

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

**Substantive Meeting
Thursday, 1 October 2026 – Wednesday, 7 October 2026**

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

Name of Registrant:	Railton Orville Evelyn
NMC PIN:	23E0278O
Part(s) of the register:	RNA: Adult nurse, level 1 (4 May 2023)
Relevant Location:	Surrey
Type of case:	Lack of Competence
Panel members:	Alan Greenwood (Chair, lay member) Vivienne Evans (Registrant member) Richard Mann (Lay member)
Legal Assessor:	Monica Daley
Hearings Coordinator:	Max Buadi
Facts proved:	Charges 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 2a, 2b, 3a, 3b, 3c, 4a, 4d, 4e, 4f, 4g, 4h, 5a, 5b, 5c, 6a, 6b, 6c and 6d
Facts not proved:	Charges 1b, 4b and 4c
Fitness to practise:	Impaired
Sanction:	Suspension order 12 months with a review
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - suspension order

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Evelyn's registered email address by secure email on 20 July 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this matter was to be heard as a meeting.

In the light of all of the information available, the panel was satisfied that Mr Evelyn has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, between 8 May 2023 and 8 November 2024, failed to demonstrate the standards of knowledge, skill and/or judgement required to practise without supervision as a Band 5 nurse in one or more of the following areas:

1. Medication administration in that:

- a) On 14 June 2023 in relation to Patient A, did not fully inject insulin medication.
- b) On 14 June 2023, required prompting that eyedrops for a patient had been administered before signing.
- c) On 15 June 2023, attempted to administer Ondansetron early.
- d) On 20 July 2023, attempted to give a patient 2 tablets of Ferrous Gluconate instead of 1 tablet they were prescribed.
- e) On 3 August 2023 signed for the compression stocking for a patient when you hadn't put it on the patient first.
- f) On 15 August 2023 did not administer a patient's eyedrops.
- g) On 20 November 2023, required prompting to check the PRN for a patient.
- h) On 23 May 2024, nearly gave 10mg of Amitriptylin instead of 10mg Amlodipine to a patient.
- i) On 23 May 2024, did not lock the drugs trolley.
- j) On one or more occasions had poor timekeeping when administering medication.
- k) Lacked knowledge in relation to medication.

2. Observations in that:

- a) On 5 August 2023, did not check the patient's pulse before administering Digoxin.
- b) On one or more occasions, required prompting to check patient's observations

3. Escalation in that:

- a) On 8 August 2023 did not identify the correct NEWS score for a patient
- b) On 7 February 2024, failed to act and/or escalate a patient experiencing a vasovagal syncope
- c) On 21 March 2024 failed to escalate concerns about a deteriorating patient who had rising blood sugar

4. Patient care in that:

- a) On 14 June 2023, did not complete the mouthcare assessment for one or more patients
- b) On 20 July 2023, gave an enema to a patient with diarrhoea and did not sign for it
- c) On 20 July 2023, did not give patient care to any of your patients
- d) On 16 May 2024, did not check whether 2 air mattresses were properly inflated
- e) On 26 September 2024, gave a nil by mouth patient with nasogastric tube in place tea
- f) On one or more occasions required prompting to check patients' allergies
- g) On one or more occasions did not follow proper hand hygiene
- h) On one or more occasions did not check/assess a patient for pain

5. Communication in that:

- a) On 20 November 2023 did not inform and did not obtain consent before checking the patient's legs
- b) On one or more occasions spoke too fast
- c) On one or more occasions did not introduce yourself to patient before administering medication

6. Record keeping in that:

- a) On 7 April 2024, unable to prioritise care needs as spent too long with documentation
- b) On 16 May 2024, did not complete nursing notes for one or more patients
- c) On 16 May 2024, did not complete the fluid chart documentation for a patient
- d) On one or more occasions, did not complete the daily assessments for one or more patients

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

Background

Mr Evelyn was referred to the Nursing and Midwifery Council (“NMC”) on 25 November 2024 by the Surrey and Sussex Healthcare NHS Trust (“the Trust”).

Mr Evelyn commenced employment at the Trust on 12 December 2022. He joined as part of an international recruitment cohort and was required to complete the Objective Structured Clinical Examination (“OSCE”). Mr Evelyn received his NMC PIN after 3 attempts at the OSCE assessment. He started working as a band 5 staff nurse on 8 May 2023.

It is alleged that on 26 September 2024, Mr Evelyn gave tea to a nil by mouth patient with a nasogastric tube in place due to the patient’s low blood sugar level. Mr Evelyn allegedly failed to identify other means of correcting the patient’s blood sugar. There were reports of multiple drug errors and near misses which could have had a fatal outcome.

Mr Evelyn is alleged to have demonstrated a lack of understanding of Infection Prevention Control (“IPC”) as evidenced in Mr Evelyn’s management of a patient urine filled container. This action, it is alleged, could have resulted in sepsis and an increased length of stay in the hospital, outbreak of infection and even fatality.

Other allegations include that Mr Evelyn failed to check deflated mattresses that could have led to skin deterioration, infection, sepsis and even fatality. He was alleged to be unable to recognise deteriorating patients and escalate concerns and to have failed to act on an emergency call. He was also alleged to be unable to effectively look after 3 patients and provide safe care (the usual patient to nurse ratio is 1:6).

Further, Mr Evelyn was alleged to be unable to use the Electronic Patient Record (“EPR”) system effectively: there is evidence of multiple errors and wrong entries, which could have resulted in a patient not receiving the right treatment.

A Stage 1 capability hearing was held with the Trust on 7 November 2023 whereby an action plan was put in place. A Stage 2 capability hearing was then held on 27 February 2024 whereby a further action plan was put in place.

