

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

Substantive Hearing

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

Monday, 29 September 2025 – Tuesday, 7 October 2025

Virtual Hearing

Wednesday, 8 October 2025 – Thursday, 9 October 2025

Monday, 12 October 2026 – Monday, 19 October 2026

Wednesday, 21 October 2026 – Friday, 23 October 2026

Name of Registrant:	Roselyn Kahuga Washington
NMC PIN:	07B2707E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA, Registered Nurse - Adult (20 September 2007)
Relevant Location:	London
Type of case:	Misconduct and lack of competence
Panel members:	Nicola Dale (Chair, Lay member) Michelle Wells-Braithwaite (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	Tracy Ayling (29 - 30 September 2025) Simon Walsh (1 - 9 October 2025) Joseph Magee (12 - 16 October 2026) Jayne Salt (19 October 2026, 21 – 23 October 2026)
Hearings Coordinator:	Hazel Ahmet (29 September 2025 – 9 October 2025) Stanley Udealor (12 - 19 October 2026, 21 – 23 October 2026)
Nursing and Midwifery Council:	Represented by Madeleine Price, Case Presenter (29 September 2025 – 9 October 2025)

Represented by Raj Joshi (12 - 19 October 2026, 21 – 23 October 2026)

Mrs Washington:	Present and unrepresented at the hearing
Facts proved by admission:	Charge 5
Facts proved:	Charges 1a(i), 1b(i), 1b(ii), 1b(iii), 1d(i), 1i(i), 1i(ii), 2a, 2b, 3 and 4
Facts not proved:	Charges 1c(i), 1c(ii), 1c(iii), 1e(i), 1e (ii), 1e(iii), 1f, 1g, 1h, 1j(i), 1j(ii), 6a and 6b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - striking off order

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

At the outset of the hearing, you made an application that this case should be held partly in private on the basis that proper exploration of your case involves matters relating 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 Price, on behalf of the Nursing and Midwifery Council (NMC), indicated that she supported the application to the extent that any reference to [PRIVATE] should be heard in private.

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

The panel accepted the advice of the legal assessor.

The panel determined to hold this hearing partly in private. It will go into private session as and when matters relating to your [PRIVATE] are raised in order to protect your privacy and [PRIVATE].

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Price to amend the wording of charge 6.

The proposed amendment was to change the following wording in charge 6:

6) *'Your actions at allegation 3 5 were dishonest in that [...]*

Ms Price submitted that the proposed amendment was merely to correct a typographical error, and that it would provide clarity and more accurately reflect the evidence.

You indicated that you did not oppose the amendment as proposed by Ms Price.

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 determined that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy. The panel therefore granted the application.

Details of charge as amended

That you, a registered nurse:

- 1) Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - a. On or around 10 September 2020 in relation to Patient A:
 - i. Administered Urokinase by IV infusion without the required competency. **[PROVED]**
 - b. On or around 1 June 2021 in relation to Patient C:
 - i. Did not demonstrate adequate knowledge of preparing the Phosphate Polyfusor IV; **[PROVED]**

- ii. Administered Phosphate Polyfusor without the required competency; **[PROVED]**
 - iii. Administered Phosphate Polyfusor without appropriate supervision; **[PROVED]**
- c. On or around 6 July 2021 in relation to Patient B:
 - i. Provided medication to the patient without carrying out the required observations; **[NOT PROVED]**
 - ii. Did not carry out regular observations on the patient; **[NOT PROVED]**
 - iii. Did not escalate concerns when the patient's blood pressure and / or oxygen saturation deteriorated **[NOT PROVED]**
- d. On or around 6 May 2021 In relation to Patient D:
 - i. Did not conduct regular observations when you were required to do so; **[PROVED]**
- e. On or around 19 January 2022 in relation to Patient E:
 - i. Did not take reasonable and/ or prompt actions following the patient's blood pressure medication discrepancy; **[NOT PROVED]**
 - ii. Did not escalate the patient's increasing blood pressure; **[NOT PROVED]**
 - iii. Unnecessarily withheld fluid from the patient; **[NOT PROVED]**
- f. On or around 19 September 2020 did not carry out the required safety checks and/ or observations whilst carrying out a blood transfusion; **[NOT PROVED]**
- g. On a date unknown, stopped a Heparin IV without instruction from a Doctor to do so; **[NOT PROVED]**

- h. In or around August 2020, did not take any and / or reasonable steps to escalate a deteriorating patient **[NOT PROVED]**
- i. On or around 26 September 2020:
 - i. Did not take any and/ or reasonable steps to escalate failed medical equipment; **[PROVED]**
 - ii. Did not take any and/or reasonable steps to obtain an alternative form of equipment for the patient; **[PROVED]**
- j. On or around 9 September 2021:
 - i. Left an unknown patient naked and / or unsupervised; **[NOT PROVED]**
 - ii. Did not escalate the patients care to another nurse whilst on break; **[NOT PROVED]**
- 2) On or around 15 January 2022, cared for one or more patients who had altered airways:
 - a) when not being signed off as being competent to care for such patients, and/or **[PROVED]**
 - b) having been informed previously that you could not care for such patients. **[PROVED]**
- 3) On or around 15 January 2022, failed to inform Colleague B (Amy Hill) that you could not be allocated patients who had altered airways. **[PROVED]**

- 4) On or around 20 January 2022 you threatened to punch Colleague A (Selina Diven) in the face; **[PROVED]**
- 5) You worked at King Edward VII's Hospital on one or more of the following occasions: **[PROVED BY WAY OF ADMISSION]**
 - a. 20 June 2023
 - b. 21 June 2023
 - c. 23 June 2023
 - d. 1 July 2023
 - e. 2 July 2023
 - f. 3 July 2023
- 6) Your actions at allegation 5 were dishonest in that:
 - a. You knew your NMC registration had been interim suspended at a hearing on 16 June 2023; **[NOT PROVED]**
 - b. You failed to inform King Edward VII's Hospital of the fact your registration was currently suspended prior to undertaking the shifts. **[NOT PROVED]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in relation to charge 1 and by your misconduct in relation to charge 2a and/or 2b and/or 3 and/or 4 and/or 5 and/or 6.

Decision and reasons on application to recall witnesses

Within your written final submissions submitted on day eight of the hearing, you asserted that two witnesses who had given live evidence on days one and two should be recalled. You stated:

'I wanted to probe each one of these two witnesses in a bit more details but I was constantly being reminded by the panel that it was not within my remit to ask certain questions and I humbly accepted that guidance. So to me the credibility of these two witnesses has not so far been properly tested therefore they should be recalled for further probing so the panel can get to the core of their allegations.'

With only panel notes of the questioning and no prior indication that you felt there had been any unfairness, the panel was unable to determine this application without the benefit of the full hearing transcript and the hearing was adjourned.

On resumption of this hearing, you were invited to make an application to recall the two witnesses, namely, Ms Selina Diven and Ms Jade Potter, and set out your reasons with the benefit of the hearing transcript bundle.

You submitted that, during the course of your cross-examination of those witnesses, there were several interruptions by the previous legal assessor at that time and the chair which prevented you from adequately cross-examining the witnesses.

You submitted that the legal assessor had paraphrased and reframed your questions to Ms Diven and Ms Potter, which enabled the witnesses to dodge the questions you had put to the witnesses. You submitted that the witnesses understood your questions when you asked them and therefore, there was no need for the legal assessor to paraphrase or reframe your questions. You asserted that the legal assessor changed the meaning of

your questions and presented different questions from what you had intended to ask. You submitted that you needed to challenge the credibility of these two witnesses. You expressly stated to the panel that both of these witnesses had lied in giving their evidence and you also asserted on one occasion that the legal assessor assisted one of the witnesses in doing so.

You referred the panel to various areas of the Transcript Bundle of the Physical Hearing held at 2 Stratford place from 29 September 2025 to 7 October 2025, specifically, the sections of the live evidence of Ms Diven and Ms Potter. You submitted that a close examination of the highlighted areas of the transcript bundle showed that the legal assessor and the chair, on various occasions, interrupted your questions to the witnesses, changed the meaning of your questions or prevented you from presenting certain questions to the witnesses. You alleged that, on one occasion, the chair and the legal assessor tried to assist the witness to answer your questions and therefore, aided the witnesses. You further submitted that, when the witnesses concluded their evidence on the first occasion, you realised that there were further questions you wanted to ask them.

In conclusion, you submitted that Ms Diven and Ms Potter were not credible witnesses who had not been properly cross-examined and that they should both be re-called to answer further questions from you.

Mr Joshi, on behalf of the NMC, opposed your application. He highlighted that the panel has already heard the entirety of the witnesses' evidence whereby you had the opportunity to cross-examine the witnesses. He stated that the panel also asked supplementary questions and you subsequently gave extensive evidence in which you articulated your criticisms of the witnesses. Mr Joshi submitted that the panel was therefore fully aware of the nature of your case.

Mr Joshi submitted that you have not been able to identify any prejudice to you, and your application was generally focused on collateral matters and witness credibility rather than the facts and the charges. He submitted that the core issues before the panel were

whether a recall of the witnesses would produce relevant evidence capable of materially assisting the panel or whether a recall was contrary to the interests of efficient and fair proceedings. He submitted that, in making its decision, the panel should balance the proportionality of recalling witnesses who have completed their evidence with your own interests.

Mr Joshi submitted that the panel has a broad case management discretion to control proceedings and admit only evidence that is necessary for a fair determination of the charges. He submitted that the overriding objective is to ensure that these proceedings were conducted fairly, proportionately and expeditiously whilst protecting the public interest. He asserted that the central question was not whether a registrant would like to ask additional questions, but whether refusal of the application would create a material unfairness affecting the reliability of the fact-finding process. He highlighted that the Courts have consistently recognised that tribunals are entitled to prevent repetitive, irrelevant or oppressive questioning of witnesses and that cross-examination is not unlimited. He submitted that proceedings must focus on the issues that are relevant to the allegations and any recall application requires a demonstrable forensic purpose.

Mr Joshi submitted that the panel needs to consider whether there is a material fact which remains unexplored or whether a witness had not been challenged on material allegations or whether there is an answer that exists that could realistically affect the determination of a charge. He asserted that the main issue was whether there was any additional evidence that could be obtained by recalling the witnesses. He referred the panel to the NMC Guidance on Evidence (DMA-6) which highlighted relevance and fairness as factors to be considered in admitting evidence.

Mr Joshi noted that you had alleged that the witnesses had conspired and fabricated allegations against you. He submitted that the witnesses have denied such allegations and it was a matter for the panel to assess the credibility of the witnesses. He asserted that your reasons for recalling the witnesses in order to repeat your allegations to them would not serve any evidential purpose and the other concerns you had raised against them

were merely collateral issues. He submitted that the panel could determine what weight to be placed on the witnesses' evidence without reopening evidence on peripheral issues.

