

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

**Substantive Hearing
Monday, 12 October – Friday, 16 October 2026**

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Sarah Jayne Didymus
NMC PIN:	99B1158E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) - 28 January 2002 V300: Nurse Independent / Supplementary Prescriber - 18 December 2013
Relevant Location:	Cornwall
Type of case:	Misconduct
Panel members:	Christine Nwaokolo (Chair, lay member) Carole McCann (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Amy Woolfson, Case Presenter
Mrs Didymus:	Not present and not represented
Facts proved:	All charges
Facts not proved:	N/A
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 service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Didymus was not in attendance and that the Notice of Hearing letter had been sent to Mrs Didymus' registered email address by secure email on 11 September 2026.

Ms Woolfson, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing and, amongst other things, information about Mrs Didymus' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Didymus has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Didymus

The panel next considered whether it should proceed in the absence of Mrs Didymus. It had regard to Rule 21 and heard the submissions of Ms Woolfson who invited the panel to continue in the absence of Mrs Didymus. Ms Woolfson submitted that Mrs Didymus has been afforded every opportunity to attend but has voluntarily waived her right to be present. She referred the panel to the Proceedings in Absence Bundle, which demonstrates that Mrs Didymus was notified of the hearing dates as early as January 2026. Although legally represented at that time, she is now unrepresented. Mrs Didymus confirmed receipt of the case papers on 16 September 2026, and that same day, emailed

the Case Coordinator stating she did not intend to attend. Furthermore, Mrs Didymus expressed that she wishes to leave the NMC register and indicated that she has nothing to contribute to the process.

Given this clear disengagement, Ms Woolfson submitted that it is in the public interest to proceed with the hearing in Mrs Didymus absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised '*with the utmost care and caution*'.

The panel has decided to proceed in the absence of Mrs Didymus. In reaching this decision, the panel has considered the submissions of Ms Woolfson, the emails between Mrs Didymus and the NMC, and the advice of the legal assessor. It had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Didymus;
- Mrs Didymus was in correspondence with the NMC as early as 16 September 2026, and by 11 October 2026, she confirmed she would not be attending the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022 and 2023;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Didymus in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the NMC's charges. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Didymus's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that Mrs Didymus had deliberately chosen not to exercise her right to be present or to give adequate instructions to enable lawyers to represent her and that it is fair to proceed in the absence of Mrs Didymus. The panel will draw no adverse inference from Mrs Didymus's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Woolfson, on behalf of the NMC, who provided the panel with written submissions proposing amendments to the charges. These included the addition of charges 7c) and 12c), as well as revised wording for charges 10 and 14. She submitted that while this expanded the scope of the charges, it was consistent with the evidence and captured the full scale of the alleged misconduct:

- 7) On 6 June 2022:
 - a) Accessed Patient A's records with no consultation and/or clinical justification;
 - b) Issued a 12 month course of 1mg/0.74ml Ozempic under the preparation of Semaglutide for Patient A

c) Collected the prescription for 1mg/0.74ml Ozempic for Patient A from Lloyds Pharmacy.

10) Your action/s at some or all of charges 7 and / or 8a) were dishonest in that you generated **and/or collected a** prescription which you knew was not required for Patient A, intending to take the Ozempic for your own personal use.

12) On 26 January 2023:

a) Accessed Patient B's records with no consultation and/or clinical justification;

b) Issued a 4 week course of 0.5mg/0.37ml Semaglutide for Patient B.

c) Collected the prescription for 0.5mg/0.37ml Semaglutide for Patient B from Lloyds Pharmacy.

14) Your action/s at some or all of charge 12 and/or 13a) was dishonest in that you generated **and/or collected a** prescription which you knew was not required for Patient B, intending to take the Semaglutide for your own personal use.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was satisfied that allowing the proposed charges would not introduce any new evidence, nor would it increase the overall severity of the allegations against Mrs Didymus. The panel noted that the NMC Case Coordinator had served the proposed amended charge on Mrs Didymus with the accompanying written submission, and that she subsequently stated that she had no comments to make and did not dispute them. Furthermore, the panel determined that the amendments caused no unfairness or prejudice to Mrs Didymus.

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

Ms Woolfson [PRIVATE]. She accepted it would be appropriate for those matters to be held in private, pursuant to Rule 19.

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, of its own volition, that matters relating to Mrs Didymus' [PRIVATE] to be held in private in order to protect her privacy.

NMC's opening note (Background)

Mrs Didymus was employed by Port View Surgery as a V300 advanced nurse practitioner from 2021 until her resignation in June 2023.

Mrs Didymus' responsibilities were to run clinics, triage patients, see patients face-to-face, review minor illnesses, and complete home visits. Mrs Didymus was a nurse prescriber, meaning she could prescribe the necessary medication for her patients.

In April 2023 the Practice Manager, Tina Seedhouse, became suspicious of Mrs Didymus' practice in relation to weight loss drugs. This was triggered by a phone call Patient Adviser Linzie Cushing received from Boots pharmacy, querying the large quantity of Ozempic Mrs Didymus had prescribed Patient E. This, combined with the fact that Mrs Didymus had lost a lot of weight in recent months, caused her to investigate the Mrs Didymus' prescribing of these drugs.

Tina Seedhouse's investigation revealed inappropriate prescribing in respect of 5 patients. These are Patients A-E in the charges. In each case, the NMC allege that Mrs Didymus prescribed Trulicity or Ozempic when it was not clinically justified. These prescriptions were issued on paper and then cancelled on the patient's record shortly afterwards. The cancellation of the prescriptions was done to conceal the issue of the prescription as it meant that the medication would not show on a patient's active record.

On 2 May 2023 Tina Seedhouse contacted Person A, a pharmaceutical advisor at Cornwall and the Isles of Scilly Integrated Care Board (“the ICB”). This revealed that three prescriptions of concern issued by Mrs Didymus were dispensed i.e. the medication was collected. The NMC allege that Mrs Didymus collected these prescriptions intending to consume the medication herself. The prescriptions were issued without the knowledge of the patients and the NMC invited the panel to conclude that Mrs Didymus was the person who collected the prescriptions. Charges 4c, 7c and 12c relate.

Person A shared correspondence with Mrs Didymus from August 2022 where Mrs Didymus stated she would put a note on a Patient A’s record that she should not be prescribed Ozempic/Semaglutide until 2023 (Exhibit TS9). This was in response to the ICB querying the high value of Patient A’s Ozempic prescriptions. Mrs Didymus did not put a note on Patient A’s record. Mrs Didymus said that this was not required. The NMC invite the panel to conclude that this was because Patient E was never in receipt of the prescription drug, because she intended to take it herself.

The consultation notes made by Mrs Didymus about Patients A-E were accurate, and did not refer to the drugs Mrs Didymus had prescribed for which she prepared paper prescriptions, and in one case (Patient E) the patient had specifically asked to come off Ozempic and go back on Metformin. Mrs Didymus had prepared prescriptions for both, Metformin by electronic prescription for the patient, and Ozempic by paper prescription which Mrs Didymus accepted she had collected herself for personal use.

Ms Didymus was on leave from 2 May 2023 until 19 May 2023. [PRIVATE]. Mrs Didymus was informed of the allegations at a meeting on 19 May 2023 and suspended from duty.