As there was limited improvement, Stage 3 capability hearings were held on 7 and 9 October 2024 whereby the decision was made to dismiss Mr Evelyn. His last day of employment was on 8 November 2024.

Decision and reasons on application to amend the charge

During its deliberation of the charges, the panel of its own volition proposed to amend the wording to charges 1j, namely to replace “timekeeping” to “time management”. The panel was of the view that the proposed amendment would provide clarity and more accurately reflect the evidence.

Proposed Amendment

That you, between 8 May 2023 and 8 November 2024, failed to demonstrate the standards of knowledge, skill and/or judgement required to practise without supervision as a Band 5 nurse in one or more of the following areas:

1. Medication administration in that:

- j) On one or more occasions had poor ~~timekeeping~~ **time management** when administering medication.

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 was of the view that the proposed amendments did not change the nature of the allegation and was in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Evelyn and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment to ensure that the charge was accurately expressed in order to ensure clarity and accuracy.

Details of charges (as amended)

That you, between 8 May 2023 and 8 November 2024, failed to demonstrate the standards of knowledge, skill and/or judgement required to practise without supervision as a Band 5 nurse in one or more of the following areas:

1. Medication administration in that:

- a) On 14 June 2023 in relation to Patient A, did not fully inject insulin medication.
- b) On 14 June 2023, required prompting that eyedrops for a patient had been administered before signing.
- c) On 15 June 2023, attempted to administer Ondansetron early.
- d) On 20 July 2023, attempted to give a patient 2 tablets of Ferrous Gluconate instead of 1 tablet they were prescribed.
- e) On 3 August 2023 signed for the compression stocking for a patient when you hadn't put it on the patient first.
- f) On 15 August 2023 did not administer a patient's eyedrops.
- g) On 20 November 2023, required prompting to check the PRN for a patient.
- h) On 23 May 2024, nearly gave 10mg of Amitriptylin instead of 10mg Amlodipine to a patient.
- i) On 23 May 2024, did not lock the drugs trolley.
- j) On one or more occasions had poor time management when administering medication.
- k) Lacked knowledge in relation to medication.

2. Observations in that:

- a) On 5 August 2023, did not check the patient's pulse before administering Digoxin.
- b) On one or more occasions, required prompting to check patient's observations

3. Escalation in that:

- a) On 8 August 2023 did not identify the correct NEWS score for a patient
- b) On 7 February 2024, failed to act and/or escalate a patient experiencing a vasovagal syncope
- c) On 21 March 2024 failed to escalate concerns about a deteriorating patient who had rising blood sugar

4. Patient care in that:

- a) On 14 June 2023, did not complete the mouthcare assessment for one or more patients
- b) On 20 July 2023, gave an enema to a patient with diarrhoea and did not sign for it
- c) On 20 July 2023, did not give patient care to any of your patients
- d) On 16 May 2024, did not check whether 2 air mattresses were properly inflated
- e) On 26 September 2024, gave a nil by mouth patient with nasogastric tube in place tea
- f) On one or more occasions required prompting to check patients' allergies
- g) On one or more occasions did not follow proper hand hygiene
- h) On one or more occasions did not check/assess a patient for pain

5. Communication in that:

- a) On 20 November 2023 did not inform and did not obtain consent before checking the patient's legs
- b) On one or more occasions spoke too fast
- c) On one or more occasions did not introduce yourself to patient before administering medication

6. Record keeping in that:

- a) On 7 April 2024, unable to prioritise care needs as spent too long with documentation
- b) On 16 May 2024, did not complete nursing notes for one or more patients
- c) On 16 May 2024, did not complete the fluid chart documentation for a patient
- d) On one or more occasions, did not complete the daily assessments for one or more patients

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Airene Salomeao-Bagolor: Head of Nursing at the Trust;
- April Joy Yet: Practice Development nurse at the Trust;
- Dana Rosu: Ward Sister at the Trust;
- Alisha Kuriakose: Matron at the Trust.

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

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

Charge 1a

1. Medication administration in that:
 - a) On 14 June 2023 in relation to Patient A, did not fully inject insulin medication.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet and Ms Kuriakose.

Ms Yet in her witness statement, under the heading “Supervision on 14 June 2023”, stated that she had observed Mr Evelyn’s drug administration round. She stated that Mr Evelyn administered insulin at around 09:30 but had not fully injected the insulin.

The panel took account of the Supervision record dated 14 June 2023. Under the heading “Target Goals”, Ms Yet recorded that Mr Evelyn administered insulin at around 09:30 but he had not fully injected the insulin.

The panel also took account of the “Capability Hearing Management Report” provided by Ms Kuriakose. She stated that Mr Evelyn had been shown on the previous day how to administer insulin via a flexpen but he had to be prompted how to do it correctly.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record and Capability Hearing Management Report corroborated the details in Ms Yet’s witness statement.

The panel therefore found this sub-charge proved.

Charge 1b

1. Medication administration in that:

- b) On 14 June 2023, required prompting that eyedrops for a patient had been administered before signing.

This sub-charge is found not proved.

In reaching this decision, the panel took into account the evidence of Ms Yet and Ms Kuriakose.

The panel noted that the NMC's evidence matrix cites Ms Yet's witness statement and the Supervision record as evidence in support of the charge. In her witness statement, under the heading "Supervision on 14 June 2023", she stated that Mr Evelyn signed for medications without them being administered. She also stated that she reminded Mr Evelyn that he should only sign for medication when they have been administered.

The panel noted that Ms Yet has reiterated this in the Supervision record dated 14 June 2023.

However, the panel noted that there is no specific reference to eye-drops in either her witness statement or the Supervision record.