Mr Joshi stated that he had examined the areas on the transcript where you stated that the legal assessor and the chair had interrupted your cross-examination of the witnesses. He submitted that the interventions were made by the legal assessor and the chair in order to clarify your questions to the witnesses and understand the crux of your questions. Mr Joshi asserted that the questions you propose to ask the witnesses did not identify any precise factual issue or relate to a particular charge. He submitted that a recall of witnesses should only be made on the basis of any new evidence that affects the witnesses' previous evidence or any specific factual gap that has been identified. He submitted that there has to be an explanation as to why the matter was not adequately explored previously in cross-examination and it was not about repeating previous cross-examinations or making comments on the witnesses' evidence.

In conclusion, Mr Joshi invited the panel to refuse your application.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel recognised that it would be an exceptional course of action to recall a witness and although it is within the panel's discretion to recall a witness, such decision should be made after careful consideration. The panel had regard to Rules 22 and 31 as well as the NMC Guidance on Evidence (DMA-6).

The panel noted your submissions that the basis for your application to recall witnesses was that, during your cross-examination of Ms Diven and Ms Potter, there were interruptions by the previous legal assessor at that time and the chair which prevented you from adequately cross-examining the witnesses. The panel therefore proceeded to consider each area of the transcript bundle where you had highlighted that there were

interventions from the previous legal assessor and the chair, in order to determine whether it was relevant and fair to recall the witnesses.

PDF Page 53: paragraphs A – F of the transcript

‘Q. THE REGISTRANT: Ms Diven do you remember the way you answered me back that was very rude, after asking you that question. I didn't want to come back to ask you anymore because the way you answered me was unprofessional.

Q. THE LEGAL ASSESSOR: What you think or know, this witness can't answer. Can we try this one please, Ms Diven. Do you remember if you were rude to Ms Washington or cross or terse or anything like that?

A. No, I was directing her to have a look at the prescription so that Ms Washington was given a chance to read the prescription again to work out how much to give.

Q. THE REGISTRANT: Do you remember that after it was a bit late, I decided to go and find another nurse to help me to put up the poly-fuser. Because every time I came to you, you said you were busy. I thought you were really busy. I got another nurse because this patient had been allocated to me and if the poly-fuser hadn't been given in time it would still reflect on the system that I had given it.

Q. THE LEGAL ASSESSOR: I'm sorry Ms Diven, I know it sounds like you're being asked questions by two people but I'm trying to sort out what you can answer and what you can't answer. Were you busy that day?

A. Yes, it was a busy time on the ward. But I knew that this assessment needed to be done and what I was doing in terms of doing the assessment I would have been able to put it aside. I can't recall exactly what I was doing but it's something that I would have been

able to put aside to enable the assessment to have been carried out at the bedside.

Q. In relation to other nurses that might have been called by Ms Washington, did you know anything about that at the time, or did you find that out later?

A. I found that out later after I then approached Ms Washington about if she was ready to give the phosphate infusion.

Q. THE REGISTRANT: It's just an addition to what my actions were at that time because I was liable for this patient. If I hadn't given the medication, it would still reflect on me. I decided to go to another nurse to help because you were still very busy. Was that okay or it wasn't okay for you? Because it looked like you went and emailed to the manager and it was a grievance against me.

THE LEGAL ASSESSOR: I think it's a question, are you asking was it okay for you to ask another nurse to help you?

THE REGISTRANT: Yeah, because you know what she has written.'

In respect of page 53: paragraphs A – F of the transcript, the panel was of the view that the interventions were made by the legal assessor to clarify your questions to the witness and to convert your narrative into a question for the witness. The panel also noted that the legal assessor had asked a follow-up question to the witness, but this was derived from your narrative that you had earlier presented to the witness. The panel also noted that the legal assessor had at one point checked with you on what you were trying to ask the witness and you confirmed your question. The panel noted that you had submitted that the legal assessor had answered the questions for the witness. The panel did not find any

evidence of any unfairness or of the legal assessor answering a question on behalf of the witness.

PDF Page 53: paragraph H

PDF Page 54: paragraphs A – H of the transcript

Q. THE REGISTRANT: Okay let's get off that. As I explained before I wanted the patient, it's not about my signing off, it was the patient's safety so that's why that happened. Okay let's go to another point Mr Diven. In paragraph 13 Deputy Nurse Marlon, I approached him and was concerned about asking nurses to help me things out because I'm not signed off. He actually emailed the manager and the matron to make sure that all the Band 6 should be able to help me not to look out to one person. So that's why they sent an email. Were you are aware about what Marlon did? Because it was taking a bit too long for people to sign me off.

THE LEGAL ASSESSOR: I'm sorry can you help with what question you are actually asking?

THE REGISTRANT: Paragraph 13.

THE LEGAL ASSESSOR: Sorry?

THE REGISTRANT: 13.

THE LEGAL ASSESSOR: Paragraph 13, yes so that's agreed, yes?

THE REGISTRANT: Yes.

THE LEGAL ASSESSOR: She says, "The Deputy Nurse said all of us nurses including myself was not signed off to give medications, she needed to be assessed." So what's your question about that?

THE REGISTRANT: No, it wasn't a question I was just telling her was she aware that Deputy Marlon did that because he was getting concerned that most of the nurses were busy and including my patients, it was hard for them to keep on running up and down to help

me. So he was emailing all the deputy nurses to help me to sign me off my IVs.

Q. THE LEGAL ASSESSOR: Did you know Ms Diven why you received that email at page 13 or was it just an email you received, sorry paragraph 13? A. It was an email that I had received the day before which was why on the first when Ms Washington had an intravenous medication to give I spoke with her and we made a plan to do that IV medication as her assessment to get her signed off.

Q. THE REGISTRANT: My last question about the polyfusor, I'm just getting interested why there was an email against me about the polyfusor when you went and checked with Catherine Mew and the medication was running at the right time.

THE LEGAL ASSESSOR: What is the question you want to ask Ms Diven?

Q. THE REGISTRANT: The question is Ms Diven emailed my manager and my matron about the administration of the polyfusor. Yet after some time she was found out from Catherine Mew that everything had gone in the right way. It is coming as a complaint against me for having asked another nurse to help me to administer the medication.

Q. THE LEGAL ASSESSOR: Can you help with that in any way, Ms Diven? Was it all right to have been helped by Catherine because it was working all right because the polyfusor was working?'

The panel noted that you had submitted that the legal assessor changed the questions that you posed to the witness in this exchange. However, the panel found that the interventions from the legal assessor were to establish what your questions were from the narrative that you had presented to the witness. The panel did not find any evidence of unfairness and determined that the legal assessor had assisted the process by giving

clarity to the question and had at no time unduly influenced the witness in answering the questions.

PDF Page 57: paragraphs A – F of the transcript

'Q. Ms Diven, do you remember or you don't remember?

A. I do not remember you informing me that e-noting was down.

Q. Okay, that's fine. I'm just going, also because they are the same patient, so I'm going over to something else now. If you cannot remember about this patient, then there's no need for us to go on. Let me just get another point. Can you please clarify on paragraph 39, because I don't remember the patient you're talking about. The one

who had a drain in the neck because I don't remember looking after any patient with a drain in the neck.

A. The patient that did not receive the fluids, any NG fluids or any IV fluids.

Q. Because I can't remember looking after that patient at all.

A. It is the patient that had the elevated blood pressure.

Q. Do you have any evidence that shows that she was under my care? I can't remember which patient you're talking about.

A. Bear with me.

THE LEGAL ASSESSOR: I'm not sure whether that's being looked up, I'm not sure whether that's appropriate.

THE CASE PRESENTER: I don't think she's ...

Q. THE CHAIR: Ms Diven, can I just check where you're looking. Are you looking in your exhibits?

A. I am looking in the exhibits because I have her anaesthetic note, her med chart and I have observations that were completed by Ms Washington.

Q. THE CHAIR: Do you know what exhibit number that is please?

A. That is exhibit SD07.

Q. THE CHAIR: Page 61 for us. It might be helpful if you can talk through what we're looking at on that page.

A. On page 70.

Q. THE CHAIR: Is that the page that starts, "National Early Warning Score News"?

A. Yes.

Q. THE CHAIR: I think I see what you're saying because it's got Ms Washington's name at the bottom. Is that why you are taking us to it?

A. Yes.'

You identified this passage as another interruption. The panel noted that although the hearing was being conducted physically at the hearing centre, this witness had attended

the hearing virtually. The panel recalled that at the time when you had asked the witness the question, she appeared to start to refer to other documents to aid her memory. The panel was of the view that the interventions by the chair and the legal assessor were necessary in order to establish that the witness was not using any other document that had not been formally presented as evidence in these proceedings. This was to ensure fairness to all parties and maintain the integrity of these proceedings. The panel found that these interventions did not impede you from asking your questions of the witness.

PDF Page 84: paragraphs C – E of the transcript

'Q. Yeah. You said you were verbally handed over by Matron about me, especially about me. Do you remember the documents what Matron had handed over to you as a manager when you were taking over?

A. She handed over to me -- she handed -- one second. It was a verbal handover of all concerns and areas of the ward.

THE LEGAL ASSESSOR: Sorry, Ms Washington. What are you asking for? Are you asking for a note of the verbal handover, or are you asking for a note of when this witness became the manager?

THE REGISTRANT: Yeah, because when you become a manager and you're handing over somebody, especially with my concerns, that was my question too. There should be proper documentation about Roselyn and what will be the next stage.

Q. THE LEGAL ASSESSOR: Do you have any documentation about the handover, Ms Potter, that you had in relation to Ms Washington?

A. The handover was a verbal handover that I would have written my personal notes of about everybody and all of the things I was handed over. The specific concerns regarding Roselyn and the previous management have all been documented, and was a part, from my recollection, of the management case. Like I said earlier, it was quite difficult because I took over and there had previously been two

managers managing Roselyn, and they'd previously taken steps via the informal and formal process of capability prior to this, and that is all documented in the case.'

The panel noted your submissions that your question to the witness was straight forward and the legal assessor should not have intervened. However, the panel was of the view that the intervention was appropriately made by legal assessor in order to clarify exactly what documentation you were asking the witness about in your question as this was not clear from your original question. You were then able to follow this up and went on to ask this witness further questions on this area.

PDF Page 85: paragraphs C – E of the transcript

'Q. THE REGISTRANT: You also say they told you I was struggling with completing my competencies. Did you ask me why there was a struggle and did you try to help me in any way?

A. What did you say?

Q. You also say that they told you I was struggling with my competencies, completing my competencies. Did you ask me why there was a struggle and did you try to help me to accomplish my competencies?

A. Not prior to being handed over because I wasn't aware of it until I was handed over.

THE LEGAL ASSESSOR: Do you mean before she was handed over?

THE REGISTRANT: No, after handing over.

