Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Monday, 8 September 2025 – Thursday, 18 September 2025

Wednesday, 14 October 2026 – Tuesday, 27 October 2026

Virtual Hearing

Name of Registrant:	Elizabeth Davies
NMC PIN:	16H1583E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (5 September 2016)
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	John Millar (Chair, Lay Member) Lisa Holcroft (Registrant Member) Catherine Beckett (Lay Member)
Legal Assessor:	Hala Helmi (8 September 2025 - 10 September 2025, 12 September 2025 - 18 September 2025) Mike Bell (11 September 2025) Cyrus Katrak (14 October 2026) Justin Gau (15 October 2026) Andrew Granville Stafford (16 October 2026) Graeme Sampson (19 October 2026 - 27 October 2026)
Hearings Coordinator:	Maya Khan (8 September 2025 - 18 September 2025)

	Sabrina Khan (14 October 2026 - 27 October 2026)
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter (8 September 2025 - 18 September 2025) Represented by Rowena Wisniewska (14 October 2026 - 27 October 2026)
Ms Davies:	Present and represented by Gerard McGettigan
No Case to Answer:	Rejected
Facts proved:	Charge 1a, 1b, 1c, 1d, 1e, 1f, 2a, 3, 4, 5a, 5b, 6a, 6b, 7b, 7c, 8, 9a, 9b, 10, 11, 12a, 12b, 13b and 13c,
Facts proved by admission:	None
Facts not proved:	Charge 2b, 7a, 12c, 13a and 13d
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**
Final outcome:	**FTP impaired - striking off order**

Decision and reasons on application to admit Patient D's local signed statement as hearsay evidence

The panel heard an application made by Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (the Rules) to allow Patient D's local signed statement into evidence. He drew the panel's attention to the principles of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) when deciding whether to admit hearsay evidence.

Mr Malik submitted that Patient D's statement dated 10 November 2017 relates to charge 12. He submitted that witnesses are attending to give evidence in relation to charge 12, Joanne Jones reports what Patient D told her and she exhibits Patient D's local signed statement and Fiona Altintas was aware that Patient D made a complaint to Joanne Jones. He further submitted that the allegation came directly from Patient D and therefore it is the sole and decisive evidence. He submitted that there is no evidence before the panel that Patient D had any reason to fabricate the evidence. He submitted that the panel will also be hearing evidence from Patient B and Patient C who are members of the public and raise similar concerns regarding your attitude whilst caring for them at the hospital and therefore Patient D's statement does not say anything substantially different to the other two patients.

In respect of the seriousness of the charge and the impact it may have on your career, Mr Malik submitted that charge 12 is serious and relates to a failure to attend to a patient, a failure to meet the patient's needs and speaking abruptly to a patient which is not acceptable behaviour of a registered nurse.

Mr Malik submitted that the NMC was unable to take any steps to secure Patient D's attendance as [PRIVATE] on 29 January 2020. He further submitted that you received prior notice of this application.

Mr Malik advanced the argument that there was no lack of fairness to you in allowing Patient D's statement into evidence. He submitted that it would be both fair and relevant

to admit Patient D's statement into evidence. He submitted that it is a matter for the panel to give the appropriate weight to the local signed statement.

Mr McGettigan, on your behalf, referenced the principles in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He submitted that it is acknowledged that Patient D has sadly passed away and therefore there is a reason for non-attendance at the hearing. He submitted that Patient D's account is the sole or decisive evidence for charge 12a, 12b and 12c because those complaints came directly from Patient D and therefore it is Patient D's allegation against you.

Mr McGettigan took the panel through Patient D's patient notes which make reference to [PRIVATE]. He submitted that Patient D's account arguably contains largely subjective opinions as opposed to objective facts which cannot be challenged and therefore the evidence should not be adduced as it cannot be proven as reliable.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The panel was referred to *NMC v Ogbonna* [2010] EWCA Civ 1216 and *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel gave careful consideration to the application in regard to admitting Patient D's statement. It noted that requirements of relevance and fairness need to be met and the evidence is not inadmissible just because it is hearsay. The panel decided there was no dispute that the evidence in question was relevant to charge 12. The panel noted that the admission of a local signed statement from an absent witness should not be regarded as a routine matter.

Considering the principles in *Thorneycroft* the panel considered that Joanne Jones has stated in her witness statement that she refers to what Patient D told her, meaning that Patient D's statement is not the sole or decisive evidence in relation to charge 12. You will be able to cross examine Joanne Jones. The panel considered Fiona Altintas to be

further removed from the evidence source, although you will also be able to cross examine her on this charge.

You challenge the evidence given by Patient D.

There is no evidence that Patient D has fabricated the allegations. The local statement is signed and dated which adds to its formal nature and is near contemporaneous.

The panel considered charge 12 to be serious, although not as serious as some of the other charges you are facing at this hearing. Whilst there could be a negative impact on your career, this may be less than if it was a more serious charge.

The panel noted that there is a good reason for nonattendance of Patient D.

The panel further noted that you were provided with the bundle prior to the hearing and therefore had good notice that the NMC would be relying on this evidence.

In light of all of the above, the panel came to the conclusion that it would be fair and relevant to accept Patient D's local signed statement into evidence and would give it appropriate weight once the panel had heard and evaluated all the evidence before it.

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

Mr McGettigan made a request that parts of this case be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 (2) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Malik had no objection to this application.

The legal assessor reminded the panel that while Rule 19 (1) provides, as a starting point, that hearings shall be conducted in public, Rule 19 (3) states that the panel may

hold hearings partly or wholly in private if it is satisfied that it is justified by the interests of any party or by the public interest.

Having heard that your case involves reference to [PRIVATE], the panel determined to hold those parts of the hearing in private.

Decision and reasons on application for Patient B's oral evidence to be held wholly in private

Mr Malik made a request that Patient B's oral evidence held in private on the basis that there will be reference to [PRIVATE]. The application was made pursuant to Rule 19 (2) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr McGettigan had no objection to this application.

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

Having heard that Patient B's oral evidence relates to [PRIVATE], the panel determined to hold the entirety of Patient B's oral evidence in private.

Decision and reasons on application to redact paragraph 11 of Patient B's witness statement

Mr Malik and Mr McGettigan agreed and made an application for paragraph 11 of Patient B's witness statement to be redacted as it does not relate to the charges.

The panel accepted the advice of the legal assessor.

The panel noted the agreement between the parties as to redacting paragraph 11 of Patient B's witness statement. The panel used their professional judgment when

deciding on the proposed redactions and notified both the parties of its decision to redact the document.

Decision and reasons on application for special measures/reasonable adjustments

The panel heard an application made by Mr Malik for the provision of special measures/reasonable adjustments for Patient B. The application was made pursuant to Rule 23 (1) (b) of the Rules.

Mr Malik stated that, prior to this hearing, Patient B provided [PRIVATE] and requested for the provision of special measures/reasonable adjustments to assist them to attend the hearing and give oral evidence as witness. He submitted that Patient B requested that your camera be turned off when they are giving evidence.

Mr Malik submitted that the special measures/reasonable adjustments were necessary in order to provide support for Patient B throughout the duration of their evidence and to enable them to give their best evidence to the panel.

Mr McGettigan did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel decided to grant the application. The panel therefore directed that you should keep your camera off throughout the duration of Patient B's evidence. The panel was satisfied that these special measures were necessary to enable Patient B to give their best evidence in these proceedings and that no injustice would be posed to you by such special measures.

Decision and reasons on application to redact the last paragraph of Ruth Devonshire's local statement dated 19 October 2017

Mr Malik and Mr McGettigan agreed and made an application for the last paragraph of Ruth Devonshire's (who was the specialist pain nurse) local statement to be redacted and excluded from evidence.

The panel accepted the advice of the legal assessor.

The panel noted the agreement between the parties as to redacting the last paragraph of Ms Devonshire's local statement. The panel used their professional judgment when deciding on the proposed redactions and notified both the parties of its decision to redact the statement.

Decision and reasons on application to redact the paragraph four of Donna Molyneux's witness statement and a section of Donna Molyneux's meeting notes dated 3 January 2018

Mr Malik and Mr McGettigan agreed and made an application for paragraph four of Donna Molyneux's witness statement and a section of Ms Molyneux's meeting notes dated 3 January 2018 to be redacted and excluded from evidence as it does not relate to the charges.

The panel accepted the advice of the legal assessor.

The panel noted the agreement between the parties. The panel used their professional judgment when deciding on the proposed redactions and notified both the parties of its decision to redact the documents.

Decision and reasons on application to redact the paragraph five of Colleague G's witness statement

Mr Malik and Mr McGettigan agreed and made an application for the second and third sentence of paragraph five of Colleague G's witness statement to be redacted and excluded from evidence as it does not relate to the charges.

The panel accepted the advice of the legal assessor.

The panel noted the agreement between the parties. The panel used their professional judgment when deciding on the proposed redactions and notified both the parties of its decision to redact the statement.

Decision and reasons on application to admit Colleague G's meeting notes dated 24 October and Colleague G's 'exhibit 19' as evidence

Mr Malik informed the panel that it has been agreed with Mr McGettigan under Rule 31 to allow Colleague G's meeting notes dated 24 October into evidence.

In respect of Colleague G's 'exhibit 19', Mr Malik informed the panel that both him and Mr McGettigan have agreed redactions and agreed for it to be admitted into evidence.

The panel accepted the advice of the legal assessor.

In light of all of the above, the panel came to the conclusion that it would be fair and relevant to accept Colleague G's meeting notes dated 24 October and Colleague G's 'exhibit 19' into evidence and would give it appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to redact parts of the 'Disciplinary Investigation Report' dated 29 May 2018

Mr McGettigan proposed a number of redactions in the 'Disciplinary Investigation Report' dated 29 May 2018 that do not relate to the charges.

Mr Malik made no objection to this.

The panel accepted the advice of the legal assessor.

The panel noted the agreement between the parties. The panel used their professional judgment when deciding on the proposed redactions and notified both the parties of its decision to redact the report.

Decision and reasons on application to admit Colleague G's meeting notes with you and Colleague H as evidence

Mr Malik informed the panel that this document has not been withheld deliberately, it is a document that only came to light at the start of Colleague G's oral evidence. Whilst Colleague G was giving her evidence she made reference to this document, meeting notes with you and Colleague H. Mr Malik submitted that Colleague G confirmed she had an independent recollection of the meeting which she attended, the notes were jointly written with Colleague H and she can speak to what is in the notes. The notes were written on the day of the meeting and are relevant to the charges you are facing. Mr Malik submitted it is therefore fair and relevant to admit this document into evidence.

Mr McGettigan objected to the admission of this document. He submitted that Colleague G said in oral evidence that Colleague H had written the notes and then Colleague G added to the notes. He submitted that Colleague G did not say in her initial oral evidence that it was jointly written. He submitted that even if Colleague G contributed by amending grammatical errors or name corrections at a later point, she did not write them, it is someone else's record of a meeting, and they are not attending this hearing as a witness. He submitted that there is no signature or date on the document and that anyone can produce such a document. He further submitted that Colleague G can talk about the meeting as much as she can remember in her oral evidence, but she should not use another person's notes to assist her in her recollection.

The panel accepted the advice of the legal assessor.

The panel was directed to Rule 31 of the Rules, which states that evidence can be admitted subject only to the requirement of relevance and fairness. The panel concluded that this would apply at any time during a hearing including a situation like this where a document was brought up during oral evidence.

The panel also took note of NMC guidance DM-6.

The only evidence that may be provided to the panel is evidence which is relevant to one of the issues the panel needs to decide. It also needs to be fair to the people involved in the case, including patients, family members and loved ones, the nurse, midwife or nursing associate and the NMC as a regulator, that the panel considers that evidence.

The panel deliberated with these considerations at the forefront of their minds.

The panel first considered relevance. Paragraph 25 of Colleague G's witness statement refers to a meeting held with you along with Colleague H on 5 September 2017 articulating the concerns and discussing putting you on an action plan and reinstating a supernumerary period. In oral evidence, Colleague G stated that she had a meeting on 5 September 2017 with you and Colleague H (the matron at the time) and then referred to the meeting notes. This document was examined by the parties and admission of this document became a matter that the panel were asked to consider. Whilst the meeting notes are undated and unsigned, the panel is satisfied that it relates to the period covering at least one charge and is therefore relevant under this test.

The panel did not have sight of the meeting notes before making its decision.

The panel went onto consider fairness. In line with DM-6, the panel considered fairness to the people involved in the case, including patients, family members and loved ones, the nurse, midwife or nursing associate and the NMC as a regulator. The panel considered that this was a balancing exercise and took careful consideration of the points raised by both parties to come to their decision.

The panel considered the following points:

- There was no deliberate attempt by the NMC to withhold this evidence. The panel accepted Colleague G's explanation that she did not know how she had not sent all of this documentation to the NMC. It was confirmed by Mr Malik that the NMC had not seen this document prior to today.

- The panel noted that in oral evidence, Colleague G *stated "in the notes written by [Colleague H]"* which suggested the meeting notes were not her own. The panel carefully considered this in light of fairness, and whether Colleague G could speak to them if they were not written by her. The panel listened to the Colleague G's responses when questioned further on this point. The panel found Colleague G's account to be credible when she stated the meeting notes were jointly written with Colleague H and that Colleague G had an independent recollection of the meeting. The panel was cognisant of the fact that a meeting is often led by one individual and an additional person acts as notetaker for practical purposes; the meeting notes were acting as a record of the meeting and Colleague G is entitled to see those meeting notes as her record of the meeting.
- In terms of fairness to you, the panel acknowledged that this was a late submission, and you were unaware of the existence of these meeting notes. The panel then considered how best to mitigate any unfairness to you. The panel decided to ensure that you are provided with sufficient time to review the meeting notes and give instructions to your legal representative, and request redactions of any content which is not relevant to the charges.
- In addition, Colleague G will be subject to cross examination on any part of these notes.
- Furthermore, you will also be able to present any evidence, should you so wish, in relation to the meeting and the meeting notes.

In light of all of the above, the panel have determined that the evidence is relevant and that it is fair to allow these meeting notes to be admitted into evidence.

Details of charge

That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    a. Failed to check, or properly check, that all of Patient F's nasogastric tube had come out after they had cut it with scissors.

b. When asked by Colleague D if Patient F was fine you said “yes, the patient is fine” or words to that effect.

c. When asked by Colleague D if the rest of the tube had come out you said “yes” or words to that effect.

d. Failed to properly escalate the incident involving Patient F’s nasogastric tube to Colleague D in that you did not provide Colleague D with full and/or accurate details.

e. Said to Colleague E you knew half of the nasogastric tube was still inside Patient F, or words to that effect.

f. Said to Colleague E you had escalated to Colleague D that some of the nasogastric tube was still inside Patient F, or words to that effect.

2. Your actions in charge 1c were dishonest because you:

    a. Did not know if the rest of the nasogastric tube had come out because you did not properly check; or

    b. Knew the rest of the nasogastric tube had not come out.

3. Your actions in charge 1e were dishonest because you did not know if any of the nasogastric tube had remained inside Patient F because you did not properly check.

4. Your actions in charge 1f were dishonest because you had not escalated to Colleague D that some of the tube was still inside Patient F.

5. On 30 August 2017:
    a. failed to carry out medication rounds at 12:00 and/or 14:00.

b. failed to tell other staff on duty that the medication rounds at 12:00 and/or 14:00 had not been carried out.

6. On 1 September 2017 in relation to Patient H, having acknowledged Colleague C's instructions to undertake hourly observations of Patient H:

    a. Failed to undertake hourly observations of Patient H.

    b. Failed to maintain the fluid balance chart and/or have oversight of the fluid balance chart.

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:
    a. Failed to change her gown which was covered in blood.

    b. While on an open ward asked her if she had an eating disorder.

    c. Sat her at a table in the middle of the ward to eat her meal.

8. Your actions in charge 7b breached Patient B's confidentiality.

9. On or around 19 October 2017, having been asked by Colleague A to give Patient E 5mg of immediate relief oxycodone and to reduce their 10pm prolonged relief oxycodone to 10mg instead of 20mg:

    a. You prepared 20mg of prolonged release oxycodone to administer to Patient E.

    b. Told Colleague A that you wanted to give the prolonged release oxycodone to Patient E because you had already signed it out and didn't want to waste the medication, or words to that effect.

10. On or before 3 November 2017 snapped and/or huffed at Patient C when he was on the phone to his wife.

11. On 9 November 2017, having been told by Colleague B that Patient D had to be given Gentamicin around 8pm on 9 November 2017, administered Gentamicin to Patient D around 9:47am on 9 November 2017.

12. On or before 10 November 2017 in relation to Patient D:
    a. Were abrupt when speaking to Patient D.

    b. Failed to attend to weeping wounds.

    c. Failed to help them out of bed.

13. On 25 March 2019 in relation to Patient G:

    a. Failed to increase Patient G's oxygen when you were told by Colleague F that his oxygen levels were low.

    b. Failed to promptly provide proper and/or complete equipment to Colleague F.

    c. Failed to assist Colleague F with Patient G's deteriorating condition.

    d. Failed to escalate Patient G's abnormal oxygen saturations levels to senior clinic staff.

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

Decision and reasons to anonymise Patient C

Ms Wisniewska on behalf of NMC made an application under Rule 19 to provide their evidence in private. It was submitted that to give evidence in public would cause potential prejudice to the witness, [PRIVATE]. It was further submitted by her that the need to [PRIVATE] the principles of open justice in these circumstances, and that

hearing the evidence in private was necessary to protect the proper administration of justice.

Mr McGettigan indicated that he supported the application.

The panel had regard to NMC's guidance on anonymisation and to the cases of *Lu v SRA* [2022] EWHC 1729 (Admin) and *Phillips v NMC* [2025] EWHC 2993.

The panel considered that Patient C does meet the defined categories of individuals who should be granted anonymity, and the potential prejudice identified by providing their evidence in public does outweigh the fundamental legal principle of open justice and therefore accepted the application.

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

Ms Wisniewska made a request that this case be held partly in private on the basis that proper exploration of your case involves references to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr McGettigan indicated that he supported the application.

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

The panel determined to go into private session in connection with the evidence of Patient C in its entirety in order to protect his privacy and confidentiality.

Decision and reasons to adduce six Facebook posts and put them to Patient C

Mr McGettigan submitted that the panel should admit six public Facebook posts appearing in the 9 page registrant's evidence bundle and permit him to put them to Patient C. He explained that you had identified and produced the posts and could give evidence about their provenance if required. He characterised the application as one to adduce new evidence rather than an application concerning hearsay.

Mr McGettigan submitted that the posts, dated between 25 April 2021 and 9 May 2025 on your instructions, were relevant to statements made by Patient C in his witness statement dated 17 July 2023. He referred the panel to the witness statement bundle, where Patient C stated, "*I am not the type to complain, so I just got on with it at first."* He also referred to the paragraph where Patient C stated, "*As mentioned above, I am not somebody who would normally make a complaint*."

Mr McGettigan submitted that the purpose of adducing the posts was to rebut what you considered to be a false impression created by those statements. He advanced two principal reasons for their relevance. First, Patient C had twice presented himself as someone who would not ordinarily complain, whereas the posts arguably suggested otherwise. He submitted that it was appropriate to put that apparent inconsistency to Patient C and give him an opportunity to explain it.

Secondly, Mr McGettigan submitted that Patient C's description of himself as someone who would not normally complain arguably gave additional weight to his complaint about you. It could convey that the circumstances had been sufficiently serious to compel him to complain on this particular occasion. He submitted that the posts potentially challenged that impression by indicating that Patient C had also complained about other healthcare professionals and services.

Mr McGettigan explained that other posts concerning more general matters had been identified, but the six posts selected for the application concerned medical care and services specifically. He submitted that their selection reflected the particular issue raised by Patient C's witness statement.

Mr McGettigan referred the panel to the NMC's guidance on evidence, identified as DMA-6, and submitted that the principal considerations were relevance and fairness. He submitted that the posts were relevant to the panel's assessment of Patient C's credibility in circumstances where you disputed his account. The panel would need to resolve the allegations on the balance of probabilities, and evidence which arguably challenged the impression created by Patient C's witness statement could assist that assessment.

In relation to fairness, Mr McGettigan submitted that it was in the interests of fairness to you that these matters could be explored. He submitted that admitting the posts would cause no particular unfairness to Patient C because they were public posts which Patient C had himself published. The material had been provided in advance for consideration, and Patient C could be shown the posts and have their suggested relevance explained before giving evidence. He would also have an opportunity to challenge the material, explain its context and address any apparent inconsistency with his witness statement.

In response to the concerns about provenance, Mr McGettigan relayed your instructions that, around the time of the hearing the previous year, Patient C had appeared on Facebook as a suggested friend. You had not added him as a friend or attempted to establish a Facebook friendship with him. You had clicked on his profile and accessed posts which were publicly available. Mr McGettigan made clear that he was relaying your instructions rather than giving evidence himself. He also acknowledged that there was no evidence establishing that Patient C had viewed your profile.

Mr McGettigan disputed the characterisation of your actions as a fishing expedition. He submitted that you were entitled to examine publicly available information about a witness, just as the NMC could examine information about your history. He reiterated that the posts were public and had been accessible without you becoming Patient C's Facebook friend.