The panel also took account of the "Capability Hearing Management Report" provided by Ms Kuriakose. She stated that Mr Evelyn had nearly signed that he had administered eyedrops for a patient. She also stated that when prompted, he confirmed that this had not been given. However, the panel noted that the date referred to this incident is 15 June 2023.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

Nevertheless, the panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC's contemporaneous evidence to support the sub-charge does not specifically reference eye-drops, it just refers to medication. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 1c

1. Medication administration in that:

c) On 15 June 2023, attempted to administer Ondansetron early.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet, Ms Kuriakose and Ms Salomeo-Bagolor.

In her witness statement, under the heading “Supervision on 15 June 2023”, Ms Yet stated that she supervised Mr Evelyn. She said that he intended to administer Ondansetron at 13:15, although it was not yet due, having given the morning dose late at 10:17. That afternoon, she asked whether he intended to administer the second dose. She expected him to consult the British National Formulary for medication guidance and explained that Ondansetron should be administered at four-hour intervals.

The panel also took account of the “Capability Hearing Management Report” provided by Ms Kuriakose which supported Ms Yet’s witness statement.

This is further supported by the “Stage Three Capability Hearing Outcome Letter” dated 10 October 2024. In this letter, Ms Salomeo-Bagolor stated that Mr Evelyn’s practice fell far below what was expected from a nurse and cited the administration of Ondansetron when it was not due.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel bore in mind that the “Capability Hearing Management Report” and the “Stage Three Capability Hearing Outcome Letter” are not contemporaneous. However, it was persuaded by the evidence of Ms Yet due to how specific she is when providing time references. It deemed her evidence to be credible, reliable and consistent. It had no evidence before it of a reason for Ms Yet to fabricate this.

Therefore, on the balance of probabilities, the panel found that on 15 June 2023 Mr Evelyn attempted to administer Ondansetron early.

The panel therefore found this sub-charge proved.

Charge 1d

1. Medication administration in that:

- d) On 20 July 2023, attempted to give a patient 2 tablets of Ferrous Gluconate instead of 1 tablet they were prescribed.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu and Ms Kuriakose.

In her witness statement, under the heading “Supervision on 20 July 2023”, Ms Rosu stated that Mr Evelyn was doing his medication round and was going to give a patient two tablets of Ferrous Gluconate instead of one. She stated that a higher dose than has been prescribed can cause side effects such as constipation/diarrhoea, nausea, vomiting, stomach pain and loss of appetite.

The panel took account of the Capability Hearing Management Report. Next to the date 20 July 2023, Ms Kuriakose has recorded that Mr Evelyn was supervised by Sister Rosu and he was going to give two tablets of Ferrous Gluconate instead of one.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Capability Hearing Management Report corroborated the details in Ms Yet’s witness statement. It had no evidence before it of a reason for Ms Rosu to fabricate this.

The panel therefore found this sub-charge proved.

Charge 1e

1. Medication administration in that:

- e) On 3 August 2023 signed for the compression stocking for a patient when you hadn't put it on the patient first.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet.

Under the sub-heading "Supervision on 3 August 2023" Ms Yet, in her witness statement stated that Mr Evelyn wanted to sign for the compression stocking for a patient when he had not put it on the patient first.

The panel took account of the "Supervision record" dated 3 August 2023. Under the heading "Things to Improve" Ms Yet recorded that Mr Evelyn had to be prompted not to sign "TEDS" (Thrombo-Embolus Deterrent anti-embolism stockings) unless applied on patient. She also recorded that Mr Evelyn applied TEDS right away before patient had breakfast.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet's witness statement.

The panel therefore found this sub-charge proved.

Charge 1f

1. Medication administration in that:

- f) On 15 August 2023 did not administer a patient's eyedrops.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet and Ms Kuriakose.

In her witness statement, under the heading “Supervision on 15 August 2023”, Ms Yet stated that Mr Evelyn needed to administer an eye drop to a patient which he prepared and nearly moved on to the next patient. She also stated that he almost signed the drug chart without having administered the eyedrop.

The panel took account of the “Supervision record” dated 15 August 2023. Under the heading “Things to Improve” Ms Yet recorded that Mr Evelyn had returned medication to the POD cupboard without administering the eye drop to the patient.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet’s witness statement.

The panel therefore found this sub-charge proved.

Charge 1g

1. Medication administration in that:

g) On 20 November 2023, required prompting to check the PRN for a patient.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu and Ms Kuriakose.

In her witness statement, under the heading “Supervision on 20 November 2023”, Ms Rosu stated that when Mr Evelyn had finished the medication round, she asked if he had checked the PRN (meaning ‘when required’) medication side. She said that Mr Evelyn stated that he had not.

The panel took account of the “Supervision Record” dated 20 November 2023 and Ms Rasu recorded that she had Mr Evelyn if he had checked “PRN medication side”. She had recorded that Mr Evelyn had not.

The panel took account of the “Capability Hearing Management Report”. Next to the date 20 November 2023, Ms Kuriakose has recorded that Mr Evelyn was supervised by Sister Rosu and she had asked if he had checked the PRN medication side and he stated that he had not.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record and Capability Hearing Management Report corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge proved.

Charge 1h

1. Medication administration in that:

- h) On 23 May 2024, nearly gave 10mg of Amitriptylin instead of 10mg Amlodipine to a patient.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu, Ms Kuriakose and Ms Salomeo-Bagolor.

In her witness statement, under the heading “Incident of 23 May 2024”, Ms Rosu stated that Staff Nurse Neethu Thomas escalated an incident to her. Ms Thomas informed Ms Rosu that Mr Evelyn nearly administered Amitriptylin instead of Amlodipine to a patient. Ms Kuriakose reiterated this in her witness statement.

The panel took account of the Supervision Record dated 23 May 2024. Under the heading “Findings”, Ms Thomas recorded that Mr Evelyn was about to administer 10mg of Amitriptylin instead of 10mg Amlodipine.

