

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

**Substantive Hearing
Monday, 12 October 2026 – Wednesday, 21 October 2026**

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

Name of Registrant:	Laura Louise Stockton
NMC PIN:	09L0516E
Part(s) of the register:	Registered Nurse – RNA Adult Nursing - 3 January 2010
Relevant Location:	Shrewsbury
Type of case:	Misconduct
Panel members:	Alan Greenwood (Chair, Lay member) Catherine McCarthy (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Eyram Anka (12 -13 October 2026 and 16 - 21 October 2026) Rene Atkar (14 October 2026) Max Buadi (15 -16 October 2026)
Nursing and Midwifery Council:	Represented by Alicia Harrison, Case Presenter
Miss Stockton:	Present and unrepresented
Facts proved by way of admission:	Charges 3a and 3b
Facts proved:	Charges 4
Facts not proved:	Charges 1a, 1b and 2
Fitness to practise:	Impaired

Sanction:	Suspension order with review (12 months)
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - suspension order

Details of charge

That you, whilst employed as a Band 5 Community Nurse at Severn Hospice:

1. On 4 October 2024 in relation to Patient A wrote to Dr 1:
 - a. Requesting that their medication Dexamethasone be increased from 1mg to 4mg without the necessary qualification and or authorisation from the Hospice Practitioners.
 - b. Stated that you had discussed the matter as 1 (a) with the Hospice Practitioners.
2. Your actions at charge 1 (b) were dishonest in that you sought to give the impression that you had sought advice from the Hospice Practitioners when you knew you had not.
3. On 7 October 2024 in relation to Patient B wrote to Dr 2:
 - a. Requesting that their Fentanyl patch be stopped and replaced with Morphine Sulphate Tablets modified release without the necessary qualification and or authorisation from the Hospice Practitioners.
 - b. Stated that you had discussed the matter as 3 (a) with the Hospice Practitioners.
4. Your actions at charge 3 (b) were dishonest in that you sought to give the impression that you had sought advice from the Hospice Practitioners when you knew you had not.

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

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

The panel considered whether your case should be held in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Harrison, on behalf of the Nursing and Midwifery Council (NMC), submitted that the NMC is neutral on this matter and there is no specific application for the hearing to be held in private. She acknowledged that there are references [PRIVATE] in the documentary evidence before the panel and submitted that she will not refer to it in her submissions.

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.

Having heard that there will be reference to your [PRIVATE], the panel determined to go into private session as and when such issues are raised in order to protect your privacy.

Background

You joined Severn Hospice on 17 June 2024 as a Band 5 Registered Nurse in the Hospice at Home team.

The charges concern two letters that you wrote to two palliative patients' General Practitioners (GP) in October 2024, three days apart. In each letter, you asked the GP to make specific changes to those patients' medication.

The first alleged incident, relating to Patient A, occurred on 4 October 2024. You visited Patient A at home. He had metastatic prostate cancer with spinal cord compression and had been on a reducing dose of dexamethasone, a steroid. The letter you then wrote to his GP, Dr 1, says: *'After discussion with hospice practitioners can the dex please be increased back up to 4 mg twice daily.'*

There is no record on the clinical system of any such discussion and none of the nurse practitioners asked during the hospice's investigation could recall one.

When asked, you said you had discussed it but could not say with whom. The change was not implemented after the Community Team queried the recommendation.

The second alleged incident, relating to Patient B, occurred on 7 October 2024. You were working in Day Services at the Telford site, Apley. Patient B attended clinic with his wife and daughter. He had several cancers and a painful chronic wound, and he was in significant pain. After the appointment, you spoke to the Day Services Nurse Manager, Sandra Morris, and a plan was agreed between you: you would write to the GP asking for a review of Patient B's medication and request a visit by the Hospice at Home Team. No specific medications or doses were discussed on that occasion.

The letter you subsequently sent, asked the GP to stop Patient B's Fentanyl patch, to start Morphine Sulphate tablets modified release instead, and to prescribe immediate-release Morphine for breakthrough pain. It opens: *'after discussion with hospice team regarding analgesia medication'*. A colleague queried the recommendation, and the changes were not made.

You accept that you had not discussed Patient B's medication with anyone before the letter was sent. Your explanation is that you wrote the letter earlier in the day, intending to discuss it later, and then sent it to the administrative team without re-reading it.

Decision and reasons on facts

You made full admissions to charges 3a and 3b.

The panel therefore finds charges 3a and 3b proved in its entirety, by way of your admissions.

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

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:

- Clare Gregory (Ms Gregory): Matron for Clinical Services at the relevant time
- Sandra Morris (Ms S Morris): Day Services Manager at the relevant time
- Debbie Morris (Ms D Morris): Community Services Manager and your Line Manager at the relevant time

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

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

Charge 1a)

“That you, whilst employed as a Band 5 Community Nurse at Severn Hospice:

On 4 October 2024, in relation to Patient A wrote to Dr 1:

- a) Requesting that their medication Dexamethasone be increased from 1mg to 4mg without the necessary qualification and or authorisation from the Hospice Practitioners.”

This charge is found not proved.

In reaching this decision, the panel took into account the evidence provided by Ms Gregory and yourself.

Ms Gregory stated in her witness statement that she had authorised the Head of Hospitality to investigate concerns that changes had been made to prescribed controlled drug medication without appropriate medical guidance being sought. She stated that, on 4 October 2024, you wrote to Patient A’s GP requesting an increase in his dose of Dexamethasone from 1 mg to 4 mg. Ms Gregory considered that the medication changes were beyond your scope of knowledge. She further stated that you had not spoken to any of the nurse practitioners who were present in the office on 4 October 2024.

The panel was provided with a copy of the letter you sent to Patient A’s GP. Under the section entitled ‘*Requested GP Action*’, you wrote:

'After discussion with hospice practitioners can the dex please be increased back up to 4 mg twice daily currently taking 1 mg twice daily. Can you please review all current medications and stop as many medications that no longer required please.'

The panel noted that there was no dispute that you had written the letter or that it contained a specific request to increase Patient A's dose of Dexamethasone. You stated that you had discussed the medication with a nurse practitioner or consultant before writing the letter. The NMC's case was that no such discussion had taken place.