Addressing the distinction drawn between informal Facebook posts and formal complaints, Mr McGettigan invited the panel to consider the entirety of the post dated 22

July 2022. He emphasised its express reference to Patient C having threatened to report two nurses for negligence. He submitted that, at the very least, the post contained a complaint about those nurses and was relevant to Patient C's description of himself as someone who would not ordinarily complain.

Mr McGettigan invited the panel to admit all six posts and permit them to be put to Patient C. However, he acknowledged that the panel could assess the posts individually and admit selected pages while excluding others.

Ms Wisniewska submitted that the NMC opposed the application made on your behalf to adduce six Facebook posts and put them to Patient C. She confirmed that the NMC did not regard the application as one concerning hearsay evidence. Rather, the NMC's objections concerned the relevance of the posts and the fairness of admitting them.

Ms Wisniewska referred the panel to Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. She submitted that, having received the advice of the legal assessor, the panel could admit oral, documentary or other evidence, whether or not it would be admissible in civil proceedings, subject to the requirements of relevance and fairness.

Ms Wisniewska submitted that there were concerns about the provenance of the Facebook posts. They had not been exhibited to a witness statement from you, and there was no explanation in a witness statement of why you had searched for or identified these particular posts. She submitted that the exercise appeared to be a fishing expedition intended to discredit Patient C. She further submitted that there was no connection between the factual circumstances described in the posts and those underlying these proceedings. She reminded the panel that fairness applied both to you and to the NMC.

In relation to relevance, Ms Wisniewska submitted that there was a significant distinction between comments posted informally on Facebook and formal complaints submitted through the appropriate channels. There was no evidence before the panel

that Patient C was a vexatious or serial complainant, or that he had made multiple formal complaints. She submitted that the Facebook posts did not establish otherwise.

Ms Wisniewska referred the panel to Patient C's witness statement, and submitted that, Patient C described having been an inpatient at the hospital for approximately three months from September 2017, [PRIVATE].

Ms Wisniewska submitted that Patient C's account presented a balanced picture of his experience, rather than a general criticism of the hospital. His concerns focused on your behaviour, which he described as different from that of the other nurses and staff. He stated that he initially thought you had a personal grudge against him, but later believed that other staff and patients shared his concerns.

Ms Wisniewska acknowledged the passages identified by Mr McGettigan in the witness statement bundle, in which Patient C described himself as someone who would not ordinarily complain. She submitted that there was no reason to conclude that this was an unfair description of him. In any event, the content of the Facebook posts was not relevant to the serious allegations addressed in his evidence.

Ms Wisniewska also submitted that the posts were remote in time from the alleged events. The allegations concerned events in 2017, whereas the posts were dated 25 April 2021, 30 May 2021, 2 October 2021, 21 October 2021 and 22 July 2022. The remaining post displayed the date 9 May without a year, although the NMC had been informed that it dated from 2025. She submitted that neither their timing nor their content connected them sufficiently to the matters the panel had to determine.

By way of example, Ms Wisniewska referred to a post, in which Patient C [PRIVATE] because, according to the post, staff were not trained to undertake it. She submitted that this was an informal Facebook post seeking other people's views, rather than evidence of a formal complaint.

Ms Wisniewska also referred to the postdated 22 July 2022. In that post, Patient C described difficulties obtaining his morning care visit and assistance from district nurses,

resulting in him remaining in bed without access to necessary personal care for several days. She submitted that, although the circumstances described were regrettable, the post remained an informal account on Facebook and did not establish that a formal complaint had been made.

Ms Wisniewska acknowledged that the same post referred to Patient C having threatened to report two members of staff for negligence, identified as a tissue viability nurse and a district nurse, and alleged that staff had “closed ranks to protect their own”. However, she submitted that there was no evidence that Patient C had acted on those threats by making formal complaints.

Ms Wisniewska submitted that admitting the posts would create a sideshow and distract from Patient C’s evidence, which principally concerned charge 10. She submitted that his evidence should be heard fairly and that only relevant material should be admitted and put to him. For those reasons, together with the concerns regarding provenance and fairness, she invited the panel to refuse the application.

The panel accepted the advice of the legal assessor.

The panel decided to refuse the application made on your behalf to adduce six Facebook posts and put them to Patient C.

The panel considered the submissions of Mr McGettigan and Ms Wisniewska and had regard to the legal assessor’s advice. The panel considered whether the proposed evidence was relevant and whether its admission would be fair, taking account of fairness to you, the NMC and Patient C.

The panel understood that the purpose of the posts being introduced was to challenge Patient C’s statements that he was not someone who would ordinarily complain. The panel recognised Mr McGettigan’s submission that those Facebook posts could undermine Patient C’s complaint about you.

The panel considered that the posts did not concern you, the alleged incident or Patient C's treatment during the hospital admission relevant to these proceedings. They concerned other healthcare experiences several years after the events in 2017. The panel therefore found that they did not assist in establishing what had happened on the occasion addressed by charge 10.

The panel distinguished between informal expressions of dissatisfaction on Facebook and formal complaints made through the appropriate channels. The panel did not consider that the existence of these posts established that Patient C was a serial or vexatious complainant, or that his description of himself as someone who would not ordinarily complain was materially inconsistent with them.

The panel gave consideration to the post dated 22 July 2022, which referred to Patient C having threatened to report a tissue viability nurse and a district nurse for negligence. The panel acknowledged that this went beyond a general expression of dissatisfaction. However, there was no evidence before it that Patient C had acted on those threats by making formal complaints. The panel did not consider that this post provided a sufficient basis for admitting the material to challenge his credibility.

The panel also considered that the posts concerned Patient C's subsequent experiences of obtaining ongoing health and care services. The panel did not consider that expressions of dissatisfaction in those circumstances provided a reliable basis for assessing whether he would ordinarily have complained about the events underlying these proceedings.

The panel considered that the proposed questioning would principally explore Patient C's general propensity to complain, rather than assist its assessment of the alleged conduct. The panel was concerned that this would divert attention from his evidence concerning charge 10 into matters about unrelated healthcare experiences.

The panel also considered the timing of the application. It noted the explanation given on your behalf that the posts had been identified around the time of the previous year's hearing. Although the precise timing of their earlier disclosure to the NMC was unclear,

the application was being considered shortly before Patient C was due to give evidence. The panel considered that introducing these unrelated matters at that stage raised concerns about fairness to the NMC and Patient C.

The panel took account of the fact that the posts were public and that Patient C could be shown them before giving evidence and offered an opportunity to explain them. However, the panel did not consider that those safeguards resolved its concerns about their relevance or the fairness of introducing them at this stage.

The panel did not regard the circumstances in which you had located the posts as determinative. Its decision did not depend on whether you had searched for Patient C's profile or encountered it through Facebook's suggested-friend feature.

The panel considered its overarching responsibility to protect the public, including whether excluding the posts would impair its ability to assess the evidence and determine the allegations fairly. The panel concluded that it would remain able to assess Patient C's account alongside the other evidence before it. The panel was satisfied that excluding these posts would not compromise its ability to reach a fair decision on the charges or lead to a failure to discharge its public protection responsibilities.

Decision and reasons on application of no case to answer

The panel considered an application from Mr McGettigan. He submitted that there was no case to answer in respect of charges 7(a), 7(c), 12(a)–(c) and 13(a)–(d). He invited the panel to dismiss those charges, relying on his written submissions and the additional matters raised orally. This application was made under Rule 24(7).

Mr McGettigan referred the panel to the NMC's guidance on evidence, specifically the section concerning submissions of no case to answer. He submitted that such an application could succeed where there was no evidence supporting an allegation, or where the evidence, taken at its highest, could not properly result in a fact being found proved against you or your fitness to practise being found impaired. He acknowledged

that the application had to be determined entirely by reference to the NMC's evidence, without taking account of evidence which might subsequently form part of your case.

Mr McGettigan also referred to *R v Galbraith* [1981] 1 WLR 1039. He submitted that its principles assisted the panel in distinguishing between evidence whose inherent weakness, vagueness or inconsistency prevented a charge from properly being proved, and evidence whose strength depended on questions of reliability or weight ordinarily determined after all the evidence had been heard. His application principally relied on the second ground identified in the NMC's guidance: that the evidence, even taken at its highest, was insufficient to support the charges.

In relation to charges 7(a) and 7(c), Mr McGettigan submitted that these concerned allegations that, between 25 September and 2 October 2017, you failed to change Patient B's blood-covered gown and sat her at a table in the middle of the ward to eat her meal. He submitted that Patient B was the only witness providing direct evidence of those allegations.

Mr McGettigan submitted that Patient B [PRIVATE]. He submitted that this concession materially undermined her earlier account. Patient B also indicated that she was not attributing responsibility for the alleged failure to change her gown to you and acknowledged that other staff had been working during the relevant period.

Mr McGettigan addressed the NMC's reliance on Patient B's account [PRIVATE]. He submitted that this account had to be considered alongside her concessions under cross-examination. In his submission, her earlier categorical assertion that she had remained in the same gown did not withstand scrutiny when her evidence was considered as a whole.

Mr McGettigan further relied on the documentary evidence indicating that Ms Victoria Quirk had been working on Cedar Ward and caring for Patient B during the day. Although Ms Quirk could not recall whether she had been the nurse in charge, he submitted that she had been clear that she had never had a postoperative patient left in a blood-covered gown and unwashed while under her care.

Mr McGettigan challenged the NMC's assertion that you were responsible for Patient B's postoperative care, pointing out that there was no evidence that you had been the nurse in charge during the relevant period. He invited the panel to consider the possibility that another member of staff, including Ms Quirk, had occupied that role, rather than assuming that responsibility rested with you.

Mr McGettigan also relied on Joanne Jones's response to the allegation that Patient B had been left unchanged and unwashed. He submitted that Ms Jones had rejected that allegation around the time it was raised and described her response as the closest the panel had to contemporaneous evidence on the issue.

Mr McGettigan submitted that the other evidence consisted of hearsay accounts repeating what Patient B had said. He referred the panel to Joanne Jones's witness statement and submitted that these did not record Patient B alleging that you had failed to change her blood-covered gown. Similarly, the PALS complaint recorded in exhibit FA/3 referred to Patient B being upset because she was covered in blood and had not been changed, but did not attribute that alleged failure to you. He also relied on exhibit FA/4, which recorded uncertainty about Patient B's concerns and her intention to write about them later.

Turning to charge 7(c), Mr McGettigan submitted that the earlier accounts differed materially from the allegation as charged. Joanne Jones's witness statement and the PALS complaint referred to Patient B being moved to the other side of the bed so that you could keep an eye on her. He submitted that this was different from sitting her at a table in the middle of the ward to eat her meal.

Mr McGettigan identified further difficulties with Patient B's account. She had associated the incident with Strictly Come Dancing being on television. He submitted that the programme was broadcast at approximately 7 pm, whereas the evening meal was served at approximately 5 pm, as had been put to Patient B. He also referred to her description of eight beds in the bay, contrasting this with Joanne Jones's oral evidence that there were four.

Mr McGettigan submitted that Patient B had also modified some of her wider allegations concerning your behaviour towards her partner. In particular, she had described your conduct as overfamiliar under cross-examination, having used language suggesting flirtation in her witness statement. He submitted that these changes were relevant to the consistency and reliability of her account. He acknowledged [PRIVATE], that her evidence was inconsistent and unclear.

Mr McGettigan submitted that, in the absence of corroboration addressing these difficulties, the evidence supporting charges 7(a) and 7(c) was so tenuous, inherently weak and inconsistent that, even taken at its highest, it could not properly result in those charges being found proved.

In relation to charges 12(a)–(c), Mr McGettigan submitted that these concerned allegations that, on or before 10 November 2017, you were abrupt when speaking to Patient D, failed to attend to her weeping wounds and failed to help her out of bed.

Mr McGettigan submitted that Patient D was the sole source of the allegations and could not attend to give oral evidence. Her account had instead been placed before the panel as hearsay, and there was no corroborating evidence supporting the alleged conduct.

Mr McGettigan referred the panel to exhibit FA/9, which contained information about Patient D's circumstances at the relevant time. He submitted that the records included [PRIVATE]. He invited the panel to consider those matters when assessing the reliability of an account which had not been tested through cross-examination.

Mr McGettigan also referred to the account in Joanne Jones's witness statement that Patient D feared that, if she said anything, you would "*come and get her*". He submitted that this raised further questions about the reliability of the account, particularly where Patient D was unable to be cross-examined.

Mr McGettigan submitted that the allegations concerned largely subjective behaviours said to have occurred almost nine years earlier. He characterised them as generalised

and insufficiently particularised and submitted that it would be extremely difficult for you to answer them fairly after that passage of time. He contended that the untested and uncorroborated evidence, taken at its highest, was insufficient for charges 12(a)–(c) properly to be found proved.

In relation to charges 13(a)–(d), Mr McGettigan submitted that these concerned Patient G's care on 25 March 2019. The allegations were that you failed to increase Patient G's oxygen when informed by Colleague F, namely Gemma McCraith, formerly known as Gemma Ford, that his oxygen levels were low; failed promptly to provide proper or complete equipment; failed to assist Ms McCraith with Patient G's deteriorating condition; and failed to escalate his abnormal oxygen saturation levels to senior clinical staff.

Mr McGettigan submitted that the only direct witness to those allegations was Ms McCraith. He emphasised that Ms McCraith had consistently stated, both in her NMC witness statement and during oral evidence, that she had no recollection of the incident.

Mr McGettigan invited the panel to review Ms McCraith's evidence in its entirety. He submitted that she had maintained her lack of recollection when your account was put to her and had been unable to address or refute it from any independent memory of the events.

Mr McGettigan acknowledged that Ms McCraith had relied on an email she had written at the time. However, he submitted that her support for the email amounted to a general belief that she would have written an accurate account. She could not explain its contents by reference to any present recollection of the incident.

Mr McGettigan submitted that the existence of the email, in those circumstances, was insufficient to establish a case for you to answer. He contended that the witness's complete lack of recollection prevented meaningful exploration of the underlying events and made it particularly difficult for you to address the allegations fairly after the passage of time.

Mr McGettigan submitted that, considering Ms McCraith's oral evidence alongside the email, the evidence was so inherently weak and insufficiently clear that, even taken at its highest, it could not properly support findings against you on the balance of probabilities. He therefore invited the panel to find no case to answer in respect of charges 13(a)–(d).

Mr McGettigan invited the panel to consider each of the identified charges individually and dismiss them on the grounds advanced. He also submitted that the panel could make a finding of no case to answer on its own initiative in respect of any other charge for which it considered the NMC's evidence insufficient.

Ms Wisniewska submitted that the NMC opposed the application made on your behalf for a finding of no case to answer in respect of charges 7(a), 7(c), 12(a)–(c) and 13(a)–(d). She relied on her written submissions and submitted that there was sufficient evidence capable of supporting findings that those charges were proved.

Ms Wisniewska referred the panel to *R v Galbraith* and submitted that the application had to be determined entirely by reference to the NMC's evidence. She explained that, although *Galbraith* concerned criminal proceedings, its principles could be applied in the regulatory context by considering whether there was evidence supporting the acts alleged in the charges.

Ms Wisniewska submitted that neither limb of the test justified granting the application. There was evidence supporting each of the disputed charges, and the NMC did not accept that this evidence was tenuous, inherently weak or inconsistent to such a degree that, taken at its highest, it could not properly support findings against you. She acknowledged that the application principally concerned the second limb of the test but submitted that its requirements were not satisfied.

In relation to charges 7(a) and 7(c), Ms Wisniewska referred the panel to Patient B's written and oral evidence, together with the relevant passages of Joanne Jones's witness statement. She submitted that this evidence provided a clear and cogent basis

for the allegations concerning Patient B's blood-covered gown and being seated at a table in the middle of the ward to eat her meal.

Addressing charge 7(a), Ms Wisniewska submitted that the panel should focus on the allegation that you had failed to change Patient B's blood-covered gown while caring for her following surgery. She referred to paragraph 1.2 of the NMC Code and the requirement to deliver the fundamentals of care effectively. She submitted that Patient B's evidence that [PRIVATE].

Ms Wisniewska emphasised Patient B's evidence that she had felt too frightened or scared to ask you to change her before she went to bed. She acknowledged the submissions made on your behalf concerning Patient B's answers under cross-examination. However, she maintained that Patient B's recollection was that [PRIVATE].

Ms Wisniewska acknowledged that other staff had been working during the relevant period. Nevertheless, she submitted that there was evidence that you were caring for Patient B and that Patient B had felt unable to ask you for assistance because she was frightened. She submitted that the matters raised during cross-examination did not remove the evidential basis for charge 7(a).

Turning to charge 7(c), Ms Wisniewska submitted that Patient B had given a detailed account during examination-in-chief of being placed in the middle of the ward. Patient B had described sitting on a chair with an overbed table in front of her and had expressly identified you as the person who placed the table and chair there. She had also described you moving the television and sitting opposite her so that you could watch both the programme and her eating.

Ms Wisniewska further relied on Patient B's account that you repeatedly shouted across to her that she was not eating enough. Patient B had described becoming upset and frightened by the situation. Ms Wisniewska submitted that this was consistent with the fear Patient B had described when explaining why she had not asked you to change her gown.

Ms Wisniewska addressed the suggested discrepancy between the timing of Strictly Come Dancing and the ward's evening meal. She submitted that the programme's broadcast time was a minor detail which did not establish that Patient B's account was unreliable. She observed that programmes could be broadcast at different times and submitted that this issue distracted from the substance of the allegation: that you had placed Patient B in the middle of the ward, watched her eating and directed her to eat in circumstances which she found upsetting and frightening.

Ms Wisniewska submitted that Patient B's evidence concerning both allegations was sufficiently clear and cogent to establish a case for you to answer. She therefore invited the panel to dismiss the application in respect of charges 7(a) and 7(c).

In relation to charges 12(a)–(c), concerning your alleged conduct towards Patient D, Ms Wisniewska submitted that Patient D's statement had already been admitted as hearsay evidence under Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. She characterised the application, insofar as it relied on the hearsay nature of that evidence, as an attempt to revisit the panel's earlier admissibility decision.

Ms Wisniewska submitted that the absence of cross-examination did not, of itself, render the statement inconsistent, weak or tenuous. She maintained that there was evidence supporting the allegations and that the panel should distinguish between assessing whether there was sufficient evidence for the case to proceed and determining the weight ultimately to attach to that evidence.

[PRIVATE]

Ms Wisniewska addressed the reliance placed on Patient D's reported fear that, if she said anything, you would "*come and get her*". She submitted that no adequate explanation had been advanced as to why this statement demonstrated unreliability. She submitted that it could instead reflect a fear of reprisals on the part of an ill and vulnerable patient.

Ms Wisniewska submitted that fear was a theme also appearing in the evidence of other patients. She referred to Patient B's descriptions of feeling frightened and Patient C's account of keeping his head down and letting matters go. She submitted that this provided relevant context when considering Patient D's expressed concerns. She also relied on the supporting evidence of Joanne Jones's witness statement.

Ms Wisniewska submitted that the appropriate weight to attach to the hearsay evidence should be assessed when the panel determined the facts. She identified relevant considerations as including the reliability of the statement's maker, the circumstances in which it was made, whether it involved multiple hearsay, any motive to conceal or misrepresent matters, and any supporting or contradictory evidence. She emphasised that the evidence had been provided in a formal, signed witness statement containing a statement of truth and submitted that no motive to misrepresent matters had been identified.

Ms Wisniewska maintained that Patient D's evidence was not weak or tenuous within the meaning of the second limb of *Galbraith*. She therefore invited the panel to dismiss the application in respect of charges 12(a)–(c), leaving the assessment of its ultimate weight to the facts stage.

In relation to charges 13(a)–(d), concerning Patient G's care on 25 March 2019, Ms Wisniewska acknowledged that Gemma McCraith, could not independently recall the incident either when preparing her witness statement or when giving oral evidence. However, she submitted that the panel should consider the evidence as a whole, particularly the length of time between the events, the initial email, the NMC statement and her oral evidence.

Ms Wisniewska referred to Ms McCraith's email sent at 10.01 am on 26 March 2019, the morning after the alleged events. She submitted that this was pivotal evidence because it was a detailed and comprehensive account prepared very shortly after the incident.

Ms Wisniewska noted the acknowledgement made on your behalf that Ms McCraith had maintained that she would have written an accurate account. She submitted that this was consistent with the email's detail and content. In the NMC's submission, the email was cogent evidence containing the information necessary to support the allegations.

Ms Wisniewska submitted that Ms McCraith's later inability to remember the incident did not render her earlier email inconsistent or tenuous. Her witness statement was dated 3 February 2025, several years after the events, and it was understandable that her recollection had diminished over time. She submitted that the panel should attach significance to the email's proximity to the incident rather than dismissing it because the witness could no longer recall the underlying events.

Ms Wisniewska reiterated that the email was the best evidence of Ms McCraith's account, given when it was written and the detail it contained. She submitted that it provided a sufficient evidential basis for charges 13(a)–(d) to proceed and invited the panel to reject the application concerning those charges.

