'

The panel determined that there has been little evidence put before it to demonstrate any relevant learning or strengthening of practice, therefore there is at present a risk to patients of unwarranted harm.

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

The panel determined that your lack of competence had brought the nursing profession into disrepute. The panel had particular regard to the patients who had referred to concerns that they would not wish to attend dialysis if you were their

nurse and expressed genuine concerns for their safety. The panel also took account of Patient 4 and Patient 7's accounts of you being rude and / or disrespectful towards your supervisor. The panel determined that informed members of the public would be extremely concerned about your practice and without it having been remediated would in the future bring the nursing profession into disrepute.

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

Your lack of competence had breached the fundamental tenets of the nursing profession namely: prioritise people; practise effectively; preserve safety and promote professionalism and trust. The panel determined that by your actions, you did not treat patients with professionalism or deliver safe care to numerous patients in a number of settings. In light of your lack of insight, reflection and remorse the panel determined that you are liable to do the same in the future.

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

In light of the fact there was no charge of dishonesty, the panel did not consider it appropriate to make a finding of dishonesty based upon the way this case has been conducted.

The panel considered the factors set out in Cohen / NMC guidance DMA-1:

- *Is the behaviour easily remediable?*

The panel was of the view that you underwent extensive one-to-one supervision, induction programmes and were set clear achievable objectives. Yet you could not achieve the standards set in those objectives and did not avail yourself of the relevant policies provided to you.

The panel considered your ability to work under supervision. It had sight of evidence from Ms 1 and heard oral evidence from Witness 1 and Witness 3 indicating that

you have attitudinal issues. The panel was concerned whether you could or would want to change your attitudinal issues. The panel was not persuaded that your attitudinal issues are currently remediable in your case.

- *Has it already been remedied?*

The panel considered whether there is a risk of repetition and in doing so assessed your current insight, remorse and remediation. The panel had sight of the three training certificates you provided at this stage. It noted that none were current and they dated back to 2023. Further the panel was aware that they were online courses and their value compared to attending a physical course was difficult to quantify. It noted one certificate's subject was confidentiality which has no obvious relevance to the regulatory concerns in your case.

The panel had sight of your reflective note dated 9 October 2025 and noted that you had not taken the opportunity to update it in light of the panels finding on facts. Your reflection related solely to one medication error and did not cover any of the wider issues relating to your competence. Whilst it did include some insight on patients and colleagues it did not include any reflection on the impact of your performance on the nursing profession as a whole.

In its consideration of whether you have taken steps to strengthen your practice, the panel recognised that you have not been working as a nurse as a result, you submit, of the interim conditions of practice order in place. The panel took into account that you have not sought alternative employment, for example as an HCA or in any allied profession, in order to demonstrate strengthened practice. The panel had particular regard to the fact that when you were in practice you were not able to engage with the local support provided to you and rejected it and at other times found the support obstructive, blaming others and perceiving it as unnecessary and punitive. The panel determined that you had shown a pattern of incompetence across both clinical practice and fundamental nursing skills.

While the panel acknowledge that holding patients' hands, relieving stress etc mentioned by you as part of your patient care and nursing practice, it was of the view that these are interpersonal skills of kindness any nurse should have.

- *Is it highly unlikely to be repeated?*

The panel was of the view that there is a risk of repetition in the future. You have not shown progress, or taken steps to gain suitable alternative employment. The panel determined that you continue to present a significant risk in future of similar conduct. You have shown no remorse for your actions and behaviour and continue to deny the charges and deflect blame. Furthermore you have provided only one testimonial and no reference from any previous employer. You have provided the panel with no up-to-date training and continued to demonstrate a lack of knowledge of policies and lack of insight for the concerns raised.

The panel was of the view that while there had been no reported prior incidents in relation to your practice in the past it further noted the deterioration in your practice between February and July 2021 at Clinic 1. The panel was aware of repeated offers of external assistance which you rejected.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

In this case, the panel could not answer affirmatively. The panel was of the view that above all, people expect a nurse to be able to practise kindly, safely and professionally at all times. The panel determined that this is absolutely necessary in order to uphold standards of conduct and performance of a professional nurse.

Taking into account the reasons given by the panel for its findings of the facts, the panel has concluded that you lacked the skill and judgement to practise safely and you had not acted professionally at all times. It therefore concluded that you are not able to practise kindly, safely and professionally.

The panel therefore decided that a finding of impairment is necessary on the ground of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required. The panel determined that informed members of the public would be extremely concerned about your practice and that on current evidence is not remediated. The panel also considered the view the public have on dialysis as a bedrock life-saving function of these patients' care where they would spend a significant amount of time attending the clinics over a substantial period of years.

The panel concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.'

The original panel determined the following with regard to sanction:

The panel went on to consider whether a suspension order would be an appropriate sanction. The panel considered the SG on when suspension orders are appropriate and in particular took into account this factor:

- *In cases where the only issue relates to your lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

In making this decision, the panel carefully considered the submissions of Ms Fergus-Simms in relation to the sanction that the NMC was seeking in this case. However, the panel had regard to the danger and risk to vulnerable patients and determined that the number of instances of your general incompetence regarding wide-ranging basic skills and specialist renal nurse skills put patients at serious risk of harm.

The panel was of the view that a suspension order would give you time to focus on the development of your practice whilst undergoing some retraining. This could be achieved by voluntary or paid employment as a HCA or in some other allied health profession, and its successful completion would provide you with retraining opportunities and potentially positive testimonials and references of your practice. A period of suspension would also give you time to come to terms with the decision of this panel and reflect upon it.