Accordingly, for this charge to be found proved, the NMC was required to establish that you had not discussed the proposed increase with a nurse practitioner or consultant.

The panel considered the evidence upon which the NMC relied to support its position that no such discussion had taken place. It noted that, in Patient A's clinical records, you had made the following entry on 4 October 2024 at 11:30:

'...Patient A and wife both feel since reducing dex pain worsening in back-gone from 4 mg BD to 1mg...To discuss with practitioners ? to increase dex back up to 4mg to help with spinal pain and reduce swelling in that area.' [sic]

The NMC's case was that there was no subsequent entry recording a discussion with a nurse practitioner or confirming that the proposed increase had been discussed.

The panel also considered the investigation notes provided by Ms Gregory and the evidence summarised in the documentation contained within your bundle. Under the heading '*Summary of Witness Evidence*', the panel noted that some nurse practitioners either could not recall having a conversation with you about Patient A's medication, including Kate Mortimer, or stated that no such conversation had taken place. One nurse practitioner also stated that they would not have advised an increase in the medication.

However, the panel was mindful that this evidence amounted to hearsay. None of the nurse practitioners whose accounts were referred to had attended the hearing to give evidence, nor had they provided formal witness statements for the panel to consider. As a result, the panel had no opportunity to hear directly from these individuals or to test the reliability of their accounts through questioning.

The panel further noted that an informal meeting had taken place between you and Ms D Morris on 17 October 2024, during which Patient A's GP letter was discussed. Ms D Morris had recorded that there were no further notes on System One identifying whom you had spoken to, and that the letter was the only relevant document present on the system.

The panel considered your evidence and the explanation you provided for denying this charge. In your oral evidence, you stated that you believed you had discussed Patient A's medication with a member of the hospice team, namely a nurse practitioner or a consultant, although you could not recall the identity of the individual concerned. You explained that, in your usual working practice, you would speak to whoever was available in the office.

You accepted that there was no contemporaneous record of the discussion in Patient A's clinical notes. You also acknowledged that your assertion that a discussion had taken place was based, in part, on your usual working practice rather than on a specific recollection of the conversation.

During cross-examination, you again accepted that you could not specifically remember the conversation with a nurse practitioner or consultant. Nevertheless, you maintained that you would have sought advice in accordance with your usual practice.

The panel reminded itself that the burden of proof rested with the NMC. It was required to determine whether, on the balance of probabilities, the NMC had established that you had not discussed the proposed increase in Dexamethasone with a nurse practitioner, as

stated in your letter to Patient A's GP, and had therefore not obtained authorisation for the proposed medication change.

The panel considered that your evidence in relation to this charge had been consistent. It noted that your account had remained consistent throughout the NMC investigation and during your evidence at the hearing. The panel also took into account that you had accepted some of the charges against you and had acknowledged making mistakes. It considered this relevant when assessing the consistency of your evidence and your willingness to make concessions where appropriate.

The panel noted Ms Harrison's submission that you had been inconsistent during cross-examination because you had raised the possibility of having spoken to Dr O'Connor only at the hearing. However, the panel considered that you had referred to this possibility previously in the investigation report. The report recorded your explanation as follows:

'When I am referring to 'Hospice Team' in my letters to confirm, I am referring to nurse practitioners and also Dr Alice O'Connor.'

In light of this, the panel identified a gap in the NMC's evidence concerning Ms Mortimer and Dr O'Connor.

Although Dr O'Connor was referenced in the investigation report, it appeared to the panel that she had not been interviewed as part of the investigation. The panel was therefore unable to exclude the possibility that you had sought advice from Dr O'Connor before writing to Patient A's GP.

The panel also considered an email contained within your bundle, which you had sent to the NMC on 7 September 2026. In that email, you had asked the NMC to place relevant sections of the Case Examiner's report before the panel for consideration.

You drew attention to the following passage from the *‘Investigation Report – Summary of Witness Evidence’*, which recorded the outcome of an interview conducted by the Head of Hospitality and Estate with Ms Mortimer on 24 October 2024. When asked whether she had discussed Patient A with you, Ms Mortimer stated: *“I don’t recall, but that’s not to say it did not happen...”*

The panel considered this evidence alongside your account. It noted that you had consistently maintained that a discussion with a member of the hospice team had taken place, notwithstanding your inability to recall the identity of the individual concerned. The panel also noted that you had drawn attention to the gaps in the NMC’s evidence while unrepresented and before the hearing commenced.

Having considered all the evidence, the panel concluded that the NMC had not discharged its burden of proof on the balance of probabilities. In particular, the absence of evidence from Dr O’Connor, together with the inconclusive nature of Ms Mortimer’s recorded account and the limitations of the hearsay evidence, meant that the panel could not safely conclude that no discussion had taken place.

Accordingly, the panel determined that there was insufficient evidence to establish, on the balance of probabilities, that you had not discussed the proposed increase in Dexamethasone with a nurse practitioner or another member of the hospice team.

The panel therefore found charge 1a not proved.

Charge 1b)

“That you, whilst employed as a Band 5 Community Nurse at Severn Hospice:

On 4 October 2024, in relation to Patient A wrote to Dr 1:

b) Stated that you had discussed the matters as 1 (a) with the Hospice Practitioners.”

This charge is found not proved.

In light of its decision in charge 1a, the panel was satisfied that that when you wrote to Patient A’s GP, what you wrote was not proved to be untrue.

The panel therefore found charge 1b not proved.

Charge 2

“Your actions at charge 1 (b) were dishonest in that you sought to give the impression that you had sought advice from the Hospice Practitioners when you knew you had not.”

This charge is found not proved.

As the panel found charge 1b not proved, there could be no dishonesty found in relation to that charge.

Charge 4

“Your actions at charge 3 (b) were dishonest in that you sought to give the impression that you had sought advice from the Hospice Practitioners when you knew you had not.”

This charge is found proved.

In reaching this decision, the panel bore in mind the legal advice in particular the principles set out in the case of *Lavis v Nursing and Midwifery Council 2014 EWHC 4083 (Admin)*

and the test for dishonesty in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. It had to determine what your actual state of mind was as to the facts and decide whether your conduct, with that state of mind, would be considered dishonest by the standards of ordinary decent people.