Ms Wisniewska submitted that there remained a case for you to answer on all the challenged charges. She therefore invited the panel to dismiss the application in its entirety.

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

In reaching its decision, the panel has made an assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that you had a case to answer.

The panel considered the application made on your behalf for a finding of no case to answer in respect of charges 7(a), 7(c), 12(a)–(c) and 13(a)–(d). The panel refused the application in its entirety.

The panel applied the principles in *R v Galbraith*, considering whether there was any evidence to support each allegation and, where there was evidence, whether it was so inherently weak, vague or inconsistent that, taken at its highest, it could not properly support a finding that the charge was proved.

The panel confined its assessment to the NMC's evidence. The panel recognised that this application did not require it to determine the disputed facts or reach final conclusions about the credibility of witnesses. Questions concerning the weight and reliability of evidence would ordinarily be determined at the facts stage, unless the weaknesses were such that the evidence could not properly support the allegation even when taken at its highest.

The panel first considered charge 7(a), concerning the alleged failure to change Patient B's blood-covered gown between 25 September and 2 October 2017.

The panel acknowledged inconsistencies in Patient B's accounts, including her uncertainty under cross-examination about whether her gown might have been changed after surgery. The panel also considered the evidence of Joanne Jones, particularly her email dated 12 October 2017 stating that Patient B had been washed and provided with appropriate personal hygiene. Joanne Jones had explained that she would have reviewed the electronic patient records before responding to the complaint and that personal care was documented on each shift.

The panel identified evidence supporting the allegation. Patient B had described [PRVATE]. Her account identified you as a nurse caring for her during the relevant period. The panel also had the earlier complaint dated 11 October 2017 and interview records, which had been produced substantially closer to the events than her subsequent oral evidence in September 2025.

The panel distinguished between an allegation that Patient B had remained unchanged throughout the entire period and an alleged failure to change her gown on an occasion within that period. The panel interpreted the charging stem as identifying the period within which the alleged conduct occurred. The inclusion of the word "inclusive" did not

require a finding that the alleged failure continued throughout every day within that period.

The panel also distinguished responsibility for Patient B's care on a particular occasion from being the nurse in charge throughout the whole period. The presence of other staff did not, of itself, exclude the possibility that you had responsibility for attending to Patient B's gown at the relevant time.

The panel considered that Joanne Jones's evidence concerning the provision of hygiene and changes of clothing raised an important issue for consideration at the facts stage. The panel did not consider that this evidence necessarily excluded the particular incident described by Patient B.

The panel considered whether the inconsistencies in Patient B's evidence, together with Joanne Jones's evidence and the contemporaneous records, left an insufficient basis for the charge to proceed. However, the panel concluded that there was sufficient evidence which, taken at its highest, could support a finding that charge 7(a) was proved. The application concerning that charge was therefore refused.

The panel next considered charge 7(c), concerning the allegation that you sat Patient B at a table in the middle of the ward to eat her meal.

The panel identified evidence that Patient B's seating position had been changed so that you could observe her eating. Patient B had described being placed with a chair and table in a different position from where she would ordinarily sit. Her oral evidence included a description of being in the centre of the ward, while the earlier complaint record referred to being moved to the other side of the bed and watched during the meal.

The panel recognised the differences between the descriptions of the location, including references to the other side of the bed, the end of the bed and the middle of the ward. These differences created a challenge for the panel, given the wording of the charge.

The panel considered that, for the purposes of this application, the evidence described Patient B being moved from her usual position to a position within the ward where you could observe her eating. Taking that evidence at its highest, the panel did not consider that the variations in her descriptions rendered the allegation incapable of being proved. The precise location, the meaning of the descriptions and their significance remained matters for the facts stage.

The panel considered the earlier complaint record important because it recorded, close to the events, Patient B's concern that she had been moved and watched while eating. Although that account did not use the words "middle of the ward", the panel considered that it provided evidence relevant to the incident described in her oral testimony.

The panel also considered the arguments about the broadcast time of Strictly Come Dancing and the ward's usual mealtime. The panel did not consider that the suggested discrepancy made the central account so inherently weak that the charge should be stopped at this stage. Its significance could be assessed alongside the other evidence when determining the facts.

The panel recognised the passage of time and Patient B's account [PRIVATE]. The panel did not determine at this stage what effect those circumstances had on the accuracy of her recollection.

The panel decided that there was sufficient evidence for charge 7(c) to proceed. The application concerning that charge was therefore refused.

The panel identified that the wording of the charging stem and the description "in the middle of the ward" had caused significant difficulty when considering charges 7(a) and 7(c). The panel considered that it would assist for the NMC to review whether the wording required clarification or amendment to reflect accurately the alleged conduct.

The panel then considered charges 12(a)–(c), concerning the allegations that you spoke abruptly to Patient D, failed to attend to her weeping wounds and failed to help her out of bed.

The panel reviewed the signed record of Patient D's interview dated 10 November 2017, which had been admitted as hearsay evidence. The panel was aware that Patient D was deceased and that her account could not be tested through oral evidence and cross-examination.

The panel was satisfied that the signed interview record contained evidence addressing each of the three allegations. The panel also considered Joanne Jones's evidence about obtaining Patient D's account and the circumstances in which Patient D had felt able to raise her concerns.

The panel did not consider that [PRIVATE] automatically rendered her evidence unreliable or inherently incapable of supporting the charges. Joanne Jones's evidence that Patient D had been reluctant to speak until she was being transferred provided relevant context.

As previously considered in respect of its decision on hearsay, the panel recognised the limitations arising from the inability to question Patient D. However, those limitations did not mean that there was no evidence or that the evidence was necessarily tenuous. The appropriate weight to attach to her account, including the circumstances in which it was recorded and any supporting or contradictory evidence, remained for assessment at the facts stage.

The panel concluded that the evidence, taken at its highest, was capable of supporting findings that charges 12(a)–(c) were proved. The application concerning those charges was therefore refused.

The panel considered charges 13(a)–(d), concerning Patient G's care and your alleged failures regarding oxygen, equipment, assistance and escalation.

The panel acknowledged that Ms McCraith had no independent recollection of the incident when providing her NMC witness statements dated 3 February 2025 and 11 February 2025 and oral evidence. However, the panel had her contemporaneous email

dated 26 March 2017, describing the clinical concerns which formed the basis of the allegations.

The panel did not consider that the witness's inability to recall the incident several years later deprived that email of evidential value. The panel considered the email to be evidence capable of supporting the charges. The extent to which it could ultimately be relied upon was a matter for the facts stage.

The panel took account of the circumstances discussed in Ms McCraith's evidence, including her explanation that the email reflected her frustration at the time and her lack of further involvement in the investigation. The panel also noted the apparent discrepancy between her evidence that she had not been interviewed and the investigation report's reference to an interview. The panel considered that these matters could be examined when assessing the evidence and did not render the contemporaneous email inherently incapable of supporting the allegations.

The panel concluded that there was sufficient evidence, taken at its highest, for each of charges 13(a)–(d) to proceed. The application concerning those charges was therefore refused.

The panel determined that there was sufficient evidence to support the charges at this stage and, as such, it was not satisfied, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on application for Patients A to H and Person A to remain anonymised

Ms Wisniewska made an application under Rule 19 and submitted that Patients A to H and Person A should remain anonymised throughout your hearing. She explained that the NMC's approach to anonymisation had changed on 13 April 2026, with the general position being that witnesses and other third parties would be named in fitness to practise proceedings.

Ms Wisniewska submitted that certain groups continued to qualify for anonymity under the revised guidance. These included people receiving care, those who had received care previously, and their relatives. Complainants in cases involving alleged sexual misconduct and children also remained within the protected categories, although those categories were not relevant to this case.

Ms Wisniewska submitted that Patients A to H fell within the category of people receiving, or having previously received, care. She therefore applied, pursuant to Rule 19(3), for their anonymity to be maintained and for them to continue to be identified as Patients A to H throughout the hearing.

Ms Wisniewska further submitted that Person A, as Patient C's wife, fell within the category of relatives of people receiving or having received care. She therefore applied for Person A's anonymity to be maintained.

In relation to Colleagues A to F, Ms Wisniewska submitted that, following the change in approach, they should be named in the proceedings.

Mr McGettigan indicated that he supported this application.

The panel had regard to NMC's guidance on anonymisation and accepted the advice of the legal assessor.

The panel considered that Patients A to H and Person A do meet the defined categories of individuals who should be granted anonymity, the potential prejudice identified by the NMC in providing their evidence in public do outweigh the fundamental legal principle of open justice and therefore the panel accepted the application.

In relation to Colleagues A to F, the panel noted that decisions around the publication of determinations rests with the NMC rather than the panel and an application to the NMC must be made by them to anonymise them in any published outcome.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Wisniewska to amend the wording of charge 7 (c).

Ms Wisniewska submitted that charge 7(c) should be amended under Rule 28 of the 2004 Rules to reflect the substance of Patient B's allegation and the different descriptions of where she had been seated.

Ms Wisniewska confirmed that she was not seeking to amend the stem of charge 7 or remove the word "inclusive". She relied on the panel's earlier distinction between an allegation that Patient B had remained unchanged throughout the entire period and an alleged failure to change her gown on an occasion within that period. She agreed with the panel's interpretation that the stem identified the period within which the alleged conduct occurred, without requiring a finding that it continued every day throughout that period.

Ms Wisniewska referred the panel to Rule 28, submitting that it permitted amendments to the charges or the underlying facts at any stage before findings of fact were made, unless, having regard to the merits of the case and the fairness of the proceedings, the amendment could not be made without injustice. She also acknowledged that the panel was required to consider representations from the parties before making an amendment.

Ms Wisniewska submitted that the existing wording of charge 7(c) referred to Patient B being seated at a table in the middle of the ward to eat her meal. Patient B's witness statement described a chair and table in the middle of the ward, and her oral evidence referred to the centre of the ward. However, the PALS complaint record described her being moved to the other side of the bed and watched during her meal.

Ms Wisniewska acknowledged the variation between those descriptions. She submitted that the essence of the allegation was that you had moved Patient B from where she would ordinarily sit to eat so that you could observe her. She relied on Patient B's evidence that she had felt exposed and watched by you and other patients.

Ms Wisniewska therefore proposed that charge 7(c) be amended to read:

“That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    a. Failed to check, or properly check, that all of Patient F’s nasogastric tube had come out after they had cut it with scissors.

    b. When asked by Colleague D if Patient F was fine you said “yes, the patient is fine” or words to that effect.

    c. When asked by Colleague D if the rest of the tube had come out you said “yes” or words to that effect.

    d. Failed to properly escalate the incident involving Patient F’s nasogastric tube to Colleague D in that you did not provide Colleague D with full and/or accurate details.

    e. Said to Colleague E you knew half of the nasogastric tube was still inside Patient F, or words to that effect.

    f. Said to Colleague E you had escalated to Colleague D that some of the nasogastric tube was still inside Patient F, or words to that effect.

2. Your actions in charge 1c were dishonest because you:

    a. Did not know if the rest of the nasogastric tube had come out because you did not properly check; or

    b. Knew the rest of the nasogastric tube had not come out.

3. Your actions in charge 1e were dishonest because you did not know if any of the nasogastric tube had remained inside Patient F because you did not properly check.

4. Your actions in charge 1f were dishonest because you had not escalated to Colleague D that some of the tube was still inside Patient F.

5. On 30 August 2017:

    a. failed to carry out medication rounds at 12:00 and/or 14:00.

    b. failed to tell other staff on duty that the medication rounds at 12:00 and/or 14:00 had not been carried out.

6. On 1 September 2017 in relation to Patient H, having acknowledged Colleague C's instructions to undertake hourly observations of Patient H:

    a. Failed to undertake hourly observations of Patient H.

    b. Failed to maintain the fluid balance chart and/or have oversight of the fluid balance chart.

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:

    a. Failed to change her gown which was covered in blood. NP

    b. While on an open ward asked her if she had an eating disorder.

    c. Sat her at a table in ~~the middle of the ward to eat her meal.~~ **a different position from where she would ordinarily sit to eat a meal so that you could observe her.**

8. Your actions in charge 7b breached Patient B's confidentiality.

9. On or around 19 October 2017, having been asked by Colleague A to give Patient E 5mg of immediate relief oxycodone and to reduce their 10pm prolonged relief oxycodone to 10mg instead of 20mg:

    a. You prepared 20mg of prolonged release oxycodone to administer to Patient E.

    b. Told Colleague A that you wanted to give the prolonged release oxycodone to Patient E because you had already signed it out and didn't want to waste the medication, or words to that effect.

10. On or before 3 November 2017 snapped and/or huffed at Patient C when he was on the phone to his wife.

11. On 9 November 2017, having been told by Colleague B that Patient D had to be given Gentamicin around 8pm on 9 November 2017, administered Gentamicin to Patient D around 9:47am on 9 November 2017.

12. On or before 10 November 2017 in relation to Patient D:

    a. Were abrupt when speaking to Patient D.

    b. Failed to attend to weeping wounds.

    c. Failed to help them out of bed.

13. On 25 March 2019 in relation to Patient G:

a. Failed to increase Patient G's oxygen when you were told by Colleague F that his oxygen levels were low. NP

b. Failed to promptly provide proper and/or complete equipment to Colleague F.

c. Failed to assist Colleague F with Patient G's deteriorating condition.

d. Failed to escalate Patient G's abnormal oxygen saturations levels to senior clinic staff.

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

Ms Wisniewska submitted that the proposed wording fairly reflected the allegation, taking account of the different descriptions in the evidence, and invited the panel to allow the amendment.

Mr McGettigan did not oppose this application.

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

The panel considered the proposed amendment to charge 7(c) and the evidence it had heard concerning where Patient B had been seated to eat her meal.

The panel noted that the descriptions varied between the middle of the ward, the side of the bed and the end of the bed. It considered that the proposed wording, referring to a different position from where Patient B would ordinarily sit, accommodated those descriptions. The panel also considered that the amendment was consistent with the PALS complaint, which was the most contemporaneous account and described Patient B being moved to the other side of the bed.

The panel determined that the central allegation concerned whether you had moved Patient B from her usual position so that you could observe her while she ate. This formed part of the disputed account of your approach to Patient B's [PRIVATE]. The panel considered that the proposed amendment captured that allegation more accurately than wording requiring a particular location within the ward.

The panel took into account its duty to ensure that the charge properly identified the alleged conduct requiring determination. It noted that no objection to the amendment had been raised on your behalf. Having considered the evidence and the fairness of the proceedings, the panel was satisfied that the amendment could be made without injustice.

The new charge as amended is as follows:

“That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    a. Failed to check, or properly check, that all of Patient F’s nasogastric tube had come out after they had cut it with scissors.

    b. When asked by Colleague D if Patient F was fine you said “yes, the patient is fine” or words to that effect.

    c. When asked by Colleague D if the rest of the tube had come out you said “yes” or words to that effect.

    d. Failed to properly escalate the incident involving Patient F’s nasogastric tube to Colleague D in that you did not provide Colleague D with full and/or accurate details.

    e. Said to Colleague E you knew half of the nasogastric tube was still inside Patient F, or words to that effect.

    f. Said to Colleague E you had escalated to Colleague D that some of the nasogastric tube was still inside Patient F, or words to that effect.

2. Your actions in charge 1c were dishonest because you:

a. Did not know if the rest of the nasogastric tube had come out because you did not properly check; or

b. Knew the rest of the nasogastric tube had not come out.

3. Your actions in charge 1e were dishonest because you did not know if any of the nasogastric tube had remained inside Patient F because you did not properly check.

4. Your actions in charge 1f were dishonest because you had not escalated to Colleague D that some of the tube was still inside Patient F.

5. On 30 August 2017:

a. failed to carry out medication rounds at 12:00 and/or 14:00.

b. failed to tell other staff on duty that the medication rounds at 12:00 and/or 14:00 had not been carried out.

6. On 1 September 2017 in relation to Patient H, having acknowledged Colleague C's instructions to undertake hourly observations of Patient H:

a. Failed to undertake hourly observations of Patient H.

b. Failed to maintain the fluid balance chart and/or have oversight of the fluid balance chart.

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:

a. Failed to change her gown which was covered in blood. NP

b. While on an open ward asked her if she had an eating disorder.

c. Sat her at a table in different position from where she would ordinarily sit to eat a meal so that you could observe her.

8. Your actions in charge 7b breached Patient B's confidentiality.

9. On or around 19 October 2017, having been asked by Colleague A to give Patient E 5mg of immediate relief oxycodone and to reduce their 10pm prolonged relief oxycodone to 10mg instead of 20mg:

    a. You prepared 20mg of prolonged release oxycodone to administer to Patient E.

    b. Told Colleague A that you wanted to give the prolonged release oxycodone to Patient E because you had already signed it out and didn't want to waste the medication, or words to that effect.

10. On or before 3 November 2017 snapped and/or huffed at Patient C when he was on the phone to his wife.

11. On 9 November 2017, having been told by Colleague B that Patient D had to be given Gentamicin around 8pm on 9 November 2017, administered Gentamicin to Patient D around 9:47am on 9 November 2017.

12. On or before 10 November 2017 in relation to Patient D:

    a. Were abrupt when speaking to Patient D.

    b. Failed to attend to weeping wounds.

    c. Failed to help them out of bed.

13. On 25 March 2019 in relation to Patient G:

a. Failed to increase Patient G's oxygen when you were told by Colleague F that his oxygen levels were low. NP

b. Failed to promptly provide proper and/or complete equipment to Colleague F.

c. Failed to assist Colleague F with Patient G's deteriorating condition.

d. Failed to escalate Patient G's abnormal oxygen saturations levels to senior clinic staff.

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

Background

The NMC received a referral on 3 August 2018 from the Divisional Head of Nursing and Quality for Medicine at the Liverpool Heart and Chest Hospital NHS Foundation Trust (the Trust) raising concerns about your nursing practice.

You were first registered with the NMC in September 2016 and began working at the Trust in May 2017. The concerns that form the subject of the referral relate to a number of alleged incidents since the beginning of your employment at the Trust that resulted in complaints being made about you by both patients and staff. The complaints cover a range of areas, which include your attitude, treatment of patients, administration and management of medicines, as well as your responses to deteriorating patients.

On 25 August 2017, an incident occurred during a night shift where you failed to appropriately assess an escalating incident involving Patient F who had cut a nasal gastric tube. You told the nurse in charge, Victoria Quirk, that you had checked Patient F and there was no tube remaining inside Patient F's mouth and throat. However, the next morning Patient F coughed up a portion of the tube. You are facing dishonesty charges in respect of this incident and your failure to escalate this incident to Colleague D, namely Victoria Quirk.

On 30 August 2017, you failed to carry out 12:00 and 14:00 medication rounds and did not notify other staff on duty.

On 2 October 2017, Patient B said that you failed to change her bloody gown and embarrassed Patient B by discussing Patient B's personal eating habits knowing [PRIVATE] breaching confidentiality.

On 3 November 2017, Patient C complained that you were rude, lacked compassion, made inappropriate comments and spoke down to patients.

On 9 November 2017, you were told by Ms Molyneux to administer Patient D's gentamicin which is an antibiotic used to treat several types of bacterial infections, not before 8pm that day, due to it being given at 8pm the day before. You administered this 12 hours too early. Ms Molyneux discovered your error and explained in her witness statement that you showed little interest when this incident was raised with you.
On 10 November 2017, Patient D complained to staff that you were rude, did not seem interested in providing care, refused to help Patient D out of bed and refused to clean weeping wounds despite multiple requests from Patient D.

Due to the concerns being raised about your nursing practice, the Trust held a disciplinary hearing dated 10 July 2018 in respect of the incidents that occurred.
On 25 March 2019, you failed to respond to instructions given by the attending physiotherapist Gemma McCraith, who was treating Patient G while Patient G was presenting with a deteriorating respiratory clinical condition. You failed to respond promptly to the physiotherapist and provide respiratory equipment to administer humidified oxygen.

Decision and reasons on facts

The panel noted that you denied all the charges.

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 Wisniewska and Mr McGettigan.

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, who held those positions at the Trust at the time of the allegations:

- Victoria Quirk: Band 5 Senior Registered Nurse
- Elizabeth Madden: (previously Cresswell) Band 6 Sister
- Catherine Watson: Band 5 Staff Nurse
- Patient B: Patient B
- Ruth Devonshire: Lead Acute Pain Nurse Specialist
- Donna Molyneux: Band 6 Staff Nurse
- Gemma McCraith: (previously Ford) Physiotherapist
- Joanne Jones: Ward Manager on Cedar Ward

- Fiona Altintas: Divisional Head of Nursing, Surgery

- Patient C: Patient C

The panel also heard evidence from you under oath.

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

The panel considered the consistency of the accounts, their relationship to the clinical and investigation records, the circumstances in which they were recorded and the passage of time. The panel recognised that most of the events occurred in 2017 and that the events concerning Patient G occurred in 2019.

The panel attached particular importance to records made at or close to the events. The panel recognised that a witness might now have limited independent recollection of an incident but still be able to identify and explain a reliable contemporaneous record. The panel did not regard an acknowledgement of a gap in memory as necessarily undermining credibility. Equally, the detail or confidence of a later recollection did not, by itself, establish its accuracy.