At an investigation meeting on 24 May 2023 the allegations around inappropriate prescribing were put to her. Mrs Didymus accepted that she had issued prescriptions for her own use. She stated that she had issued paper prescriptions rather than electronic ones because it would give her an opportunity to change her mind about whether to take

the medication. Mrs Didymus produced a paper prescription from her handbag. This had been prepared some two months before. It related to Patient D (exhibit TS17).

Mrs Didymus resigned her employment in June 2023. She did not attend her disciplinary hearing, saying that her attendance would not alter the outcome.

In representations made on Mrs Didymus' behalf in October 2024, it was stated that she had been open and honest about the regulatory concerns, and that she felt ashamed of her actions.

In no case was there any effect on any patient, and so none needed to be informed. All the patient's notes were accurate, and as the prescriptions prepared for her personal use were hidden in the past medications section of the database there was no possibility of any patient being prescribed the wrong medication by another prescriber.

Hearsay application

The panel heard submissions made by Ms Woolfson.

The panel noted that Ms Tina Seedhouse had already conducted a thorough investigation, meaning that the hearsay evidence of Ms Claire Friend would not further strengthen the case. In relation to Ms Linzie Cushing, who had provided two statements, the panel noted she was not scheduled to give evidence until Day 3.

In determining whether to admit the statement of Ms Cushing as hearsay, the panel applied the relevant legal principles. It determined that their accounts did not constitute the sole or decisive evidence in these proceedings. Furthermore, the evidence was demonstrably reliable and was unchallenged by Mrs Didymus.

Requiring her to give live evidence would cause a prolonged delay to the hearing while adding no further value to the fact-finding process.

Ms Friend was a fraud investigator. However, her evidence was that she did not need to undertake an investigation as Ms Seedhouse had done such a thorough job. Her witness statement did not more than recapitulate that of Ms Seedhouse and offer opinion. The NMC's case presented indicated that, for these reasons, it would not call Ms Friend.

Accordingly, Ms Cushing and Ms Friend were formally stood down from giving oral evidence.

Redactions

The panel determined to redact partially the expert report authored by Ms Luella Robb, dated 10 July 2026. The redactions were of all references containing her opinions and conclusions on the allegations to be determination. The panel noted that the expert's personal opinion on whether misconduct occurred did not constitute admissible evidence for this purpose. It would be unfair to Mrs Didymus to allow those findings and opinions as evidence. The responsibility of evaluating the evidence and reaching a determination on the charges rests with the panel.

Further amendments to charges

Ms Woolfson submitted that Ms Seedhouse could not explain why exhibit TS24 indicates that a single injection at 0.5mg strength was dispensed. She submitted that that charge 4c refers to Lloyds Pharmacy whereas TS24 refers to Saltash Pharmacy. The panel heard that they are different pharmacies. She submitted that the panel have the power to amend the charge to delete the reference to the specific pharmacy where the prescription was dispensed. It is submitted that this causes no injustice as the gravamen of the charge is collecting the prescription, not the location.

Pursuant to Rule 28 of the Rules, the panel determined of its own volition to amend the charges by removing all references to the specific dosage and pharmacy name. The panel

concluded that the exact dosage of the prescribed drugs and the location of collection were irrelevant to the underlying allegations of misconduct. The core of the allegation rests solely on the fact that a prescription in another individual's name was collected. It was antithetical to the public interest function of the panel, and not unfair to Mrs Didymus to omit these irrelevant details. Accordingly, the amended charges read as follows:

Details of charge (as amended)

That you, a registered nurse:

- 1) On 5 January 2022 restarted a course of Trulicity for Patient A with no clinical justification to do so.
- 2) On or around 5 January 2022:
 - a) Printed a prescription for Trulicity for Patient A;
 - b) Ended the Trulicity prescription entry on Patient A's record.
- 3) On 16 February 2022 prescribed a 12 month course of Ozempic for Patient A with no clinical justification to do so.
- 4) On or around 16 February 2022:
 - a) Printed a prescription of Ozempic for Patient A;
 - b) Ended the Ozempic prescription entry for Ozempic on Patient A's record recording it had been made in error;
 - c) Collected the prescription for Ozempic generated for Patient A from a pharmacy.

5) Your action/s at some or all of charges 1, 2a), 3, 4a) and/or 4c) was dishonest in that you generated and/or collected prescriptions which you knew were not required for Patient A, intending to take the Ozempic and/or Trulicity for your own personal use.

6) Your action/s at charge 2b and/or 4b) were dishonest in that you intended to conceal that you had generated prescriptions for Trulicity and/or Ozempic using Patient A's record, intended for your own personal use.

7) On 6 June 2022:

a) Accessed Patient A's records with no consultation and/or clinical justification;

b) Issued a 12 month course of Ozempic under the preparation of Semaglutide for Patient A.

c) Collected the prescription for Ozempic for Patient A from a Pharmacy.

8) On or around 6 June 2022:

a) Printed a prescription for Ozempic under the preparation of Semaglutide for Patient A;

b) Ended the Ozempic under the preparation of Semaglutide prescription on Patient A's record recording 'didn't use.'

9) On 24 August 2022 told Person A you would make a note on Patient A's record that Patient A would not be prescribed Ozempic and/or Semaglutide until 2023 but you did not make this entry.

10)Your action/s at some or all of charges 7 and / or 8a) were dishonest in that you generated and/ or collected a prescription which you knew was not required for Patient A, intending to take the Ozempic for your own personal use.

11)Your action at charge 8b) was dishonest in that you intended to conceal that you had generated a prescription Ozempic using Patient A's record, intended for your own personal use.

12)On 26 January 2023:

a) Accessed Patient B's records with no consultation and/or clinical justification;

b) Issued a 4 week course of Semaglutide for Patient B.

c) Collected the prescription for Semaglutide for Patient B from a Pharmacy.

13)On or around 26 January 2023:

a) Printed a prescription for Semaglutide for Patient B;

b) Ended the course of Semaglutide on Patient B's record recording 'wrong PT.'

14)Your action/s at some or all of charge 12 and/or 13a) was dishonest in that you generated and/ or collected a prescription which you knew was not required for Patient B, intending to take the Semaglutide for your own personal use.

15)Your action at charge 13b) was dishonest in that you intended to conceal that you had generated a prescription for Semaglutide using Patient B's record, intended for your own personal use.

16) On 20 February 2023 following a consultation with Patient C started a 28 day course of Semaglutide injections without clinical justification.

17) On or around 20 February 2023:

a) Printed a prescription for Semaglutide injections for Patient C;

b) Ended the course of Semaglutide injections on Patient C's records recording 'wrong PT'.

18) Your action/s at some or all of Charge 16 and / or Charge 17a) was dishonest in that you generated a prescription which you knew was not required for Patient C, intending to take the Semaglutide for your own personal use.

19) Your action at charge 17b) was dishonest in that you intended to conceal that you had generated a prescription for Semaglutide using Patient C's record, intended for your own personal use.

20) On 15 March 2023 added a 28 day course of Ozempic to Patient D's records with no clinical justification.