The panel considered that it would be appropriate to impose a sanction of a suspension order of 12 months duration, in order that you should be provided with sufficient time to reflect and focus on the steps that you must take to return to nursing.

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 competence required of a registered nurse. Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction in this case.

This would mark the seriousness of your lack of competence and allow you sufficient time to address your failings, strengthen your practice and then provide evidence of this either by courses you have taken or testimonials from employers in paid and / or voluntary work.

The panel did not go on to consider whether to impose a striking off order as this sanction is not available at this time.

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:

- *Reflection and insight covering the wide-ranging failures identified in your practice from the very basics of nursing care through to the specialist care required of a renal nurse*
- *Evidence of employment whether in a clinical setting or not*
- *Documentary evidence of completion of relevant courses that strengthen your practice including for example: understanding policies and procedures, medication management, waste management, teamwork, duty of candour, reflective practice, record keeping, infection control*
- *Testimonials and references from your employer or voluntary establishment that detail your current work practices, particularly your approach to service users*

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle and your reflections, training certificates and one testimonial. It has taken account of the submissions made by Mr Edwards on behalf of the Nursing and Midwifery Council (NMC).

Mr Edwards took the panel through the background of the case and referred it to the relevant pages within the bundle.

Mr Edwards drew the panel's attention to your reflective pieces and the training certificates provided as evidence of steps taken to strengthen your practice. Mr Edwards submitted that although you have taken these positive steps, your insight, and reflection have the potential to be limited as you are currently not employed within the health care field.

Mr Edwards submitted that your lack of role within the clinical field restricts your ability to show that you are not currently still impaired. Mr Edwards questioned whether a condition of practice order would be appropriate as it would allow you the opportunity work within the clinical setting.

The panel also had regard to submissions from your representative Ms Kettell.

Ms Kettell submitted that you are no longer impaired and do not pose a risk to the public, should your suspension order be allowed to lapse. Ms Kettell submitted that you feel that you have done your upmost to comply with the requirements of the previous panel and to show that you can return to your nursing practice unrestricted.

Ms Kettell highlighted that you have struggled to find employment, in or out of the clinical field.

Ms Kettell referred to your attendance on several training courses which relate to the charges brought against you. She submitted that you have taken the time to address the previous panels concerns and that this shows that you have accepted responsibility and acknowledged your past errors.

Ms Kettell submitted that you have taken time to reflect on past actions, drawing the panels attention to your reflective pieces, that speak of steps you would now take to uphold the NMC Code and protect patients from any harm.

Ms Kettell drew the panel's attention to the testimonial provided on your behalf, which highlights your belief that you can now practise safely and professionally.

In response to panel questions regarding why you found yourself before the panel and what you would do to ensure the same would not happen again, Ms Kettell informed the panel that in future you would not allow distractions to take away from your practice.

The panel also enquired as to what you would do in the future in reduce the risk of similar behaviours happening again. Ms Kettell informed the panel that you were not sure why the behaviour occurred, but you would ensure that you were respectful to colleagues.

In regard to concerns about your attitude, Ms Kettell informed the panel that you were never made aware that patients had complained about your care. However, you accept that it is important that patients are confident in their nurses.

The panel heard the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that original panel found that you had insufficient insight.

Today's panel highlighted that there is still a lack of insight as to how you made patients feel, particularly as patients had stated that they felt scared in your care. The panel took account of your reflective piece and the answers to their questions, and noted that there was no reference to why the charges were found proved, your actions in relation to this and how you would do things differently in the future. It further noted that you have not addressed the impact your lack of competence had on patients, colleagues and the wider nursing profession. In the panels view you still have developing insight.

The panel acknowledged that you have taken proactive steps, referring to your training certificates, particularly Record Keeping dated 20 October 2026 and Drug Calculation dated 15 September 2026. However, in the panels view, the certificates you provided do not address all the areas of concern.

The panel also had regard to the original panel's view on your lack of respect to colleagues and supervisors. It was also noted that you have not addressed this in either your reflective statements or your certificates. It took the view that there is no evidence of strengthened practice in this area.

The panel took account of your testimonial and noted that it was from a nurse who had retired. It found that the testimonial was very general and lacked detailed information as to the specifics of the charges found proved.

The original panel determined that you were liable to repeat matters of the kind found proved. Today's panel was of the view that it is unable to say if the risk to patients has now been mitigated as there is no evidence of current clinical practice. The panel stated that there is still a lack of insight as to how your behaviour brought the nursing profession into disrepute and put patients at risk.

In light of this, this panel determined that you remain liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

The panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

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

The panel first considered whether to take no action. It concluded that this would be inappropriate given the seriousness of the concerns identified, the ongoing risks to patient safety, and the need to maintain public confidence in the profession. The panel determined that it would be neither proportionate nor in the public interest to take no further action.

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

The panel next considered whether a conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. However, the panel found that although conditions could address clinical concerns, they would not be sufficient to address attitudinal concerns that are still present.

The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on your previous failings. The panel concluded that a further 9-month suspension order would be the appropriate and proportionate response and would afford you adequate time to develop your insight and take steps to strengthen your practice.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 5 December 2026 in accordance with Article 30(1).

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

Any future panel reviewing this case may be assisted by:

- Reflection and insight covering points raised by this panel, including demonstrating and understanding of the impact of your practice towards patients, colleagues and the wider nursing profession.
- Evidence of (or attempts to gain) employment whether in a clinical setting or not.
- Documentary evidence of completion of relevant courses that strengthen your practice including for example: understanding policies and procedures, medication management, waste management, teamwork, duty of candour, reflective practice, record keeping, infection control
- Testimonials and references from your employer.

This will be confirmed to you in writing.

That concludes this determination.