The panel took account of the “Capability Hearing Management Report”. Next to the date 23 May 2024, Ms Kuriakose has recorded that Ms Neethu was supervised had witnessed Mr Evelyn nearly administer 10mg of Amitriptylin instead of 10mg Amlodipine to a patient.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record and Capability Hearing Management Report corroborated the details in both of their respective witness statements.

The panel therefore found this sub-charge proved.

Charge 1i

1. Medication administration in that:
 - i) On 23 May 2024, did not lock the drugs trolley.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading “Incident of 23 May 2024”, Ms Rosu stated that Staff Nurse Ms Thomas stated that Mr Evelyn had failed to ensure that the drug trolley was locked when not in use as per the Drug policy.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel took account of the Supervision Record dated 23 May 2024. Under the heading “Findings”, Ms Thomas recorded that Mr Evelyn at times forgot to lock the medication pod.

The panel accepted the evidence of Ms Rosu which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record which corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge proved.

Charge 1j

1. Medication administration in that:

- j) On one or more occasions had poor time management when administering medication.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading “Medication Administration”, Ms Kuriakose stated that Mr Evelyn was supervised by Staff Nurse Fletcher Dragee. She was informed by Staff Nurse Dragee that it took Mr Evelyn three hours to administer three to six patients their medication.

The panel took account of a File note, dated 3 September 2024 and 10 September 2024. Next to the sub-heading “Medication”, Ms Kuriakose recorded that it took Mr Evelyn 45 minutes to administer medication to a patient who was capable of responding to safety

questions. Additionally, next to the sub-heading “Feedback”, Ms Kuriakose recorded that Mr Evelyn is still struggling with time management.

The panel took account of the “Supervision record” dated 7 February 2024. Under the sub-heading “Medication Administration” and “Actions/Learning” Ms Kuriakose recorded that Mr Evelyn still takes two to three hours to administer medication to the same patients he has been working with for the past two to three days.

The panel took account of the “Minutes from Stage Three Capability Hearing” dated 7 October 2024. It bore in mind that Ms Salomeo-Bagolor and Ms Kuriakose were both present for this meeting. It noted that Mr Evelyn acknowledged that there appeared to be a problem with the speed at which he administered medication. He stated *“I don’t have time to be concentrating or thinking on something because there are always things that need to be done. Most time only get to the drug chart when the Nurse then came over to me to look at it.”*

The panel also noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record and File Note corroborated the details in her witness statement.

The panel therefore found this sub-charge proved.

Charge 1k

1. Medication administration in that:
 - k) Lacked knowledge in relation to medication.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet and Ms Kuriakose.

In her witness statement, under the heading “Supervision on 14 June 2023”, Ms Yet stated that she had asked Mr Evelyn what Cholecalciferol is used for and he said it was used for cancer. She explained that Cholecalciferol is a vitamin D3, a dietary supplement to help the body absorb calcium.

The panel took account of the “Supervision record” dated 15 June 2023. Under the heading “Target Goals” Ms Yet recorded that Mr Evelyn had difficulty looking for Macrogol (laxido) in the (WOW) Workstation On Wheels and that he should be more familiar with how medication looks. She also recorded that he is to complete the list of medications he is not familiar with.

Ms Kuriakose in her witness statement stated that on 23 May 2024, Staff Nurse Ms Thomas observed that Mr Evelyn was going to administer laxatives to a patient who was having type 6 loose stools. She stated that it had been mentioned to hold laxatives because the patient was having loose stools but Mr Evelyn did not check the handover or the stool chart prior to dispensing the laxatives.

The panel also took account of the File Note dated 3 September 2024 and 10 September 2024. Ms Kuriakose recorded that Mr Evelyn’s, *“medication rounds showed some improvement, including checking doses, allergies, and expiry dates. However, he was unsure about precautions before administering drugs, such as checking vital signs before giving Furosemide. He also lacked knowledge about morphine toxicity and its treatment, misread the drug administration route.”*

The panel then took account of the “Competency document and supervision record” dated 8 August 2023 where the assessor has recorded that Mr Evelyn *“requires more practice and an improved knowledge of drug administration in the areas indicated on the assessment sheet. Following a further period of supervised practice, the assessment needs to be repeated.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision records, File note and Competency document and supervision record corroborated the details in their respective witness statements.

The panel therefore found this sub-charge proved.

Charge 2a

2. Observations in that:

- a) On 5 August 2023, did not check the patient's pulse before administering Digoxin.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading "Medication Administration", Ms Kuriakose stated that on 5 August 2023, Mr Evelyn was going to give a patient Digoxin, a heart medication, without checking the patient's pulse.

The panel took account of the "Supervision record" dated 5 August 2023. Under the heading "Actions/Learning" the supervisor Marie Jacques recorded, *"Overall today, Railton was not himself, not confident, nervous and struggle. Making a lot of mistakes along the way, forgetting to sign, check allergy, vital sings for Digoxin, appears as 1st time, he is doing a medication rounds. Not safe today. Needed a lot of prompting and be there always to prevent medication errors."* [Sic]

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record and corroborated the details in Ms Kuriakose's witness statement.

The panel therefore found this sub-charge proved.

Charge 2b

2. Observations in that:

b) On one or more occasions, required prompting to check patient's observations

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet and Ms Kuriakose.

In her witness statement, under the heading "Supervision on 15 June 2023", Ms Yet stated that Mr Evelyn would have to be prompted to check observations such as blood pressure and heart rate. She stated that it was important as some medication could have side effects on blood pressure. Under the heading "Supervision on 15 August 2023", Ms Yet stated that Mr Evelyn was doing observations on patients, but he was not doing it consistently as he would check the first two patients and then skip the rest.