21) On or around 15 March 2023:

a) Printed a prescription for Ozempic for Patient D;

b) Ended the course of Ozempic on Patient D's records recording 'not issued as needs review 1st' and/or 'Ozempic RX cancelled as added before realised she needs a review'

22)Your action/s at Charge 20 an /or Charge 20a) was dishonest in that you generated a prescription for Ozempic which you knew was not required for Patient D, intended for your own personal use.

23)Your conduct at charge 21b) was dishonest in that you intended to conceal that you had generated a prescription for Ozempic using Patient D's record, intended for your own personal use.

24)On or around 20 April 2023 issued a 4 month prescription of Ozempic for Patient E with no clinical justification.

25)On or around 20 April 2023:

a) Printed a 4 month prescription of Ozempic for Patient E;

b) Cancelled the prescription on Patient E records.

26)Your action/s at charge 24 and / or 25a) was dishonest in that you generated a prescription for Ozempic which you knew was not required for Patient E, intended for your own personal use.

27)Your action at charge 25b) was dishonest in that you intended to conceal that you had generated a prescription for Ozempic using Patient E's record, intended for your own personal use.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence including telephone recordings, together with the submissions made by Ms Woolfson.

The panel accepted the advice of the legal assessor, who referred the panel to the test for dishonesty contained in the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords)* [2017] UKSC 67.

The panel has drawn no adverse inference from the non-attendance of Mrs Didymus.

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:

- Ms Luella Robb: Expert witness instructed by the NMC to prepare a report
- Ms Tina Seedhouse: Practice Manager at Port View Surgery

The panel also considered the hearsay evidence of Ms Linzie Cushing (Patient Adviser at Port View Surgery).

Witness – Ms Tina Seedhouse

The panel found Ms Seedhouse to be a clear, consistent and knowledgeable witness. It identified no reason for her to give an inaccurate account. Her investigation was thorough, impartial, comprehensive and supported by contemporaneous records. She also sought advice from other experts and remained supportive of Mrs Didymus throughout the process. In interview with Ms Seedhouse Mrs Didymus had made significant admissions, to the effect that she accepted that her actions were wrong, that the prescriptions were for

her personal use (although she had destroyed some of them and not utilised them) and that her computer entries concealed what she had done. For those reasons, the panel placed significant weight on both her oral and documentary evidence when determining the charges.

Mrs Didymus' admissions at the investigations interview meeting with Ms Seedhouse.

On 24 May 2023 Ms Didymus attended an investigatory meeting at the surgery. The meeting was led by Ms Seedhouse. A colleague took a note of the meeting. Mrs Didymus was asked to approve the note but did not do so. Nor did she indicate that she disagreed with it.

In respect of Patient A, Mrs Didymus agreed with the account put to her. She said the prescriptions issued on 5 January 2022 and on 16 February 2022 were issued for her personal use. She said she was not sure about the prescription issued on 6 June 2022. She was asked why she had not made a note on the patient's record when she had agreed to do so on 24 August 2022, she said she would not have done so as it would not have been relevant.

In respect of Patient B, Mrs Didymus said she would have issued the prescription for the 'same reason' and that she thought she might have destroyed it, but that she could not recall.

In respect of Patient C, Mrs Didymus said she could not recall issuing a prescription but would have probably destroyed it.

In respect of Patient D, Mrs Didymus said she printed a prescription because she considered using it for personal use. She said she had destroyed the prescription but later produced it from her handbag.

In respect of Patient E, Mrs Didymus agreed with the account put to her. She said that she had issued a paper prescription because she knew what she was doing was wrong and it would give her a chance to change her mind. She said the prescription had been issued for personal use.

[PRIVATE].

The panel then considered the charges and made the following findings.

Charges 1 – 11 Relating to Patient A

Charges 1, 2a) and 2b)

- 1) On 5 January 2022 restarted a course of Trulicity for Patient A with no clinical justification to do so.
- 2) On or around 5 January 2022:
 - a) Printed a prescription for Trulicity for Patient A;
 - b) Ended the Trulicity prescription entry on Patient A's record.

These charges are found proved.

The panel considered Ms Seedhouse's statement, the recording of Mrs Didymus' telephone consultation with Patient A on 5 January 2022 and the corresponding clinical record.

The clinical record for Patient A states:

*"History: says heart problems, keep him awake
Says pulse running fast, can feel missed beats*

*Some chest pain over xmas and new year, GTN helps,
Comment: offered pt a f2f today (weds), he cannot get to surgery until Friday
advised if worse before must call 999 as we needs ecg/pulse/bp check and prob
bloods he understands this.” [sic]*

Neither the recording nor the clinical note refers to Trulicity. The panel also noted that Trulicity had previously been prescribed to Patient A in 2018 but had not been continued because Patient A experienced an adverse reaction.

After the consultation, Mrs Didymus accessed Patient A’s historic medication record, restarted Trulicity, printed the prescription and then ended the course again. That sequence is recorded in Patient A’s prescribing history.

The panel also considered the minutes of Mrs Didymus’ investigatory meeting on 24 May 2023, which state:

“You had a consultation with this patient on 05.01.2022 regarding breathlessness and palpitations. During this consultation you discussed current medications there was no mention of Trulicity. Prescribing of Trulicity had been stopped for this patient in 2018 due to adverse reactions.

Once the consultation ended it would seem that you accessed the past medication screen for this patient, re-started the medication, issued a prescription in printed format for 12 prefilled injections and then ended the course again.

Are you able to explain why this might have happened?

SD: for personal use.”

The panel found no clinical basis for the prescription. Had Trulicity been clinically indicated, it would reasonably have been discussed with Patient A and documented in the consultation note. Mrs Didymus also admitted during the investigatory meeting that she

had restarted the medication, printed the prescription and then ended the course, intending the prescription for her own use.

Accordingly, the panel found proved that, on 5 January 2022, Mrs Didymus restarted Trulicity for Patient A without clinical justification, printed the prescription and ended the Trulicity entry on Patient A's record.

Charges 3, 4a), 4b) and 4c)

- 3) On 16 February 2022 prescribed a 12 month course of Ozempic for Patient A with no clinical justification to do so.
- 4) On or around 16 February 2022:
 - a) Printed a prescription of Ozempic for Patient A;
 - b) Ended the Ozempic prescription entry for Ozempic on Patient A's record recording it had been made in error;
 - c) Collected the prescription for Ozempic generated for Patient A from a pharmacy.

These charges are found proved.

The panel considered Ms Seedhouse's witness statement, the recording of Mrs Didymus' further telephone consultation with Patient A on 16 February 2022 and the corresponding clinical record.

Patient A's record for February 2022 states:

*"History: low mood continues
has contacted crisis line, needs ref for further support
forgetting and muddling meds- discussed blister packs- tasked to presc team to
arrange has run out of bisoprolol and cannot remember some days if he has taken*

or not, has lots of tablets and at risk of adverse effects if forgets council coming friday afternoon to assess damage in house due to fall last week, they are adamant he needs to pay, he is happy with this but will have to make an arrangement as very worried about rising costs of utilities etc may need foodbank again-- advised we can authorise that, let us know if he needs another ref/form sciatica worse at moment since fall last week, but he has forgotten to order pregabalin so needs that today" [sic]

The panel noted that there was a detailed conversation about the patient's current medications. Ozempic was not discussed.