Q. THE LEGAL ASSESSOR: So, I think what Ms Washington is asking you is, did you know of her struggling with her competencies

after you were handed over to be in charge of her, and did you help her with that struggle?

A. Sorry, I didn't catch all you said.

Q. Did you become aware that Ms Washington was struggling with her competencies after the handover?

A. Yes, but I also was aware that she was struggling prior because I was a nurse on the ward.'

The panel was of the view that the legal assessor had intervened in order to clarify the answers of the witness as to whether she was aware of any issues regarding your competencies either before or after the handover. This intervention was made to assist the panel with timings and did not prevent you from asking your follow up questions.

PDF Page 87: paragraph H of the transcript

PDF Page 88: paragraph A - C of the transcript

'Q. You mentioned Siobhan Chambers. Exactly what did she say to you in her email, and why was Siobhan not made a witness statement to confirm what you had discussed with her? She was also one of the concerns about why things escalated from Esther to come to the Blundell Ward --

Q. THE CHAIR: Well, can we take those points one at a time because let's start with the first one. I think you wouldn't know, would you, Ms Potter, why Siobhan hadn't made a statement?'

Q. THE REGISTRANT: She knew. A. Sorry, I can't hear whoever's talking.

Q. THE CHAIR: I think we might need to move the microphone back because I think when Ms Ayling speaks, we're not picking it up. Sorry.

We're not working on the most up-to-date equipment here, so apologies.

A. No, I'm sorry.

THE CHAIR: Try again, Ms Ayling.

Q. THE LEGAL ASSESSOR: Can you help with, did you know whether or not Siobhan Chambers-Russell was making a statement to the NMC? Did you know that or not?

A. No, I wouldn't have discussed -- I haven't discussed this with anybody, so I wouldn't know if anybody was giving a statement or not.'

The panel noted that you submitted that the chair had intervened to assist the witness in answering your questions. However, the panel was of the view that the intervention made by the chair was to assist in breaking down your question which had multiple parts. The intervention made by the chair regarding another witness providing a witness statement to the panel was an NMC case management issue, recognising that this witness would not be privy to this information. The panel deemed this to be an appropriate intervention.

PDF Page 89: paragraphs B – D of the transcript

'Q. Siobahn, when I was on Esther Ward, she stopped me to go and even observe. They were decannulating a patient and she stopped

me, and she said because you had the conversation with her, I shouldn't go and even observe. Were you aware of that?

A. No, I wasn't present. I don't know what conversation she had with Siobhan.

Q. THE LEGAL ASSESSOR: Can I just help with the question. I think the question is, did you tell Siobhan that Ms Washington couldn't observe a procedure? Did you ever say that to anybody, that she couldn't observe a procedure?

A. No, it was just that she couldn't independently look after patients with tracheostomy because of the concerns.

Q. THE REGISTRANT: But this is where I was even stopped to observe. Was that part of the basic care? Because I was not even allowed to go and observe. Even students on the ward were able to go and observe except me. That was what Siobhan Chambers told me, that your manager told you can't even observe trachea.

A. No, I wouldn't say --

Q. THE LEGAL ASSESSOR: I think it's the same question, have you ever told anybody that Ms Washington could not observe a procedure?

A. No, she just wasn't allowed to provide care of tracheostomies independently.'

The panel noted that your submissions that there was no need for an intervention from the legal assessor as it had enabled the witness to avoid answering your question. The panel was of the view that the intervention from the legal assessor was made in order to clarify your narrative into a question and assist the witness in understanding your question. The

panel found that this was not as you submitted allowing the witness to ‘dodge’ the question but rather to expand on her answer.

PDF Page 90: paragraphs B – C of the transcript

‘Q. Do you remember that when all of you dispersed, the two oncology nurses went back to Esther and they stopped in the corridor because I was really crying, and one of them said, "[PRIVATE]" That’s when they tried to get a cab for me. It was Ms Diven, the two CNS, all of you in the corridor. It wasn’t that Ms Diven was, she said she was not part of the team, but she was part of the six when you dispersed from the office. I walked and I wanted to walk back to go home, and one of you said, "[PRIVATE]." Do you remember that incident?

A. I don’t know who you’re referring to as six people, because there was never six people having a conversation with you at one time and -

Q. Okay, let me be clear to you.

Q. THE CHAIR: Just let her finish. There’s quite a lot of parts to that question, so just let her finish, please.

A. I do not remember saying anyone -- I do not remember anybody saying that you were going to [PRIVATE]. I remember us saying that you were upset and we would call you a cab. But I do not remember saying that you were going to [PRIVATE], nor was there ever six people talking at you.’

The panel noted that, at the time the witness was answering your question, you interrupted the witness mid-answer. The panel was of the view that the chair had

intervened in order to enable the witness to complete her answers to your questions and you were not impeded from asking further questions of the witness.

PDF Page 90: paragraph D of the transcript

'Q. THE LEGAL ASSESSOR: Can you remember, Ms Potter, who you think was there at the time it was suggested that a cab was going to be called? Can you remember who was there?

A. No. I'm pretty sure it was in -- I'm pretty sure we said we were going to call a cab when we were in the office, because she was upset.'

The panel was of the view that the legal assessor had intervened to ask a follow-up question to the witness in order to assist the panel to understand the witness evidence and this question had come from the narrative you had previously set out to this witness. The panel noted that you proceeded to ask further questions based on the follow-up question by the legal assessor.

PDF Page 91: paragraph E of the transcript

'Q. Exactly.

A. What you're saying happened and what I'm saying happened is the same situation, but they're different. That's what I'm saying. The meeting that happened where we called the cab for you is in reference to Exhibit JP10, where it was myself and Alex following a conversation with HR, met with you.

Q. No, because the person who called the cab was Kate, one of the CNS. It wasn't Alex. Alex was not in the room. It was Ms Diven, the two clinical nurses, Matron Bav and you, and you were questioning me why I had worked and looked after the patient with a trachea. It was

that same day that six of you were interrogating me in the room. Alex was not there.

THE LEGAL ASSESSOR: Ms Washington, I think the answer is that you've put your case in relation to this. The witness says that's not right. There were never six people in the room, and she said it twice now. I think we might move on to your next question.'

The panel noted that you submitted that the legal assessor had intervened to stop the witness from answering your questions, had answered the question herself and had therefore assisted the witness in her fabrications. The panel did not find any evidence to support your submissions. It noted that you had continued to present the same question in different formats to the witness and the legal assessor had appropriately intervened as this point had already been dealt with and the legal assessor repeated the answer of the witness to you in order to demonstrate to you that your question had been answered, not to give the answer herself.

PDF Page 91: paragraphs G – H of the transcript

PDF Page 92: paragraph A – C of the transcript

Q. Is humiliating a colleague part of your managerial duties as part of the hospital policy, or part of the hospital policy? Because the way it

happened, both wards, Blundell and Esther, all of them knew of what had happened to me.

THE LEGAL ASSESSOR: I'm sorry, Ms Washington. Did you say is humiliating a colleague --

THE REGISTRANT: Part of her managerial duties.

THE LEGAL ASSESSOR: I'm afraid I wouldn't allow that question from anybody. That's not a proper question.

THE CHAIR: I agree with the legal assessor. You could the question, do you feel you humiliated me? But not is it part of the policy.

THE REGISTRANT: Okay, as a manager, was it right --

THE CHAIR: Because obviously we know the answer.

THE REGISTRANT: Okay, was it right as a manager to humiliate a colleague?

THE CHAIR: Did you say would it be right for a manager to humiliate someone; I think we know the answer to that. You can put that question, but not is it part of the policy. I think you're making a statement rather than asking a question.'

The panel noted that you submitted that the legal assessor had intervened to prevent the witness from answering your question. The panel was of the view that the intervention of the legal assessor was necessary to maintain the integrity of these proceedings given that your question was not relevant to the charges nor the facts of the case. The panel considered the nature of your question to be inappropriate and unfair to the witness.

When reaching its decision, the panel bore in mind that any decision to recall witnesses after they have completed giving their evidence is an exceptional course of action to avoid any miscarriage of justice. The panel considered in detail all the areas you raised where

you asserted that you had not been allowed to properly cross-examine these two witnesses fairly due to the interventions of the legal assessor and the chair.

In so doing, the panel considered the specific areas of the transcript that you had highlighted. The panel determined that the various interventions made by the previous legal assessor and the chair during your cross-examination were to clarify your questions, to assist you in presenting your questions to the witnesses (given that you were unrepresented) and to ensure that the witnesses understood the questions that you had asked them in the interest of fairness and justice. The panel determined that, given that there was no evidence to support your assertions that the interventions from the legal assessor and the chair prevented you from adequately cross-examining the witnesses, there was therefore no basis for a recall of either Ms Diven or Ms Potter as witnesses.

The panel was of the view that cross-examination of witnesses should not be unlimited, and any cross-examination should be relevant to the charges. It noted that recall of witnesses should not be used as an avenue to explore questions that you had forgotten to ask them during cross-examination nor to repeat previous questions that had already been answered. The panel therefore concluded that given that the witnesses had concluded their evidence and the NMC had closed its case, it would be unfair to the NMC for the witnesses to be recalled without any substantial basis, and it would be contrary to public interest for these proceedings to be delayed in such manner. The panel determined that the recall of the witnesses was not required to clear up any confusion or ambiguous points that were essential to reaching a fair decision. The panel therefore refused your application to recall witnesses.

Background

The charges arose whilst you were employed as a registered Band 5 staff nurse by Guy's and St Thomas' NHS Foundation Trust (the Trust) and King Edward VII's Hospital. On 19 May 2023, you were referred to the NMC by the Trust.

You commenced your employment at the Trust in February 2020 where you worked on both Blundell Ward (the Ward) and Esther Ward in Guys Hospital (the Hospital).

There were several concerns raised about your performance as a Band 5 nurse in the Hospital and it was asserted that you had repeatedly failed to achieve some of your basic competencies, including the administration of intravenous (IV) medication. In August 2020, you were placed on a performance improvement plan under the Trust informal capability procedure. However, despite the performance improvement plan, the following concerns were raised about your practice: on 10 September 2020, it was alleged that you administered Urokinase to Patient A via IV infusion without the required competency to do so; on 6 May 2021, it was alleged that you did not conduct the regular observations on an end-of-life patient (Patient D); on 1 June 2021, it was alleged that you administered Phosphate Polyfusor without the required competency and appropriate supervision and it was also alleged that you did not demonstrate adequate knowledge of preparing the medication; on 6 July 2021, it was alleged that you failed to escalate concerns when Patient B 's blood pressure and oxygen saturation deteriorated and it was also alleged that you failed to carry out regular observations as well as required observations before administering medication to Patient B.