The panel took account of the "Supervision record" dated 23 May 2023. Under the heading "Findings" staff nurse, Ms Thomas recorded that Mr Evelyn *"Didn't check obs. NIC has to prompts him to check obs"*.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision records corroborated the details in Ms Yet's witness statement.

The panel therefore found this sub-charge proved.

Charge 3a

3. Escalation in that:

a) On 8 August 2023 did not identify the correct NEWS score for a patient

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet.

In her witness statement, under the heading “Supervision on 8 August 2023”, Ms Yet stated that there was an incident where Mr Evelyn failed to identify the correct NEWS score for a patient. She stated that he did not understand that if a patient needed a certain amount of oxygen, then that patient would score a 2 which meant it needed to be escalated to the medical team. She stated that Mr Evelyn did not know why the patient would be scoring a 2 when they were on oxygen.

The panel took account of the “Supervision record” dated 8 August 2023. Under the heading “Things to Improve” Ms Yet recorded that Mr Evelyn did not understand why a patient had a NEWS score of 2. She also recorded that Mr Evelyn, “...*to be able to demonstrate understanding of the NEWS 2 system and to be able to make clinical decisions with regards to administering the medications in relation to patient EWS.*” [sic]

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet’s witness statement.

The panel therefore found this sub-charge proved.

Charge 3b

3. Escalation in that:

- b) On 7 February 2024, failed to act and/or escalate a patient experiencing a vasovagal syncope

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading “Observations and Escalations”, Ms Kuriakose stated on 7 February 2024, Mr Evelyn did not act when a patient was unresponsive, pale and unconscious. She stated that the patient was experiencing a vasovagal syncope (fainting) which occurs when there is a sudden drop in blood pressure and heart rate leading to temporary loss of consciousness.

The panel took account of the “Supervision record” dated 7 February 2024. Under the sub-heading “Patient assessments (recognising when assessments including skin, MUST, Observations and Blood sugar are needed” and “Actions/Learning” Ms Kuriakose recorded that Mr Evelyn, “...*was unable/is unable to use “clinical eye” to determine if there is somethings off with the patient. Patient was already pale and was experiencing a possible vasovagal.*”

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Kuriakose’s witness statement.

The panel therefore found this sub-charge proved.

Charge 3c

3. Escalation in that:

- c) On 21 March 2024 failed to escalate concerns about a deteriorating patient who had rising blood sugar

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading “Supervision on 21 March 2024”, Ms Rosu stated that she heard a nursing assistant telling Mr Evelyn that the patient’s blood sugar was high. She stated that she had returned to the bay after 15 to 20 minutes to check what actions were taken by Mr Evelyn but he continued to ignore the information doing other jobs. She stated that the protocol would be to inform the nurse in charge and the on-call doctor.

Ms Kuriakose reiterated Ms Rosu’s account in her witness statement.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel found the evidence of Ms Rosu and Ms Kuriakose credible, reliable and consistent, and had no reason to believe that either had fabricated their account.

The panel therefore found this sub-charge proved.

Charge 4a

4. Patient care in that:

- a) On 14 June 2023, did not complete the mouthcare assessment for one or more patients

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet.

In her witness statement, under the heading “Supervision on 14 June 2023”, Ms Yet stated Mr Evelyn was meant to do bedside and assessment for his four patients, however he missed the mouthcare assessment for all of them.

The panel took account of the “Supervision record” dated 14 June 2023. Under the heading “Target Goals” Ms Yet recorded that Mr Evelyn missed doing the mouthcare assessments on all four patients.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet’s witness statement.

The panel therefore found this sub-charge proved.

Charge 4b

4. Patient care in that:

- b) On 20 July 2023, gave an enema to a patient with diarrhoea and did not sign for it

This sub-charge is found not proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu, Ms Kuriakose and Ms Salomeo-Bagolor.

In her witness statement, under the heading “Supervision on 20 July 2023”, Ms Rosu stated that Mr Evelyn gave an Enema to a patient and did not sign for it.

The panel took account of the “Capability Hearing Management Report”. Next to the date 20 July 2023, Ms Kuriakose has recorded that Mr Evelyn gave an Enema to a patient and did not sign for it.

The panel noted that there is no direct mention of diarrhoea in either the witness statement or the Capability Hearing Management Report.

The panel took account of the “Minutes from Stage Three Capability Hearing” dated 7 October 2024. It bore in mind that Ms Salomeo-Bagolor and Ms Kuriakose were both present for this meeting. It noted that Ms Salomeo-Bagolor referred to Mr Evelyn trying to give an enema for a patient who had diarrhoea, however Mr Evelyn does not directly respond to this.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel reminded itself that it is for the NMC to prove the charge. The panel bore in mind that the NMC’s contemporaneous evidence to support the sub-charge does not specifically reference diarrhoea, rather it mentions that Mr Evelyn gave an Enema to a patient and did not sign for. There is no other contemporaneous evidence before the panel to support the charge.

The panel therefore found this sub-charge not proved.

Charge 4c

4. Patient care in that:

c) On 20 July 2023, did not give patient care to any of your patients

This sub-charge is found not proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading “Supervision on 20 July 2023”, Ms Rosu stated that Mr Evelyn did not give personal care to any of his patients.