Ms Gregory stated in her witness statement that Ms S Morris, the Day Service Manager, had discussed a plan with you regarding the management of Patient B's pain. She stated that it had been agreed that you would write to the GP requesting a review of the patient and his medication. However, she stated that you did not do this and instead made your own recommendations to the GP.

The panel considered the GP letter referred to by Ms Gregory in Patient B's medical records. On 7 October 2024, you recorded the following:

'After discussion with hospice team regarding analgesia medication please can fentanyl patch be stopped – Patient B feels not helping at all can, Can MST modified release please be commenced instead and MST immediate release please be prescribed and commenced for breakthrough pain.' [sic]

The panel bore in mind that it was not in dispute that no discussion with the hospice team had taken place before the letter was sent. The investigation report recorded an informal meeting between you and Ms D Morris on 17 October 2024, during which the following was noted:

'[Ms Stockton] was trying to get everything done and she did plan on speaking to someone, however at the point of sending the letter, hadn't discussed this with anyone.'

The panel therefore had to determine whether you knew, when you sent the letter, that it incorrectly stated that a discussion had taken place. The panel also had to determine

whether you had written the words in anticipation of a later discussion but had later asked the administrative team to send the letter without proofreading it.

The panel took account of your oral evidence. You accepted charge 3, explaining that the contents of the GP letter reflected what you had written. You said that you had completed numerous referrals for patients in the day services unit that day and had intended to review them later before asking the administrative team to send them. You explained that each patient required five or more referrals.

You accepted that you should have proofread all the referrals before they were sent. You said that, had you done so, you would have reworded the GP letter to remove the inaccurate information and ensure that it requested a review of Patient B's medication, rather than making a specific request to stop and restart medication. You acknowledged that prescribing decisions were the responsibility of the GP and that you should have written, *'Please can the GP review the medication?'*

You explained that Patient B was distressed and in pain and had told you that he was experiencing unbearable pain and that nobody was helping him. You said that your intention was for the GP to review Patient B's medication, but you acknowledged that you should not have specified a particular medication change. You stated that you were not a prescriber and that, at the time, [PRIVATE].

[PRIVATE]

You said in evidence that you intended to discuss the matter with the hospice team. You said that you had not intended to mislead anyone or give a misleading impression when writing the GP letter. Rather, you had intended to return to the letter later that day, proofread it and amend its contents. You explained that your failure to do so was not deliberate but arose from the pressure you were under [PRIVATE].

You said that you had sent all the GP letters together at approximately 20:00. When asked why you should have proofread the referrals, you explained that you would have reworded the letter to remove the specific request for a medication change and instead asked the GP to review Patient B's medication. You reiterated that the decision regarding any change in medication was for the GP to make.

You explained that it had been difficult to give a straightforward "yes or no" answer in relation to charge 4 because you did not want to create a misleading impression.

The panel considered Ms Gregory's witness statement, in which she stated that you had discussed a plan with Ms S Morris to write to the GP requesting a review of Patient B and his medication. Ms Gregory stated that you did not follow this plan.

The panel considered that the contents of the GP letter were inconsistent with an intention to seek advice. Furthermore, the letter did not reflect the plan discussed with Ms S Morris and appeared to represent a deliberate departure from that plan.

The panel also noted that advice was readily available to you until 18:00. It considered the investigation report, which contained a formal statement you had made on 25 October 2024. In that statement, you confirmed that you had contacted nurse practitioners that day regarding another patient. You stated:

'I already had been in communication with the Nurse Practitioners that day about another patient, but with him I hadn't spoken to anyone. I did tell Ms Sandra Morris how much pain he was in, but didn't discuss the medication.'

The panel considered that, if you had genuinely intended to seek advice before making a recommendation, you would not have written instructions specifying the medication changes to be made. If you were awaiting advice, you would not yet have known what treatment would be recommended.

In the panel's view, the contents of the letter were not consistent with an intention to seek advice. Rather, they were consistent with you having decided upon the medication changes yourself and communicating those changes to the GP as recommendations. The panel considered that, had you been awaiting a discussion with the hospice team, you would have waited to establish what treatment was advised rather than setting out specific medication changes before that discussion had taken place.

The panel further considered that the letter was not consistent with it being a draft that you intended to review and amend later. It noted that the letter had been sent in its existing form and therefore represented the final version communicated to the GP.

The panel also bore in mind that you appeared to have been genuinely concerned about Patient B's welfare. It noted the record of the informal meeting between you and Ms D Morris on 17 October 2024, during which Patient B's circumstances were discussed. The following was recorded:

'[Ms Stockton] got very tearful and stated that she wanted to help the man and when she had seen him in clinic, he was crying and in pain. [Ms Stockton] stated that [PRIVATE] that day and just wanted to help him. She felt that the family had been positive in the clinic and that she had wanted to help.'

The panel accepted that you were concerned about Patient B and wanted to alleviate his pain. However, it considered that, in your desire to help him, you had taken matters into your own hands and devised a treatment plan yourself. In doing so, you had departed from the plan originally agreed with Ms S Morris.

The panel also took into account that you were [PRIVATE] at the time. However, there was no evidence before the panel to suggest that at the relevant time you lacked the capacity to distinguish right from wrong or truth from falsehood and to understand the nature of your actions when writing and sending the GP letter.

Applying the standards of ordinary decent people, the panel considered that your actions were intended to create the impression that you had sought advice from the hospice practitioners when you knew that you had not done so. The panel concluded, on the balance of probabilities, that your actions satisfied both the subjective and objective elements of the dishonesty test set out in *Ivey v Genting*. Accordingly, the panel found that your actions were both subjectively and objectively 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

NMC submissions on misconduct

Ms Harrison provided a skeleton argument which she supplemented with further oral submissions. Her written and oral submissions are summarised below.

Ms Harrison referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 in which misconduct is defined as a ‘*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances*’. She also referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin).