The panel took into account Patient A's Ozempic record.

After the consultation, Mrs Didymus added a new course of Ozempic to Patient A's record for 12 pre-filled injections, amounting to a 12-month supply.

The panel found no clinical indication for that prescription. If Ozempic had been clinically required, it would reasonably have been discussed with Patient A and recorded in the consultation note. Mrs Didymus printed the prescription and, approximately 20 minutes later, ended it on the record using the reason "error".

The panel noted Ms Robbs's evidence that a patient who had not previously or recently been prescribed Ozempic, or who had experienced an adverse reaction, would ordinarily start at a dose of 0.25 mg.

The panel determined that Mrs Didymus then took the printed prescription to a pharmacy, where it was dispensed to Mrs Didymus. It noted that Patient A would have been unaware of the prescription and there is no reason to think it would have been dispensed to anyone else.

The panel found that, in February 2022, Mrs Didymus prescribed a 12-month course of Ozempic for Patient A without clinical justification.

The panel also considered the minutes of Mrs Didymus' investigatory meeting dated 24 May 2023, which states:

“When consulting with this same patient on 16.02.2022 you again discussed the medication, he was currently taking, he was running out of some of them and you read out the list on his screen, electronically issuing prescriptions for the ones he needed. Ozempic was not mentioned during this consultation, and it was not on the patients list of current medication.
It would appear that you then added Ozempic to his medication screen, issued a prescription for a 12 month supply and printed the prescription.
Once the prescription was printed, the medication course was then ended.
Are you able to explain why this might have happened?

SD: I thought about using it for personal use”

Taken together, the absence of any clinical discussion, the quantity prescribed, the printing and rapid cancellation of the entry, Mrs Didymus' admissions and the evidence that she collected the medication satisfied the panel that charges 3, 4a, 4b and 4c were proved.

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

5) On 6 June 2022:

- a) Accessed Patient A's records with no consultation and/or clinical justification;
- b) Issued a 12 month course of Ozempic under the preparation of Semaglutide for Patient A.
- c) Collected the prescription for Ozempic for Patient A from a pharmacy.

- 6) On or around 6 June 2022:
- a) Printed a prescription for Ozempic under the preparation of Semaglutide for Patient A;
 - b) Ended the Ozempic under the preparation of Semaglutide prescription on Patient A's record recording 'didn't use.'

These charges are found proved.

The panel took into account Ms Seedhouse's witness statement which states:

"On 6 June 2022, Mrs Didymus went into Patient A's past medication record and restarted a course of Ozempic under the preparation of Semaglutide. I can confirm that there is no record of Patient A having a consultation on 6 June 2022 at the Surgery. Mrs Didymus then issued a prescription for 12 pre-filled injections, which is 12 months' worth, printed a paper prescription, then ended the course with the reason 'didn't use.' I know this because it became apparent during my audit of Mrs Didymus' prescribing practice, which is again detailed later in this statement. This prescription was picked up by Mrs Didymus at Lloyds Pharmacy Saltash. I know this due to the data I had received from the NHS Prescription Team, as detailed later in this statement."

The panel noted that Mrs Didymus did not have a consultation with Patient A on 6 June 2022. Despite this, Mrs Didymus went into Patient A's past medication record and restarted a course of Ozempic under the preparation of Semaglutide. Mrs Didymus then issued a prescription for 12 pre-filled injections, which is 12 months' worth, printed a paper prescription, then ended the course with the reason 'didn't use'.

The panel determined that this prescription was picked up by Mrs Didymus at a pharmacy. It noted that Patient A would have been unaware of the prescription and there is no reason to think it would have been dispensed to anyone else.

As per the email between Mrs Didymus and the Lead Pharmacist, the cost of the items dispensed was £822.

Having considered the evidence as a whole, the panel found proved that, on 6 June 2022, Mrs Didymus accessed Patient A's record without a consultation or clinical justification, issued and printed a 12-month course of Ozempic under the preparation Semaglutide, collected the prescription from a pharmacy and then ended the entry using the reason 'didn't use'. The lack of any consultation, the use of a paper prescription, the collection of the medication and the way the entry was subsequently closed were mutually reinforcing evidence that the prescription was not issued for Patient A.

Charge 9

- 9) On 24 August 2022 told Person A you would make a note on Patient A's record that Patient A would not be prescribed Ozempic and/or Semaglutide until 2023 but you did not make this entry.

These charges are found proved.

The panel considered the audit trail dated 24 August 2022, which recorded Mrs Didymus' issue of the medication.

On 24 August 2022, Person A from the Independent Commissioning Board emailed Mrs Didymus about her prescription of 12 injections for Patient A: i.e. the prescription of 6 June 2022 as 12 months of Semaglutide is considered a high cost.

Mrs Didymus replied that she had understood 12 injections to represent a 12-week, rather than a 12-month, supply. She also stated that she had added a note to Patient A's record directing that no further supply should be issued until 2023. The audit trail showed that she had not made that entry.

Ms Seedhouse said that, during the investigatory meeting, she asked Mrs Didymus why the note had not been made. Mrs Didymus replied: *“I don’t recall saying I would add a note to his record but if I didn’t it was because it wouldn’t have been relevant.”*

Having considered the email trail, the audit trail and the investigatory meeting minutes, the panel found proved that Mrs Didymus told Person A she would add the note but did not do so.

Charges 12 – 15 Relating to Patient B

Charges 12a), 12b), 12c) 13a) and 13b)

12) On 26 January 2023:

- a) Accessed Patient B’s records with no consultation and/or clinical justification;
- b) Issued a 4 week course of Semaglutide for Patient B.
- c) Collected the prescription for Semaglutide for Patient B from a pharmacy.

13) On or around 26 January 2023:

- a) Printed a prescription for Semaglutide for Patient B;
- b) Ended the course of Semaglutide on Patient B’s record recording ‘wrong PT.’

These charges are found proved.

The panel took into account Ms Seedhouse witness statement, which states:

“On 26 January 2023, Patient B had an appointment with..., the Surgery’s Diabetic Nurse, for a routine diabetic review. I attach Patient B’s notes from this consultation at Exhibit “TS10”. Mrs Didymus had never had any contact with Patient B, however, she had once reviewed Patient B’s urine sample results, but Patient B was never contacted

by her. Mrs Didymus went into Patient B's records on 26 January 2023, added a course of Semaglutide, issued a paper prescription, printed it, and then ended the course with the reason 'wrong PT,' which meant wrong patient. Patient B had never been prescribed Semaglutide previously. I attach Patient B's Semaglutide history at Exhibit "TS11". I know this from my audit into Mrs Didymus' prescribing practice, which is detailed later in this statement. Patient B would normally use the electronic prescription system to send their prescriptions to their normal pharmacy, Tamar Pharmacy, as would most patients; it is very unusual to issue printed prescriptions. I know that this prescription was collected from Lloyds Pharmacy by Mrs Didymus through my contact with the NHS Prescriptions Team, as detailed later in this statement."

The panel also considered Patient B's records from 26 January 2023, Patient B's Semaglutide history, and the email trail with Person A dated 2 May 2023.