The panel took account of the “Minutes from Stage Three Capability Hearing” dated 7 October 2024. It bore in mind that Ms Salomeo-Bagolor and Ms Kuriakose were both present for this meeting. It noted that Mr Evelyn stated the following at different points of the meeting, *“I don’t have time to be concentrating or thinking on something because there are always things that need to be done. Most time only get to the drug chart when the Nurse then came over to me to look at it... My concern is that when I am on the ward I am not functioning and I am not supernumerary. I would expect to be doing all the duties of a Nurse but with someone shadowing me... No, yes supernumerary you are supported, I was working both roles – band 5 & 3. As the ward is most time short staffed I am working as the band 3, that is still my concern.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel reminded itself that the burden was on the NMC to prove the charge. The NMC’s evidence was limited to Ms Rosu’s witness statement that Mr Evelyn had not provided personal care to any of his patients. However, the panel considered that Mr Evelyn’s responses during the capability meetings appeared to contradict that account, particularly his reference to being shadowed, which suggested that he had been providing patient care. There was no other contemporaneous evidence supporting the charge.

The panel therefore found this sub-charge not proved.

Charge 4d

4. Patient care in that:

d) On 16 May 2024, did not check whether 2 air mattresses were properly inflated

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu and Ms Kuriakose.

In her witness statement, under the heading “Supervision on 16 May 2024”, Ms Rosu stated that Mr Evelyn did not check whether two air mattresses were properly inflated. She stated that one of the air mattresses was not plugged in after the patient went for an x-ray and the other one was not plugged in at the bedside. She stated that it is a nurses duty to check that mattresses are well inflated as a patient would not be able to sit on uninflated mattress. She further stated that if the air mattresses are not inflated properly, then it could cause the patient discomfort, pain, or further skin damage could be caused due to the patients reduced mobility.

Ms Kuriakose reiterated this in her witness statement.

The panel took account of the “Supervision record” dated 16 May 2024. Ms Rosu has recorded that Mr Evelyn “...*was not aware to check air mattress -2 of them was not inflated-not plugged appropriate.*” [sic]

The panel took account of the “Minutes from Stage Three Capability Hearing” dated 7 October 2024. It bore in mind that Ms Salomeo-Bagolor and Ms Kuriakose were both present for this meeting. It noted that Mr Evelyn stated that he would have noticed if the patient’s mattress had been deflated. He also stated that there had been a “*deliberate attempt to sabotage*”.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel was persuaded by the evidence of Ms Yet and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet’s witness statement. It had no reason to believe that either had fabricated their account

The panel therefore found this sub-charge proved.

Charge 4e

4. Patient care in that:

- e) On 26 September 2024, gave a nil by mouth patient with nasogastric tube in place tea

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Salomeo-Bagolor.

Ms Salomeo-Bagolor in her witness statement stated that Mr Evelyn gave a nil by mouth patient with nasogastric tube in place tea due to the patient's low blood sugar level. He failed to identify other means of correcting the patient's blood sugar and risk aspiration could with fatal consequence.

The panel took account of the Incident Report. Next to "Describe what happened", the following has been recorded, *"Patient was NBM and the staff member looking after the patient gave him a cup of tea..."*

The panel took account of the "Minutes from Stage Three Capability Hearing" dated 7 October 2024. It bore in mind that Ms Salomeo-Bagolor and Ms Kuriakose were both present for this meeting. It noted that Mr Evelyn appeared to accept that he gave a patient, who was nil by mouth, sips of water and stated that he *"didn't know it would be a problem"*.

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Salomeo-Bagolor which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Incident report and Minutes from the Stage Three Capability Hearing and Capability corroborated the details in Ms Salomeo-Bagolor's witness statement.

The panel therefore found this sub-charge proved.

Charge 4f

4. Patient care in that:

- f) On one or more occasions required prompting to check patients' allergies

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Yet.

In her witness statement, under the heading "Supervision on 14 June 2023", Ms Yet stated that Mr Evelyn was not asking patients their allergies so she advised him to practice this even if it was already recorded on the system just in case some allergies had not been documented. Under the heading "Supervision on 15 June 2023", Ms Yeti also stated that regarding medication administration, Mr Evelyn would have to be prompted to ask patients if they had any allergies. She stated that he had been doing this for months and he still had to be reminded.

The panel took account of the "Supervision record" dated 3 August 2023. Under the heading "Target Goals" Ms Yet recorded the following about Mr Evelyn, *"Prompted to check/allergies prior to drug administration. [Mr Evelyn] to practice doing the aforementioned on every [patient] administration."*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Yet and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Yet's witness statement.

The panel therefore found this sub-charge proved.

Charge 4g

4. Patient care in that:

g) On one or more occasions did not follow proper hand hygiene

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading “Patient Care”, Ms Kuriakose stated that Mr Evelyn could not show proper hand hygiene multiple times during her observations.

In her File note, dated 3 September 2024 and 10 September 2024, Ms Kuriakose has recorded the following, *“Infection Prevention and Control (IPC): Railton did not adhere to the five moments of hand hygiene and failed to demonstrate proper hand hygiene multiple times during the assessment.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned File note corroborated the details in Ms Kuriakose’s witness statement.

The panel therefore found this sub-charge proved.

Charge 4h

4. Patient care in that:

h) On one or more occasions did not check/assess a patient for pain

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading “Supervision on 20 July 2023”, Ms Rosu stated that Mr Evelyn did not complete any of the daily assessments which included pain. Under the heading “Supervision on 20 November 2023, Ms Rosu stated that she had to suggest to Mr Evelyn to ask if the patient was in pain, which the patient verbally denied. Under the heading “Incident of 23 May 2024”, Mr Rosu stated that during this shift, Mr Evelyn did not assess a patient for pain, as not all the patients are able to express pain.

The panel took account of the “Supervision record” dated 20 November 2023. Ms Rosu has recorded the following regarding Mr Evelyn, *“On my suggestion he ask patient if it is any pain, verbally patient denied.”* [sic]

The panel took account of the “Supervision record” dated 23 May 2024. Staff Nurse Ms Thomas has recorded the following regarding Mr Evelyn, *“No pain reassessment for a patient who was having a pain score of 5...”* [sic]

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision records corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge proved.