Ms Harrison submitted that the facts found proved amount to serious professional misconduct. She referred to ‘The Code: Professional standards of practice and behaviour for nurses and midwives 2015’ (the Code) and identified specific and relevant sections of the Code which she submitted were breached as a result of your conduct.

Ms Harrison submitted that the breaches of the Code fall under four principal themes:

Competence and Scope (6.1, 8.1, 8.2, 8.5, 8.6, 13.3): You made a specific medication recommendation outside the scope of your role, without consulting your colleagues, despite advice being readily available to you.

Accurate records and communications (10.2 and 10.3): You made a false statement in Patient B’s clinical letter concerning the basis of the recommendation.

Medicines and safety (18.1, 18.2 18.3, 19.1, 19.4): You recommended medication for a palliative care patient, which was subsequently assessed by the specialist team as constituting incorrect advice.

Honesty and integrity (20.1, 20.2, 25.1): The panel found that you had acted dishonestly on 7 October 2024. Ms Harrison submitted that the finding of dishonesty alone (charge 4) amounts to serious misconduct, honesty being one of the fundamental tenets of the nursing profession. She further submitted that the dishonesty did not arise in the context of your private life but concerned a false statement made in clinical correspondence regarding the clinical basis for changing Patient B’s medication. Ms Harrison reminded the panel of Ms Gregory’s evidence that GPs could reasonably be expected to act upon such

clinical correspondence. She further submitted that you accepted in your evidence that a GP might take your recommendation at face value.

In relation to the charges 3a and 3b, Ms Harrison submitted that these are also serious matters. She submitted that a registered nurse recommending specific changes to controlled medication outside their competence, without the necessary authorisation constitutes conduct that fellow practitioners would regard as deplorable. She reminded the panel that all three witnesses stated that they would not expect a registered nurse in your position to recommend medication changes without seeking advice.

Ms Harrison invited the panel to take into account the context you described, including that you were working in a new role, your workload [PRIVATE]. She accepted that these circumstances might be relevant to the panel's consideration of impairment. However, she submitted that it does not reduce the seriousness of the conduct. Accordingly, Ms Harrison invited the panel to find that the facts found proved amount to misconduct.

NMC submissions on impairment

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

Ms Harrison took the panel through the limbs of the test set out by Dame Janet Smith in her fifth Report to the Shipman Inquiry and set out in the case of *Grant*:

'Do our findings of fact in respect of the (nurse's) misconduct show that her fitness to practise is impaired in the sense that she:

- a) *'has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Harrison submitted that limbs (a), (b), (c) and (d) are engaged in respect of your past conduct. She submitted that your recommendation to the GP was assessed as incorrect, and that, had it been acted upon, it could have caused harm to Patient B. Although no harm occurred, she submitted that this was because colleagues had specifically queried the contents of the letter before the proposed changes were implemented.

Ms Harrison submitted that members of the public would be concerned to learn that a hospice nurse had falsely informed a GP that specialist advice had been obtained in relation to a palliative care patient when it had not. She submitted that dishonesty and practising within the scope of competence are fundamental tenets of the nursing profession, both of which have been breached in this case. In particular, she reminded the panel that, as charge 4 has been found proved, you have in fact acted dishonestly in the past.

Ms Harrison took the panel through the factors set out in *Cohen*.

Ms Harrison asked the panel to consider the nature of the concerns, submitting that dishonesty and a failure to practise within your scope of competence motivated by a

desire to secure a particular outcome for a patient, represents an attitudinal concern rather than a gap in clinical knowledge. She submitted that concerns of this nature are less easily remedied through training or similar measures.

In relation to insight, Ms Harrison accepted that you have engaged with these proceedings, expressed regret for your conduct and accepted that you should not have recommended a specific medication change. She noted your evidence that you should have checked the letter before sending it, escalated concerns regarding your workload and taken time off work [PRIVATE].

However, Ms Harrison submitted that your insight is limited. She submitted that you continue to categorise your conduct as a failure to proofread or as a documentation error rather than acknowledging it as a false statement. She further submitted that your reflective statement repeatedly attempts to place the responsibility on others. In particular, she reminded the panel that you referred to GP as being the '*decision maker*'. She also referred to your response bundle, in which you stated, '*no harm could have been caused by the writing of a letter*'. Ms Harrison further submitted that you had attributed responsibility to management, by stating that you had been '*set up to fail*', as you believe that there should have been a senior review of your letters. She also referred to your comment at the conclusion of your disciplinary hearing on 21 November 2024, when you stated, '*It was just a letter*'.

Ms Harrison submitted that these matters demonstrate a lack of insight into personal responsibility for the events. She further submitted that you had not demonstrated any particular understanding of the potential impact or consequences of incorrect medication changes.

Turning to strengthened practice, Ms Harrison noted that you are not currently working as a registered nurse. She submitted that there is no evidence of relevant training or any recent testimonial addressing your practice or honesty since these events. She acknowledged the positive reference from Mrs Jennifer English (Mrs English) dated 20

April 2026. However, she submitted that the reference is general in nature, describes your earlier employment and does not address the concerns arising from charges found proved.

Ms Harrison submitted that there are relevant previous regulatory findings. She referred to February 2021, when a Fitness to Practise Committee (FTPC) accepted a Consensual Panel Determination (CPD) in which you admitted dishonesty concerning training records. Your fitness to practise was found impaired on public interest grounds, and a five-year caution order was imposed from 10 March 2021. Ms Harrison highlighted that the present conduct occurred in October 2024, while that caution order was in force.

Ms Harrison reminded the panel that, during the previous substantive hearing in 2021, you had provided a reflective piece which demonstrated strong insight and contained assurances regarding candour. She submitted that the 2021 panel was assured that the conduct was out of character and would not be repeated. She further noted that the context you offered at that time is similar to context offered now (new role, workload and [PRIVATE]). Ms Harrison submitted that the present conduct could be regarded as more serious in terms of risk, given that the previous regulatory findings concerned training records, whereas the current concerns relate directly to patient care.

Ms Harrison submitted that the repetition of dishonest conduct, notwithstanding the previous regulatory findings, your reflection, the assurances provided in 2021, and the caution order imposed, is relevant to the assessment of risk. She submitted that this suggests a deep-seated attitudinal concern and shows insight and reflection has not prevented further dishonest conduct.