There were other concerns raised in August 2020 and September 2020 where it was alleged that you failed to carry out the required safety checks/observations and escalate concerns regarding deteriorating patient and failed medical equipment. It was further alleged that, on 9 September 2021, you left a patient naked/unsupervised and did not escalate the patient's care to another nurse whilst on break.

On 27 July 2021, the first formal stage capability meeting was held when it was reported that you had allegedly failed to meet your objectives within the eight allocated weeks. As you had not met the outcomes in your action plan, it was extended for another eight weeks to 26 September 2021.

In October 2021, you were deemed to have met the objectives of your action plan as Ms Sophie Swaisland stated that there was a significant improvement in your performance. You were reverted back to being monitored informally under the capability policy for three months. However, further alleged concerns were raised about your practice including, but not limited to the following: on 15 January 2022, it was alleged that you cared for one or more patients who had altered airways when you had not been signed off as competent and you had been told that you could not care for such patients; on an unknown date, it was alleged that you stopped a heparin IV on a patient without instruction from a doctor; on 19 January 2022, in respect of Patient E, it was alleged that you failed to take reasonable/prompt actions following the patient's blood pressure medication discrepancy, where it was alleged that you failed to escalate that patient's increasing blood pressure and you withheld fluid from that patient.

As a result, you were moved to stage two of the capability process on 20 January 2022 and you were informed that from that day, you could only undertake Band 2 nursing duties and no longer work as a Band 5 nurse. It was alleged that on the same day, you threatened to punch Selina Diven (Colleague A) in the face. You resigned on 28 February 2022. The Trust capability hearing took place in your absence on 7 October 2022.

As a result of your referral to the NMC by the Trust, an interim suspension order was imposed on your nursing practice on 16 June 2023. On 19 June 2023, the NMC informed you of the interim suspension order by email. It was alleged that despite the interim suspension order, you worked at King Edward VII's Hospital as a staff nurse on 20, 21, 23 June 2023 and on 1, 2, 3 July 2023. You informed the NMC on 6 July 2023 that you had been working at a private hospital and you resigned from your nursing role on 21 August 2023.

Decision and reasons on facts

You were not represented. At the outset of the hearing, the panel heard from you, whereby you informed the panel that you made full admissions to charge 5 in its entirety

but disputed that the intention of your actions within this charge was one of a dishonest nature.

The panel therefore finds charge 5 proved in its entirety, by way of your admission.

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

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:

- Sophie Swaisland: Ward manager and Ward Sister of the Ward at the time of the incidents occurring May – September 2021.
- Selina Diven: Deputy Ward Sister of the Ward at the time of the incidents.
- Naseemah Begum: Screening Case Officer at the NMC.
- Michael Elliott: Medical doctor on the Ward in January 2022

- Jade Potter: Ward Sister and Ward manager on the Ward at the time of the incidents occurring January 2022
- Charlie Bright: Tracheostomy Clinical Nurse Specialist at the Hospital
- Amy Hill: Staff Nurse at Guys' and St' Thomas' Hospital
- Abbie Cooper: Ward Sister and temporary ward manager between August – September 2020

The witness statement of the following witness was read into the record:

- Elizabeth Jones: Case Officer at the NMC.
- Jose Lorenzo Diokno: Inpatient Nurse Manager at King Edward VII's Hospital.

The panel also heard evidence from you under oath.

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

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

Charge 1a (i)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - a. On or around 10 September 2020 in relation to Patient A:
 - i. Administered Urokinase by IV infusion without the required competency.

This charge is found proved.

The panel took into account the Datix and Administration Record for Patient A dated 11 September 2020 in which it was reported that on 10 September 2020, you had administered Urokinase by IV infusion without having completed the required competency. The panel took into consideration the oral and documentary evidence of Ms Abbie Cooper and noted that although Ms Cooper had stated in her witness statement that you attempted to administer the medication, she confirmed in her oral evidence that you had actually administered the medication to the patient without the required competency. The panel also had sight of the Record of Concern about Roselyn's Practice in which it was reported that you had administered the IV medication on 10 September 2020 without the required competency and that a Datix had been completed in that regard.

The panel noted that the Trust's Medication Administration Policy states that:

'All staff administering medicines must have undertaken relevant training and have met Trust approved competencies.... All Trust employees administering medicines to patients are accountable for their actions and must seek advice or assistance if they are required to prepare, administer or check a medicine which is unfamiliar to them.'

The panel noted that you denied the allegation. The panel noted that although you initially denied the allegation in your first Registrant Response bundle, in your updated Response to the charges bundle, you presented a different position in that you had assumed because nurses had administered Urokinase at your previous employment, you were *'meant to do it'* as no one in the Hospital had explained to you that the medication was administered by either the doctor or the IV team. In your oral evidence, you stated that you presumed that you were expected to do it, if you had known that you were not competent, you would not have done it but you presumed you could and should based on your experience at your previous employment, where doctors never administered Urokinase as this was done by nurses. You also stated that you were sorry for not having read all parts of the Medication Administration Policy.

You also admitted during your oral evidence that you were not competent to administer an IV infusion at the time of the incident but stated that you were allowed to do it with supervision.

The panel noted that Ms Cooper stated during her oral evidence that you were required to complete the required competency at the Trust even if you had passed such competency in your previous workplace or university. She stated that you were required to liaise with the IV team and complete supervised assessments in administering such type of medication before you could be deemed competent. The panel noted that in the Administration Record for Patient A, you are shown as the nurse that administered the Urokinase on 10 September 2020.

The panel was of the view that although you stated that you had not read the entirety of the Trust's Medication Administration Policy, you were under a duty as a Band 5 nurse at the Trust to be aware of the provisions of this policy. Therefore, you ought to have known that you could not administer Urokinase by IV infusion without the required competency. The panel noted that, in the List of Competencies contained in your Registrant Response bundle, you were not signed off as competent in the administration of IV medication and

therefore, you were fully aware that you did not have the required competency as required by this Trust when you administered the medication.

The panel determined that you were under an obligation to read and adhere to the Medication Administration Policy which you admitted that you did not do. The panel found that you were aware that you were not signed off competent at this time, and yet you proceeded to administer the medication.

The panel found your explanations to be extremely inconsistent. Taking all of its findings together, the panel was satisfied that it was more likely than not that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you administered Urokinase by IV infusion to Patient A without the required competency on 10 September 2020. Accordingly, the panel found charge 1a proved.

Charge 1b (i)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - b. On or around 1 June 2021 in relation to Patient C
 - i. Did not demonstrate adequate knowledge of preparing the Phosphate Polyfusor IV;

This charge is found proved

The panel accepted that Patient B required a Phosphate Polyfusor IV and Ms Diven asked you to do the infusion under her supervision as part of your IV medication administration competency assessment on 1 June 2021. The panel took into consideration the local

statement of Ms Diven contained in her email to Ms Swaisland dated 5 June 2021 in which she stated:

..... Also with her usage of med chart and reading all parts of the prescription is still not at an acceptable standard. One of her patients needed to have a phosphate polyfusor, the dose 20mmol. Roselyn had commented to me that the prescription did not say how long to give it over. I pointed out to her that it was in the prescribing instructions to give over 6 hours. I then got the polyfusor for her and Roselyn said does she get the whole thing. I made her read out to me the dose on med chart and got her to look at how much phosphate was in the polyfusor and to work out the amount needed...'

The panel noted that Ms Diven confirmed this account of the incident in her witness statement and her oral evidence that you did not demonstrate adequate knowledge of preparing the IV medication to the required volume as necessitated by the prescription. Ms Diven also confirmed in her oral evidence that you had not been signed off as competent to administer IV medication.

The panel noted that you denied the allegation as you stated in your Registrant Response to the charges and in your oral evidence that you had reasonable knowledge of preparing the IV medication.

The panel noted that Ms Diven was clear and consistent in both her oral and documentary evidence that for a Band 5 nurse with more than 10 years' experience, you did not demonstrate adequate knowledge of reading the medication administration record and she stated that she had to assist you in calculating the correct volume of medication. Ms Diven told the panel that you should have been able to calculate the correct volume of medication on your own and you should not have been seeking assistance from her. To do this was part of the assessment.

The panel found Ms Diven to be a credible witness who demonstrated consistency in her account which was supported by contemporaneous note of her concern of you asking if the patient should be given a whole bottle of Phosphate Polyfusor IV. The panel noted your response to this charge focused solely on the administration of the medication and you gave no account of the difficulties in its preparation.

Based on the evidence before it, the panel was satisfied that it was more likely than not that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that, in relation to Patient C, you did not demonstrate adequate knowledge of preparing the Phosphate Polyfusor IV on 1 June 2021. Accordingly, the panel found charge 1b (i) proved.

Charges 1b (ii) and 1b (iii)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - b. On or around 1 June 2021 in relation to Patient C
 - ii. Administered Phosphate Polyfusor without the required competency;
 - iii. Administered Phosphate Polyfusor without appropriate supervision;

These charges are found proved

The panel considered these sub-charges together. The panel took into consideration the local statement of Ms Diven contained in her email to Ms Swaisland dated 5 June 2021 in which she stated:

..... I told Roselyn that once she was ready to give it to get me and I could do the outstanding summative assessment, Roselyn wnet (sic)

to get the phosphate ready, she was taking a long time and I went to do something else while I was waiting. In the mean time she got Katie to check the phosphate and watch her put it up. All Roselyn would say was that I was busy and she didn't want to interrupt. I can't remember what I was doing but it was something that I would have been able to set aside so I could focus on the assessment...'

In oral evidence to the panel, you stated that you went to Ms Diven approximately six times for her to come and assess you and that she refused to do so because she said she was busy. However, Ms Diven stated that she had no recollection of you approaching her at all. You told the panel that because Ms Diven was too busy, you had asked another nurse to assist. You also told the panel that you felt that you put the patient's safety above the need to be signed off. You told the panel that you did administer Phosphate Polyfusor IV and you had requested help to make sure that the patient had received the medication at the right time.

You told the panel during your oral evidence that the Phosphate Polyfusor Medusa administration record was an electronic record and given that you were the first nurse to log into the system before Catherine Mew, the record erroneously showed that you signed as the nurse that administered the IV medication and Catherine Mew signed as counter signatory.

The panel noted that Ms Diven confirmed her account of the incident in her witness statement and her oral evidence that you proceeded to administer the IV medication without her being there and without supervision. She told the panel that she had gone to see you to find out what was happening because she noted that it had been a number of minutes and that was when you told her that the medication had been given.

The panel had sight of the Phosphate Polyfusor Medusa administration record which showed that you signed as the nurse that administered the IV medication whilst another staff nurse Catherine Mew countersigned as a witness.

The panel rejected your evidence as it found your explanations to be implausible and not aligned with the documentary evidence on the electronic record which you had signed as the administrator of the medication. The panel accepted Ms Diven's evidence both in regard to you not approaching her to witness your administration of the medication and that you proceeded to do so without the required supervision.