Charge 5a

5. Communication in that:

- a) On 20 November 2023 did not inform and did not obtain consent before checking the patient’s legs

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading “Supervision on 20 November 2023”, Ms Rosu stated that she asked Mr Evelyn to check the patient’s skin on both legs. She stated that he removed the top sheet and blanket from the patient’s legs without informing the patient what he was doing. She stated that he did not obtain consent.

The panel took account of the “Supervision record” dated 20 November 2023. Ms Rosu has recorded the following regarding Mr Evelyn, *“He removed top sheet and blanket from [patient] legs without informing [patient] what he was doing, without obtaining [patient] consent...”* [sic]

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge proved.

Charge 5b

5. Communication in that:
 - b) On one or more occasions spoke too fast

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu and Ms Yet.

In her witness statement, under the heading “Supervision on 10 July 2023”, Ms Rosu stated that Mr Evelyn also struggled in other areas, namely, communicating with patients, as Mr Evelyn was talking in a fast pace and a low tone.

The panel took account of the “Supervision record” dated 15 June 2023. Under the sub-heading “Things to Improve” Ms Yet recorded the following about Mr Evelyn, *“Communication – Railton speaks very quickly. Suggested to speak slowly and modulate voice so patients can hear clearly and better.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu and Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge proved.

Charge 5c

5. Communication in that:

- c) On one or more occasions did not introduce yourself to patient before administering medication

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading “Patient Care”, Ms Yet stated that when she observed Mr Evelyn, he did not introduce himself with patients before starting medication rounds.

The panel took account of the “Supervision record” dated 7 February 2023. Under the sub-heading “Actions/Learning”, next to “Communication Skills” the following has been recorded, *“[Mr Evelyn] needs to practice introducing himself and gain consent from patient.”*

The panel also took account of the “Supervision record” dated 1 February 2024. Under the sub-heading “Actions/Learning”, next to “Communication Skills” the following has been recorded about Mr Evelyn, *“Staff has not introduced himself to patient. Patients has complained about being unable to understand staff.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision records corroborated the details in Ms Kuriakose’s witness statement.

The panel therefore found this sub-charge proved.

Charge 6a

6. Record keeping in that:

- a) On 7 April 2024, unable to prioritise care needs as spent too long with documentation

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Kuriakose.

In her witness statement, under the heading “Record Keeping”, Ms Kuriakose stated that on 7 April, Staff Nurse Thomas observed that it took Mr Evelyn a long time to complete documentation which meant there was not enough time to focus on patient’s needs.

The panel took account of the “Supervision record” dated 7 April 2023. Under the heading “Identified Actions”, next to “Time Management”, Ms Thomas recorded the following about Mr Evelyn, *“Taking long time for documentation and thereby not getting enough time to focus on patient needs”*.

[PRIVATE]

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Kuriakose which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Kuriakose's witness statement.

The panel therefore found this sub-charge proved.

Charge 6b

6. Record keeping in that:

b) On 16 May 2024, did not complete nursing notes for one or more patients

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

In her witness statement, under the heading "Supervision on 16 May 2024", Ms Rosu stated that on 16 May 2024, Mr Evelyn was asked to complete nursing documentation for all six patients by 17:00 so she could check. She stated that when she went to check, she noted that he had only managed to complete nursing documentation for three patients and for two of them he did it twice blaming the system for not saving his documentation.

The panel took account of the "Supervision record" dated 16 May 2024. Ms Rosu recorded the following about Mr Evelyn, *"established in the morning to finish nursing notes at 17:00 for me to be able to check, at 19:30 when I checked he did not write anything for 3 of the patients and for two of them double entrance (different writing). When I asked him what it is happening he was blaming the system, not saving his documentation."*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision record corroborated the details in Ms Rosu's witness statement.

The panel therefore found this sub-charge proved.

Charge 6c

6. Record keeping in that:

c) On 16 May 2024, did not complete the fluid chart documentation for a patient

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms Rosu.

The panel took account of the "Supervision record" dated 16 May 2024. Ms Rosu recorded the following about Mr Evelyn, *"I allocated him to do all assessments for one patient in the bay, at 18:00 nothing documented in the fluid chart."*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu which it deemed to be credible and reliable. It had no reason to believe Ms Rosu would fabricate what has been documented in the Supervision record.

Therefore, on the balance of probabilities, the panel found that on 16 May 2024, Mr Evelyn did not complete the fluid chart documentation for a patient.

The panel therefore found this sub-charge proved.

Charge 6d

6. Record keeping in that:

- d) On one or more occasions, did not complete the daily assessments for one or more patients

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr Rosu.

In her witness statement, under the heading “Supervision on 20 July 2024”, Ms Rosu stated that none of the daily assessments were completed.

The panel took account of the “Supervision record” dated 15 August 2023. Under the heading “Target Goals”, Ms Yet recorded the following about Mr Evelyn, *“[Mr Evelyn to do complete assessment for 6 patients.]”*

The panel also took account of the “Supervision record” dated 24 August 2023. Under the heading “Actions/Learning”, the following has been recorded about Mr Evelyn, *“Missed some of the daily assessments. Filled in the others well.”*

The panel noted that Mr Evelyn had completed an NMC context form dated 13 December 2024. However, it also noted that Mr Evelyn had not addressed this charge within the form.

The panel accepted the evidence of Ms Rosu which it deemed to be credible, reliable and consistent and was satisfied that the aforementioned Supervision records corroborated the details in Ms Rosu’s witness statement.

The panel therefore found this sub-charge 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 lack of competence and, if so, whether Mr Evelyn's 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, Mr Evelyn's fitness to practise is currently impaired as a result of that misconduct.