Ms Harrison accepted that you had been experiencing [PRIVATE] at the material time. [PRIVATE].

Ms Harrison also noted that [PRIVATE] formed part of the context of the previous concerns in 2018/2019. She submitted that there is no evidence of what has changed so as to reduce the risk of repetition should you return to practice [PRIVATE].

For these reasons, Ms Harrison submitted that there is a real risk of repetition and that your fitness to practise remains currently impaired on the ground of public protection.

Ms Harrison submitted that a finding of impairment is required in the public interest. She submitted that whatever view the panel take to future risk, dishonesty and clinical communications about a vulnerable patient's medication by a nurse who is subject to a caution order at that time for previous dishonesty, is so serious that public confidence in the profession and the NMC would be undermined, and proper standards not upheld, without a finding of impairment.

Ms Harrison made reference to Exhibit 5 (your bundle on impairment). In respect of the references and testimonials within that bundle, Ms Harrison pointed out that these are historical, they predate the events with which we are now concerned because since these events in 2024 you have not been working. Accordingly, Ms Harrison submitted that these documents are of no assistance to the panel in respect of insight or strengthened practice after these events. Ms Harrison submitted that the documents in Exhibit 5 do not affect the NMC's position as it relates to impairment.

Your submissions on misconduct and impairment

You told the panel that over the course of your 17-year career as a registered nurse, you have been a dedicated, kind and compassionate nurse, who recognises the importance of working within your limitations and your own level of competence.

You have recently submitted as Exhibit 5 a bundle of testimonials and certificates which provide evidence of the good service that you have given as a registered nurse over a long period. You have asked the panel to consider all those documents and your written

submissions when deciding whether you are currently impaired. Your submissions within Exhibit 5 included:

'In October of 2024 I again was open and honest from interview about the caution order. I was in a new job role employed as a hospice at home nurse, on my probation period having only been employed 4 months, felt I had inadequate support, had insufficient competencies/trainings completed, placed into a totally different environment to which I was employed to work, [PRIVATE] was working full time and ended up [PRIVATE] and my judgment was significantly impaired, wrong decisions were made, [PRIVATE] causing me to act outside of my scope of practice and failing to uphold my professional standards.

I acted completely out of character to which I feel incredibly remorseful and have spent 2 years reflecting and showing significant insight into the incident in October of 2024. Taking many actions as mentioned to improve.

I could of remained working as a nurse from 2024 until today October of 2026 I was informed by the NMC but knew I needed to take some time away from my nursing career to address [PRIVATE] and reflect on the incident of 2024, seeking the support of professional help from various disciplines.

The two separate FTP referrals were made 9 years apart 2018 and 2024 so I have practiced for all the years in between as a registered nurse and without any issues and worked within the professional standards required of a registered nurse.'

You referred the panel to the testimonials, including that of Mrs English dated 20 April 2026, in which she stated:

'As an RGN in my employment at my nursing home, Miss Stockton was a valued employee. Her devotion to the clients in our care was unswerving, full of care and compassion and the utmost professionalism. Miss Stockton was always on time

and fulfilled her duties fully and beyond. Sta and clients were very complimentary about her work and care.'

You said that you have always provided the best possible holistic care to patients and their families, showing empathy and compassion. You stated that over the course of your nursing career you have improved yourself as nurse through continuous professional development, using your own initiative, completing university courses, training courses, attending webinars, reading books and, when possible, attending the Nursing Live Conference.

You informed the panel that, although your practice was not restricted by the NMC, you chose not to practice as a registered nurse for the past two years to manage [PRIVATE] and reflect on your nursing practice

[PRIVATE].

[PRIVATE] you have reflected on the events that occurred in October 2024 and sought advice and support to ensure you are [PRIVATE] and fit to practise.

In response to Ms Harrison's submission that your previous regulatory referral had similar contextual factors to these proceedings, [PRIVATE].

You reminded the panel that you have not actively practised as a nurse in the past two years, as you did not feel it was the right thing to do because you sought to [PRIVATE]. However, you have kept up to date with nursing practices over the last two years by reading books and online journals.

You feel you are currently fit to practise due to length of time since the incidents occurred.

You told the panel that you fully acknowledge your mistakes and accept that you failed to uphold the professional standards required of a registered nurse. However, you stated that

it was not your intention to deliberately mislead anyone. You submitted that you have learnt from this experience the importance of clear and accurate documentation. You acknowledge that communication with the team is of paramount importance.

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

Decision and reasons on misconduct

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

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

‘6 Always practise in line with the best available evidence

To achieve this, you must:

- 6.1 *make sure that any information or advice given is evidence-based including information relating to using any health and care products or services’*

‘8 Work co-operatively

To achieve this, you must:

- 8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
- 8.5 *work with colleagues to evaluate the quality of your work and that of the team’*

'13 Recognise and work within the limits of your competence

To achieve this, you must:

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence'

'18 Advise on, prescribe, supply, dispense, administer medicines within the limit 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

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

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.9 maintain the level of health you need to carry out your professional role'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, having considered the nature and seriousness of the charges found proved, the panel was satisfied that your conduct amounted to misconduct.

In reaching its decision, the panel had particular regard to the finding of dishonesty. It determined that, your dishonest conduct is sufficiently serious to amount to misconduct.

The panel also considered that you had acted outside of your scope of competence by writing a letter requesting that Patient B's Fentanyl patch be stopped and replaced with Morphine Sulphate Tablets modified release without the necessary qualification and or authorisation from the Hospice Practitioners and determined that is serious and also amounts to misconduct.

Having considered the circumstances of the case and the nature of the charges found proved, the panel found that your actions fell seriously short of the conduct and 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, your fitness to practise is currently impaired.

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

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

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

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

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

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

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found that all the limbs of *Grant* are engaged in this case in relation to your past conduct.

In the panel's judgement, by acting without the necessary qualification and authorisation, your conduct put Patient B at an unwarranted risk of harm. The panel had regard to the evidence that your medication recommendation was incorrect and considered that Dr 2 may have taken your letter at face value had they received it. The panel determined that, had the recommendation been acted upon, Patient B could have been at risk of receiving either an insufficient or excessive dose of medication.