The panel noted that Patient B had a diabetes review at the surgery on 26 January 2023. Patient B did not have a consultation with Mrs Didymus. However, she went into Patient B's records, added a course of Semaglutide, issued a paper prescription for Ozempic, printed it, and then ended the course with the reason 'wrong PT [Patient],' The panel determined that there was no clinical justification for accessing the record.

The panel noted the evidence that Patient B had never been prescribed Semaglutide previously.

It considered Ms Seedhouse's evidence in which she explained that Patient B would normally use the electronic prescription system to send their prescriptions to their normal pharmacy, Tamar Pharmacy, as would most patients; it was very unusual to issue printed prescriptions. Ms Seedhouse's evidence was that the practice had been using electronic prescriptions for around a decade at the time and that only around 5% of prescriptions were issued on paper.

The panel regarded the use of a paper prescription as significant because it reduced the visibility and traceability associated with the practice's usual electronic system. In the context of a prescription unsupported by any consultation or clinical need, the decision to print it supported the conclusion that it was not a legitimate prescription for Patient B. Mrs Didymus' explanation—that printing allowed her time to decide whether to collect it—did not withstand scrutiny, because she could equally have chosen not to collect an electronic prescription.

The panel therefore found proved that, on 26 January 2023, Mrs Didymus accessed Patient B's record without a consultation or clinical justification, issued and printed a four-week course of Semaglutide, collected it from a pharmacy and then ended the course on the record using the reason "wrong PT".

Charges 16 – 19 Relating to Patient C

Charges 16, 17a) and 17b)

16) On 20 February 2023 following a consultation with Patient C started a 28 day course of Semaglutide injections without clinical justification.

17) On or around 20 February 2023:

- a) Printed a prescription for Semaglutide injections for Patient C;
- b) Ended the course of Semaglutide injections on Patient C's records recording 'wrong PT'.

These charges are found proved.

The panel took into account Ms Seedhouse witness statement, which states:

On 20 February 2023, Mrs Didymus had a telephone consultation with Patient C regarding peak flows and recent asthma problems. I attach a recording of this call

at Exhibit "TS12" and Patient C's records of this consultation at Exhibit "TS13". Following this call, Mrs Didymus initiated a course of Semaglutide 1mg/0.74ml injections for Patient C, despite there being no clinical indication that it was necessary, nor did she discuss it with Patient C. I know this from my audit of Mrs Didymus' prescribing practice, which is detailed later in this statement; you can see it having been prescribed with a date and time stamp on the medication screen. I attach Patient C's Semaglutide history at Exhibit "TS14". Mrs Didymus then printed a paper prescription and ended the course with the reason 'wrong pt,' (wrong patient) which I know through my audit as above. Patient C would have usually used the electronic prescription system to send their prescriptions to their normal pharmacy, Tamar Pharmacy. I am not aware of whether this prescription was collected by Mrs Didymus. This did not come to light when speaking to the NHS Prescription team, as paper prescriptions take a long time to work their way through the system. I did not chase further for this information as the investigation had been taken over by NHS Counter Fraud at the time, as detailed later in this statement.

The panel noted that Mrs Didymus had a telephone consultation with Patient C. They discussed her peak flow and her inhalers. They did not discuss Ozempic and there is no reason to think Ozempic was clinically indicated.

Following this call, Mrs Didymus initiated a course of Semaglutide injections for Patient C. She then printed a paper prescription before ending the course and recording the reason as 'wrong pt,' (wrong patient).

Patient C's recorded preference was for her prescriptions to be issued electronically to Tamar Pharmacy.

The panel found that printing the prescription, despite Patient C's recorded preference for electronic prescriptions to Tamar Pharmacy, was further evidence that it was not intended for Patient C. That inference was strengthened by the absence of any discussion or clinical indication for Semaglutide and by the subsequent entry of "wrong PT". The panel

concluded that the prescription was intended for Mrs Didymus' own use.

The panel therefore found proved that, on 20 February 2023, Mrs Didymus started a 28-day course of Semaglutide for Patient C without clinical justification, printed the prescription and ended the course on Patient C's record using the reason "wrong PT".

Charges 20 – 23 Relating to Patient D

Charges 20, 21a) and 21b)

20) On 15 March 2023 added a 28 day course of Ozempic to Patient D's records with no clinical justification.

21) On or around 15 March 2023:

- a) Printed a prescription for Ozempic for Patient D;
- b) Ended the course of Ozempic on Patient D's records recording '*not issued as needs review 1st*' and/or '*Ozempic RX cancelled as added before realised she needs a review*'.

These charges are found proved.

The panel took into account the witness statement of Ms Seedhouse, which states:

"18. On 15 March 2023, Mrs Didymus completed a consultation for Patient D as they had written to the Surgery requesting an adjustment to their medication. This was just a handwritten note asking if it was possible to change medications. I attach Patient D's records displaying this consultation at Exhibit "TS15". Patient D had sent in a letter which was scanned onto their records. Mrs Didymus then sent a text back to Patient D asking them to go for a blood test before their medication could be updated. This is because Patient D had not attended their last diabetic check and their bloods were not up to date. Following this consultation, Mrs Didymus added a course of Ozempic

1mg/0.74ml, for one month, which was four pre-filled injections. I attach Patient D's Ozempic history at Exhibit "TS16". Mrs Didymus then printed this prescription and cancelled it on Patient D's records, stating the reason as being 'not issued as needs review 1st.' I again discovered this during my audit of Mrs Didymus' prescribing practice, which is detailed later in this statement. Patient D would usually use the electronic prescription system to send their prescriptions directly to Tamar Pharmacy. This prescription was not dispensed by the pharmacy, nor was it collected by Mrs Didymus, as when I called Mrs Didymus in for the investigation meeting, which is detailed later in this statement, she handed it over to me and said she had not taken it to the pharmacy yet. I attach a copy of this prescription at Exhibit "TS17".

The panel noted that on 15 March 2023, Mrs Didymus completed a consultation for Patient D as they had written to the Surgery requesting an adjustment to their medication. The panel took into account the record of the consultation from 15 March 2023 which states that the patient had asked for an increase in their Ozempic prescription. This implies that the patient had been prescribed Ozempic 0.25mg or 0.5mg.

Mrs Didymus then sent a text back to Patient D asking them to go for a blood test before their medication could be updated. This is because Patient D had not attended their last diabetic check and their blood results were not up to date.

Following this consultation, Mrs Didymus added a course of Ozempic for one month, which was four pre-filled injections. Mrs Didymus then printed this prescription and cancelled it on Patient D's records, stating the reason as being '*not issued as needs review 1st.*'

The panel determined that the prescription was not clinically justified as it was generated without the patient being reviewed for suitability.

The panel noted Ms Robb's evidence that it was necessary to review Patient D before prescribing an increase in Ozempic.

Having considered the evidence as a whole, the panel concluded that the prescription was intended for Mrs Didymus' own use. In particular, Mrs Didymus still had the prescription in her handbag when she attended the surgery for the investigatory meeting on 24 May 2023. If it had genuinely been generated for Patient D and then cancelled because a review was required, the panel considered that it would have been destroyed. The conclusion was further supported by Patient D's recorded preference for prescriptions to be sent electronically to Tamar Pharmacy, and not to have paper prescriptions.