Representations on Lack of Competence

The NMC invited the panel to take the view that the facts found proved amount to lack of competence specified sections of the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code").

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin), (*Council for the Regulation of Health Care Professionals v GMC and Biswas* [2006] EWHC 464 and *Meadow v General Medical Council* [2006] EWCA Civ 1390.

The NMC invited the panel to find Mr Evelyn's fitness to practise impaired on the grounds of public protection and also in the public interests.

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

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

5 Respect people's right to privacy...

...

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

7 Communicate clearly

To achieve this, you must:

7.5 be able to communicate clearly and effectively...

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection'

The panel bore in mind, when reaching its decision, that Mr Evelyn should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

In the panel's view, the charges are wide ranging and represent a fair sample of Mr Evelyn's work. It noted that patients were put at risk by Mr Evelyn's competence failings.

The panel was satisfied that Mr Evelyn failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as band 5 nurse.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Evelyn's practice was below the standard that one would expect of the average registered nurse acting in Mr Evelyn's role.

In all the circumstances, the panel determined that Mr Evelyn's performance demonstrated a lack of competence and there remains an ongoing risk to public safety, public confidence in the profession and professional standards.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mr Evelyn's 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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..., 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/their fitness to practise is impaired in the sense that S/He/They:

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

For reasons already set out above, the panel considered that limbs a, b and c were engaged by Mr Evelyn’s lack of competence in this case.

The panel was of the view that Mr Evelyn’s failure to address his competency had placed patients at an unwarranted risk of harm. This was because he was unable to achieve the standard required of a band 5 nurse despite extensive support and supervision.

The panel found that Mr Evelyn’s lack of competence had breached the fundamental tenets of the nursing profession. It also bore in mind that the public would lose faith in the medical profession and therefore brought the reputation of the medical profession into disrepute.

The panel recognised that it must make an assessment of Mr Evelyn’s fitness to practise as of today. It referred to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* and considered whether the concerns identified in her nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the lack of competence and considered whether Mr Evelyn had provided evidence of insight and remorse.

The panel was of the view that the lack of competence in this case was not easily remediable because the failings are significant and wide-ranging. It bore in mind that there has been limited engagement and determined that there is a lack of reflection, insight, remorse, personal accountability and responsibility.

The panel noted that Mr Evelyn had completed the NMC Context Form and that he had set out some of the difficulties he had experienced was due to having insufficient time to complete the tasks allocated to him as he was required to deal with tasks and run errands.

However, he did not address the specific incidents which gave rise to the charges or what he had done subsequently to address his competence other than *“utilising the library and other training materials”*.

In its consideration of whether Mr Evelyn has taken steps to strengthen his practice, it determined that he had not presented any evidence to demonstrate steps taken to strengthen his practice and remedy the concerns identified in relation to the matters in this hearing.

The panel is of the view that in the absence of insight, remorse and evidence that Mr Evelyn had strengthened his practice in the areas of concern, he was liable to repeat his actions in the future. Were those actions to be repeated, there would be a risk of more patients in his care being placed at an unwarranted risk to harm. Additionally, there would be further damage to the reputation of the profession and further breaches of fundamental tenets of the profession. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel was satisfied that, having regard to *“the need to uphold proper professional standards and public confidence in the profession would be undermined”* if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if Mr Evelyn’s fitness to practise was not found to be impaired and therefore public confidence in the nursing profession would be undermined if you were allowed to practice unrestricted.

Having regard to all of the above, the panel was satisfied that Mr Evelyn’s fitness to practise is currently impaired.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Representations on sanction

The NMC took the panel through the aggravating and mitigating factors he considered to be engaged in this case. The NMC invited the panel to impose a suspension order for a period of 12 months.

Decision and reasons on sanction

Having found Mr Evelyn's 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 panel had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Lack of insight into failings
- Pattern of behaviour over a period of time
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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 overall Mr Evelyn’s lack of competency was wide ranging, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mr Evelyn’s 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 placing conditions of practice on Mr Evelyn’s registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on ‘*Conditions of practice order*’ (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *‘no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional’s practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*

- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel considered that conditions of practice could have been formulated to address the areas raised regarding Mr Evelyn's lack of competency. However, it also considered that conditions of practice would only be workable if Mr Evelyn had shown remorse and insight, and there was an absence of evidence of those factors.

However, it noted that Mr Evelyn is no longer in the country and it is not clear if he would be able to comply with any conditions imposed on him as he is not in the UK. It also noted that he has not responded to the NMC's offer of undertakings.

Furthermore, the panel concluded that the placing of conditions on Mr Evelyn's registration would not adequately address the seriousness of this case and would not protect the public.

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.’*

The panel was satisfied that the impairment in this case was serious but was not fundamentally incompatible with remaining on the register. It was of the view that Mr Evelyn could be fit to practise in future with a period out of practice to allow him to fully strengthen his practice through reflection, the development of his professional skills and knowledge and the development of insight and remediation.

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

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

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

The panel determined that a suspension order for a period of 12 months with a review was appropriate in this case to mark the seriousness and extent of the lack of competence.

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

Any future panel reviewing this case would be assisted by:

- Mr Evelyn's attendance in person, via video link or telephone at the review hearing;
- A comprehensive reflective piece addressing the facts found proved detailing your understanding of the potential impact your conduct had on patients, colleagues and members of the public;
- Evidence of any relevant training undertaken;
- Up to date references and testimonials from any work undertaken whether it be paid or unpaid;

This will be confirmed to Mr Evelyn in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that invited the panel to consider an interim suspension order for the period of 18 months. The NMC submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

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 substantive suspension order 28 days after Mr Evelyn is sent the decision of this hearing in writing.

That concludes this determination.