The panel further determined that, by acting outside your scope of competence and engaging in dishonest conduct, you brought the profession into disrepute and consequently breached the fundamental tenets of practising effectively and promoting professionalism and trust.

The panel also had regard to the previous incidents of dishonesty which occurred between November 2019 and April 2020 and resulted in a caution order being imposed in March 2021. The panel considered that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

In considering whether you pose a risk in the future, the panel had regard to the factors set out in the case of *Cohen*:

- Is the behaviour easily remediable?
- Has it already been remedied?
- Is it highly unlikely to be repeated?

The panel considered that your conduct is not easily remediable. It determined that, when viewed as a whole, the circumstances of the case demonstrate an underlying attitudinal concern, particularly in relation to your repeated dishonesty. The panel considered that the concerns of this nature are more difficult to remediate.

The panel gave careful consideration to the documentary evidence which you have provided in Exhibit 5 and noted the numerous testimonials referring to your practice as a nurse over many years. The panel noted that you are described in those testimonials as

'professional', 'competent', 'kind' and having *'excellent clinical skills'*. The panel took into account the context to which these testimonials refer and in particular that they all predate the events which gave rise to the charges which were found proved in these proceedings.

In relation to insight, the panel acknowledged that you have engaged throughout the proceedings, expressed regret for your conduct and accepted certain failings. The panel recognise that you made admissions and have demonstrated some understanding of why your actions were wrong and how they negatively impacted the reputation of the nursing profession. However, the panel was not satisfied that you had demonstrated a sufficient understanding of how your actions had placed Patient B at a risk of harm.

The panel also considered that, although you have acknowledged the dishonesty, you continued to refer to other contributing factors, including management and the fact that you had felt unsupported in your role. The panel took these matters into account when assessing the extent of your insight and acceptance of personal responsibility.

The panel noted that there is no evidence before it of relevant training undertaken to address the concerns identified in the charges. It acknowledged the positive references you provided but considered that they do not specifically address the concerns arising from the charges.

The panel also considered your undated reflective statement in which you explained the circumstances surrounding your actions and identified steps you would take differently in the future. You stated:

'This experience has changed my practice to ensure I always ask for support from colleagues(sic) if I feel the workload is too much and ensure that any work I do is proof read by myself and a colleague prior to it being sent from within the organisation.'

The panel acknowledged the steps you identified in your reflection. However, it considered that these focused primarily on seeking support with your workload. The panel determined that your reflection does not demonstrate a sufficient understanding of the potential impact of your actions on patient safety, the importance of practising safely or the full extent of the dishonesty and its implications for public confidence in the profession.

The panel also noted that you had provided a very similar reflection during the previous regulatory proceedings in 2021. However, notwithstanding those reflections and the assurances provided at the time, a further incident of dishonesty occurred while you remained subject to the five-year caution order.

[PRIVATE]

However, having considered the evidence as a whole, particularly the repetition of dishonest conduct during your five-year caution order, the panel determined that there is a risk of repetition. Having considered this history, the panel reviewed the *Grant* test and concluded that you are liable in the future to place those receiving care at an unwarranted risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession. Accordingly, the panel determined that a finding of impairment is necessary on public protection grounds.

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

The panel determined that public confidence in the nursing profession would be seriously undermined if a finding of impairment were not made in this case. This is due not only to the public protection concerns identified, but also to the seriousness of the charges found proved, which include dishonesty. The panel concluded that the nature of your

misconduct, when considered alongside the risk of repetition, necessitates a finding of impairment on public interest grounds in order to uphold proper professional standards of conduct.

Having regard to all of the above, the panel was satisfied that your 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. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2, SAN-3 Last Updated: 28/01/2026 and SAN-4 Last Updated: 31/07/2026).

The panel accepted the advice of the legal assessor.

NMC submissions on sanction

Ms Harrison provided a skeleton argument which she supplemented with further oral submissions. Her written and oral submissions are summarised below.

Ms Harrison informed the panel that the NMC had advised you in the Notice of Hearing dated 13 August 2026 that it would seek the imposition of a striking-off order if it found your fitness to practise impaired. The NMC recognises that the panel's findings are narrower than the case originally brought but Ms Harrison submitted that they still require removal from the register.

Ms Harrison submitted that dishonesty is always serious, although its degree of seriousness may vary. She noted that the forms of dishonesty most likely to call registration into question include dishonesty involving a direct risk to patients and dishonesty involving vulnerable victims. Ms Harrison acknowledged that the finding concerns a single letter, that there had been no direct personal gain, and your actions were motivated by a desire to help a distressed patient. However, she submitted that your dishonesty occurred within a clinical letter concerning a palliative patient's opioid medication. She noted that GPs could reasonably be expected to act upon the advice provided, and the advice in question was assessed as incorrect.

Ms Harrison submitted that the aggravating features in this case are as follows:

- Risk of harm to a vulnerable patient
- A previous finding of dishonesty (February 2021) with a five-year caution order imposed from 10 March 2021
- The present conduct occurred while the previous caution order was in force
- Your misconduct occurred despite a reflection that the 2021 panel accepted showed strong insight, and assurances about candour
- Limited insight
- You departed from the plan agreed with your manager

Ms Harrison submitted that the mitigating features in this case are as follows:

- You made admissions to charge 3 and have always accepted that no discussion took place
- You have engaged with the proceedings and expressed regret
- You were in a new role, on probation and working in a less familiar setting
- [PRIVATE]
- You have had a long career and positive references

Ms Harrison submitted that these mitigating features carry less weight, given that similar contextual matters had been advanced at the previous substantive hearing in 2021. She further submitted that there is no evidence of subsequent training or current clinical practice, and that the references you provided do not address the findings made against you.

Ms Harrison submitted that taking no further action would be inappropriate, having regard to the nature and seriousness of the charges proved in this case.

Ms Harrison further submitted that a caution order would also be inappropriate as such an order would ordinarily be considered where the concerns fall at the lower end of the spectrum of impaired fitness to practise and there is no risk to the public. She submitted that neither consideration applies in this case, as it involves dishonesty.