The panel therefore found proved that, on or around 15 March 2023, Mrs Didymus added and printed an Ozempic prescription for Patient D without clinical justification and then ended the course on the record using the reasons '*not issued as needs review 1st*' and '*Ozempic RX cancelled as added before realised she needs a review*'.

Charges 24 – 27 Relating to Patient E

Charges 24, 25a and 25b

24) On or around 20 April 2023 issued a 4 month prescription of Ozempic for Patient E with no clinical justification.

25) On or around 20 April 2023:

- a) Printed a 4 month prescription of Ozempic for Patient E;
- b) Cancelled the prescription on Patient E records.

These charges are found proved.

The panel considered the witness statements of Ms Seedhouse and Ms Cushing, Ms Seedhouse's oral evidence together with the supporting exhibits: the recording of Mrs Didymus' telephone consultation with Patient E on 20 April 2023; Patient E's clinical

record, Metformin history and Ozempic history; the call from Boots Pharmacy on 27 April 2023; and the revised prescription dated 28 April 2023.

The panel noted that Mrs Didymus had a lengthy telephone consultation with Patient E on 20 April 2023 regarding various issues, including menopause, ongoing diarrhoea, and dermatology issues. During the call Patient E explicitly stated that she wished to stop taking Ozempic but that she wanted to be put back on Metformin; Mrs Didymus agreed and recorded Patient E's wishes to stop Ozempic in her notes.

At around 31 minutes in, Mrs Didymus can be heard telling Patient E she will be going on holiday to Turkey soon. Following this call, Mrs Didymus issued a prescription electronically for 500mg modified release tablets of Metformin to Tamar Pharmacy. However, Mrs Didymus then, on the same date, issued a prescription for four months' worth of Ozempic (16 pre-filled injections), printed the prescription, and cancelled it on Patient E's records, providing no reason.

The panel found that the Ozempic prescription had no clinical justification. Patient E had expressly said that she wished to stop Ozempic, and Mrs Didymus had agreed and documented that decision. Issuing a four-month supply immediately afterwards was therefore directly contrary to the consultation and the recorded treatment plan.

The panel noted that, on 27 April 2023, Ms Cushing received a call from Boots Pharmacy about the prescription issued for Patient E on 20 April 2023. Ms Seedhouse gave evidence that the paper prescription had been delivered to Boots but not dispensed.

The panel also listened to the call received from Boots Pharmacy on 27 April 2023. The pharmacy employee can be heard stating that the quantity prescribed is 4 boxes, which is 4x4 weeks supply. The employee queries whether this is a mistake.

Ms Cushing's witness statement stated that, when she raised the matter with Mrs Didymus, Mrs Didymus' demeanour changed: she began to stutter and over-explain her

actions. Mrs Didymus initially asked Ms Cushing to print an amended prescription, which Mrs Didymus said she would deliver to the pharmacy herself. Ms Cushing considered that explanation illogical when the patient requested an electronic prescription which could be issued and became suspicious. Mrs Didymus eventually agreed that the prescription should be reissued electronically.

The panel found no legitimate reason to issue or reissue the Ozempic prescription because it had never been clinically justified. The contrast between the electronically issued Metformin prescription and the printed Ozempic prescription, the delivery of the latter to a different pharmacy, the quantity supplied, the cancellation of the entry and Mrs Didymus' response when challenged formed a coherent body of evidence that the Ozempic prescription was not intended for Patient E. The panel therefore found charges 24 and 25 proved.

Dishonesty charges

In determining dishonesty, the panel first identified Mrs Didymus' actual knowledge intention from the evidence and the surrounding circumstances. It then considered what she had been found to have done, and then whether her conduct would be regarded as dishonest by the standards of ordinary decent people.

The panel noted that Mrs Didymus obtained weight loss drugs at NHS subsidised prices.

The panel considered the repeated features of the conduct to be significant: prescriptions were generated on patients' records without clinical need; they were printed rather than sent through the patients' usual electronic pathway; the medication was collected or retained by Mrs Didymus; and the corresponding entries were then ended using reasons such as 'error', 'didn't use', 'wrong PT' or the need for a review. The same method was used across several patients and over an extended period. In the panel's view, this was not consistent with isolated error or poor record-keeping, but demonstrated a deliberate course of conduct. The way the prescriptions had been prepared was to conceal what had

been done, and it was apparent that these prescriptions were never intended to be for patients.

The panel also took account of evidence that a previous incident at the practice had made Mrs Didymus aware of how prescriptions could be generated, printed and then removed from the active medication record. Her repetition of that process supported the inference that she understood both what she was doing and how the subsequent entries could make the prescribing more difficult to identify.

Charges 5 and 6

- 5) Your action/s at some or all of charges 1, 2a), 3, 4a) and/or 4c) was dishonest in that you generated and/or collected prescriptions which you knew were not required for Patient A, intending to take the Ozempic and/or Trulicity for your own personal use.
- 6) Your action/s at charge 2b and/or 4b) were dishonest in that you intended to conceal that you had generated prescriptions for Trulicity and/or Ozempic using Patient A's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus knew the Trulicity and Ozempic prescriptions were not clinically required for Patient A and generated and/or collected them for her own use. It further found that ending the prescription entries was intended to conceal that the prescriptions had been generated through Patient A's record. The absence of clinical discussion, the printing and collection of the medication, Mrs Didymus' admissions and the deliberate ending of the entries supported those findings as to knowledge and intention. Ordinary decent people would regard both the misuse of a patient's record to obtain prescription only medication for personal use and the subsequent concealment as dishonest.

Charges 10 and 11

10) Your action/s at some or all of charges 7 and / or 8a) were dishonest in that you generated and/ or collected a prescription which you knew was not required for Patient A, intending to take the Ozempic for your own personal use.

11) Your action at charge 8b) was dishonest in that you intended to conceal that you had generated a prescription Ozempic using Patient A's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus knew the 12-month Ozempic prescription was not required for Patient A, yet generated, printed and collected it for her own use. Ending the entry with the reason 'didn't use' was not an innocent administrative step; in the context of the unauthorised prescription and collection for illicit personal use, it was intended to conceal what had occurred. Ordinary decent people would regard that conduct as dishonest.

Charges 14 and 15

14) Your action/s at some or all of charge 12 and/or 13a) was dishonest in that you generated and/ or collected a prescription which you knew was not required for Patient B, intending to take the Semaglutide for your own personal use.

15) Your action at charge 13b) was dishonest in that you intended to conceal that you had generated a prescription for Semaglutide using Patient B's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus knowingly used Patient B's record to generate, print and collect Semaglutide that Patient B had neither requested nor clinically required. Recording 'wrong PT' after printing the prescription was intended to disguise the true purpose of the transaction. The repeated use of the same process, the departure from the usual electronic prescribing route and the absence of any legitimate clinical explanation made the inference of deliberate concealment compelling. Ordinary decent people would regard that conduct as dishonest.

Charges 18 and 19

18) Your action/s at some or all of Charge 16 and / or Charge 17a) was dishonest in that you generated a prescription which you knew was not required for Patient C, intending to take the Semaglutide for your own personal use.