The panel considered your assertions that colleagues had bullied you or sought to attribute blame to you.

The panel considered the written submission by Mr McGettigan and the specific reference to the context of the case and the account by you that you had been bullied by colleagues. It was stated that:

"…..this may allow more open consideration to be given to the fact that some accounts given by others may not always have been entirely accurate. At worst, there could be lies. At best, there could be embellishments or assumptions, clouded by personal contextual factors".

The panel gave careful attention to your evidence in respect of this issue and balanced that against the testimony of the individual witnesses, both documentary and oral. It noted that there was evidence that you had been encouraged to engage in mediation with colleagues and also to invoke the Trust's grievance procedure.

The panel considered the investigation meeting notes dated 19 December 2017 and noted:

At this meeting, you made the comment that:

"I was being bullied but I was discouraged into putting a complaint in, Jo Jones said it was very stressful"

It was pointed out to you by the investigating team:

"you had also had a lot of meeting with Jo Jones and she actively encouraged you to submit a grievance under the Trust's dignity at work policy if you felt that you were being treated unfairly, this was also confirmed in writing to you, and discussed in the presence of your union representative."

Your representative responded that:

"And I have wanted Libby to approach me regarding this, if a member is aggrieved, they need to come to me and I can support them with that, and that is what I have wanted Libby to do."

The panel examined those explanations against the evidence relevant to the individual incidents, including when the accounts were recorded and whether the witnesses had a

direct connection with the events. The panel did not regard the existence of workplace difficulties as sufficient, without supporting evidence, to establish that a particular complaint or record had been fabricated.

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

Charge 1a)

"That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    a. Failed to check, or properly check, that all of Patient F's nasogastric tube had come out after they had cut it with scissors."

This charge is found proved.

The panel considered the allegation that, on 25 August 2017, you failed to check, or properly check, that all of Patient F's nasogastric tube had come out after Patient F cut it with scissors.

The panel took account of Ms Wisniewska's submission that your checks concerned injuries from the scissors and did not establish that you had checked for retained tubing. She relied on the absence of a recorded tube check, the subsequent discovery of retained tubing and the evidence of Ms Quirk and Ms Madden. She clarified that the NMC's submission concerned the absence of relevant information within the Datix report, rather than an absence of any Datix report.

The panel took account of Mr McGettigan's submission that the presence of retained tubing did not itself establish the failure charged. He relied on the checks you described, the rarity of the incident, your relative inexperience and your report to the senior nurse

in charge. He submitted that Ms Quirk's lack of further enquiries or directions was relevant to whether your actions amounted to a failure in those circumstances.

The panel accepted that Patient F was allocated to your care. There was a lack of clarity about whether you remained on preceptorship or were supernumerary, but your own evidence was that you had your own group of patients. The panel was satisfied that you had responsibility for assessing Patient F following this incident and ensuring that the consequences of the tube being cut were addressed.

The panel took account of the unusual circumstances. The tube had been cut rather than simply pulled out, feed had spilled onto the floor and the immediate situation required attention. The panel also considered your relative lack of experience and your evidence that you did not appreciate that part of the tube might remain inside the patient.

The panel nevertheless found that the completeness of the tube required checking. Your evidence described looking in Patient F's nose and mouth for injuries from the scissors. This did not establish that you had checked whether the whole tube had been removed. The record of the subsequent investigation meeting also recorded that you had not measured the tube to ascertain whether any remained inside the patient.

The panel noted that neither the patient records nor the Datix report recorded a check establishing that the tube was complete, or an unresolved concern that part remained inside Patient F. A further length of tube was subsequently coughed up. The panel considered these matters together with your account of what you had checked and found that the checks you undertook were inadequate to establish that all the tube had come out.

The panel did not make this finding merely because tubing was later found to remain inside Patient F. The panel accepted that some checks could have been undertaken without locating retained tubing. Its finding was that the checks you described did not properly address whether the cut tube was complete. Your relative inexperience and the unusual circumstances did not remove that responsibility.

On the balance of probabilities, the panel therefore found charge 1(a) proved.

Charge 1b)

"That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    b. When asked by Colleague D if Patient F was fine you said "yes, the patient is fine" or words to that effect."

This charge is found proved.

The panel considered the allegation that, when Colleague D, identified as Victoria Quirk. asked whether Patient F was fine, you replied, "*yes, the patient is fine*", or words to that effect.

The panel considered Ms Wisniewska's reliance on Ms Quirk's account that she asked whether Patient F was fine and received an affirmative answer. Ms Wisniewska invited the panel to find that this exchange occurred.

The panel considered Mr McGettigan's acknowledgement that the exchange occurred as part of a wider conversation. He submitted that Patient F appeared fine following your checks and that the words should be assessed in that context. He argued that an ordinary factual exchange, without the wrongdoing alleged, would not constitute a charge capable of engaging your fitness to practise.

The panel noted that Ms Quirk described this exchange in her evidence. Your oral evidence also accepted that you had told her the patient was fine. Your representative confirmed that the existence of that exchange, as part of a wider conversation, was not disputed.

The panel considered the submission that your answer reflected how the patient appeared to you and that the exchange did not establish wrongdoing of sufficient seriousness to constitute a fitness to practise allegation. The panel determined that the factual issue was whether the words had been spoken. Your evidence and Ms Quirk's evidence established that they had. The panel therefore found charge 1(b) proved.

Charge 1c)

"That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    c. When asked by Colleague D if the rest of the tube had come out you said "yes" or words to that effect."

This charge is found proved.

The panel considered the allegation that, when Ms Quirk asked whether the rest of the tube had come out, you answered "*yes*", or words to that effect.

The panel took account of Ms Wisniewska's submission that Ms Quirk clearly described asking whether the remaining tube was out and being told that it was. Ms Wisniewska drew attention to Ms Quirk's oral correction removing the assertion that you had been a nurse longer than she had, so that the panel assessed her evidence as corrected.

The panel took account of Mr McGettigan's submission that you denied this specific question being asked and that there was no contemporaneous record of it in the Datix. He acknowledged Ms Quirk's correction but submitted that the original inclusion of the inaccurate assertion about relative experience in her signed statement remained relevant to reliability. He also questioned the extent to which her evidence depended on her statement rather than an independent recollection.

The panel considered your denial that Ms Quirk asked this question. Your account was that she had asked whether the patient was fine but had not raised the possibility of retained tubing. Ms Quirk's account was that she asked both questions and that you answered affirmatively to each.

The panel recognised that Ms Quirk's formal witness statement was made several years after the incident. The panel therefore examined whether the specific question about the remainder of the tube appeared in an earlier account. The panel identified Joanne Jones's internal investigation account from January 2018, which recorded that the nurse in charge had asked whether all the nasogastric tube was out and that you had said it was.

The panel recognised that Ms Jones was reporting what she had been told and was not an eyewitness to the exchange. Nevertheless, this earlier record was significant because it contained the substance of Ms Quirk's account well before her later NMC witness statement. It addressed the panel's concern about whether the additional question might have emerged only after a long interval.

The panel also considered that the question was a natural and relevant enquiry following a report that a patient had cut a nasogastric tube. This supported the plausibility of Ms Quirk's account, although the panel did not treat plausibility alone as proof that the exchange occurred.

The panel took account of Ms Quirk's correction to her statement concerning your relative experience. The panel also recognised that the Datix report did not record the specific exchange. Having considered those limitations, the panel preferred her consistent account of the question and answer, supported by the earlier investigation record, to your denial. The panel found on the balance of probabilities that you answered "*yes*" when asked whether the rest of the tube had come out. The panel therefore found charge 1(c) proved.

Charge 1d)

“That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    d. Failed to properly escalate the incident involving Patient F’s nasogastric tube to Colleague D in that you did not provide Colleague D with full and/or accurate details.”

This charge is found proved.

The panel considered the allegation that you failed properly to escalate the incident to Ms Quirk because you did not provide full and/or accurate details.

The panel considered Ms Wisniewska’s submission that Ms Quirk was told the tube was out, rather than being given information indicating that tubing might remain. She relied on Ms Quirk’s evidence that, had retained tubing been reported, she would have assessed the patient or obtained medical assistance.

The panel considered Mr McGettigan’s reliance on your account that you informed the nurse in charge about the incident and that she did not pursue further checks. He invited the panel to assess the alleged failure in the context of your understanding at the time and the senior nurse’s response.

The panel accepted that you informed Ms Quirk that an incident involving the nasogastric tube had occurred. The issue was the adequacy and accuracy of the information you provided. As the nurse caring for Patient F, you had a duty to give the nurse in charge sufficient information to enable the patient’s safety and the need for further assessment to be considered.

The panel had found that you had not properly checked whether the whole tube had come out, but had reassured Ms Quirk that the patient was fine and that the remainder of the tube was out. Those assurances did not accurately convey that the completeness

of the tube had not been established. They presented the incident as resolved when an important aspect remained unchecked.

The panel considered your evidence that you had reported the incident and that no one appeared concerned. The panel also considered the subsequent meeting record, which recorded your account of reporting the incident and your acknowledgement that you had not measured the tube. The panel was satisfied that informing Ms Quirk in general terms did not discharge your duty to provide full and accurate details. The absence of any recorded unresolved concern about retained tubing in the Datix and patient records was consistent with that conclusion. The panel therefore found charge 1(d) proved.

Charge 1e)

"That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    e. Said to Colleague E you knew half of the nasogastric tube was still inside Patient F, or words to that effect."

This charge is found proved.

The panel considered the allegation that you told Colleague E that you knew part of the nasogastric tube remained inside Patient F, or words to that effect. The panel identified Colleague E as Elizabeth Madden, formerly known as Elizabeth Cresswell.

The panel considered the parties' submissions concerning both charges 1(e) and 1(f). Ms Wisniewska relied on Ms Madden's email of 1 September 2017 and her witness evidence recording that you said you knew tubing remained and had told Ms Quirk. She submitted that this account conflicted with the account of the original incident and invited the panel to prefer Ms Madden's and Ms Quirk's evidence to yours.

The panel considered Mr McGettigan's submission that you denied the alleged conversation with Ms Madden. He questioned her independent recollection, the interpretation recorded in her email and the circumstances in which accounts were gathered by Ms Jones. He also submitted that it was implausible for you to give Ms Madden that account while telling Ms Jones that you had not known tubing remained, and invited the panel to assess this alongside the alleged bullying context.

The panel placed substantial weight on Ms Madden's email dated 1 September 2017, which recorded her conversation with you following the discovery of the retained tube. Her account was that, after she explained the seriousness of the incident, you said you had been aware that tubing remained in situ. The email also recorded your explanation that you had informed Ms Quirk but that no one was listening and that attention had focused on the scissors.

The panel considered your denial of the conversation and your evidence that you had gone straight home at the end of your shift. The panel did not consider that this established that the conversation could not have occurred. The account was recorded in an email sent approximately a week after the incident, and the evidence did not require the conversation to have taken place immediately at the end of the shift you described.

The panel considered your explanation during oral evidence that Ms Madden belonged to a group who bullied you and that Ms Jones had sought emails a considerable time after the events. The panel noted that the email was written close to the incident. Its wording presented it as an update about a conversation Ms Madden had had with you. The panel was not satisfied that the evidence established that Ms Jones had prompted Ms Madden to invent or alter the contents of that account.

The panel also considered Ms Madden's acknowledgement of the limits of her present memory and her reliance on the email. The panel regarded this as an appropriate recognition of the passage of time. Ms Madden had not been the nurse in charge during the incident and the panel identified no persuasive explanation for her inventing an account which would also cast doubt on the response of another senior nurse.

The panel preferred Ms Madden's account, supported by her email, to your denial. The panel's finding was that you said you had known tubing remained inside Patient F. Whether you actually had that knowledge was a separate issue addressed under the dishonesty charges. The panel therefore found charge 1(e) proved.

Charge 1f)

"That you, a registered nurse:

1. On 25 August 2017 in relation to Patient F:

    f. Said to Colleague E you had escalated to Colleague D that some of the nasogastric tube was still inside Patient F, or words to that effect."

This charge is found proved.

The panel considered the allegation that you told Ms Madden that you had escalated to Ms Quirk that some of the nasogastric tube remained inside Patient F, or words to that effect.

The panel relied on the same email and evidence considered under charge 1(e). Ms Madden recorded that you said you had informed Ms Quirk of the retained tube but that your concerns had not been listened to. This was an express part of her account of the conversation and was recorded close to the events.

The panel considered your denial, the suggested influence of workplace bullying and your criticism of Ms Jones's role in gathering information. The panel was satisfied that those explanations did not outweigh the contemporaneous account. The panel found that you made the statement attributed to you and therefore found charge 1(f) proved.

Charge 2a)

"That you, a registered nurse:

2. Your actions in charge 1c were dishonest because you:

    a. Did not know if the rest of the nasogastric tube had come out because you did not properly check; or

This charge is found proved.

The panel considered whether your answer in charge 1(c) was dishonest because you did not know whether the rest of the tube had come out, having failed properly to check.

The panel considered Ms Wisniewska's submissions on the alternative allegations in charges 2(a) and 2(b). She invited the panel first to ascertain your actual knowledge or belief and then assess your conduct by the objective standards of ordinary decent people. She submitted that the assurance that the tube was out was dishonest if you either had not properly checked and did not know, or knew that tubing remained.

The panel considered Mr McGettigan's submission that the dishonesty allegation depended on proving the disputed exchange in charge 1(c). He maintained that the question was never asked. Alternatively, he submitted that a lack of knowledge following inadequate checking was more plausible than actual knowledge that tubing remained and deliberate concealment of it. He invited the panel to reject dishonesty.

The panel first considered your knowledge at the time. Your own account was that you had not appreciated the possibility of retained tubing and had looked for injuries from the scissors. The investigation record also recorded that you had not measured the tube. The panel found that you had not established whether the whole tube had come out and did not know that it had.

The panel then considered your affirmative answer to Ms Quirk. By saying that the rest of the tube was out, you conveyed certainty about a matter which you had not checked and did not know. The panel was satisfied that you knew what checks you had undertaken and that your answer represented the position as established when it was not.

The panel considered whether this could have been an innocent description of the patient appearing well. That explanation related to the more general question in charge 1(b). It did not adequately explain an affirmative answer to the separate, specific question about the remainder of the tube.

The panel found that the answer was a false reassurance given in circumstances where you had not properly checked. Applying the standard of ordinary decent people to the conduct in light of your knowledge, the panel found that the answer was dishonest. The panel therefore found charge 2(a) proved.

Charge 2b)

"That you, a registered nurse:

2. Your actions in charge 1c were dishonest because you:

    b. Knew the rest of the nasogastric tube had not come out."

This charge is found not proved.

The panel considered the alternative allegation that your answer in charge 1(c) was dishonest because you knew that the rest of the tube had not come out.

The panel distinguished between finding that you later told Ms Madden you had known tubing remained and finding that you actually possessed that knowledge during the original incident. The panel accepted that you made the later statement but did not accept its truth. The panel's findings were that you had not properly checked and did not know whether tubing remained inside Patient F.

The panel was therefore not satisfied that the NMC had proved the actual knowledge required by charge 2(b). The panel found this alternative charge not proved.

Charge 3

“That you, a registered nurse:

3. Your actions in charge 1e were dishonest because you did not know if any of the nasogastric tube had remained inside Patient F because you did not properly check.”

This charge is found proved.

The panel considered whether your statement in charge 1(e) was dishonest because you did not know whether any of the tube remained inside Patient F, having failed properly to check.

The panel took account of Ms Wisniewska’s submission that your statement to Ms Madden about already knowing tubing remained was made only after Ms Madden explained that the patient had coughed up the remaining tube. She submitted that the statement was a dishonest attempt to deflect responsibility for not checking properly.

The panel took account of Mr McGettigan’s submission that the underlying conversation was denied and that it made little sense for you to claim prior knowledge to Ms Madden while acknowledging to Ms Jones that you had not appreciated the possibility of retained tubing. He relied on that acknowledged conversation with Ms Jones and the Datix as supporting your account.

The panel had found that you told Ms Madden you knew tubing remained inside the patient. The panel had also found that you had not properly checked and had not possessed that knowledge at the time. Your later statement represented you as having identified the retained tubing during the original incident, which the panel found you had not done.

The panel considered the apparent inconsistency between this account and the account you gave Ms Jones that you had not realised tubing remained. The panel found that the

statement to Ms Madden was an attempt to protect yourself from criticism once the seriousness of the retained tube had been explained. The fact that the explanation could later be contradicted did not persuade the panel that it could not have been given.

The panel was satisfied that you knew the statement about your earlier awareness was untrue. Ordinary decent people would regard such a false account of your knowledge in a clinical incident as dishonest. The panel therefore found charge 3 proved.

Charge 4

"That you, a registered nurse:

4. Your actions in charge 1f were dishonest because you had not escalated to Colleague D that some of the tube was still inside Patient F."

This charge is found proved.

The panel considered whether your statement in charge 1(f) was dishonest because you had not escalated to Ms Quirk that some of the tube remained inside Patient F.

The panel considered Ms Wisniewska's submission that you falsely represented to Ms Madden that you had escalated retained tubing to Ms Quirk, although you had actually told Ms Quirk that the tube was out. She submitted that this discrepancy established dishonesty.

The panel considered Mr McGettigan's submission that you denied making the alleged statement. He also questioned why you would knowingly give Ms Madden an account which Miss Quirk could readily contradict, while providing Ms Jones with a different account. He invited the panel to find that the alleged dishonesty had not been established.

The panel had found that your original report reassured Ms Quirk that the patient was fine and that the tube was out. You had not reported a known retained section of tube. The

panel nevertheless found that you later told Ms Madden that you had escalated that precise concern and had not been listened to.

The panel was satisfied that you knew what you had reported to Ms Quirk. The later account falsely represented that you had identified and escalated the retained tubing, thereby shifting responsibility for the response to someone else. The panel considered that ordinary decent people would regard that conduct as dishonest. The panel therefore found charge 4 proved.

Charge 5a)

"That you, a registered nurse:

5. On 30 August 2017:

    a. failed to carry out medication rounds at 12:00 and/or 14:00."

This charge is found proved.

The panel considered the allegation that, on 30 August 2017, you failed to carry out medication rounds at 12:00 and/or 14:00.

The panel took account of Ms Wisniewska's submissions on both parts of charge 5. She relied on Catherine Watson's evidence that some 12:00 medication and all the 14:00 medication remained unadministered and unsigned on the electronic system. She submitted that medication should have been given at the prescribed times, challenged your explanation about combining rounds at 13:00 and maintained that there was no record establishing administration even on that basis.

The panel took account of Mr McGettigan's submission that Ms Watson's conclusion depended on an electronic work-list which had not been produced. He identified the absence of medication counts, patient enquiries or other checks and the conflicting evidence about the alleged telephone call. He submitted that you had not omitted

medication, whether through separate rounds or an authorised combined round, without handing this over, and that the evidential gaps prevented either part of charge 5 being proved.

The panel considered Ms Watson's evidence that medication due during the relevant period had not been given. Her account was supported by Ms Jones's evidence and the record of the subsequent investigation meeting. That meeting record stated that you explained that you had been called into dementia-awareness training and had not given the 14:00 medication. When asked whether you completed it after the training, you said you had not because you were too busy with documentation.

The panel recognised that the underlying electronic medication records had not been produced. It considered the limitations of evidence based on later descriptions of those records. Nevertheless, the meeting record made close to the events recorded both the concern shown on the electronic system and your own explanation for not completing the medication. This gave the panel a basis for determining the allegation beyond Ms Watson's recollection alone.

The panel considered your evidence about combining the 12:00 and 14:00 rounds into a round at approximately 13:00. The panel accepted that the administration of medication on a busy ward could involve some variation in timing. It did not find the charge proved simply because a round might have occurred at 13:00 rather than precisely at 12:00 or 14:00.

The panel's finding was that medication due at 14:00 had not been administered before you left, rather than merely that it had been given at a different time. You had a duty to complete the medication round allocated to you or make appropriate arrangements for it to be completed. The panel preferred the evidence of Ms Watson and Ms Jones, supported by the earlier meeting record, to your later denial.

The panel also considered the suggested problems with the electronic system. The witnesses did not support the existence of a system failure explaining the omission, and the meeting record contained your explanation in terms of training and documentation.

The panel was satisfied that at least the 14:00 medication round had not been carried out. This established the allegation as framed using “and/or”. The panel therefore found charge 5(a) proved.

Charge 5b)

“That you, a registered nurse:

5. On 30 August 2017:

    b. failed to tell other staff on duty that the medication rounds at 12:00 and/or 14:00 had not been carried out.”

This charge is found proved.

The panel considered whether you failed to tell other staff on duty that the relevant medication round had not been carried out.

The panel relied particularly on the investigation meeting record, which recorded that you had not asked another nurse to complete the medication. The omission was subsequently identified by other staff rather than through an adequate handover from you. This was consistent with Ms Watson’s account of discovering that the medication remained outstanding.

The panel recognised that the evidence about who had made an alleged telephone call to you was inconsistent. The panel did not resolve that uncertainty by attributing the call to Ms Watson. Its finding rested on the evidence that the medication remained outstanding, the way this came to light and the earlier record of your explanation that you had not arranged for another nurse to give it.