The panel was of the view that although Ms Diven did not witness you administering the IV medication, the Phosphate Polyfusor Medusa administration record, which was an official contemporaneous record, clearly showed that you signed as the nurse that administered the IV medication and another staff nurse Catherine Mew countersigned as a witness. It was your duty as a nurse to ensure that all records were accurately recorded and any error was corrected. The panel determined that the electronic record accurately reflected that you had administered the Phosphate Polyfusor IV. Furthermore, the panel noted that Ms Diven confirmed in her witness statement that all IV medications needed to be checked by two nurses with the required competency which did not include you as you did not possess the required competency.

The panel was also of the view that given that Ms Diven had asked you to do the infusion under her supervision as part of your IV medication administration competency assessment, you should have waited for Ms Diven to supervise you to administer the medication. The panel further noted that Ms Diven stated that Catherine Mew was not a Band 6 nurse who could supervise you. The panel found that you had taken your own decision to override the instructions of your supervisor and acted outside of your competence. This placed Patient C at risk of harm.

Based on the evidence before it, the panel was satisfied that it was more likely than not that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that, in relation to Patient C, you administered Phosphate Polyfusor IV on 1 June 2021 without the required competency

and without adequate supervision. Accordingly, the panel found charges 1b (ii) and 1b (iii) both proved.

Charges 1c (i) 1c (ii) and 1c (iii)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - c. On or around 6 July 2021 in relation to Patient B:
 - i. Provided medication to the patient without carrying out the required observations;
 - ii. Did not carry out regular observations on the patient;
 - iii. Did not escalate concerns when the patient's blood pressure and / or oxygen saturation deteriorated

These charges are found NOT proved

The panel considered these sub-charges together. The panel took into account the witness statement of Ms Swaisland in which she stated:

'It was brought to my attention verbally by a doctor and nurse in charge of the shift on 6 July 2021 (I cannot recall who specifically) that Ms Washington failed to check the vital signs of a patient (I do not know which patient) prior to administering antihypertensives. I am unsure if this requirement is in the trust medication policy but basic expectation of a qualified nurse who has passed their medications assessment to know to check certain vital signs prior to administering certain medications.... Ms Washington administered this medication

at 17:21 despite the only observations being recorded on eNoting at 10:48 and 19:08....

Mrs Washington made an addendum note on the enoting system after the patient had the hypotensive episode and noted that she had checked the patient's blood pressure before she administered the medication and it was stable. However, she hadn't written it on the eNoting neither did she make a note of what the blood pressure was. There is no way to know whether she did actually check the blood pressure or not....'

The panel took into consideration the oral and documentary evidence of Dr Elliott in which he stated that on 6 July 2021 whilst he was walking along the Ward, he looked into Patient B's room and there was a blood pressure cuff on the patient's arm which showed a low reading of 55/32mmHg but the patient was unattended with the cuff and a sats probe on showing a low oxygen saturation of 88%. Dr Elliot stated that you were outside the patient's room documenting your notes for the day. He further stated that he shouted for help and when you entered the room, you stood there for a while, and you looked surprised when he told you about the low blood pressure and oxygen levels and you did nothing.

The panel noted that Dr Elliott also stated that the last set of observations on Patient B were conducted at 10:50 before he found the patient and there was a nine-hour gap in observations, but he would have expected it to be done a minimum of four hourly. He stated that the patient had undergone major head and neck surgery and should have been having more frequent observations. Dr Elliott further stated that he expected observations to have been taken prior to the administration of antihypertensives to Patient B, but they were not taken. He stated that he did not know whether there is a policy that stipulated for blood pressure to be checked prior to the administration of antihypertensives but felt that it was common sense and a general nursing requirement to do so.

The panel had sight of Patient B's Clinical Records, and it noted that you administered the medication to Patient B on 6 July 2021 at 17:21 but that there was no record on the National Early Warning Score (NEWS) chart that you had carried out observations on Patient B around that time. However, the panel noted that you had made an addendum note to Patient B's Clinical Records stating that you had carried out the patient's blood pressure observation before administering the evening medication.

The panel noted that you denied the allegations. You stated in your Registrant Responses to the charges that you had carried out regular observations on Patient B and that when you noticed Patient B's blood pressure was low; you had decided to contact the doctor. You stated that:

'When the patient opened his bowels (type 7) he was not feeling well. So I reported the BP and the systolic was 87. That was when I decided to contact the doctor. Apparently, the doctor was on the ward coming through when he also recognised the low blood pressure.'

You told the panel during your oral evidence that you were unaware that Patient B's blood pressure had dropped further until you were informed by Dr Elliott who was already with the patient.

In respect of charge 1c (i), the panel noted that there was no evidence before it to indicate that there was a Trust policy or a medical instruction that stipulated for observations to be carried out before the administration of Patient B's antihypertensive medication. The panel noted that both Dr Elliott and Ms Swaisland confirmed in their respective evidence that there was no such policy, but it was a general good practice for such observations to be conducted. The panel further noted that there was evidence in the addendum note to Patient B's Clinical Records that you had conducted the required blood pressure observation before administering the medication to the patient.

In this regard, the panel determined that, whilst there was evidence of what might be good practice, there was insufficient evidence that you had a duty to carry out observations before providing medication to Patient B. The panel was therefore not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1c (i) not proved.

In respect of charge 1c (ii), the panel considered the NEWS chart in Patient B's Clinical Records. It noted that there was a nine-hour gap on 6 July 2021 between the observations conducted at 10:48 and those taken at 19:08. The panel further noted that there was also a nine-hour gap on 5 July 2021 (the day before the alleged incident) between the observations conducted at 8:48 and those taken at 17:22 but there was no concern raised about the sequence of those observations. The panel therefore determined that there was no evidence to demonstrate that more regular observations should have been conducted and noted the evidence of Ms Swaisland that she did not know the policy that set out the required sequence of observations to be conducted in these circumstances.

Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1c (ii) not proved.

In respect of charge 1c (iii), the panel was of the view that there would only be a duty on you to escalate concerns if you were aware of Patient B's deteriorating blood pressure and oxygen saturation as the patient's allocated nurse. The panel noted that Dr Elliott confirmed in both his oral and documentary evidence that when he noticed Patient B's deteriorating blood pressure and oxygen saturation, you were outside the patient's room documenting your notes and when he informed you about the concerns, you looked surprised. In this regard, the panel determined that given that you were not aware of Patient B's deteriorating blood pressure and oxygen saturation prior to being informed by Dr Elliott, there was no reasonable expectation on you to have escalated concerns that you were not aware of. The panel also found that as the doctor was on the scene at the point you became aware of the concerns, you would not be required to escalate this situation further.

Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1c (iii) not proved.

Charge 1d (i)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - d. On or around 6 May 2021 In relation to Patient D:
 - i. Did not conduct regular observations when you were required to do so

This charge is found proved

The panel took into account the witness statement of Ms Diven in which she stated:

'...On this day, at the beginning of the shift Ms Washington was told that her responsibilities included caring for an EOL patient (Patient D) I therefore ensured that Ms Washington knew what was needed for the patient and how to do it. I then left her, and checked again at the end of the shift to make sure it had been done, and I saw that Ms Washington had not documented anything for the patient during those seven hours.... the symptom observation chart was completed at 12:35 on 6 May 2021 and was not completed again until 19:40 on 6 May 2021. It should have been completed every 4 hours in line with the policy.... Ms Washington therefore failed to complete the symptom observation chart and carry out four hourly checks which are documented in the nursing notes and is called the 'plan and do'.

The panel had sight of the local statement of Ms Diven dated 6 May 2021 in which she provided feedback via email to you and highlighted that you had not conducted four-hourly observations on Patient D as there was a time gap on the system observation chart.

The panel had regard to the Trust's Symptom Control Guidelines for Adults in the Last Days of Life, and the Trust's The Priorities for Care of the Dying Person: Trust Protocol for Care in the Last Days of Life. The panel noted that both Trust policies stated that four-hourly observations should be conducted on patients who were at end of life (EOL).

The panel considered Patient D's Clinical Records, and it noted that, on the symptom observation chart, there was a time gap between 12:35 and 19:40 on 6 May 2021 in which there was no observation recorded to have been conducted on Patient D. It further noted that Patient D was an EOL patient.

The panel took into consideration that you denied the allegation as you stated in your Registrant Responses to the Charges that the assessments observations for Patient D were done by different people at different times of the day on 6 May 2021. You further stated that there were two Band 6 nurses who were involved in the patient's care and that the observation chart was not clear as it runs from 05 May 2021 to 07 May 2023.

The panel noted that your oral evidence changed from initially asserting that for EOL patients, there was no requirement to do end of life observations at all to you conceding that there was a requirement for four-hourly observations. In your oral evidence, whilst you asserted that there were two other Band 6 nurses also responsible for Patient D, you accepted that you were the nurse allocated to care for Patient D on 6 May 2021 and that a minimum of four-hourly observations should be conducted on end-of-life patients. The panel noted that another nurse Veronica Malani had conducted an assessment at 13:30 but Patient D had no other assessments during your shift. The panel also noted that Ms Diven confirmed in her oral evidence that your shift hours on the Ward were between 7:30 and 20:00 and that even if other nurses may have conducted observations, it was your

responsibility as the nurse in charge of Patient D to ensure that four-hourly observations were conducted on Patient D and recorded on the symptom observation chart.

The panel accepted the account of Ms Diven as she was clear and consistent in both her oral and documentary evidence that you did not conduct regular observations on Patient D on 6 May 2021. The panel was of the view that given that you were the nurse in charge of Patient D's care on the day of the incident, there was a duty on you to conduct or ensure that four-hourly observations on Patient D were performed in line with the Trust's policies.

Based on the evidence before it, the panel was satisfied that it was more likely than not that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that, in relation to Patient D, you did not conduct regular observations when you were required to do so on 6 May 2021.

Accordingly, the panel found charge 1d (i) proved.

Charges 1e (i) 1e (ii) and 1e (iii)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - e. On or around 19 January 2022 in relation to Patient E:
 - i. Did not take reasonable and/ or prompt actions following the patient's blood pressure medication discrepancy;
 - ii. Did not escalate the patient's increasing blood pressure;
 - iii. Unnecessarily withheld fluid from the patient;

These charges are found NOT proved

The panel considered these sub-charges together. The panel took into account the witness statement of Ms Diven in which she stated:

'...Ms Washington completed the patient's blood pressure in the morning at 09:35 and it was 152/84, which was something to be concerned about since the patient was taking medication for high blood pressure. This is concerning because that is high blood pressure. The NHS state that high blood pressure is considered to be from 140/90. However, the patient's blood pressure was not high enough to be flagged by the NEWS system. This did not need escalating at the time but Ms Washington should have questioned it, especially because the patient had told her that she takes medication for high blood pressure. I knew this as Ms Washington told me that the patient told her this although I don't know what time during the shift the patient told her this. Ms Washington told me this at the end of the day. The patient did not know what blood pressure medication she was on.