19) Your action at charge 17b) was dishonest in that you intended to conceal that you had generated a prescription for Semaglutide using Patient C's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus knew Semaglutide had not been discussed with, or clinically required by, Patient C. She nevertheless generated and printed the prescription for her own use and then recorded 'wrong PT' to conceal the transaction. Those steps were deliberate, formed part of the same repeated methodology and could not reasonably be explained as an isolated prescribing error. Ordinary decent people would regard that conduct as dishonest.

Charges 22 and 23

22)Your action/s at Charge 20 an /or Charge 20a) was dishonest in that you generated a prescription for Ozempic which you knew was not required for Patient D, intended for your own personal use.

23)Your conduct at charge 21b) was dishonest in that you intended to conceal that you had generated a prescription for Ozempic using Patient D's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus generated and retained the Ozempic prescription for her own use despite knowing that Patient D required a clinical review before any increase could be prescribed. The paper prescription remained in her handbag, while the record was ended using explanations referring to the need for review. In context, those entries were intended to conceal an unauthorised prescription rather than document a genuine clinical transaction. Ordinary decent people would regard that conduct as dishonest.

Charge 26 and 27

26)Your action/s at charge 24 and / or 25a) was dishonest in that you generated a prescription for Ozempic which you knew was not required for Patient E, intended for your own personal use.

27)Your action at charge 25b) was dishonest in that you intended to conceal that you had generated a prescription for Ozempic using Patient E's record, intended for your own personal use.

These charges are found proved.

The panel found that Mrs Didymus knew Patient E had expressly chosen to stop Ozempic, yet she generated and printed a four-month prescription for her own use and then cancelled the entry. The contrast with the legitimate Metformin prescription—which was sent electronically to Patient E’s usual pharmacy—was significant. The Ozempic prescription was printed, delivered to Boots and only questioned because of the unusually large quantity. Those circumstances, together with Mrs Didymus’s reaction when challenged, demonstrated both dishonesty and an intention to conceal her actions. Ordinary decent people would regard that conduct as dishonest.

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 Mrs Didymus’ 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, Mrs Didymus’ fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Woolfson provided the panel with written submissions on misconduct and impairment. She invited the panel to take the view that the facts found proved amount to misconduct. She submitted that there were several specific, relevant standards which were breached by Mrs Didymus' actions and amounted to misconduct.

In respect of impairment, Ms Woolfson submitted the following:

“Impairment is a separate stage to misconduct. It only falls to be considered where a finding of misconduct has been made.

The panel are referred to NMC guidance DMA-1, and the ‘test’ set out in the case of Grant.

The NMC respectfully submit that limbs b-d of the test set out by Dame Janet Smith and endorsed by Mrs Justice Cox in Grant [2011] EWHC 927 (Admin) is engaged....

...

It is submitted that public confidence and the need to uphold professional standards demands a finding of impairment in this case. The panel have found that patient records were repeatedly misused in order to generate prescriptions for the Registrant's own benefit, and that subsidised prescription medicines were obtained to the detriment of the NHS. She misled her colleagues, the CCG, and local pharmacies. The Registrant continued her behaviour even when her prescribing habits came under scrutiny from Person A.

The NMC's values include honesty and openness. The Registrant's behaviour is evidence of a deep-seated attitudinal issue contrary to these values. NMC guidance DMA-1 on dishonesty refers to sustained dishonesty as an example of behaviour that would indicate a deep-seated attitudinal issue.

The Registrant has not attended the hearing or sent in any submissions for the panel. She made admissions in her investigation meeting in May 2023. Whilst admissions may be the first step towards gaining insight, she has not given a full explanation for why she acted as she did or why she would not abuse her status as a nurse in future. The NMC and the panel have not been able to test the explanations she has offered. The Registrant has not presented any evidence that would indicate she has strengthened her practice. In an application for removal from the register dated July 2026 (which was refused) she stated that she was 'paralysed with shame' for her actions. She states that she does not feel strong enough to work with people who know what she has done. [PRIVATE]. The panel are referred to the case of GOC v Clarke [2018] EWCA Civ 1463 – a stated intention to leave the profession does not assist a registrant in arguing they are not impaired.

The NMC argue that on a personal level, the registrant's fitness to practise is currently impaired. Furthermore the wider public interest demands a finding of impairment."

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.' That act or omission must be serious to amount to misconduct.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, and that matters may amount to misconduct even if not specifically breaching the Code.

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

20.2 *act with honesty and integrity at all times...*

The panel noted that over a 16-month period, Mrs Didymus repeatedly obtained weight-loss medication for her own use by creating prescriptions in the names of several patients (Patients A–E) and falsifying their records. She also attempted to conceal her actions. The

conduct was devious, sustained, calculated and planned and involved multiple patients. It was dishonest.

The panel noted that, as a V300-qualified nurse prescriber, Mrs Didymus occupied a position of significant trust and authority. She misused her prescribing authority in a manner wholly inconsistent with the standards expected of a registered nurse.

The panel therefore concluded that Ms Didymus' actions fell seriously below the conduct and professional standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Didymus' 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. 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) ...

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

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

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

The panel determined that limbs (b), (c) and (d) were engaged. Mrs Didymus' dishonesty was repeated over a 16-month period and involved five patients. She accepted that she had falsified prescriptions by generating patient prescriptions for her own use and attempting to conceal her actions. This conduct breached fundamental tenets of the

nursing profession and brought the profession into disrepute. The panel did not find (a) engaged as there was no suggestion of any risk to patients.

The panel considered DMA-1 on *'Impairment'*, which states:

"A finding of impairment on the grounds that the professional's practice needs to be restricted or marked to maintain public confidence in the professions generally, or to uphold professional standards, requires panels to consider whether the substance of the charges found proved, (whether or not the conduct occurred within the professional's clinical practice), means that there would be a risk to the public's confidence in the professions or to professional standards if the professional was permitted to practise without restrictions.

...

Decision makers will therefore need to consider whether:

- the conduct or behaviour was by and of itself so serious that a finding of impairment is necessary to maintain the public's confidence and trust in the professions and to uphold, declare and maintain professional standards.*
- The conduct or behaviour arose because of a deep seated attitudinal issue that places those receiving care at risk of harm or that undermines public confidence and professional standards."*

Applying that guidance, the panel found that Mrs Didymus' dishonesty in obtaining the medication, in the circumstances described above, clearly breached fundamental tenets of the nursing profession.

Mrs Didymus was a senior nurse with an additional registered prescribing qualification, including controlled drugs, and therefore occupied a position of enhanced trust. She abused that position by deliberately selecting individual patients, creating and printing prescriptions for medication she wanted, cancelling those prescriptions and concealing them within the patients' medication histories. The panel was satisfied that public

confidence in the nursing profession would be undermined if conduct involving dishonesty of this seriousness did not result in a finding of impairment. The calculated and sophisticated nature of this conduct made a finding of impairment on public interest grounds necessary.

The panel also considered the factors set out in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that the misconduct was, in principle, capable of remediation. The panel considered the NMC guidance at FTP-16a. The dishonesty was serious and directly linked to Mrs Didymus' nursing practice: patient records were repeatedly misused to generate prescriptions for her own benefit, and further dishonest steps were taken to conceal the misconduct. The panel considered that this indicated a deep-seated attitudinal issue, making remediation more difficult and requiring considerable evidence of insight, reflection, remorse and sustained change.