The panel considered your explanations concerning training, documentation, [PRIVATE] and your interaction with Ms Watson. Those matters did not remove your duty to alert

another member of staff to outstanding medication. The panel was satisfied that you had not done so and therefore found charge 5(b) proved.

Charge 6a)

"That you, a registered nurse:

6. On 1 September 2017 in relation to Patient H, having acknowledged Colleague C's instructions to undertake hourly observations of Patient H:

    a. Failed to undertake hourly observations of Patient H."

This charge is found proved.

The panel considered the allegation that, on 1 September 2017, having acknowledged the instructions referred to in the charge, you failed to undertake hourly observations of Patient H.

The panel considered Ms Wisniewska's submissions on both parts of charge 6. She relied on your acknowledgement that another person undertook the allocated tasks and that you did not check whether they were completed. She submitted that you remained responsible for Patient H and that delegation without follow-up established the failures concerning hourly observations and fluid-balance monitoring.

The panel considered Mr McGettigan's submission that Ms Jones had not witnessed the incident and that the available contemporaneous material was limited. He relied on your explanation that the duties had been allocated to another member of staff whom you believed was a nurse. He acknowledged your failure to check subsequently but submitted that the panel had to determine whether that omission, in the context of the delegation, established the failures as charged.

The panel accepted that hourly observations had been required. The observation record reproduced within Ms Jones's material showed a recorded observation at approximately

16:31 and no further observation until approximately 20:10. This was inconsistent with the required hourly monitoring.

The panel considered your evidence that another member of staff had undertaken, or agreed to undertake, these duties. Your oral account included your belief that the person was a nurse, although the earlier meeting record referred to a healthcare assistant. The panel noted that no delegation was documented and that you accepted you had not checked that the observations were completed.

The panel recognised that the full original patient notes were not before it. It considered your suggestion that Ms Jones's document was an interpretation rather than a reproduction of the records. The panel was satisfied that the material reproduced the relevant observations and was supported by the earlier meeting record in which the allocation of the tasks and your failure to check were discussed.

The panel found that delegating a task to another member of staff did not remove your responsibility to ensure that the required observations were undertaken. Even taking your account of the arrangement into account, the gap in the observations remained and you had not checked that the required monitoring occurred. The panel therefore found charge 6(a) proved.

Charge 6b)

"That you, a registered nurse:

6. On 1 September 2017 in relation to Patient H, having acknowledged Colleague C's instructions to undertake hourly observations of Patient H:

    b. Failed to maintain the fluid balance chart and/or have oversight of the fluid balance chart."

This charge is found proved.

The panel considered the allegation that you failed to maintain and/or have oversight of Patient H's fluid-balance chart.

The panel noted that the reproduced fluid-balance record contained an entry at approximately 15:00, followed by no further entry until midnight. The panel was satisfied that this did not demonstrate the ongoing monitoring and recording required for Patient H.

The panel considered your account that you trusted the healthcare assistant to complete the chart. It also considered the difference between that description in the earlier meeting record and your later account of believing the person to be a nurse. The panel did not find that the latter account adequately explained the absence of recorded monitoring or your failure to exercise oversight. Your acknowledgement that you should have checked the chart was significant.

The panel also considered the entry you made the following afternoon concerning urine passed into a commode, bottle or bed. That later narrative did not establish that the fluid-balance chart had been maintained or overseen during the relevant period on 1 September. The panel did not need to make any determination about the nursing note entries being made the following day.

The panel was satisfied that, irrespective of the arrangement you described, you had failed to maintain the chart or ensure that the delegated task was being completed. The panel therefore found charge 6(b) proved.

Charge 7a)

"That you, a registered nurse:

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:

    a. Failed to change her gown which was covered in blood."

This charge is found not proved.

The panel considered the allegation that, between 25 September and 2 October 2017 inclusive, you failed to change Patient B's gown which was covered in blood.

The panel considered Ms Wisniewska's submission that Patient B's uncertainty about an earlier change of gown did not displace her recollection of [PRIVATE]. She relied on Patient B's description of feeling too frightened to ask you for help and changing herself at approximately 04:00. She submitted that other staff being present did not negate Patient B's account of your involvement in her care.

The panel considered Mr McGettigan's submission that Patient B had accepted she might have been changed after surgery and had not attributed the alleged omission to you when questioned. He relied on other staff being involved, your supernumerary status, Ms Quirk's evidence about postoperative care and Ms Jones's contemporaneous assurance that personal hygiene had been provided. He submitted that your responsibility for the particular alleged failure had not been established.

The panel interpreted the charging period as identifying when the alleged omission occurred. The word "inclusive" did not require proof that Patient B had remained in an unchanged gown throughout every day of that period.

The panel considered Patient B's description [PRIVATE] also appeared in the PALS complaint. [PRIVATE].

The panel also considered Ms Jones's email of 12 October 2017, which stated that Patient B had been washed and provided with personal hygiene care. That general assurance did not necessarily resolve whether a gown required changing on a particular occasion. Equally, the panel was not satisfied that the evidence identified sufficiently when the gown became blood-stained, your responsibility at that time or the circumstances in which you should have changed it.

The panel noted that several nurses and healthcare assistants were involved in Patient B's care. The evidence did not establish with sufficient clarity that the relevant occasion coincided with a period when the duty to change the gown fell to you. Nor was there sufficiently clear evidence of a request to you to change it or of your awareness of a need to do so at the relevant time.

The panel was prepared to accept that Patient B had experienced the concern she described. Its decision did not depend on rejecting her account of blood-stained clothing. The panel determined that the NMC had not discharged its burden of establishing the particular failure by you alleged in this charge. The panel therefore found charge 7(a) not proved.

Charge 7b)

"That you, a registered nurse:

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:

    b. While on an open ward asked her if she had an eating disorder."

This charge is found proved.

The panel considered the allegation that, while on an open ward, you asked Patient B whether she had an eating disorder.

The panel took account of Ms Wisniewska's submission that Patient B consistently described a loud question about [PRIVATE] on the open ward. She submitted that this was inconsistent with the gentle conversation you described and relied on Patient B's account of feeling watched and exposed.

The panel took account of Mr McGettigan's challenge to Patient B's reliability, including changes in her account and unsupported assumptions about your conduct towards her

and her partner. He relied on your account of the circumstances in which the eating concern was discussed and invited the panel to prefer it.

The panel considered Patient B's evidence that you addressed her loudly from some distance while the curtains were open. She was clear that you were looking at her and that the question was directed to her. Her oral evidence was consistent with the substance of the complaint recorded close to the events.

The panel relied particularly on the PALS record, which referred to the question about [PRIVATE]. Ms Jones's evidence also recorded Patient B's complaint about the way food and eating had been addressed in front of other people. The panel recognised that these records repeated Patient B's account, but their proximity to the events was significant when assessing her later recollection.

The panel considered your account that the matter arose during a quiet conversation and that Patient B disclosed the information herself and you stated that you did not ask her any follow-up questions. The panel determined that this was unlikely as you subsequently referred her to a dietician and would have been very unlikely to do so without further information. The panel also considered your clinical entry at 17:18 on 1 October 2017 related to her food intake.

> *"…filled herself with sweets, Lucozade and crisps earlier then complained of feeling sick. Advised patient to choose healthier options for snacks and sit out during meal times."*

These records supported the fact that eating concerns had been discussed, although they did not, by themselves, establish the volume or setting of the conversation.

The panel recognised that Patient B had made assumptions about other matters, including your interaction with her partner and what another patient had allegedly been told. The panel did not accept every inference she drew. It nevertheless found her account of this particular question, supported by the earlier complaint, sufficiently clear

and consistent to prefer it to your account. The panel therefore found charge 7(b) proved.

Charge 7c)

"That you, a registered nurse:

7. Between 25 September and 2 October 2017 (inclusive) in relation to Patient B:

    c. Sat her at a table in different position from where she would ordinarily sit to eat a meal so that you could observe her."

This charge is found proved.

The panel considered the amended allegation that you sat Patient B at a table in a different position from where she would ordinarily sit to eat a meal so that you could observe her.

The panel considered Ms Wisniewska's submission that the differing descriptions of the location did not undermine the central allegation: you moved Patient B from where she ordinarily sat so that you could observe her eating. She relied on the earlier PALS account and submitted that the amended wording fairly captured the substance of the allegation.

The panel considered Mr McGettigan's submission that the amendment did not remove the relevance of the varying accounts of the location. He also relied on inconsistencies concerning the ward layout and timing, together with your explanation that sitting in the position described could be an ordinary arrangement. He invited the panel to assess these matters when deciding whether the alleged conduct was proved.

The panel recognised the differences between later descriptions of the middle or centre of the ward and the description in the PALS complaint of being moved to the other side of the bed. The amended charge required the panel to determine whether Patient B had

been moved from her ordinary position for observation. It did not require the panel to identify a precise geometrical location in the ward.

The panel placed particular weight on the PALS complaint recorded on 11 October 2017. This described Patient B being moved to the other side of the bed from where she would normally sit and being watched during the meal. The panel considered this a clear account made relatively close to the incident.

The panel also considered your clinical entry of 1 October 2017, which referred to encouragement with diet and fluids, insisting that Patient B sat in her chair for her meal, and advice concerning snacks and sitting out at mealtimes. The panel recognised that this entry did not record moving her to a different position. It nevertheless supported the context of your actively directing and monitoring her eating arrangements.

The panel considered your denial that she had been moved from her usual position. It preferred Patient B's earlier account that she was placed somewhere different so that you could watch her intake. The panel was satisfied that the purpose of observing her was established by the description of being moved and watched during the meal and the associated exchange about her eating. The panel therefore found the amended charge 7(c) proved.

Charge 8

"That you, a registered nurse:

8. Your actions in charge 7b breached Patient B's confidentiality."

This charge is found proved.

The panel considered whether your conduct in charge 7(b) breached Patient B's confidentiality.

The panel took account of Ms Wisniewska's submission that asking Patient B about [PRIVATE] on an open ward disclosed a private health matter and breached confidentiality. She invited the panel to prefer Patient B's account of that exchange.

The panel took account of Mr McGettigan's submission that Patient B had disclosed the information spontaneously and unexpectedly, rather than through a public disclosure by you. He also relied on the limited detail about the location, who was present and what could be overheard, and the absence of a witness saying that they heard the alleged disclosure.

The panel had found that you asked Patient B about [PRIVATE] on an open ward, loudly and in circumstances in which others could hear. The question concerned sensitive information about her health. The panel was satisfied that addressing it in this manner exposed a private health matter to other people on the ward.

The panel considered the practical difficulties of discussing care in a shared ward. Those difficulties did not remove the confidential nature of the information or justify the manner of this particular exchange. The panel's finding concerned the disclosure inherent in the public question. Its assessment of the seriousness of that breach was reserved for the subsequent stage. The panel therefore found charge 8 proved.

Charge 9a)

"That you, a registered nurse:

9. On or around 19 October 2017, having been asked by Colleague A to give Patient E 5mg of immediate relief oxycodone and to reduce their 10pm prolonged relief oxycodone to 10mg instead of 20mg:

    a. You prepared 20mg of prolonged release oxycodone to administer to Patient E."

This charge is found proved.

The panel considered whether, having been asked by Colleague A to give Patient E 5 mg of immediate-release oxycodone and reduce the 22:00 prolonged-release dose to 10 mg instead of 20 mg, you prepared 20 mg of prolonged-release oxycodone for administration. The panel identified Colleague A as Ruth Devonshire, the specialist pain nurse.

The panel considered Ms Wisniewska's submissions on both parts of charge 9. She relied on Ms Devonshire's account that she gave clear instructions for immediate-release oxycodone and a reduction of the later prolonged-release dose. She submitted that you nevertheless prepared 20 mg of prolonged-release medication and then wanted to give it because it had already been signed out and you did not wish to waste it. She invited the panel to reject your explanation that you had not been told of the change.

The panel considered Mr McGettigan's submission that you received no advance instruction to change the medication and that the electronic prescription had not been amended before preparation. He relied on your account that Mr Mawdsley made the disputed comment, Ms Devonshire's recorded acknowledgement that you said you were unaware of a reduction and the absence of contemporaneous prescription records. He also submitted that the medication was ultimately corrected and apparently administered correctly, and questioned whether the conduct charged was capable of engaging your fitness to practise.

The panel placed substantial weight on Ms Devonshire's email of 19 October 2017, made on the day of the incident, and her internal investigation account of May 2018. The panel considered these alongside her later witness statement and oral evidence. Her account remained consistent that she had explained the intended medication.

The panel noted that Sean Mawdsley, acting as second checker, approached Ms Devonshire to question the proposed 20 mg prolonged-release dose. Ms Devonshire

then found you involved in preparing that medication. Her account of what she saw and the discussion which followed supported the allegation that the preparation was yours.

The panel considered your evidence that the relevant instruction was given only after medication had been prepared, that the prescription still showed the previous dose and that Mr Mawdsley was responsible for preparing it. The panel also considered the absence of the underlying patient records. It nevertheless preferred Ms Devonshire's detailed account of the sequence, recorded on the day and repeated in the investigation, to your later account.

Ms Devonshire confirmed that at the time in question, she was not a non-medical prescriber. She confirmed that 5mg PRN oxycodone had already been prescribed to this patient. The panel determined this conflicted with your evidence that you were made to wait in the medicine room until Ms Devonshire had updated the prescription.

The panel was satisfied that you had received the direction described in the charge before preparing the prolonged-release medication. The panel did not regard the fact that medication was ultimately corrected as answering whether the preparation alleged had occurred. The panel therefore found charge 9(a) proved.

Charge 9b)

"That you, a registered nurse:

9. On or around 19 October 2017, having been asked by Colleague A to give Patient E 5mg of immediate relief oxycodone and to reduce their 10pm prolonged relief oxycodone to 10mg instead of 20mg:

    b. Told Colleague A that you wanted to give the prolonged release oxycodone to Patient E because you had already signed it out and didn't want to waste the medication, or words to that effect."

This charge is found proved.

The panel considered whether you told Ms Devonshire that you wanted to give the prolonged-release oxycodone because it had already been signed out and you did not want to waste it, or words to that effect.

The panel relied on Ms Devonshire's account that, when she intervened, you said the medication had already been taken out and asked whether it could be given rather than wasted. Her internal investigation account and witness statement consistently attributed those comments to you. The panel found her account of the conversation clear and supported by the sequence she had recorded close to the event.

The panel considered your evidence that Mr Mawdsley made the disputed comment. The panel preferred Ms Devonshire's account, which distinguished his role in raising a query from your response about the medication already being prepared. The panel also noted that her contact with you arose through her specialist role and identified no persuasive basis for finding that she had fabricated the words as part of the workplace difficulties you described.

The panel additionally considered the investigation meeting of 19 December 2017. In the meeting you stated:

> *"With regards to complaint number 6, complaint from Ruth Devonshire, this is in relation to Patient E"*

You further stated:

> "*I think when they mentioned it to me, I agree, I was sorry, wouldn't do it again*."

The panel noted the limited context of that passage. It did not treat it as an unequivocal admission of every element of charge 9. It nevertheless considered the recorded response when assessing your later complete denial of the account attributed to Ms Devonshire. The principal basis for the finding remained her consistent evidence and the records made close to the incident. The panel therefore found charge 9(b) proved.

Charge 10

"That you, a registered nurse:

10. On or before 3 November 2017 snapped and/or huffed at Patient C when he was on the phone to his wife."

This charge is found proved.

The panel considered the allegation that, on or before 3 November 2017, you snapped and/or huffed at Patient C while he was on the telephone to his wife.

The panel considered Ms Wisniewska's submission that Patient C was clear and consistent about being snapped and huffed at while speaking to his wife. She relied on his written and oral accounts and the records of his complaint. She also invited the panel to consider the importance of telephone contact to him following his life-changing condition.

The panel considered Mr McGettigan's submission that Patient C had distanced himself from parts of the statement bearing his name, added allegations during oral evidence and made assumptions unsupported by personal experience. He relied on the absence of another witness to the incident, staff having spoken adversely about you to Patient C and Ms Jones's role in persuading him to make a statement. He submitted that these matters could have affected his perception and the reliability of the account.

The panel recognised that Patient C took strong issue with several passages in the written statement attributed to him. It considered this carefully and did not assume that everything in that document accurately represented his account. The panel distinguished those disputed passages from his evidence about the telephone incident.

The panel found that Patient C was clear about the particular incident charged. He described being spoken to sharply while using the telephone and the way this made him feel. This aspect of his evidence was consistent with the substance of his earlier

complaint. The panel was satisfied that his objections to other wording in his statement did not displace his clear account of this event.

The panel considered your denial. It also considered evidence from staff, including Ms Watson and Ms Jones, about your manner and the use of huffing or similar responses. That evidence provided context but was not direct eyewitness evidence of this telephone exchange. The panel's finding rested principally on Patient C's specific and consistent account of the charged incident.

The panel took account of the long interval since the event and the circumstances in which Patient C gave evidence. Having weighed the identified difficulties, the panel preferred his account of this incident to your denial. The panel was satisfied that you snapped and/or huffed at him while he was speaking to his wife and therefore found charge 10 proved.

Charge 11

"That you, a registered nurse:

11. On 9 November 2017, having been told by Colleague B that Patient D had to be given Gentamicin around 8pm on 9 November 2017, administered Gentamicin to Patient D around 9:47am on 9 November 2017."

This charge is found proved.

The panel considered whether, on 9 November 2017, having been told by Colleague B, identified as Donna Molyneux that Patient D's gentamicin was due at approximately 20:00, you administered it at approximately 09:47. The panel considered Ms Molyneux's evidence alongside the medication and clinical records.

The panel took account of Ms Wisniewska's submission that Ms Molyneux gave a clear handover that the gentamicin was due that evening because of the timing of the preceding dose. She relied on Ms Molyneux's witness evidence and the documentary

accounts of the subsequent early administration and invited the panel to find the instruction and the failure to follow it proved.

The panel took account of Mr McGettigan's submission that the evidence contained inconsistencies about the date and timing of the relevant handover and earlier doses. He relied on the absence of the proposed Datix report, the absence of evidence from the other person said to be present and the lack of a change to the electronic prescription. He invited the panel to consider your denial of the alleged instruction in that evidential and workplace context.

The panel accepted Ms Molyneux's account that the morning dose was to be withheld and administered that evening because of the timing of the preceding dose. Her account was supported by the clinical entry recording that the dose had been handed over as rescheduled but had nevertheless been given that morning. The panel considered the proximity of that record to the event important.

The panel also examined the administration record. This recorded an evening administration under your name on 8 November and a further administration at 09:47 on 9 November. These entries supported the concern that the morning administration followed the preceding dose too soon, as gentamicin is a once per 24 hour medication.

The panel considered your acknowledgement during your oral evidence that the morning dose had been premature and that you should have checked the timing of the preceding dose. The principal dispute concerned what you had been told. Your account was that Ms Molyneux directed you to give it in the morning and that she and another colleague were setting you up.

The panel considered the detail of that explanation. When asked why your account differed from Ms Molyneux's, you said:

> *"It's a set up. She gave the gent late. Or twice within 12 hours herself and this was the reason to suspend me. I was told to do it do it. She wouldn't second*

check it with me, nor Ciara, no other nurse would do it with me, only this nurse from India who would."

You denied she had told you it was a 24hr drug and said:

"…She didn't say to give it at 8pm as I would not have been in, she did not tell me it was a 24 hour drug. She said give it now and had a weird cheerful face on. As I was waiting for Sheren to come over to me I remember Ciara and Donna looking at each other, side eyeing each other I thought that was odd. Being told by a B6 to give it give it now."

The panel did not accept that explanation. The clinical and administration records supported the account of a dose given in the morning of 9 November 2017, despite a handover that it was due in the evening. The panel was not satisfied that your interpretation of colleagues' manner or their unavailability to second-check established collusion or falsification of those records.

The panel recognised that the other colleague said to have been present at handover had not given evidence. It also noted that, although the records referred to a Datix report being completed, no such report had been produced. The panel did not assume that a missing report had been completed. It considered that these evidential limitations did not outweigh Ms Molyneux's account and the contemporaneous clinical and medication records.

The panel further considered the point that the electronic prescription had not been changed to show the later administration time. This was relevant context but did not negate the panel's finding that a clear verbal instruction had been given. Having weighed your denial against the evidence supporting that instruction and the recorded administration, the panel found charge 11 proved.

Charge 12a)

"That you, a registered nurse:

12. On or before 10 November 2017 in relation to Patient D:

    a. Were abrupt when speaking to Patient D.”

This charge is found proved.

The panel considered whether, on or before 10 November 2017, you were abrupt when speaking to Patient D.

The panel considered Ms Wisniewska’s submissions on all three parts of charge 12. She invited the panel to attach significant weight to Patient D’s account despite her absence, relying on its typed and signed form, the circumstances of the complaint and Ms Jones’s evidence. She submitted that [PRIVATE] raised on your behalf should not detract from the account. In her oral reply, she expressly withdrew the description of the document as containing a statement of truth and maintained her reliance on it as a typed and signed account.