As the patient had said that they were taking blood pressure medication and their blood pressure was high, I would have expected Ms Washington to have noticed that the medication chart did not have a prescribed blood pressure medication on it. She should have highlighted this to me, the ward pharmacist or a doctor and we would have been able to assist Ms Washington to find the information of which blood pressure medication and dosage the patient was on so that her medication could be administered and her blood pressure could be reduced. Ms Washington did not take any action.

Ms Washington should have known that it was possible to find this information out, but she had not taken the necessary steps. Later on in the evening the blood pressure was taken again and it was 178/87. This is still high. Ms Washington told me about this high blood

pressure and that the patient had informed her that she takes blood pressure medication.'

'In addition to this, when I looked at the patient's chart I saw that the patient had not been given any fluids through her tube. I asked Ms Washington why this was the case and she said that she had not given water because she was concerned about the patient's blood pressure being high.... This meant that Ms Washington had denied a patient her basic human right of having fluids. She should have given the patient water from the NG tube or intravenously through the cannula that the patient had.'

The panel had sight of Patient E's Clinical Records, and it noted the blood pressure readings for Patient E was 152/84mmHg at 9:35 on 19 January 2022 and at 17:32 on the same day, it was 178/87mmHg.

The panel noted that you denied the allegations. You stated in your Registrant Responses to the Charges that, on the day of the alleged incident, Ms Diven took you off your duties on the Ward and sent you to the line manager for a meeting regarding your coronavirus vaccination. You stated that Ms Diven had told you she would take over your duties in respect of Patient E whilst you were at the meeting, but when you returned, she had not done anything including taking steps to escalate Patient E. You stated that you rechecked Patient E's blood pressure and noted that it had elevated. You stated that you escalated the elevated blood pressure to Ms Diven and also told her that the blood pressure medication for Patient E had not been yet prescribed on the system. You stated that Ms Diven did not contact the doctors or even bother to find out why there was no medication on the system yet.

In respect of charge 1e (i), the panel considered the ordinary meaning of '*discrepancy*' to connote an inconsistency. The panel noted that Ms Diven had stated that the blood pressure medication discrepancy was that Patient E had stated that she was taking blood

pressure medication but did not know what it was and you were expected to have taken action to find out what blood pressure medication that Patient E was taking. However, the panel was of the view that such a scenario did not indicate that there was any blood pressure medication discrepancy. The panel noted that the NMC did not provide further evidence to specifically identify what the blood pressure medication discrepancy was and Ms Diven also did not identify the discrepancy during her oral evidence.

In this regard, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1e (i) not proved.

In respect of charge 1e (ii), the panel took into account that Ms Diven stated that when Patient E's blood pressure was 152/84mmHg in the morning, you should have questioned it. However, the panel noted that Ms Diven had also stated that Patient E's blood pressure in the morning was not high enough to be flagged by the National Early Warning Score (NEWS) system and therefore, did not need escalating at the time. The panel further noted that Ms Diven confirmed in her evidence that you had escalated to her that Patient E's blood pressure had increased to 178/87mmHg in the evening, which was high.

The panel was therefore of the view that, based on the evidence before it, you had escalated Patient E's increasing blood pressure. Accordingly, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1e (ii) not proved.

In respect of charge 1e (iii), the panel was of the view that the mischief of the charge was that you deliberately withheld fluid from Patient E without reasonable cause. The panel noted that there was a difference between a failure to administer fluid and deliberately withholding fluid from Patient E. The panel further noted that there was no evidence that Patient E had requested water and you deliberately withheld fluid or that there was an instruction in Patient E's clinical records that she should be given fluid at that time and you deliberately withheld fluid. In this regard, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1e (iii) not proved.

Charge 1f

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - f. On or around 19 September 2020, did not carry out the required safety checks and/ or observations whilst carrying out a blood transfusion;

This charge is found NOT proved

The panel took into account the witness statement of Ms Cooper in which she stated:

'...On 19 September 2020 there was a further incident involving Roselyn and medication. Roselyn was assisting with a blood transfusion, whilst completing this blood transfusion Roselyn did not display adequate knowledge of how to complete a blood transfusion. Before any blood transfusion could take place, we would usually Conduct Observations and then safety checks. When Roselyn was doing to blood transfusion, she did not conduct the safety checks and then was unable to use the blood transfusion kit...'

The panel had sight of the Record of Concern about your practice in which Ms Cooper provided feedback on 19 September 2020 stating:

'Feedback 19/9/20 - Blood transfusion conduct. Did not display adequate knowledge Of Trust Policy on Blood Transfusion administration/safety checks. Required direct prompting and support under supervision, despite having completed the Trust Transfusion

training fully online indicating a level of knowledge that should be held prior to practice under supervision...'

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that you had not yet been signed off with regard to blood transfusion procedures and you were not allowed to conduct such procedures. You stated that no patient was identified and there was no evidence of any hospital document record that showed that you carried out a blood transfusion. You stated that the full details regarding the affected patient were not provided to you to enable you to make a proper response to this allegation.

The panel had sight of your list of competencies document which showed that you had not been signed off on conducting blood transfusions. The panel noted that although Ms Cooper confirmed that she had written the feedback dated 19 September 2020 contained in the Record of Concern, she stated during her oral evidence that she was unsure whether she had directly supervised you on the day of the alleged incident or that it was reported to her by another staff member. The panel further noted that there was no evidence to identify the patient in this charge, no evidence of a clinical record to show that the required safety checks and observations were not conducted and no Trust policy or evidence provided to the panel to identify the safety checks and observations that were required to be conducted whilst conducting a blood transfusion.

The panel noted that Ms Cooper's feedback in the Record of Concern only stated that you did not demonstrate adequate knowledge of the Trust Policy on Blood Transfusion administration/safety checks and that you needed prompts and support under supervision whilst carrying out a blood transfusion. The panel was of the view that it was not identified in the feedback that you did not conduct the required safety checks and observations.

In light of insufficient evidence, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1f not proved.

Charge 1g

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - g. On a date unknown, stopped a Heparin IV without instruction from a Doctor to do so

This charge is found NOT proved

The panel took into account the witness statement of Ms Potter in which she stated:

'...Prior to being Roselyn's line manager I was working as the nurse in charge on a night shift with her, I cannot recall exactly when this happened. At some point during the shift Roselyn stopped an infusion of heparin for one of her patients based on some test results the patient had received.... Roselyn then came to inform me that she had stopped the heparin. I then asked Roselyn why she had stopped the heparin and she replied that she just thought it needed to be stopped. In response I told her that this needed to be raised with a doctor. ...'

'Roselyn should not have stopped the infusion without speaking to a doctor. If she had concerns about the patient then she should have escalated to a doctor and waited for them to come and review the patient. Roselyn should have known to do this as it was contained in the Hospitals medication administration policy...'

The panel noted that you denied the allegation. You stated that the date of the alleged incident and the details of the patient in this charge were not provided to you to enable you

respond to the allegation. You stated that there was no evidence of any hospital document record that showed that you stopped a Heparin IV.

The panel had sight of the Hospital Medication Administration policy. However, the panel could not identify a specific provision in the policy that stipulated that you could not stop a Heparin IV without instruction from a doctor. The panel further noted that there was no evidence to identify the patient in this charge, no evidence of an incident report/Datix detailing the alleged incident and no clinical record to show that you stopped the Heparin IV. The panel also noted that Ms Potter could not provide such information during her oral evidence. Whilst the panel did not question the credibility of Ms Potter's evidence, it was of the view that it was not fair that the relevant information in relation to the date of the alleged incident, the patient or any other documentary evidence was not provided to you to enable you to adequately respond to this allegation.

In light of insufficient evidence, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1g not proved.

Charge 1h

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - h. In or around August 2020, did not take any and / or reasonable steps to escalate a deteriorating patient

This charge is found NOT proved

The panel took into account the witness statement of Ms Cooper in which she stated:

‘...In August 2020, I cannot recall the exact date, a patient with a chest drain was brought to the Ward... I think Roselyn volunteered herself to look after this patient as she had previously worked with thoracic patients. However, this patient became increasingly unwell and Roselyn failed to escalate concerns relating to the patient. I believe when observations were conducted this patient had a National Early Warning Score (NEWS) above 5...’

The panel had sight of the Trust’s Responding to Acutely Unwell Patients Policy which provided that if the NEWS goes above 5, then the patient needs to be escalated to critical care outreach and the responsible doctors.

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that when the patient was allocated to you, you noticed the deteriorating condition of the patient, and you immediately contacted the thoracic senior nurse. You stated that the thoracic nurse did not respond to you well and when she refused to help, you went to the nurse in charge to report the situation and she contacted the critical care team.

The panel noted that there was no evidence to identify the patient in this charge, no evidence of a clinical record to show that the patient’s health condition deteriorated and no evidence of an incident report/Datix detailing the alleged incident.

In light of insufficient evidence, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charge 1h not proved.

Charges 1i (i) and 1i (ii)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy’s and St Thomas’ Hospital, failed to demonstrate the standards of knowledge, skill and

judgement required to practice without supervision as a Band 5 nurse in that you:

- i. On or around 26 September 2020:
 - i. Did not take any and/ or reasonable steps to escalate failed medical equipment;
 - ii. Did not take any and/or reasonable steps to obtain an alternative form of equipment for the patient;

These charges are found proved

The panel considered these sub-charges together. The panel took into account the witness statement of Ms Cooper in which she stated:

‘A further incident relating to escalation of patient care occurred on 26 September 2020 Roselyn was caring for a patient who had a pressure relieving mattress, an inflated mattress filled with air.... As the pressure relieving mattress was filled with air there was a chance it could deflate, usually when this happened the mattress would bleep to let the staff know that it needed reflatting. However, on 26 September 2020 the mattress fully deflated during Roselyn’s shift leaving the patient lying on just the metal bed frame. After becoming aware of this incident, I spoke with the patient and they told me that they had told Roselyn that the mattress was bleeping. In response Roselyn had told the patient that they were on bed rest and so she was unable to move them in order to fix the mattress. This was incorrect as the patient had previously been sitting and walking around and it was not documented in any of their notes that they were on bed rest. In addition, Roselyn

had not handed over to the next shift that the pressure relieving mattress was broken.'

'If a patient's pressure relieving mattress deflated then Roselyn should have escalated this as soon as possible to the nurse in charge or someone more senior on the Ward. Roselyn should have also seen if a foam mattress was available for the patient to temporarily lie on whilst the other one was fixed, this would have ensured the patient was comfortable... A formal apology was sent to the patient following this incident. I also spoke with Roselyn about this incident and she replied that she did not know anything about this incident.'