In assessing Mrs Didymus' insight and remediation, the panel noted that her unsuccessful application for Agreed Removal from the register contained expressions of shame and remorse. However, she had not given evidence to the panel or provided a detailed reflection on her conduct and its effect on the reputation of the profession, nor provided any evidence of strengthened practice or other material demonstrating meaningful insight and remediation, despite approximately three years having passed since the events.

Looking forward, the limited material before the panel did not provide a sufficient basis to assess whether Mrs Didymus had fully understood the impact of her misconduct on the profession or taken effective steps to address them. In the absence of detailed reflection and evidence of remediation, the panel could not be satisfied that the misconduct was highly unlikely to be repeated.

Accordingly, the panel found that a finding of impairment was therefore required both to address the damage to the reputation of the profession and to maintain public confidence in it.

In reaching this conclusion the panel bore in mind the NMC's overarching objectives: to protect, promote and maintain the health, safety and well-being of the public and patients; to promote and maintain public confidence in the nursing and midwifery professions; and to uphold proper professional standards. It concluded that Mrs Didymus' fitness to practise was impaired on public interest grounds, and because it was not satisfied that there was no risk of repetition.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Didymus off the register. The effect of this order is that the NMC register will show that Mrs Didymus has 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 (SG), in particular:

SAN-1: The purpose of and approach to sanctions;

SAN-2: The sanctions available;

SAN-2d: Suspension Order;

SAN-2e: Striking-off order; and

SAN-3: Deciding between suspension and strike off.

Submissions on sanction

Ms Woolfson provided the panel with written submissions on sanction, including reference to the NMC Guidance and *Bolton v Law Society* [1994] 1 W.L.R. 512. The written document identifies aggravating and mitigating factors. In relation to the type of order, Ms

Woolfson submits:

The Registrant has been subject to an interim suspension order since June 2023. The NMC submit that it would be wrong to adjust the sanction in this case in light of this order. An interim order and a final order serve different purposes. Furthermore, a striking off order reflects that behaviour is fundamentally incompatible with registration. A period of suspension does not change whether behaviour is fundamentally compatible with registration.

The Registrant has no fitness to practise history however, as per SAN-1, the absence of such history is of limited relevance given the attitudinal concerns.

Given the seriousness of the case, it is submitted that the only real choice is between a suspension and a striking off order. However, the NMC submit that a suspension is not sufficient to protect the public as the impairment is fundamentally incompatible with registration. The guidance suggests that factors which indicate a suspension may be appropriate include:

- 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.*
- 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.*

These factors do not apply. There has been very limited engagement and no evidence of meaningful insight.

The panel are referred to NMC guidance SAN-3 which concerns deciding between suspension and strike off. It is submitted that public confidence in the profession would not be protected if the Registrant was allowed to return to

practice after a suspension. The Registrant's engagement with the process has been limited. Furthermore she has stated her intention not to return to practice so she is unlikely to do the work necessary to demonstrate insight and remediation in future.

Guidance SAN-3 cautions panels against imposing a suspension order to give the Registrant who has not engaged with the fitness to practise process a 'last chance' to engage, reflect, or show insight.

The following factors are highlighted by the sanctions guidance (SAN-2e) as factors a panel should consider before imposing a striking off order:

- 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?*

It is submitted that the answers to each of these questions confirm that a striking off order is necessary."

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Didymus' 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:

- dishonesty is at the highest end of the spectrum;
- abuse of a position of trust;
- deliberate breaches of the Code;
- repeated dishonest use of patient records to generate prescriptions for Mrs Didymus' own personal use, over a period of nearly 16 months; and
- lack of evidence of insight and remediation, despite the events being over three years ago.

The panel also took into account the following mitigating features:

- Mrs Didymus made admissions during her employer's investigation and accepted the regulatory concerns raised in the NMC investigation;
- Mrs Didymus appears remorseful and ashamed of her actions, however she has not participated in the hearing which limits the opportunity to evaluate this;
- [PRIVATE].

The panel went on to assess the seriousness of the dishonesty in this case. The panel had regard to the SG for cases involving dishonesty. The panel considered that this was not a one-off episode of dishonesty, nor was it opportunistic nor spontaneous. The panel considered that the dishonesty was premeditated, systematic and involved longstanding deception. For these reasons the panel determined that the dishonesty in this case fell at the highest end of the spectrum of seriousness.

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 Mrs Didymus’s actions were not at the lower end of the spectrum. 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 order on Mrs Didymus’s 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 could not formulate conditions which could address the misconduct or the dishonesty found proved. The panel considered that conditions are generally directed towards identifiable areas of practice which are capable of being remediated and monitored. In this case, the concerns were not related to clinical deficiency. The panel noted that the misconduct in this case involved serious dishonesty in professional practice, which indicated deep seated attitudinal problems on Mrs Didymus’ part. The panel considered that it was not possible to formulate practicable and workable conditions as the misconduct was inherently linked to her behaviour. Furthermore, given the seriousness of

Mrs Didymus' misconduct, the panel determined that imposing a conditions of practice order would not satisfy the public interest in this case.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on '*Suspension order*' (Reference: SAN-2d Last Updated: 28/01/2026) which includes the following factors which may indicate that a suspension order may be appropriate:

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

The panel was not satisfied that these factors were met in Mrs Didymus' case.

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*

- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel considered that temporary removal from the Register would not be sufficient to uphold public confidence in the profession and maintain professional standards because of the seriousness and nature of the facts found proved.

The panel noted and took account of the guidance in SAN-3 that where professionals have failed to engage with the fitness to practise process, it will not usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.

Given Mrs Didymus' lack of engagement, limited insight, together with no evidence of training and development, the panel considered that there is no realistic possibility that she would address the concerns such that public confidence in the profession would be upheld. Nor would this adequately maintain professional standards.

The panel therefore 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?* The panel so considered.
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?* The panel decided that it could not.
- *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?* The panel considered that there was no level of insight that would be sufficient to maintain public confidence in the profession and uphold professional standards (public safety not being an issue in this case).
- *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?* This was not applicable as Mrs Didymus' misconduct did not pose a risk to the public.

The panel decided that the findings in this particular case demonstrate that Mrs Didymus' actions were so serious that to allow her to continue practising, even after a period of suspension would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel had regard to Mrs Didymus' long term, devious sophisticated and calculated abuse of her professional practice privileges, which she had attempted to conceal. It determined that Mrs Didymus' actions were such significant departures from the standards expected of a registered nurse, fundamentally incompatible with her remaining on the register.

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 Mrs Didymus' 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.

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 Mrs Didymus' own interests until the striking-off sanction takes effect.

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

Submissions on interim order

Ms Woolfson submitted that given the panel's findings, an interim suspension order for a period of 18 months is required in the public interest. She submitted that the panel found serious dishonest misconduct connected to Mrs Didymus' practice. She submitted that the public will be baffled if Mrs Didymus was allowed to practice unrestricted. The 18 months would provide for the gap between the making of any substantive order and closure of the statutory appeal window or any actual appeal.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day period and allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.

This will be confirmed to Mrs Didymus in writing.