The panel considered Mr McGettigan’s submission that Patient D’s account could not be tested in cross-examination and that the panel knew little about her reliability beyond the clinical records. He relied on the [PRIVATE], the document’s title of ‘Conversation with Patient D’, its third-person wording and the absence of a statement of truth. He questioned how the account had been recorded and relayed, submitted that there was no direct corroboration of the allegations and invited the panel to give greater weight to your live evidence under oath denying them.

The panel recognised that Patient D had not given oral evidence and that her account had been admitted as hearsay. The panel could not assess her responses in cross-examination. The panel therefore considered the circumstances in which the complaint was made, the record of the conversation and Ms Jones’s evidence about speaking to Patient D.

The panel noted that the account described you responding abruptly when Patient D sought help or attention. Ms Jones recorded the concern after speaking to Patient D herself. Although Ms Jones's evidence and the written conversation arose from the same source, the panel considered them reliable records of the complaint made at the time.

The panel considered your account that Patient D interrupted you during medication administration and that you wished to avoid making an error. The panel accepted that a nurse might need to explain that a request would be addressed after completing a medication task. That did not determine whether the request had been answered abruptly. The panel preferred Patient D's recorded account of your manner on the occasions described.

The panel took account of the limitations of the hearsay evidence and your denial. It also considered the broader evidence concerning the way you responded to patients, while assessing this complaint on its own evidence. The panel was satisfied on the balance of probabilities that the abruptness alleged had occurred. The panel therefore found charge 12(a) proved.

Charge 12b)

"That you, a registered nurse:

12. On or before 10 November 2017 in relation to Patient D:

    b. Failed to attend to weeping wounds."

This charge is found proved.

The panel considered whether you failed to attend to Patient D's weeping wounds.

The panel initially considered the limitations of Patient D's untested account and examined the clinical records for supporting or contradictory evidence. It noted entries on 8 and 9 November describing wounds or dressings as clean, dry and intact. Those entries were relevant but did not establish the condition of the wound on every earlier occasion within the charging period.

The panel identified a clinical entry on 7 November which recorded that Patient D had asked numerous times that morning for her sternal wound dressing to be changed because it was soaking wet. The entry recorded that an apology was given and the dressing changed immediately. The panel considered this a significant contemporaneous record supporting the substance of Patient D's complaint about an unattended weeping wound.

The panel considered this alongside your care entry for the same day and Patient D's identification of you as the nurse from whom she had sought help. The panel was satisfied that this provided the connection between your responsibility for her care and the failure alleged. The entry recording repeated requests and the eventual change of a soaking dressing materially strengthened the evidence beyond the hearsay complaint alone.

The panel considered your explanation that dressings were changed on scheduled days. A routine schedule did not answer the need to respond to a dressing which had become wet and required attention. The panel also recognised that refusing a general skin inspection was not the same as refusing care of an identified surgical wound and did not explain the recorded requests for that dressing to be changed.

The panel was satisfied, having considered the clinical entry together with the complaint and your evidence, that you had not attended to the wound when attention was required. The panel did not treat the later clean and dry entries as inconsistent with a failure on the earlier occasion. The panel therefore found charge 12(b) proved.

Charge 12c)

“That you, a registered nurse:

12. On or before 10 November 2017 in relation to Patient D:

    c. Failed to help them out of bed.”

This charge is found not proved.

The panel considered the allegation that you failed to help Patient D out of bed.

The panel noted the recorded account that other patients had been helped up while Patient D remained in bed. However, the evidence did not identify the precise occasion, the assistance required, the availability of another member of staff or the circumstances in which mobilisation should have occurred.

The panel considered your explanation that you had been unable to obtain the help of a healthcare assistant. Where two members of staff were required to move a patient safely, the availability of appropriate assistance could be material. The panel was not satisfied that the records resolved those circumstances sufficiently to establish an unjustified failure by you.

The panel distinguished this allegation from charge 12(b), for which the clinical entry identified a specific unmet need and repeated requests. The evidence concerning getting out of bed lacked comparable detail establishing the particular duty and omission. The panel therefore found that the NMC had not discharged its burden and found charge 12(c) not proved.

Charge 13a)

“That you, a registered nurse:

13. On 25 March 2019 in relation to Patient G:

a. Failed to increase Patient G's oxygen when you were told by Colleague F that his oxygen levels were low."

This charge is found not proved.

The panel considered whether, on 25 March 2019, you failed to increase Patient G's oxygen when Colleague F told you that his oxygen levels were low. The panel identified Colleague F as Gemma McCraith, formerly known as Gemma Ford, the physiotherapist.

The panel considered Ms Wisniewska's submissions on all four parts of charge 13. She acknowledged Ms McCraith's lack of independent recollection but submitted that her detailed email, sent the next morning, deserved significant weight. She relied on its account of the patient's acuity, your remaining outside the bay and the lack of support, submitting that it established the failures concerning oxygen, equipment, assistance and escalation.

The panel considered Mr McGettigan's submission that Ms McCraith could not remember the incident or meaningfully address your detailed account, which substantially limited the weight of her email. For charge 13(a), he submitted that the email described the physiotherapist intending to increase the oxygen herself, rather than directing you to do so and encountering a refusal. For charge 13(d), he relied on your account of contacting Outreach and informing the nurse in charge, together with the sequence of readings and reviews. He invited the panel to prefer your evidence and find all four particulars not proved.

The panel considered Ms McCraith's email, the clinical records and her oral evidence. The account was that she assessed Patient G, identified low oxygen saturations and stated that she would increase his oxygen. She confirmed in oral evidence that she had intended to make that adjustment herself and had done so, explaining that this was a common part of a physiotherapist's assessment.

The panel recognised the concern that you had not responded adequately to the patient's condition. However, the particular allegation required the panel to identify a

failure by you to increase the oxygen after being told of the low readings. The evidence did not establish that this adjustment was a task you were expected to undertake in the circumstances where the physiotherapist had assessed the patient, announced her intention to adjust the oxygen and proceeded to do so.

The panel did not consider the evidence sufficient to establish the particular failure charged. This did not determine the separate allegations concerning equipment and assistance. The panel therefore found charge 13(a) not proved.

Charge 13b)

"That you, a registered nurse:

13. On 25 March 2019 in relation to Patient G:

    b. Failed to promptly provide proper and/or complete equipment to Colleague F."

This charge is found proved.

The panel considered whether you failed promptly to provide proper and/or complete equipment to Ms McCraith.

The panel recognised that Ms McCraith had no independent recollection of the incident by the time she made her NMC witness statements dated 3 and 11 February 2025 or gave oral evidence. The panel nevertheless had her detailed email written the morning following the incident and her clinical entries made at the time. Those records were consistent in their description of the patient's condition, the equipment requested and the assistance received.

The panel considered her evidence that she would not have written the email about inadequate support had she received the help she required. The panel identified no

previous or subsequent dealings between you and Ms McCraith providing a persuasive basis for personal hostility. Its assessment nevertheless rested principally on the content and timing of the records, rather than the absence of an apparent motive to complain.

The panel noted the account that a nebuliser mask was suggested when different oxygen equipment was required and that an Aquapack was supplied without the additional equipment needed to set it up. The account recorded that you then left the room and a healthcare assistant assisted with the equipment. The panel was satisfied that providing an isolated component without what was needed to use it did not amount to providing proper and complete equipment promptly.

The panel considered your evidence that Ms McCraith was overreacting and that you had provided appropriate support. It also considered your concerns about Patient G's COPD and the amount of oxygen being given. Those concerns did not explain the failure to provide the equipment required for his assessment and treatment. The panel preferred the consistent clinical account and email to your later account.

The panel was satisfied that, as the nurse caring for Patient G, you had a duty to assist in obtaining and supplying the necessary equipment. The panel found that this duty had not been fulfilled and therefore found charge 13(b) proved.

Charge 13c)

"That you, a registered nurse:

13. On 25 March 2019 in relation to Patient G:

    c. Failed to assist Colleague F with Patient G's deteriorating condition."

This charge is found proved.

The panel considered whether you failed to assist Ms McCraith with Patient G's deteriorating condition.

The panel relied on the clinical entries and email recording that Patient G was markedly unwell on assessment and had low oxygen saturations. The account described you remaining at the computer outside the bay for much of the review while the healthcare assistant provided practical assistance. Ms McCraith's email explained her concern about the lack of nursing support and recorded that you came to check the patient only towards the end of her treatment.

The panel considered your account that Patient G had been comfortable and that the physiotherapist's treatment had caused his oxygen levels to fall. The panel recognised that oxygen saturations could fall during treatment. However, Ms McCraith's account described low readings at her initial assessment, before the treatment to which you attributed the deterioration. The chronology did not support your explanation for the absence of assistance during the review.

The panel also considered your evidence about earlier contact with Outreach. Earlier assessment by another team did not remove the need to assist when the physiotherapist identified deterioration and required support. The panel was satisfied that your responsibility for Patient G's care required you to engage with his condition and assist the clinician treating him.

The panel preferred the consistent records made at the time and the following morning to your account. The panel found that you had failed to provide the required assistance and therefore found charge 13(c) proved.

Charge 13d)

"That you, a registered nurse:

13.On 25 March 2019 in relation to Patient G:

d. Failed to escalate Patient G's abnormal oxygen saturations levels to senior clinic staff."

This charge is found not proved.

The panel considered whether you failed to escalate Patient G's abnormal oxygen saturations to senior clinical staff.

The panel examined the evidence of escalation separately from the evidence about your assistance during the physiotherapy review. The records showed that Outreach had assessed Patient G on a number of occasions during the day. Your clinical entry also referred to Outreach being contacted and the nurse in charge being informed after a drop in saturations and blood pressure during the evening review.

The panel noted that the observations recorded at approximately 17:50, before Ms McCraith's review, showed oxygen saturations of 94%. It did not consider that this earlier reading established an unmet need for escalation at that point. The panel also recognised that the physiotherapy attendance followed an earlier review and formed part of the patient's ongoing assessment.

The panel considered that the principal concerns in Ms McCraith's email were the absence of practical nursing support and the difficulties obtaining equipment. Those concerns supported charges 13(b) and 13(c) but did not establish that you had failed to contact senior clinical staff. The records of Outreach involvement and the entry concerning the nurse in charge prevented the panel from being satisfied that the particular failure to escalate had been proved.

The panel therefore found charge 13(d) not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your

fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct

Ms Wisniewska submitted that all the charges found proved amounted to serious professional misconduct. She reminded the panel that this was a matter for its independent professional judgement, with neither a burden nor a standard of proof applying at this stage.

Ms Wisniewska referred to the professional standards contained in the NMC Code. She acknowledged that a breach of the Code did not automatically establish serious professional misconduct. The panel was required to consider the nature and seriousness of your conduct in the circumstances.

Ms Wisniewska referred to *Roylance v GMC* [2000] 1 AC 311, submitting that misconduct involved an act or omission falling below the standards properly expected of a practitioner. She also relied on *Nandi v GMC* [2004] EWHC 2317 (Admin), emphasising that the requirement for misconduct to be serious must be given proper weight, including consideration of whether fellow practitioners would regard the conduct as deplorable.

Ms Wisniewska submitted that your proved conduct breached several provisions of the Code. She relied on the requirements to treat people with kindness, respect and compassion, deliver the fundamentals of care effectively, avoid making assumptions and recognise individual choice. She submitted that these standards were engaged by the findings concerning your clinical care and your treatment of patients.

Ms Wisniewska further submitted that your conduct breached the requirements to communicate effectively with colleagues, work cooperatively to preserve patient safety and share information to identify and reduce risk. She relied on the findings concerning the nasogastric tube incident, medication administration, the communication of outstanding care and your response to the physiotherapist treating Patient G.

Ms Wisniewska submitted that the failures concerning clinical checks, medication, observations, fluid-balance monitoring, wound care and assistance with a deteriorating patient breached the requirements to reduce the potential for harm and minimise mistakes and their consequences. She relied particularly on sections 1.2, 8.2, 8.5, 8.6, 19 and 19.1 of the Code.

In relation to Patient B, Ms Wisniewska submitted that the proved conduct also engaged the requirements to uphold dignity and respect privacy and confidentiality, including section 5.1. She submitted that the findings concerning your manner towards Patients C and D were inconsistent with the obligation to treat patients with kindness, respect and compassion.

Ms Wisniewska emphasised the findings of dishonesty in charges 2(a), 3 and 4. She submitted that these breached section 20.2 of the Code, which required you to act with honesty and integrity at all times, and undermined the reputation of the profession. She referred to the NMC’s guidance identifying serious dishonesty as a concern which may be less readily put right.

Ms Wisniewska submitted that the seriousness of the conduct arose both from the individual findings and their wide-ranging nature. Referring to the NMC’s guidance on misconduct, she submitted that your conduct posed risks to patient safety, public

confidence in the profession and the maintenance of professional standards. She therefore invited the panel to find that the proved conduct amounted to serious professional misconduct.

Mr McGettigan submitted that the panel must consider whether the facts found proved amounted to misconduct of sufficient seriousness to engage your fitness to practise. Referring to *Roylance v GMC* and *Nandi v GMC*, he submitted that a departure from the standards expected of a registered nurse did not automatically constitute serious professional misconduct. The seriousness of the conduct required separate consideration.

Mr McGettigan submitted that, as recognised in *Mallon v GMC* [2007] CSIH 17, the assessment was a matter for the panel's professional judgment, having regard to the facts, circumstances and evidence. He also referred to *Remedy UK Ltd v GMC* [2010] EWHC 1245 (Admin), drawing attention to the distinction between serious misconduct, deficient performance and errors of judgment. He submitted that poor judgment or an inadequately performed task would not necessarily cross the threshold for misconduct. The NMC's guidance similarly recognised that not every breach of the Code or issue with practice warranted regulatory action.

In relation to charge 1(a), Mr McGettigan submitted that the panel should consider the unusual circumstances surrounding Patient F's nasogastric tube. The tube had been cut rather than simply pulled out, feed had spilled onto the floor, and the immediate situation required attention. He referred to your relative inexperience and your evidence that you had not appreciated that part of the tube might remain inside the patient. Although these circumstances did not remove your responsibility to check properly, he submitted that they remained relevant to the assessment of seriousness. He also noted the panel's acceptance that some checks might have been undertaken without locating the retained tubing. He submitted that the failing could reasonably be characterised as poor decision-making or deficient performance rather than sufficiently serious misconduct.

In relation to charge 1(b), Mr McGettigan submitted that the panel's factual finding established that you had said Patient F was fine. He maintained that, in the circumstances in which the answer was given, the fact that those words had been spoken did not itself establish misconduct of sufficient seriousness to engage your fitness to practise.

Mr McGettigan submitted that charge 1(c) must be considered alongside the dishonesty finding in charge 2(a). He acknowledged that, given the finding of dishonesty, those matters were capable of constituting misconduct. He similarly acknowledged that the failure to provide full and accurate information under charge 1(d) could be considered capable of amounting to misconduct in light of those findings.

Mr McGettigan submitted that charges 1(e) and 1(f) must be considered alongside the associated dishonesty findings in charges 3 and 4 respectively. He acknowledged that those findings were capable of constituting misconduct and were likely to be regarded as such by the panel.

In relation to charges 5(a) and 5(b), Mr McGettigan submitted that the panel had found that the 14:00 medication round had not been completed and that you had failed to inform other staff. He acknowledged that this could represent a significant error. However, he submitted that the panel had little information about the medications missed or their actual or potential impact. He invited the panel to consider the surrounding circumstances and conclude that these failings might amount to poor decision-making or deficient performance without reaching the threshold for serious misconduct.

In relation to charges 6(a) and 6(b), Mr McGettigan submitted that the findings concerned your failure to oversee tasks which you had delegated. He acknowledged the panel's finding that delegation did not remove your responsibility to ensure that the observations were undertaken and the fluid balance chart maintained. Nevertheless, he submitted that these failures of oversight could reasonably be regarded as deficient performance rather than sufficiently serious misconduct.

In relation to charges 7(b) and 8, Mr McGettigan submitted that the panel had acknowledged the practical difficulties of discussing care within a shared ward. Although those difficulties did not justify asking Patient B about an eating disorder in an open setting, he submitted that the incident could be characterised as a significant error of judgment. He invited the panel to consider whether, in all the circumstances, it fell below the threshold for serious misconduct.

In relation to amended charge 7(c), Mr McGettigan submitted that the finding was that you had placed Patient B somewhere different so that you could observe her food intake. He submitted that, on those facts alone, the conduct did not amount to misconduct of sufficient seriousness to engage your fitness to practise.

In relation to charges 9(a) and 9(b), Mr McGettigan submitted that the panel had found that you prepared the original medication despite receiving an instruction to change it, and that you expressed a wish to administer it because it had already been signed out and you did not want to waste it. He emphasised that the medication was ultimately corrected and the appropriate medication and dosage were administered. He submitted that, in those circumstances, the findings did not necessarily establish serious misconduct.

In relation to charge 10 and charge 12(a), Mr McGettigan submitted that the findings of snapping or huffing at Patient C and speaking abruptly to Patient D required careful assessment against the seriousness threshold. He submitted that the conduct described in those particulars might not be sufficiently serious to constitute misconduct.

In relation to charge 11, Mr McGettigan referred to the panel's acknowledgment that the electronic prescription had not been amended to reflect the later administration time. Although that did not displace the finding that you had received a clear verbal instruction, he submitted that it remained relevant context. He invited the panel to regard this medication error as poor decision-making which, in all the circumstances, did not reach the threshold for serious misconduct.

In relation to charge 12(b), Mr McGettigan submitted that important details concerning the failure to attend to Patient D's weeping wounds remained unclear, including the extent of the weeping, the duration of the failure and its impact. He submitted that the panel could reasonably regard the failing as poor decision-making or deficient performance rather than serious misconduct.

In relation to charges 13(b) and 13(c), concerning the provision of equipment and assistance with Patient G, Mr McGettigan submitted that the panel should similarly consider whether the failings amounted to deficient performance or poor decision-making rather than sufficiently serious misconduct.

Mr McGettigan submitted that the panel should assess the seriousness of the proved matters in their particular circumstances. While acknowledging that the dishonesty findings were likely to constitute misconduct, he invited the panel to distinguish those findings from other failings which, he submitted, did not necessarily cross that threshold.

Submissions on impairment

Ms Wisniewska moved on to the issue of impairment. She submitted that your fitness to practise was currently impaired by reason of your misconduct. Referring to the NMC's guidance on impairment, she invited the panel to find that you were not fit to practise without restriction.

Ms Wisniewska relied on the approach identified in the Fifth Shipman Inquiry Report and endorsed in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She submitted that all four considerations concerning unwarranted risk of harm, dishonesty, breaches of fundamental professional tenets and bringing the profession into disrepute were engaged.

In relation to patient safety, Ms Wisniewska submitted that the proved conduct demonstrated that you had exposed vulnerable patients to unwarranted risks of harm.

She maintained that there was a continuing risk of similar conduct because you had not demonstrated sufficient insight, reflection or remediation.

In relation to dishonesty, Ms Wisniewska relied on the findings under charges 2(a), 3 and 4. She submitted that these indicated a serious attitudinal concern, compounded by the other clinical and professional failures found proved. In her submission, the absence of demonstrated learning or remediation meant that the risk of future dishonest conduct remained.

Ms Wisniewska submitted that your conduct breached fundamental tenets of the profession, including prioritising people, preserving safety, practising effectively and promoting professionalism and trust. She further submitted that the nature and seriousness of the findings brought the profession into disrepute and engaged the need to maintain public confidence and professional standards.

Ms Wisniewska also referred to *Cohen v GMC* [2008] EWHC 581 (Admin), inviting the panel to consider whether the concerns were capable of remediation, whether they had been remedied and whether repetition was highly unlikely. She submitted that the gravity of the conduct, particularly the dishonesty, weighed against the concerns being adequately addressed through steps to strengthen practice. She maintained that there was no sufficient evidence of reflection and remediation and that repetition could not be regarded as highly unlikely.

Addressing your impairment bundle in her oral submissions, Ms Wisniewska confirmed that she had read the material and acknowledged that it contained a number of testimonials and training certificates. She recognised that a substantial body of information had been provided. However, she submitted that it did not contain evidence from you demonstrating insight, reflection and proper remediation of the concerns identified.

Ms Wisniewska invited the panel to take that distinction into account when assessing current impairment. In her submission, the testimonials and training certificates did not

resolve the absence of demonstrated personal reflection, learning and remediation relevant to the findings.

Ms Wisniewska submitted that there remained a real risk of repetition and a serious risk of harm to patients. She invited the panel to consider both public protection and the need to maintain public confidence in nursing and uphold professional standards. She therefore invited the panel to find your fitness to practise currently impaired.

Mr McGettigan submitted that a finding of misconduct did not automatically lead to a finding of current impairment. Referring to *Cohen v GMC*, *Cheatle v GMC* [2009] EWHC 645 (Admin) and *CHRE v NMC and Grant*, he submitted that the panel's assessment must address your fitness to practise at the date of the hearing. Although past conduct remained relevant, the assessment was forward-looking.

Mr McGettigan submitted that the panel must consider both the personal and public components of impairment. He referred to the considerations identified in *Grant*, including the risk of harm to patients, damage to the reputation of the profession, breaches of fundamental professional tenets and dishonesty. He also invited consideration of whether the failings were remediable, whether they had been remedied and whether they were likely to recur.