The panel had sight of the Record of Concern about your practice in which Ms Cooper provided feedback on 26 September 2020 stating:

'26/09/2020 — Patient remained on completely deflated air mattress post GCCU step- down. Mattress not escalated and patient left in discomfort for the entire nightshift, patient reports mentioning this at beginning of the Night shift. Patient also informed incorrectly that he was to remain on bedrest, despite having been mobilised on GCCU prior to transfer. Disregarding patient handover and leaving patient in pain for a full shift, requiring DOC conversation and apologies to the patient in order to avoid a complaint.'

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that no patient was identified, there was no clinical record and there was no evidence to show how any patient was affected or what medical conditions they had at the time of the alleged incident.

The panel noted that there was no evidence to identify the patient in this charge, no evidence of a clinical record and no evidence of an incident report/Datix detailing the

alleged incident. However, the panel was of the view that Ms Cooper provided detailed, clear and consistent oral and documentary evidence of the incident. She told the panel that a formal apology had been given to the patient and also that she had noted this incident in her Record of Concerns and had spoken to you about it. In this regard, the panel accepted the evidence of Ms Cooper.

Based on the evidence before it, the panel was satisfied that it was more likely than not that you failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that on 26 September 2020, you did not take any steps to escalate failed medical equipment and to obtain an alternative form of equipment for the patient. Accordingly, the panel found charges 1i (i) and 1i (ii) proved.

Charges 1j (i) and 1j (ii)

1. Between 2 March 2020 and 7 October 2022 whilst employed at Guy's and St Thomas' Hospital, failed to demonstrate the standards of knowledge, skill and judgement required to practice without supervision as a Band 5 nurse in that you:
 - j. On or around 9 September 2021:
 - i. Left an unknown patient naked and / or unsupervised;
 - ii. Did not escalate the patients care to another nurse whilst on break;

These charges are found NOT proved

The panel considered these sub-charges together. The panel took into account the Trust's Management Case in which the following was stated:

'Incident — 09/09/2021 Patient Shouting for help as Roselyn left patient naked in bed with a towel covering her body to go on her break'

The panel took into consideration that Ms Potter provided a detailed account of the alleged incident in her oral evidence. She stated that the alleged incident was reported to her by a staff member on the Ward and she spoke to the patient. Ms Potter further stated that the patient told her that whilst she was being washed, you left the room or the nurse left the room and she was left naked. Ms Potter stated that she expected you to have asked another nurse to take over the care of the patient if you were leaving for an extended period and to ensure the patient was adequately covered.

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that no patient was identified in these charges, no details of the ward where the alleged incident occurred was provided and the facts in relation to the charges were insufficient.

The panel found that there was insufficient evidence of the alleged incident, Ms Potter did not mention the alleged incident in her witness statement and although she stated that she spoke to the patient, there was no formal written statement obtained. The panel further noted that no Datix or incident report of the alleged incident was provided to it and the management case stated that a towel was covering the patient, which contradicted the evidence of Ms Potter that the patient was left naked. Given that Ms Potter stated that the patient had told her that you or the nurse left the room, the panel was of the view that it was unclear if you were the nurse that left the patient or it was another nurse. The panel therefore could not be satisfied on the basis of Ms Potter's evidence that you were the nurse involved in this incident.

In light of insufficient evidence, the panel was not satisfied that the NMC had discharged the burden of proof. It therefore found charges 1j (i) and 1j (ii) not proved.

Charges 2a and 2b

2. On or around 15 January 2022, cared for one or more patients who had altered airways:
 - a) when not being signed off as being competent to care for such patients, and/or
 - b) having been informed previously that you could not care for such patients.

These charges are found proved

The panel considered these sub-charges together. The panel took into account the witness statement of Ms Bright in which she stated:

'Mrs Washington had not been signed off tracheostomies. It had been reported to me that concerns had been raised by her managers that a point had not been reached that her managers were confident with her tracheostomy skills and were concerned about her safety with tracheostomy patients despite ample opportunity. It was therefore decided by Ms Banham, Sophie Swaisland, another of Mrs Washington's line managers and I, that she should not be allocated tracheostomy patients while we reviewed her training needs.'

'On 12 January 2022, ... Mrs Washington approached me in my office...I recall that Mrs Washington was initially upset and confused when she came to find me. She wanted to know why her airway patients had been reallocated.... I explained to her that she was not signed off to look after these patients independently and there was no airway trained staff available to supervise her skills on today's shift alone, especially with a patient who was requiring deep suctioning. I discussed with her how we could support her to become competent in

tracheostomy skills. I made it clear to her that from that day onwards, she was not to look after airway patients.'

'From my recollection, Mrs Washington seemed to understand that she was not to be allocated airway patients. I cannot recall her exact response but I thought she understood the direction because I recall that I did not have any concerns that she had not understood that she was not to be allocated airway patients. I recall that the discussion ended pleasantly and and (sic) she seemed open to exploring opportunities for training.'

The panel had sight of the email from Ms Bright to senior nurses on Blundell Ward and Esther Ward Deputy Sister dated 13 January 2022 in which she informed them that you should not be allocated tracheostomy patients and that she had informed you about the restriction on the previous day. The panel also had sight of the email chain between Ms Bright and senior nurses on the Ward including Ms Potter dated 12 January 2022, 13 January 2022 and 19 January 2022 respectively in which it was stated that you were not to be allocated tracheostomy patients and alleged concerns were raised about your care for tracheostomy patients.

The panel found that Ms Bright was consistent in both her witness statement and her oral evidence that in her conversation with you on 12 January 2022 that she made it very clear to you that you were not to care for patients with altered airways. The panel did not consider this to be a difficult instruction to understand.

The panel took into account the witness statement of Ms Potter in which she stated:

'On 12 January 2022 I was approached on the Ward by the tracheostomy clinical nurse specialist, Charlie Bright. Charlie informed me that she was concerned about Roselyn looking after patients with tracheostomy's. Charlie raised concerns regarding Roselyn not having

the adequate training or skills to look after altered airway patients safely, showing inadequate skills surrounding deep Suctioning, escalation of care, and emergency management if required which is essential for looking after these patients. Consequently, Charlie advised me that Roselyn should not be allocated any tracheostomy patients until she had completed the study day again in order to restart/complete competencies on caring for tracheostomy patients. After speaking with Charlie, Roselyn was informed that she should not be allocated any tracheostomy patients. Roselyn's practice was reduced to only providing basic care, such as observations. The rest of the nursing team were also made aware of this...'

'On 20 January 2022 I had a meeting with Roselyn, ... During this meeting I asked Roselyn about moving the patient with the tracheostomy. In response Roselyn said that the restriction had not been communicated to her properly. She thought that she was allowed to look after any green patients.... Roselyn said that it was the nurse in charges fault as she thought she could look after any green patients irrespective of their airway.'

The panel had sight of the Meeting Notes dated 23 February 2022 in which Ms Potter had discussed the incident with you. The panel also had sight of the Managements Case in which the incident was recorded.

The panel took into account the witness statement of Ms Hill in which she stated:

'I worked a night shift on the Ward with Ms Washington from 20:00 on Saturday 15 January 2022 until 08:00 on Sunday 16 January 2022.....Ms Washington chose to take the patients she had pointed to on the board which included one patient with a tracheostomy and one

with a laryngectomy.... Ms Washington had overall responsibility for these patients overnight during the night shift....'

'In the morning, at the end of the night shift, another member of staff came on duty (I cannot recall who due to passage of time) and they asked me why Ms Washington had been caring for airway patients overnight as she was not allowed to care for them. They knew that she had been caring for altered airway patients as the board showed that she was allocated these patients.... From memory, I believe the staff member informed me that Ms Washington had had her competencies relating to altered airway patients revoked due to providing unsafe care and that she had been told by the leadership team that she was not allowed to look after them. If I had known this, then I would not have allowed Ms Washington to take these patients...'

The panel noted that Ms Hill confirmed this account of the incident in her local statement via an email to Ms Potter dated 17 January 2022 and in her oral evidence.

The panel also had sight of an email from Chevone Chambers Russell (Ward Sister on Esther Ward) to you dated 19 January 2022. The email contained a summary of the meeting she held with you in which the concern that you had cared for a patient with an altered airway on 15 January 2022 was discussed with you. The panel found this to represent a contemporaneous record of this allegation.

The panel had regard to the Trust's Ward based Tracheostomy Care Bundle which stated that the policy was intended to guide and support care being delivered to tracheostomy patients by staff who have been deemed competent to do so.

The panel noted that you denied the allegation. Your position was that you were asked to assist on Esther Ward because they were short-staffed and you had volunteered to take two patients who were not marked red. The panel found that your responses to all aspects

of these charges were inconsistent and often not relevant to the charges. Your position fluctuated as to whether you had or had not been made aware that you could not care for altered airways patients, but you accepted that you had cared for two patients on Esther Ward who had altered airways.

The panel had sight of an email from Ms Swaisland to you dated 9 August 2021 which contained a schedule for 1:1 sessions to enable you to work towards your tracheostomy competencies. The panel noted that there was a hand-written note scribbled on the email in which you stated that you had only attended the session on 24 August 2021 as they told you that they were too busy to meet you for other sessions. It was Ms Bright's evidence to the panel that it was you that did not attend all the training sessions that you had been offered and this was part of the problem. Therefore, the panel accepted the evidence of Ms Bright that on 15 January 2022, you cared for patients who had altered airways when you had not been signed off as competent to do so.

The panel noted that you accepted during your oral evidence that you had been informed by Ms Bright on 12 January 2022 that you were not allowed to care for patients with altered airways as you had not been signed off as competent to do so. The panel further noted that you accepted during your oral evidence that you looked after patients with altered airways on 15 January 2022. The panel noted that your evidence tended to focus solely on '*red*', '*amber*' and '*green*' patients, the colours assigned to indicate risk during the coronavirus pandemic rather than whether the patients had altered airways or not. The panel determined that you had volunteered to care for patients based on this colour criteria alone, ignoring the direction from Ms Bright that you were not to care for altered airways patients. In oral evidence, you told the panel that you had refused bed one and accepted bed three because they were green and you did that because they were the only ones that did not have coronavirus.

Based on the evidence before it as well as your admissions during your oral evidence, the panel was satisfied that it was more likely than not that on 15 January 2022, you had cared for one or more patients who had altered airways when not being signed off as

being competent to care for such patients and having been informed previously that you could not care for such patients. Accordingly, the panel found charges 2a and 2b proved.

Charge 3

3. On or around 15 January 2022, failed to inform Colleague B (Amy Hill) that you could not be allocated patients who had altered airways.