In addition, Ms Harrison noted that you were subject to a caution order in relation to a separate NMC matter at the time the present concerns arose. She invited the panel to consider that the previous caution order had not prevented similar conduct from occurring and submitted that a further caution order would therefore be insufficient to address the concerns identified.

Ms Harrison submitted that a conditions of practice order is unsuitable in this case because dishonesty is attitudinal and cannot be addressed by retraining. She further submitted that there are no workable conditions capable of managing dishonesty in clinical correspondence. Additionally, she noted that you do not currently have an employer to support any conditions imposed. For these reasons, Ms Harrison submitted that a conditions of practice order is not sufficient to protect the public and satisfy the wider public interest considerations.

Turning to a suspension order, Ms Harrison acknowledged that the findings concern a single letter and that there has been no repetition of the conduct since October 2024.

However, she submitted that a suspension would nevertheless be insufficient in the circumstances of this case.

In support of this position, she reminded the panel that this is the second finding of dishonesty, which occurred whilst the first sanction was in force. She submitted that this suggests a deep-seated attitudinal problem. Ms Harrison further submitted that a five-year caution order and the insight you demonstrated in 2021 did not prevent repetition, therefore a period of suspension followed by a return to practice is unlikely to achieve more.

Furthermore, Ms Harrison submitted that your insight is limited and that the dishonesty in the present case relates directly to patient care, which is arguably more serious than the dishonesty identified in 2018/2019.

Ms Harrison submitted that a striking-off order is the appropriate order in the circumstances. She submitted that your misconduct raises fundamental questions regarding your professionalism, given that there have been two findings of dishonesty in two separate professional contexts, with the second occurring whilst you were subject to a sanction for the first.

Ms Harrison submitted that public confidence in the profession could not be maintained if a nurse who acted dishonestly while under a caution order for similar concerns were permitted to remain on the register.

Ms Harrison submitted that a striking-off order is the only sufficient sanction in this case, given that a lesser sanction had previously been imposed and failed to prevent further misconduct. She reminded the panel of its finding that your insight is limited and that there is no evidence of strengthened practice.

Ms Harrison accepted that a striking-off order would have a serious impact on you but submitted that the public interest outweighs your interests in this matter.

Your submissions on sanction

You provided written submissions which you supplemented with further oral submissions. Your written and oral submissions are summarised below.

You told the panel that you have never disputed the original facts, namely that you wrote the letter to Dr 2 and sent the task to the administration team. You accept that you should not have made specific medication recommendations as you are not a nurse prescriber. You acknowledged that it was the responsibility of the GP to undertake a holistic assessment of the patient.

You fully acknowledged that your actions appear to have been dishonest, as the GP may have been given the impression that you had sought advice from the hospice practitioners, when you had not. You told the panel that you take full responsibility for your actions in October 2024 and recognise the potential impact of the letter had the GP implemented the changes you recommended.

You recognise that the letter should have been reviewed and reworded to accurately reflect what you were specifically asking the GP. You stated that the letter should have instead read:

“Please can the GP review all this gentleman’s medications as a matter of urgency”

You acknowledged that you failed to uphold the professional standards expected of a registered nurse and had acted outside your scope of professional practice. You stated that you have demonstrated significant remediation and insight. You explained that during the two years you had chosen to take a break from nursing, you reflected on your actions and have taken steps to address your [PRIVATE] through various sources of professional support. [PRIVATE] You also reminded the panel that you have engaged fully with the NMC proceedings.

You recognise that your actions have brought the profession into disrepute and expressed remorse for your misconduct. You state that you wish the circumstances had been different. You reiterated that you were new to your role as a Hospice at Home Community Nurse when you were moved to Day Services as a supportive measure and the day services manager not being aware of this. You explained that [PRIVATE] believed that you should not have been running the clinic independently that day. You referred to the evidence you provided of your circumstances at the time. [PRIVATE] You believe that this had impaired your judgement and contributed to you acting out of character.

You told the panel that you have been open and honest about your mistakes and have demonstrated insight and remorse in various ways. You referred the panel to your response bundle and invited it to consider the numerous reflections you provided. You stated that, during the two years you chose not to practise as a nurse, you have taken steps and put measures in place [PRIVATE].

You invited the panel to impose a lesser sanction than a striking-off order. You asked the panel to consider imposing a suspension order instead, explaining that you have already spent a considerable period of two years reflecting and seeking professional help, support and advice.

You stated that those who have known you throughout your 17-year career would recognise you as a kind, compassionate and dedicated nurse to the patients under your care. You emphasised that you have dedicated your life to your nursing career.

You highlighted that you have fully engaged throughout these proceedings. You told the panel that you have developed a deep understanding of the incident that occurred in October 2024 and have taken steps to address the concerns raised. You explained that you took two years away from nursing practice to reflect and engage with professional support. You asked the panel for the opportunity to demonstrate that you are capable of

change and expressed your willingness to undertake any necessary training courses to enable you to return to practice.

You stated that you have addressed the concerns to the best of your ability, taking into account [PRIVATE]. You recognise that recurrence of dishonesty in two separate matters during your professional practice is below the standards expected of a registered nurse. However, you maintain that [PRIVATE] at the time had significantly impaired your judgement. You told the panel that you are incredibly remorseful and have reflected on the seriousness of your actions.

You referred to the NMC's reliance on the previous regulatory findings in 2021 and sought to provide further context regarding the circumstances surrounding the earlier concerns. You explained that, in 2018/2019 you were working full time in a new role as a Practice Nurse in a GP practice, whilst also studying at university and [PRIVATE]. [PRIVATE]

Turning to the events leading up to the incident in October 2024, you explained that you had again been working in a new role as a Hospice at Home nurse before being moved to Day Services, an area of practice with which you were unfamiliar. [PRIVATE] You explained that you had experienced a [PRIVATE] which you believe again contributed to the poor decisions you made in October 2024.

You acknowledged that both the 2018/2019 and 2024 referrals involved dishonesty. However, you maintained that you are not an inherently dishonest person and referred to your professional practice between 2018 and 2024, during which you stated that you had practised professionally without further concerns arising.