Mr McGettigan referred to *PSAHSC v NMC* [2017] CSIH 29, repeated that not every finding of misconduct required a finding of impairment. He acknowledged that sufficiently serious misconduct could require such a finding despite mitigation or a low risk of repetition. However, he submitted that the question must be determined on its merits and that a perceived need to impose a sanction should not itself determine whether current impairment existed.

Mr McGettigan submitted that you had worked, for the most part, consistently as a nurse since the events giving rise to these proceedings. You had been registered since 2016 and, apart from the findings in this case, had no adverse regulatory findings. He submitted that your subsequent practice was relevant evidence when assessing your current ability to practise safely and the likelihood of repetition.

Mr McGettigan submitted that there was limited evidence of actual harm to patients, while acknowledging that some of the proved matters involved a risk of harm. He invited the panel to distinguish between the historical failings and the question of whether you currently presented a risk.

Mr McGettigan submitted that the workplace context also remained relevant. He acknowledged that the panel had not accepted that workplace difficulties established that particular complaints or records had been fabricated. He nevertheless maintained that your account of adverse treatment at work could be considered as contextual evidence. He expressly acknowledged that this did not excuse the proved conduct or remove your responsibility for it.

Mr McGettigan submitted that your oral evidence demonstrated enthusiasm for nursing and a longstanding wish to pursue the profession. He referred to your account of training to be a nurse after following a different career path and invited the panel to consider the knowledge of nursing practice you had demonstrated during your evidence.

Mr McGettigan submitted that the testimonials from registered nurses, other healthcare workers, patients and patients' relatives provided evidence of your current practice. He particularly relied on the repeated descriptions of your kindness and attentiveness. He submitted that these accounts could support the conclusion that the conduct found proved was not typical of your usual practice. He further submitted that the circumstances in which the historical events occurred no longer existed and could be relevant to the risk of repetition.

Mr McGettigan submitted that the training records demonstrated that you had continued to maintain your professional knowledge and skills. He invited the panel to consider that evidence alongside your subsequent employment and the substantial passage of time since the incidents, some of which were approaching ten years old.

Mr McGettigan submitted that you had demonstrated some insight and learning despite continuing to dispute the allegations. He referred to your evidence that you would

approach similar situations differently, including checking at the end of a shift that delegated tasks had been completed. He also relied on your explanations concerning charges 6, 9 and 11 about exercising greater caution in future.

Mr McGettigan submitted that, although you denied charges 1 to 4, you had expressed regret about how the nasogastric tube incident had unfolded and described having been "*reliving it for nine years*". He invited the panel to consider whether your evidence demonstrated an element of regret and insight notwithstanding your denials. He submitted that the risk of repetition was low.

Responding orally to Ms Wisniewska's submission about the absence of reflection, Mr McGettigan submitted that reflection presented a difficulty in a case in which you had disputed all the charges. He acknowledged that difficulty and left the matter to the panel's judgment.

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Mr McGettigan submitted that you had never been subject to an interim suspension order in this case and had practised without restriction for several years after the incidents. Taking your subsequent practice, testimonials, training and evidence of learning together, he invited the panel to conclude that the personal component of impairment was not currently engaged and that you could practise safely without restriction.

In relation to the public component, Mr McGettigan submitted that the panel must consider whether public confidence in nursing or the maintenance of professional standards required a finding of impairment. He invited consideration of the circumstances as a whole, including the limited evidence of actual harm, the workplace context, the age of the allegations, your subsequent practice and the steps you had taken since.

Mr McGettigan submitted that the panel could conclude that professional standards and public confidence had been upheld through the regulatory proceedings and the findings

made. He therefore invited a finding that your fitness to practise was not currently impaired. Alternatively, if the panel considered an impairment finding necessary, he submitted that it should be confined to the public component.

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), *Ivey v Genting Casinos (UK) Ltd* (t/a Crockfords Club) [2017] UKSC 67, *Grant* and *Cohen.*

Decision and reasons on misconduct

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

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

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

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights'

*'**2 Listen to people and respond to their preferences and concerns***

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely'

'5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care'

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

To achieve this, you must:

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

*'**8 Work cooperatively***

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk'

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

To achieve this, you must:

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

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times'

'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:

10.2 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'

'11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard'

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

To achieve this, you must:

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

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each charge before reviewing the recurring features across the proved misconduct. Where particulars described connected aspects of one incident, it assessed their combined significance while identifying any distinction in seriousness between them. It confined its assessment to the proved misconduct and the evidence relevant to its seriousness.

Charge 1

The panel determined that the six proved particulars of charge 1 should be considered together because they concerned your response to the same nasogastric tube incident and your subsequent communications about it. Taken together, they demonstrated a serious failure to discharge your responsibility for Patient F's safety.

The panel considered Mr McGettigan's reliance on the unusual circumstances and your relative inexperience. The tube had been cut rather than simply pulled out, feed had spilled onto the floor and the immediate situation required attention. It also recognised its earlier finding that some checks could have been undertaken without locating the retained tubing. Nevertheless, the essential failing was that your checks did not properly establish whether the cut tube was complete.

The panel found that the failure to check was compounded by your failure to communicate full and accurate information to colleagues and by the differing accounts you subsequently gave. Colleagues needed reliable information to assess the clinical concern and determine whether further action was necessary. The combined failures created a risk that tubing remained in the patient and would not be identified and appropriately managed. The panel therefore rejected the submission that charge 1, considered as a whole, represented only limited negligence or deficient performance. It amounted to serious professional misconduct.

Charges 2(a), 3 and 4

The panel found that the dishonesty proved in charge 2(a) was serious because it concerned information directly relevant to Patient F's safety. You gave an affirmative answer about the remaining tube having come out when you did not know that this was so because you had not properly checked. This could affect the response of a colleague responsible for making decisions about the patient. The panel did not base its decision on finding that you knew tubing remained inside Patient F; that alternative allegation had not been proved.

The panel noted that charge 3 concerned a further dishonest account after the event, when you claimed to have known that part of the tube remained inside Patient F. It recognised that this statement did not have the same immediate clinical implications as the earlier assurance. Nevertheless, it regarded the statement as an attempt to protect your position through an account which was not true. This was a serious departure from the honesty expected between healthcare professionals.

The panel found that charge 4 was also serious. Your dishonest assertion that you had escalated the retained tubing to Colleague D sought to place responsibility on a colleague for not acting on information which you had not provided. It undermined the reliability of the account of the incident and the trust necessary for effective professional working.

The panel assessed the nature and context of the dishonesty rather than treating every dishonest act as identical. These were repeated dishonest statements concerning a clinical incident and your responsibility for it. Each of charges 2(a), 3 and 4 amounted to serious professional misconduct.

Charges 5(a) and 5(b)

The panel distinguished between failing to complete the medication round and failing to tell colleagues that it had not been completed. It accepted that a missed round, considered alone, could arise in circumstances which did not necessarily constitute

serious misconduct. The particular seriousness here lay in leaving colleagues unaware that patients had not received their medication.

The panel considered that the two particulars formed a connected course of conduct. Having failed to complete the round, you remained responsible for communicating that omission so that another member of staff could take appropriate action. Your failure to do so left the omission unaddressed and created a potential risk to patients.

The panel considered Mr McGettigan's argument that the evidence did not identify the medications missed or establish actual harm. It did not assume a particular medication or consequence. However, the absence of demonstrated harm did not remove the seriousness of failing to hand over an outstanding medication round. Charge 5, considered as a whole, amounted to serious professional misconduct, with the serious failing identified particularly in charge 5(b).

Charges 6(a) and 6(b)

The panel considered the submission that these findings concerned inadequate oversight of delegated tasks. It accepted that delegation was a routine part of nursing practice, but it did not remove your responsibility to ensure that the required observations and fluid balance monitoring were undertaken.

The panel found that the omissions were serious in the clinical circumstances of Patient H. Hourly observations had been specifically required, yet there was a prolonged gap in monitoring and the fluid balance chart had not been maintained or adequately overseen. Patient H required drainage of retained urine. This clinical context demonstrated the importance of timely observations and an accurate understanding of fluid balance.

The panel also took account of your acknowledgment during your oral evidence that you should have checked the chart. Whatever arrangement you believed had been made, you had not ensured that the required monitoring occurred. Taken together and assessed in the circumstances of this patient, charges 6(a) and 6(b) represented a serious failure of responsibility and amounted to serious professional misconduct.

Charges 7(b), 7(c) and 8

The panel found that asking Patient B on an open ward whether she had an eating disorder was inappropriate and breached her confidentiality. However, it distinguished the finding that the question was asked from the separate question of whether the conduct was sufficiently serious to constitute misconduct for regulatory purposes. It concluded that charges 7(b) and 8, considered individually, did not reach that threshold and were matters capable of being addressed through local management procedures.

The panel noted that amended charge 7(c) established that you seated Patient B in a different position so that you could observe her while she ate. Moving a patient to facilitate observation could, depending on the circumstances, form part of nursing care. The proved act itself did not establish a sufficiently serious departure from proper practice to amount to serious professional misconduct.

The panel nevertheless noted Patient B's account of the emotional effect of the interactions. She described feeling "*humiliated*" and fearing that "*something bad might happen to her*". Those concerns were relevant to understanding her experience of your care. They did not alter the panel's conclusion that these specific proved particulars, assessed individually, did not establish serious professional misconduct.

Charges 9(a) and 9(b)

The panel considered that these particulars had to be assessed in the context of the instructions given by the specialist pain nurse. You had been directed to give immediate-release oxycodone and to reduce the later prolonged-release dose, but instead prepared 20 mg of prolonged-release oxycodone and said that you wanted to administer it because it had already been signed out and you did not want to waste it.

The panel found that this went beyond an isolated preparation error. The instruction came from a nurse with specialist expertise in pain management. Your stated reason for wishing to proceed did not address the patient's clinical needs or the potential consequences of administering the wrong preparation and dose.

The panel considered Mr McGettigan's argument that the medication was ultimately corrected and the correct medication administered. It noted the intervention of Sean Mawdsley, the second checker, who queried the medication with the specialist nurse, as important. The error was corrected through that intervention rather than through your recognition of the problem. The fact that the medication was not administered did not remove the seriousness of preparing it and expressing an intention to give it despite the instruction.

The panel also considered the explanations advanced in oral evidence in relation to colleagues, including your denial of the instruction and your attempt to attribute responsibility for the preparation to the second checker. Those accounts had not been accepted at the factual stage. They formed part of the context in which it assessed your response to the incident. Charges 9(a) and 9(b), considered together, amounted to serious professional misconduct.

Charge 10

The panel considered the specific wording of this charge. Snapping or huffing at Patient C while he was speaking to his wife was inappropriate, particularly given the importance of that contact to him. Nevertheless, the proved conduct did not itself meet the threshold for serious professional misconduct.

The panel also noted Patient C's description of feeling "*uncomfortable*" and "*unsafe*" in your care. It recognised the significance of that experience without treating wider descriptions of your behaviour as additional particulars of the charge. Its conclusion remained that charge 10 did not, individually, amount to serious professional misconduct.

Charge 11

The panel noted that this incident concerned the administration of gentamicin contrary to a clear verbal instruction about its timing. For this patient, the prescribed dosing interval was 24 hours. The administration records showed that you had given the

preceding evening dose and then administered a further dose at approximately 09:47 the following morning.

The panel considered the absence of a corresponding amendment to the electronic prescription, as relied on by Mr McGettigan. That was relevant context, but it did not remove the significance of the clear handover instruction or the need to check the timing of the preceding dose. The panel also took account of your acknowledgment that the morning dose had been premature and that you should have checked when the previous dose had been given.

The panel found that the seriousness arose from the failure to follow the instruction, the shortened interval between doses and the resulting potential for harm. It also considered the evidence about your failure to engage constructively when the error and its potential consequences were explained to you. This incident reflected a repeated difficulty in responding appropriately to clinical instructions and working professionally with colleagues.

The panel noted that your account in your oral evidence was that colleagues had directed you to administer the medication early as part of a plan to set you up. The panel did not accept this account. It considered that account in assessing your response to the incident and your attribution of responsibility. Assessed in its full clinical context, charge 11 amounted to serious professional misconduct.

Charges 12(a) and 12(b)

The panel found that speaking abruptly to Patient D, as proved in charge 12(a), was inappropriate. However, that particular did not, individually, reach the threshold for serious professional misconduct.

The panel found that the failure to attend to Patient D's weeping surgical wound was materially more serious. Patient D was vulnerable following surgery, and the evidence recorded repeated requests for a dressing to be changed because it was soaking wet. Another nurse attended to it and changed it promptly. A routine dressing schedule did

not answer the need to respond to a dressing which had become wet and required attention. Nor did a refusal of a general skin inspection amount to a refusal of care for an identified surgical wound.

The panel considered Mr McGettigan's argument about the limits of the evidence concerning the duration and consequences of the failure. Nevertheless, leaving the wound unattended exposed Patient D to discomfort and an increased risk of infection. The failure to respond to repeated requests for necessary wound care represented a serious departure from the care expected of a registered nurse. Charge 12(b) amounted to serious professional misconduct.

Charges 13(b) and 13(c)

The panel noted that these particulars concerned your failure to provide proper and complete equipment promptly and your failure to assist a colleague caring for a deteriorating patient. The situation required an effective and timely response. As the nurse caring for Patient G and familiar with the ward, you had a particular responsibility to assist the physiotherapist and obtain the required equipment.

The panel found that you knew Patient G was seriously unwell. Your own account referred to concerns about his condition and contact with outreach services. Nevertheless, you did not provide the assistance required while the physiotherapist and a healthcare assistant attempted to manage the deterioration. Your evidence that the physiotherapist was hostile did not justify failing to assist with the patient's urgent needs.

The panel found that these were substantial failures in a situation carrying a risk of serious harm. They were conduct which fellow practitioners and members of the public would regard as deplorable. Charges 13(b) and 13(c), considered together, amounted to serious professional misconduct. The panel did not rely on the oxygen increase or escalation particulars which had not been proved.

The panel concluded that its assessment identified recurring concerns about clinical care, communication and working relationships with colleagues, honesty, and the way patients experienced your care. The clinical findings concerned fundamental responsibilities, including checking a patient's condition, administering medication safely, ensuring required monitoring occurred, attending to wounds and assisting with deterioration.

The panel found that the clinical failures were repeatedly associated with difficulties in communicating with colleagues, following instructions or responding constructively to concerns. The dishonesty findings involved inaccurate accounts of a clinical incident and attempts to transfer responsibility. It also noted the distress described by patients, while maintaining the distinctions it had drawn concerning the seriousness of the individual patient interaction charges.

The panel found that these features demonstrated a pattern rather than a single isolated lapse. Its assessment of that pattern supported its conclusions on the charges identified as serious professional misconduct, without altering its separate conclusions on those particulars which did not individually reach that threshold.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 all four limbs identified in *Grant* were engaged by the past conduct. The proved clinical failures exposed patients to unwarranted risks of harm. The serious failures in care and the dishonesty brought the profession into disrepute. They breached fundamental professional obligations concerning safe care, honesty and effective professional working. The findings in charges 2(a), 3 and 4 expressly established dishonest conduct.

The panel noted that those historical findings were the starting point for its assessment. It then considered whether the concerns had been addressed and whether the risk remained current.

The panel considered that the concerns were potentially remediable. Clinical shortcomings could be addressed through appropriate learning, reflection, supervision and demonstrated changes in practice. Difficulties in professional relationships could also be addressed if their nature and impact were understood.

The panel considered that dishonesty and the associated attitudinal concerns were much more difficult to remediate, although remediation was not impossible. Meaningful progress would require an understanding of the conduct, its consequences for patients and colleagues, and the importance of reliable and honest communication.

The panel identified extremely limited insight into some clinical matters in your oral evidence. It took account of your evidence that you would check the completeness of a nasogastric tube, check the timing of an earlier medication dose and ensure that delegated tasks had been completed. It therefore did not conclude that there was no evidence of insight at all.

The panel found that those statements did not demonstrate developed insight into the full range of concerns. In particular, you had not demonstrated an understanding of the dishonesty findings or of the difficulties in working with colleagues and the consequences for patient safety. There was no reflective account explaining those matters or showing how they had been addressed in your practice.

The panel considered Mr McGettigan's oral response that reflection presented a difficulty where you disputed all the charges. It nevertheless needed evidence from which it could assess your understanding of the identified risks and the steps taken to prevent recurrence. The limited clinical observations in your evidence did not provide sufficient assurance on those matters, particularly honesty and professional relationships.

The panel found that your explanations given during the hearing continued to attribute responsibility to colleagues, including accounts that they had colluded to set you up. Those explanations had not been accepted in its findings of fact. Their significance for impairment was that they continued the pattern of deflecting responsibility rather than demonstrating an appreciation of your own failings. This supported its assessment that the attitudinal concerns remained current despite the age of the incidents.

The panel found that it had not been shown any meaningful reflection or remorse in relation to the dishonesty or your approach to colleagues. It considered the extremely limited clinical insight insufficient to address the broader pattern of conduct.

The panel considered the training material you advanced to demonstrate that you had undertaken clinical training. This included a certificate in immediate life support and a record of training compliance. It did not approach the case on the basis that no training had taken place.

The panel noted that the compliance record had not been updated since 2025 and contained different status and expiry entries without an accompanying explanation. It did not clearly establish the learning undertaken in response to the proved concerns or explain how that learning had changed your practice. The training material, without

reflection or supporting evidence of its application, did not demonstrate effective remediation of the particular failings.

The panel found that there was no evidence of training, reflection or other remedial work directed at the dishonesty or the concerns about working relationships. Those matters were central to the misconduct and were not answered by evidence of clinical refresher training alone.

The panel considered the positive testimonials and feedback, the majority of which were submitted by church colleagues. It noted that some came from healthcare professionals and referred to helpfulness and support in clinical settings, although none of these professionals work with you on a day to day basis. It also noted that a newly qualified nurse had expressed appreciation for the support you had provided.

The panel considered that the weight of those accounts was limited by their age, scope and the extent to which their authors appeared aware of the allegations. Some were several years old, including accounts dating from 2017, 2020 and 2022. Only one appeared to demonstrate awareness of the nature of the concerns before the panel, and some appeared to have been provided for registration or revalidation purposes. The material did not provide a sufficiently informed assessment of whether the specific concerns had been resolved.

The panel acknowledged your evidence that you had continued to practise and had worked on an acute cardiac unit since 2023.

The panel noted that it had not received a current management reference explaining your duties, clinical performance or working relationships. Nor was there a clear account of the roles you had undertaken over the relevant period or reflection on your practice in those roles. The available material did not provide sufficient detail to establish that the concerns identified in this case had been addressed in your current work.

The panel recognised the substantial passage of time since the incidents and Mr McGettigan's submission that your record, apart from this case, contained no adverse

regulatory findings. It also noted your participation in these proceedings. Its present task nevertheless required an assessment of current risk, and the passage of time did not itself demonstrate that the underlying concerns had been resolved.

The panel considered [PRIVATE], together with the effect of the prolonged proceedings. It recognised those matters as personal context. Its decision on impairment remained directed to the risks arising from the proved conduct and the evidence of insight, reflection and remediation.

The panel determined that, applying the considerations in *Cohen*, it could not conclude that repetition was highly unlikely. Although the concerns were potentially remediable, the evidence did not demonstrate that they had been effectively remedied. The extremely limited insight into clinical failings, absence of developed reflection and continuing attribution of responsibility to colleagues led it to assess the risk of repetition as high.

The panel considered that each of the principal areas of concern had implications for patient safety. Clinical failures created direct risks. Inadequate communication and difficulties in working with colleagues impeded coordinated care. Dishonesty could prevent colleagues from obtaining an accurate understanding of an incident and responding appropriately, and could make professional oversight less effective.

The panel found that your continued practice and examples of positive feedback did not provide sufficient assurance to resolve those risks. It found that unrestricted practice would present an ongoing risk to patients. The panel determined that your fitness to practise was therefore currently impaired on public protection grounds.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel took account of the fact that the misconduct involved repeated clinical failures, patient care, dishonesty concerning patient care and significant failures in professional communication and cooperation. These concerned responsibilities fundamental to the public's trust in registered nurses.

The panel considered Mr McGettigan's argument that the regulatory process and findings could themselves uphold confidence and standards, without a finding of impairment. It did not consider that sufficient in this case. The seriousness and pattern of the conduct, together with the unresolved concerns about insight and remediation, meant that a finding of no impairment would not adequately uphold professional standards or public confidence.

The panel emphasised that its conclusion was not based on a perceived need to impose a particular sanction. It assessed impairment as a separate question. It rejected the alternative submission that any impairment finding should be confined to the public interest, because it had also identified a continuing risk to patients.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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 sanctions (SAN1, SAN2, SAN3 and SAN4).

Submissions on sanction

Ms Wisniewska submitted that a striking-off order was the appropriate and proportionate sanction. She referred the panel to its powers under Article 29 of the 2001 Order and invited it to consider the misconduct, dishonesty and current impairment together when determining the sanction necessary to protect the public and maintain confidence in the profession.

Ms Wisniewska submitted that the panel's findings demonstrated the seriousness of the case. The misconduct was fundamentally inconsistent with the trust placed in registered nurses and involved substantial breaches of the Code. Applying the considerations in Cohen, the panel had identified a high risk of repetition, which was particularly relevant to the continuing risk you posed to patients.

Ms Wisniewska submitted that the clinical failures were repeatedly associated with difficulties in communicating with colleagues, following instructions and responding constructively to concerns. These were fundamental aspects of everyday nursing practice. She also relied on the findings that your dishonesty involved inaccurate accounts of a clinical incident and attempts to transfer responsibility to colleagues. She submitted that the distress described by patients and the pattern of behaviour, rather than a single isolated lapse, were further matters relevant to sanction.

Ms Wisniewska acknowledged that the panel had found the concerns potentially remediable. However, she submitted that you had had substantial time to address them through appropriate learning, reflection, supervision and demonstrated changes in practice. The difficulties in professional relationships could also have been addressed through an understanding of their nature and impact. She submitted that there was no sufficient evidence that this work had taken place and no evidence of a plan or intention to undertake it.

Ms Wisniewska submitted that the dishonesty and associated attitudinal concerns were more difficult to remediate, although the panel had recognised that remediation was not impossible. Meaningful progress required an understanding of the conduct, its consequences for patients and colleagues, and the importance of reliable and honest communication. She submitted that you had demonstrated extremely limited insight into

clinical matters and had not demonstrated developed insight into the full range of concerns, particularly dishonesty, working relationships and their consequences for patient safety. She also emphasised the absence of a reflective account in your bundle.

Ms Wisniewska referred the panel to the sanctions guidance, including SAN-1, SAN-3 and SAN-4. She submitted that the aggravating factors were your lack of proper insight, the high risk of repetition, the pattern of misconduct, the dishonesty findings and the exposure of patients to a risk of harm. She emphasised that the seriousness of creating a risk did not depend on evidence that actual harm had occurred.

Ms Wisniewska identified your absence of previous regulatory findings as a mitigating factor. However, she submitted that this should not detract from the seriousness of the misconduct established in these proceedings.

Ms Wisniewska submitted that taking no further action would be inappropriate given the gravity of the misconduct, the breaches of the Code and the continuing risk of repetition. Such an outcome would not provide sufficient public protection or maintain public confidence in the profession. She submitted that a caution order would be inadequate for the same reasons.

Ms Wisniewska submitted that a conditions of practice order would not adequately address either public protection or the wider public interest. She submitted that there were no workable, relevant, measurable and proportionate conditions capable of addressing the misconduct, particularly where some of the failings reflected serious attitudinal concerns.

Ms Wisniewska submitted that a suspension order would also be insufficient. She referred to the guidance identifying the absence of harmful, deep-seated personality or attitudinal problems and the absence of a significant risk of repetition as considerations relevant to suspension. She submitted that this case involved attitudinal concerns associated with dishonesty and a high risk of repetition. Those features weighed against suspension being an appropriate and proportionate response.

Ms Wisniewska drew particular attention to the guidance on deciding between suspension and striking off. She submitted that the panel should consider your insight and attitude towards addressing the concerns and whether positive change was realistically achievable during a period of suspension. She submitted that there had been insufficient remediation to date and no evidence that the concerns were likely to be addressed during a suspension period. In those circumstances, suspension should not be imposed merely in the hope that you would eventually address the concerns and return to unrestricted practice.

Ms Wisniewska referred to the guidance in SAN-4 concerning dishonesty. She submitted that honesty was central to professional practice because of the substantial trust placed in nurses. She acknowledged that not all dishonesty was equally serious and that the panel must examine the particular nature of the dishonest conduct. Nevertheless, she submitted that the findings in this case engaged the guidance concerning covering up when things had gone wrong, particularly where this could cause harm, and dishonesty creating a direct risk to people receiving care.

Ms Wisniewska submitted that your dishonest assurance concerning Patient F's nasogastric tube created such a risk. You had confirmed that the remaining tube had come out when you did not know that this was the case because you had not properly checked. She relied on the panel's finding that this could affect the response of a colleague responsible for making decisions about the patient.

Ms Wisniewska submitted that the further dishonest account addressed in charge 3 was also relevant. You had claimed to have known that part of the tube remained inside Patient F, and the panel had regarded that statement as an attempt to protect your position through an account which was not true. She submitted that this represented an attempt to cover up what had gone wrong.

Ms Wisniewska submitted that your dishonest assertion that you had escalated the retained tubing to Colleague D compounded the concern. The panel had found that you sought to place responsibility on a colleague for failing to act on information which you

had not provided. She submitted that this was further evidence of seeking to protect your position and transfer responsibility following the incident.

Ms Wisniewska invited the panel to consider the three core questions identified in the guidance on striking off. She submitted that the regulatory concerns raised fundamental questions about your professionalism; that public confidence in nursing could not be maintained if you remained on the register; and that striking off was the only sanction sufficient to protect patients and the public and maintain professional standards.

Ms Wisniewska submitted that the misconduct was extremely serious and wide-ranging, included dishonesty and justified removal from the register. She relied particularly on the high risk of repetition, the lack of effective remediation, the absence of proper insight and the lack of evidence of plans to address the concerns or improve your practice.

Ms Wisniewska submitted that, when balancing your interests against the need for public protection and the wider public interest, a striking-off order was the appropriate and proportionate sanction.

Mr McGettigan submitted that either a conditions of practice order or a suspension order could proportionately address the risks and concerns identified by the panel. His primary submission was that a striking-off order would be disproportionate in all the circumstances. He invited the panel to take account of his previous written submissions on impairment, recognising that some of those matters also informed the assessment of sanction.

Mr McGettigan submitted that the panel should carefully assess the aggravating and mitigating factors identified in the sanctions guidance. In relation to abuse of a position of trust, he submitted that there were no particular features establishing an abuse beyond the fact that you had been acting as a nurse. He submitted that treating your professional status alone as establishing this factor would mean that it applied to almost every case concerning conduct in nursing practice.

Mr McGettigan submitted that you had not deliberately placed patients at risk of harm. Although the panel had found your conduct highly unacceptable, he invited it to consider whether the actions were properly characterised as reckless or whether they reflected flawed and misjudged decisions. Similarly, while breaches of the Code had been established, he submitted that these had not been deliberate breaches.

Mr McGettigan acknowledged the panel's finding of a pattern of misconduct. However, he emphasised that, apart from charge 13, the incidents occurred between 25 August and 10 November 2017, a period of less than three months. Those incidents arose within one workplace and on one ward during a nursing career of approximately ten years. He submitted that this context was relevant when assessing the weight attached to the pattern.

Mr McGettigan submitted that there were no previous adverse regulatory findings against you apart from those in these proceedings. He also emphasised your engagement throughout the fitness to practise process. You had attended every day of both parts of the substantive hearing and had given lengthy oral evidence, although you were not obliged to give evidence.

Mr McGettigan submitted that the rejection of your account should not, without more, be treated as dishonesty in giving evidence. He referred to the guidance recognising a professional's entitlement to defend allegations and requiring careful consideration of the nature of a rejected defence before treating it as an aggravating factor. He submitted that no specific finding of dishonesty in giving evidence had been made.

Mr McGettigan submitted that the factual assessment involved weighing competing accounts and documents on the balance of probabilities. The preference for another witness's account did not necessarily establish that your evidence had been dishonest. He also relied on the considerable passage of time, its effect on everyone's recollection, the more nuanced disputes concerning some charges and your successful challenges to certain particulars. He invited the panel not to regard your decision to contest the allegations as aggravating the misconduct.

Mr McGettigan acknowledged the panel's assessment that your insight was limited. However, he submitted that there had been some insight into clinical matters in your oral evidence, particularly in relation to charges 6 and 11. He emphasised the distinction between limited insight and a complete absence of insight, while recognising the difficulty presented by your continuing to dispute the allegations.

Mr McGettigan submitted that Patient D's vulnerability was relevant to charge 12(b), but invited the panel to place that particular towards the lower end of the seriousness of the misconduct established in this case. He also noted that the proved particulars concerning Patients B and C had not individually been found sufficiently serious to constitute misconduct. He submitted that there was no evidence of premeditated or predatory behaviour.

Mr McGettigan submitted that the mitigating factors should be considered in terms of both efforts to strengthen practice and your personal circumstances. He acknowledged that early admissions and apologies were not factors on which he could rely because the allegations had been contested. However, he submitted that you had explained in oral evidence how you would approach some similar situations differently and had identified changes you would make to your practice.

Mr McGettigan submitted that you had worked almost continuously as a nurse for several years after the incidents. You had continued working at the same hospital in different areas and roles, including work on various wards and, more recently, on an ACU. He relied on that subsequent practice and the absence of other adverse regulatory findings. He also submitted that your training records indicated that you had undertaken further training and maintained your professional knowledge.

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Mr McGettigan submitted that your level of experience was an important mitigating factor. Apart from charge 13, the allegations arose when you were relatively newly

qualified, having become a registered nurse in 2016. This was your second nursing role, and the panel had heard evidence about your preceptorship and periods of supernumerary practice.

Mr McGettigan submitted that the level of workplace support was also relevant. He referred to your concerns about management support and the handling of your allegations of bullying. He submitted that most of the potential personal mitigating factors identified in the guidance were engaged and that there was substantial mitigation to balance against the aggravating features.

Mr McGettigan also invited the panel to take account of the fact that you had never been subject to an interim suspension order in this case. He submitted that the regulator had not previously considered the risks sufficient to require your urgent suspension.

Mr McGettigan acknowledged that taking no further action would be inappropriate in light of the findings. He also accepted that a caution order could not reasonably be sought. He therefore invited the panel to consider a conditions of practice order as the next sanction in ascending order.

Mr McGettigan referred to SAN-2c and submitted that there were identifiable areas of practice requiring assessment or retraining. These included communication and medication practice, which could be addressed through targeted training. Although dishonesty was more difficult to remediate, he emphasised that the panel had not found remediation impossible. He submitted that relevant learning could also be undertaken in that area.

Mr McGettigan submitted that your continued training and subsequent nursing practice supported the potential for a positive response to retraining. He submitted that conditions could be tailored to the identified concerns, monitored and assessed, while protecting people receiving care from direct or indirect risk.

Mr McGettigan drew attention to the guidance stating that conditions might be appropriate where “any” of the listed factors were present. He submitted that it was not

necessary for every factor to be satisfied before conditions could be considered. In any event, he submitted that several relevant factors were engaged in your case.

Mr McGettigan submitted, alternatively, that a suspension order would provide a proportionate response. Referring to SAN-2d, he acknowledged that the impairment found could be regarded as very serious. However, he submitted that, taking account of the circumstances, context and age of the allegations, it was not necessarily fundamentally incompatible with your continuing to be a registered professional.

Mr McGettigan acknowledged that the dishonesty findings could be regarded as towards the most serious end of the spectrum. However, he submitted that the remaining misconduct would not necessarily fall within that description. He invited the panel to assess the nature and seriousness of the individual concerns when considering whether permanent removal was required.

Mr McGettigan submitted that there remained a realistic possibility that you could be fit to practise in the future. A period away from practice could enable you to reflect, develop your skills and insight, and undertake remediation. He relied on the concentration of most incidents within a relatively short period at one workplace, where you had described difficulties.

Mr McGettigan submitted that, if the panel considered conditions insufficient to manage the current risk, suspension would prevent you from practising during the relevant period. An order subject to review would provide an additional safeguard because a future panel could assess your progress and whether you had demonstrated that it was safe for you to return.

Mr McGettigan submitted that suspension could also maintain public confidence and uphold professional standards by requiring you to stop practising for a period and demonstrate improvement before returning. He submitted that your full engagement with the proceedings and the limited insight identified in your evidence supported a realistic prospect of further development.

Mr McGettigan submitted that there were insufficient grounds to conclude that striking off was necessary and proportionate. Referring to SAN-2e, he submitted that highly significant misconduct was not necessarily fundamentally incompatible with remaining a registered professional, particularly when assessed at the present time and against the age and context of the events.

Mr McGettigan submitted that, although the findings raised very serious questions about your professionalism, they did not necessarily raise fundamental questions requiring permanent removal. He submitted that public confidence could be maintained through conditions or suspension and that further insight and reflection could address the risks, protect patients and uphold professional standards.

Mr McGettigan invited the panel to reconsider the contents of your impairment bundle when determining sanction. He relied on the positive accounts from colleagues, patients and patients' families, particularly the repeated descriptions of kindness and attentiveness. He submitted that those accounts appeared inconsistent with some of the conduct found and were relevant to the assessment of your practice as a whole.

Mr McGettigan submitted that the panel should give substantial weight to your relative inexperience at the relevant time, the age of most allegations, the surrounding circumstances, your subsequent practice and the positive material provided. He invited the panel to impose the least restrictive sanction capable of addressing the identified concerns.

Mr McGettigan submitted that a conditions of practice order or, alternatively, a suspension order would meet those concerns, whereas striking off would be disproportionate. He urged the panel to give you the opportunity to continue nursing, or to work towards a safe return, referring to your evidence that nursing had been your ambition since childhood.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- **A pattern of misconduct over a period of time**. The panel considered Mr McGettigan's submission that most incidents occurred within a relatively short period on one ward. However, the conduct involved repeated failings rather than a single isolated incident, and charge 13 concerned a subsequent incident 16 months later.

- **The dishonesty established in the charges.** The panel considered the nature and circumstances of the dishonest accounts, which concerned a clinical incident, the information provided to colleagues and responsibility for what had occurred.

- **Attempts to wrongly implicate or blame colleagues, including falsely accusing them of dishonesty.** The panel distinguished this from the mere rejection of a defence and recognised your entitlement to contest the allegations. Its concern was your continued attribution of responsibility to colleagues, including allegations that they had colluded to set you up.

- **An absence of insight in relation to the dishonesty and extremely limited insight into the clinical failings.** The panel acknowledged the limited indications in your oral evidence that you would approach certain situations differently. However, the evidence did not demonstrate sufficient understanding of the broader pattern of failings or meaningful changes addressing those serious failings.

- **No effective remediation**. Despite the substantial passage of time, the panel had not received sufficient evidence of reflection, learning and effective remediation to provide reassurance that the concerns had been resolved.

- **Failure to work collaboratively with colleagues.** The proved misconduct included failures in communicating relevant information, following clinical instructions and responding constructively to concerns. These failures affected the coordinated delivery of safe patient care.

- **Conduct which recklessly puts people receiving care at risk of suffering harm.** The failures included inadequate checking, failures concerning medication and monitoring, and failure to provide appropriate assistance with a deteriorating patient. The absence of demonstrated actual harm in a particular incident did not remove the seriousness of the risk created.

The panel also took into account the following mitigating features:

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- **Some evidence that you continued to work in healthcare roles during the intervening period without further regulatory concerns.** The panel considered the documentary material and testimonials alongside Mr McGettigan's submissions about your subsequent employment. However, the evidence provided limited information about your duties, responsibilities and clinical practice. The panel therefore distinguished continued work in healthcare roles from an established record of continuous, safe and effective practice in the full responsibilities of a registered nursing role.

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

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

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

The panel considered that your actions were at the higher end of the spectrum, and it found that there is a risk to patient and public safety. The concerns involved serious clinical failures, dishonesty and difficulties in professional working, together with a high risk of repetition. The panel therefore determined that a sanction that does not restrict your practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel considered whether it could formulate workable, practical, enforceable and measurable conditions of practice. It recognised that identifiable clinical shortcomings could, in principle, be addressed through assessment, retraining and supervision. However, the concerns in this case extended beyond clinical knowledge or competence.

The panel identified persistent attitudinal concerns relating to honesty, accepting responsibility, communicating with colleagues and responding appropriately to clinical instructions and concerns. These matters were central to the misconduct and could not adequately be addressed simply by requiring further clinical training.

The panel considered Mr McGettigan's submission that you had the potential and willingness to respond positively to retraining. However, it had not received sufficient specific evidence demonstrating that willingness or explaining how you intended to address the concerns. The paucity of the evidence related to the training material and the continuing employment, especially within your current role, did not provide the panel with confidence in your fitness to practise.

The panel could not identify conditions which would adequately protect patients from direct or indirect risk while addressing the concerns about integrity and professional relationships. It also considered that such conditions would be difficult to monitor and assess effectively. A conditions of practice order would therefore be insufficient to protect the public or reflect the seriousness of the misconduct.

The panel determined that a conditions of practice order would not be appropriate in the circumstances.

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

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*

- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could be managed by you being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved.

The panel maintained its earlier finding that the concerns were potentially remediable. It did not consider that the nature of the proven misconduct made striking off inevitable. Dishonesty is more difficult to remediate, but remediation is not impossible. The central question is whether the evidence demonstrated a realistic prospect that you would address the concerns sufficiently during a period of suspension to return safely to practice.

The panel distinguished your engagement with the hearing from evidence of insight and remediation. It acknowledged that you had attended the proceedings, had given oral evidence and were entitled to defend the allegations. It did not regard attendance alone, however, as demonstrating an understanding of the failings or a commitment to addressing them.

The panel considered Mr McGettigan's submission that reflection was difficult while you continued to dispute the charges. Nevertheless, it considered that you could have demonstrated an understanding of the importance of safe practice, the potential consequences of the misconduct and the professional obligations involved, without abandoning your defence. The panel had not received a developed account addressing those matters.

The panel acknowledged the extremely limited indications of clinical insight in your oral evidence, including statements that you would make certain checks in future. However, those statements did not sufficiently address the potential harm arising from the misconduct, the importance of integrity or the need to work constructively with colleagues. They did not provide an adequate basis for concluding that the broader concerns were being addressed.

The panel took account of the substantial time since the incidents and the approximately year-long interval between the two parts of the hearing. Despite those opportunities, it had not received any meaningful reflection, a clear account of relevant learning and its application, or sufficient current workplace evidence demonstrating that the concerns had been resolved. It also had no clear plan of remediation against which it could assess the likelihood of progress.

The panel recognised that the findings had only recently been handed down. Its assessment did not depend solely on the absence of an immediate response to those findings. It considered the evidence as a whole, including the extended period during which the concerns had been known to you and the continuing pattern of attributing responsibility to colleagues.

The panel considered the prospect of a future review but concluded that this did not resolve the present question of whether suspension was sufficient. A review could assess evidence of progress, but the panel first needed a realistic evidential basis for believing that such progress was likely. On the material before it, that basis was absent.

The panel therefore concluded that suspension would provide temporary protection without sufficient assurance that the underlying concerns would be addressed. It would amount to allowing further time in the unsupported hope that meaningful insight and remediation would emerge. The panel did not believe that providing you a further period of 12 months would ensure that you would address these concerns.

The panel considered the guidance in SAN-4 concerning dishonesty. It recognised that not all dishonesty is equally serious and that the misconduct in this case has not involved financial gain or an established premeditated scheme. It nevertheless related to dishonest information about patient care and your avoidance of professional responsibility for what had occurred.

The panel considered the significance of covering up when matters had gone wrong and the potential effect of inaccurate information on clinical decisions. It also placed substantial weight on your attempts to wrongly implicate or blame colleagues. These matters went beyond the original clinical failings and undermined the trust necessary for safe professional working.

The panel distinguished those concerns from the mere rejection of your defence. Its concern was the pattern of transferring responsibility and alleging that colleagues had been dishonest or deliberately set you up, as addressed in its earlier findings. It regarded this as particularly relevant to whether the attitudinal concerns had been understood and could realistically be addressed.

The panel considered whether you had demonstrated remorse for the dishonest conduct, recognised its nature or explained how you would prevent repetition. It had not received evidence addressing those matters. This absence was particularly significant when assessing whether suspension would be likely to achieve a safe and sustainable return to practice.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel concluded that the combination of serious clinical misconduct, dishonesty, difficulties in professional cooperation and the continued attribution of blame to other registered colleagues raised fundamental questions about your professionalism. Although the concerns were potentially remediable in principle, the evidence did not establish a realistic prospect that you would undertake the necessary work during a period of suspension.

The panel gave careful consideration to the age of the allegations and the prolonged proceedings. It also took account of the mitigating factors already identified, including [PRIVATE] at the relevant time, and some evidence of continued work in healthcare roles without further regulatory concerns. It recognised the significant professional and personal consequences that removal from the register would have for you.

The panel nevertheless concluded that those matters did not sufficiently reduce the current concerns. Its decision was based on the seriousness and pattern of the misconduct, the risk of repetition and the lack of sufficient evidence of insight, reflection and effective remediation. It did not treat dishonesty as automatically requiring removal or the concerns as incapable of remediation.

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this case demonstrate that your actions were serious and to allow you to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body. It determined that the public protection and public interest considerations outweighed your interests in remaining on the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to you in writing.

Interim order

As the striking-off 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 striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that an interim suspension order was required to cover the 28-day appeal period and maintain the position pending any appeal you might bring. She applied for an interim suspension order for 18 months.

Ms Wisniewska submitted that, if you did not appeal, the interim suspension order would cease when the substantive striking-off order took effect following the expiry of the 28-day appeal period.

Mr McGettigan did not oppose the application.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.