You stated that, with hindsight, [PRIVATE]. You invited the panel to consider the mitigating circumstances, [PRIVATE] and the steps you have taken since your referral in 2024.

The panel put questions to you.

In response to panel questions regarding the similarities between the circumstances that had contributed to the dishonesty in 2018/2019 and 2024, and what would prevent similar conduct from occurring in the future, you stated that with hindsight, you should have taken time away from nursing practice after the first referral.

You explained that this is why you decided to take two years away from nursing after the 2024 referral, to allow yourself sufficient time to reflect, [PRIVATE]. You stated that you have made every effort to obtain the help and support necessary to improve your [PRIVATE].

You told the panel that taking time away from nursing had not been an easy decision. However, you believe that continuing to practise at the time would have been negligent, [PRIVATE]. You emphasised that you made the decision to step away from practice voluntarily, despite not being subject to any interim order.

You further submitted that your conduct did not reflect a deep-seated attitudinal problem. You explained that, had this been the case, you would have expected similar concerns to have arisen throughout your 17-year nursing career. You maintained that the incidents in 2018/2019 and 2024 arose in the context of [PRIVATE], which had caused you to act out of character and fall below the professional standards expected of a registered nurse.

You stated that your conduct does not demonstrate an ongoing behavioural pattern, but rather involved two incidents occurring several years apart, against a background of similar personal circumstances.

You emphasised that you are not seeking to excuse your failure to adhere to professional standards but wish to highlight the similarities in your personal circumstances at those times. You explained that, on this occasion, you took an extended period away from nursing to allow yourself sufficient time to address those circumstances and the underlying concerns.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Previous regulatory finding of dishonesty with a five-year caution order imposed from 10 March 2021.
- Your misconduct occurred while that caution order was in force
- Conduct which put people receiving care at risk of suffering harm
- Dishonesty in the course of your practice

The panel also took into account the following mitigating features:

- You made early admissions in relation to charge 3 and made concessions to charge 4 during your evidence
- Expressed regret and remorse
- Engaged fully with the proceedings
- [PRIVATE]
- You have had a long career and positive references
- Reflective accounts
- Developing insight

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

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

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise 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 your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*

- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel determined that there are no relevant, proportionate, workable or measurable conditions that could be formulated, given the nature of the charges in this case. The panel considered that the misconduct identified is not something that can be adequately addressed through retraining alone, given that it involves dishonesty. The panel was of the view that conditions of practice would not sufficiently address the underlying concerns relating to your professional judgement and honesty, nor would it provide adequate assurance that similar conduct would not recur. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, would not protect the public or maintain public confidence in the nursing profession.

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.'*

In reaching its decision, the panel carefully considered the submissions of Ms Harrison in relation to the sanction sought in this case. However, the panel considered that you had demonstrated developing insight and a positive attitude to addressing the concerns such that there was a realistic possibility that in the future you will be able to practise safely without risk to patients and in particular without any risk of dishonesty in the course of your practice.

The panel bore in mind that you have engaged fully with the proceedings, despite being unrepresented, and made extensive representations, which the panel found persuasive.

The panel took the view that with a lengthy suspension, to be followed by a review, there is a realistic possibility that a future panel assisted by a reflective piece, and references may conclude that you can practise safely.

The panel considered whether a striking-off order would be appropriate. The panel had regard to the NMC guidance '*Deciding between a suspension order and strike off*' (SAN-3)

and carefully considered regard to the factors set out within this guidance when deciding between a suspension or a striking-off order.

The panel also had regard to the NMC guidance '*Sanctions for the highest risk cases*' (SAN-4), which states:

'...in every case the Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious.'

The panel took into account that the case involved a risk to a patient. However, it was a one-off incident, it involved spontaneous conduct, there was no personal gain and the panel took into account that you had shown remorse, had recognised that you had acted in a dishonest way and had submitted that you have taken steps to address your failings. You have engaged very fully with the panel throughout the hearing.

The panel took into account the compelling evidence that during two-year period since this incident you have been intensely working on your [PRIVATE]. [PRIVATE]

The panel also took into account the context in which the dishonesty took place. It acknowledged [PRIVATE], the fact that you were working in an environment that was unfamiliar whilst in your probationary period. [PRIVATE]

The panel acknowledged the seriousness of your misconduct, particularly the fact that there had been two separate findings of dishonesty in the course of your professional practice, approximately eight years apart. It also took into account that the more recent misconduct occurred whilst you were subject to a caution order imposed in relation to the earlier concerns. However, the panel considered the circumstances of your misconduct, the mitigation advanced and the steps you have taken towards addressing the concerns, the panel was not persuaded that a striking-off order was the only appropriate sanction available. Furthermore, the panel determined that your remaining on the register, is not

incompatible with the maintenance of public confidence in the profession or the integrity of the register.

Taking account of all the information before it, the panel concluded that a striking-off order would be disproportionate. Whilst the panel acknowledged that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order. Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

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

The panel determined that a 12-month suspension order with a review is the most appropriate sanction in this case. It considered that this period would adequately mark the seriousness of your misconduct whilst providing you with sufficient time to undertake further reflection, develop your insight and demonstrate meaningful remediation.

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 extend the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective piece setting out the following:
 - a. Your insight and understanding as to the importance of honesty, particularly in matters relating to patients which arise during the course of your practice

- b. The risk of harm in acting outside the scope of your practice
- c. How you intend to deal with [PRIVATE] and [PRIVATE]
- Testimonials relating to recent employment
- [PRIVATE]

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Ms Harrison made an application for an 18-month interim suspension order to cover the appeal period. She submitted that it would be inconsistent to allow unrestricted practice in the meantime. Ms Harrison submitted that the application is made on the grounds of public protection and in the public interest for the same reasons as the substantive order. She submitted that public confidence will be undermined if you were permitted to practise unrestricted after the panel's findings, simply because the suspension order does not take effect for 28 days.

You stated that you had nothing to add. You told the panel that you have no intention of appealing the sanction.

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 to allow for the time that may be taken before an appeal can be heard. Not to do so would be inconsistent with the sanction imposed.

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

That concludes this determination.