This charge is found proved

The panel took into account the witness statement of Ms Hill in which she stated:

'I worked a night shift on the Ward with Ms Washington from 20:00 on Saturday 15 January 2022 until 08:00 on Sunday 16 January 2022....Ms Washington had worked the previous night shift and she pointed to a group of patients (one had a tracheostomy and one had a laryngectomy) on the board who were in a bay together and said that she was happy to take responsibility for these patients as she had looked after them the night before but then she said that she was not sure that she was allowed to look after them. When she said this she was pointing at the red, amber, green scoring colour system on the board which insinuated that she was saying she was not sure that she was allowed to take the patients due to the covid-19 risks associated with them.... I was under the impression that Ms Washington was not able to take any patients who were at high risk of having covid-19 however, the patients she was pointing to were a bay of green patients.'

'I asked Ms Washington whether she was unsure as to whether she could look after them due to the covid-19 infection control procedures but I cannot recall what her response was. Although I do not recall her

response, I do know that she did not tell me that it was because she had been told that she was not allowed to look after tracheostomy or altered airway patients. Following this, Ms Washington chose to take the patients she had pointed to on the board which included one patient with a tracheostomy and one with a laryngectomy.'

The panel noted that Ms Hill confirmed this account of the incident in her local statement via an email to Ms Potter dated 17 January 2022 and in her oral evidence.

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that you had told Ms Potter that you were not allowed to care for patients marked as red on the allocation board until you were signed off as competent to do so. You stated that you were allocated to Esther Ward to care for patients marked as green as that ward was short-staffed. You stated that when you arrived at Esther Ward, you discovered that one of the patients allocated to you by a senior nurse Saida Senouci was marked as red and other nurses did not want to care for that patient. You stated that one of the patients allocated to you had laryngectomy issues and required suction of mucus from his lungs before being discharged. You stated that you knew that you were not allowed to perform such procedure, and you asked Ms Hill to assist you, which she did but she reported you for it. You stated that when the oncology nurses questioned the allocation of patients marked red, Saida Senouci falsely alleged that you took it upon yourself to care for that patient.

The panel found that you did not mention to the allocating nurse at the time that you were not to be given any patient with altered airways, and you willingly accepted a patient with altered airways on 15 January 2022. The panel took the view that you were clearly aware from your conversation on 12 January 2022 with Ms Bright that you were not allowed to take any altered airways patients whatsoever regardless of their coronavirus status. You left the allocating nurse on this day under the misapprehension that your only restriction with regard to patients on the board was in relation to all patients marked amber and red.

You were under an obligation to inform your colleague that you could not be allocated patients who had altered airways and you chose not to do so.

In this regard, the panel was satisfied that, based on the evidence before it, that it was more likely than not that you failed to inform Colleague B (Amy Hill) that you could not be allocated patients who had altered airways on 15 January 2022. Accordingly, the panel found charge 3 proved.

Charge 4

4. On or around 20 January 2022 you threatened to punch Colleague A (Selina Diven) in the face;

This charge is found proved

The panel took into account the witness statement of Ms Potter in which she stated:

'After speaking with Roselyn on 20 January 2022 we walked out of the room we were having our meeting in. Whilst walking out of the room our paths crossed with ward manager, Selena. Upon seeing Selena, Roselyn started screaming and shouting at her and threatened to punch her in the face. Roselyn was saying things like it was all Selena's fault, that she hated her and that Selena had gone behind her back by reporting concerns. As we were in the middle of the corridor I suggested we all go back into my office instead of shouting in front of patients and other colleagues.'

'Roselyn and Selena came into my office. In my office Roselyn told me that I was dealing with everything right but she was really unhappy with Selena. Roselyn said that Selena had reported her too many times and it was the last time Selena would report her or she would

punch her in the face. I then reminded Roselyn that she needs to be professional and not act in this manner towards colleagues. Upon hearing this Roselyn stormed out of my office. After Roselyn left, Selena became really worried for her safety.'

The panel had sight of the Meeting Notes dated 23 February 2022 which contained a summary of the meeting held by the Trust to discuss the alleged concerns raised about your nursing practice at the Hospital. The panel noted that Ms Potter had stated that:

'.... I began to explain once again that due to the on- going concerns that we had just discussed that we spoke to HR this morning and It was decided that we would be taking this forward to the second stage of the capability process, at this stage she stood up and said 'Selina has done this to many others but I will be her last, I'm going to punch her in the face before I leave' I reminded Roselyn that there is an expectation of professionalism and threatening behaviour will not be tolerated. She stormed out of the room and left. She returned whereby she had a conversation with myself and Selina, where Selina explained her concerns and roselyn continued to get aggressive in her tone of voice and would not listen to the concerns raised...'

The panel took into account the witness statement of Ms Diven in which she stated:

'...I fed these incidents back to the Ward Sister (Jade Potter), who had a conversation with Ms Washington and told her that she could only work as a Band 2 nurse. I believe there may have been 1 or 2 other people in the meeting, but I cannot be sure. I was not present during the conversation but I could hear that it got heated. Esther ward and Blundell ward are opposite each other and I left Esther ward to go to the toilet and I could hear the conversation they were having in the

sisters office on Blundell ward. I could not hear the exact words but I could hear a loud conversation which could be heard from the corridor.

Once Ms Potter and Ms Washington had finished their conversation, they came back to Esther ward. I was at the nurses' station and Ms Washington's jacket was on a chair at the nurses station. Ms Washington came over to the nurses' station and grabbed her jacket off the chair and flung it in the air in a threatening manner. Ms Potter was there at the time as she followed Ms Washington to the nurse's station. Ms Washington said she was going home and she left and Ms Potter told me that during the meeting she had with Ms Washington, Ms Washington told her that she was going to punch me in the face. This incident happened on 20 January 2022.'

The panel noted that you denied the allegation. You stated in your Registrant Response to Charges that Ms Potter's evidence was hearsay. You stated that you were called in to the meeting on 20 January 2022 by Ms Diven, Ms Potter, Ms Bright and two other senior nurses and they interrogated you in a humiliating manner and they decided that you would be stepped down to a Healthcare Assistant role. You stated that you begged for mercy as you started to cry but they laughed at you. You stated that a locum junior doctor accidentally walked in and told them that what they were doing was wrong. You asserted that it was not in your nature to fight and Ms Potter had fabricated the allegation because you told them that you would raise a complaint against them.

The panel noted that Ms Potter stated in her oral evidence that, in this meeting with you, the only additional person present was a Practice Development Nurse Alex Perez and not six people as you had asserted. She also stated that you said that all the concerns were someone else's fault and that there was a conspiracy with people trying to use you to advance their own careers.

The panel noted that the account of Ms Diven contradicted the account of Ms Potter in that Ms Diven stated that she was not present when you allegedly made the threat to punch her and it was Ms Potter that informed her. However, Ms Potter stated that you had allegedly made the threat directly to Ms Diven who was on the corridor at that time and you allegedly repeated the threat to Ms Diven in Ms Potter's office.

The panel was of the view that the inconsistencies in the accounts of Ms Potter and Ms Diven were in the detail of what transpired after the conversation in the office. The panel found the evidence of Ms Potter was consistent concerning the fact that the threat to punch Ms Diven was made by you and noted the evidence of Ms Diven that this was what Ms Potter had told her. The panel found that the mischief of charge 4 was the threat made to punch Ms Diven but not any other matters that occurred in this incident. The panel also noted that Ms Diven stated during her oral evidence that a Datix was made to report the incident, and she had seen the Datix, but the panel was not provided with this document. The panel noted that the account of Ms Potter was supported by the Meeting Notes dated 23 February 2022 which formed part of the official records of the Trust and the panel attached significant weight to it.

Based on the evidence before it, the panel was satisfied that it was more likely than not that you threatened to punch Colleague A (Selina Diven) in the face on 20 January 2022. Accordingly, the panel found charge 4 proved.

Charge 6

6. Your actions at allegation 5 were dishonest in that:
 - a. You knew your NMC registration had been interim suspended at a hearing on 16 June 2023;
 - b. You failed to inform King Edward VII's Hospital of the fact your registration was currently suspended prior to undertaking the shifts.

These charges are found NOT proved

Having found charge 5 proved by way of your admission, the panel went on to consider whether your conduct in that charge was dishonest in that you knew your NMC registration had been suspended and you failed to inform King Edward VII's Hospital of the fact your registration was currently suspended prior to undertaking the shifts. In considering whether your conduct was dishonest, the panel had regard to the NMC Guidance on Making decisions on dishonesty charges and the professional duty of candour (FtP-2a-iii). The panel also had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test, the panel took into account the chronology of the incident, the evidence of Ms Begum, Ms Jones, Mr Jose Lorenzo Diokno, the emails from Mr Mohammed Shakir Islam and your evidence. The panel first considered whether you knew that your NMC registration had been subject to an interim suspension at a hearing on 16 June 2023

The panel took into account the witness statement of Ms Begum in which she stated that she had contacted you via email and telephone on 12 June 2023 and 15 June 2023 to inform you about your interim order hearing scheduled on 16 June 2023. She stated that she told you that she had sent you the hearing papers bundle on 1 June 2023 via egress and told you to use your NMC personal information number (PIN) to access the bundle. She stated that you told her that you did not believe that she worked for the NMC and you were not willing to enter your NMC PIN as a password as you were concerned about fraud. She stated that you told her that you did not have a representative and you would not attend the hearing on 16 June 2023.

The panel noted that you were sent the outcome of the interim order hearing on 19 June 2023 by an NMC employee Mr Mohammed Shakir Islam via egress email including instructions on how to access the decision letter. The panel had sight of the egress emails from Mr Mohammed Shakir Islam.

The panel took into account the witness statement of Ms Jones in which she stated that on 6 July 2023, she received a telephone call from you when you sounded confused about what was happening with the NMC investigation. Ms Jones stated that she informed you about the NMC investigation and the interim order hearing that was held but you told her that you had been a victim of fraud in the past and you doubted the emails. She stated that when you casually mentioned that you were working at a private hospital, she highlighted that you were under an interim suspension order and you were not allowed to work as a registered nurse. She stated that you seemed surprised and sounded as though this was the first you had heard about the interim order. Ms Jones stated that she posted the interim order hearing decision letter to you on 6 July 2023 and told you to stop working as a registered nurse immediately. Ms Jones further stated that she received a telephone call from the Director of Nursing at King Edward VII Hospital where you had been working and he told her that you had informed him that you were under an interim suspension order and you had been working whilst suspended. Ms Jones stated that she provided him with the relevant information and told him that you had not been fully aware that you were interim suspended.

The panel also took into account the witness statement of Mr Jose Lorenzo Diokno, the Inpatient Nurse Manager at King Edward VII's Hospital in which he stated that on 6 July 2023, you sent him a WhatsApp message containing a screenshot of the NMC information indicating that you were subject to an interim suspension order.

The panel noted that you denied the allegations. You stated in your Registrant Response to Charges that you were not officially aware of the interim order hearing and you were not aware that an interim suspension order had been imposed on your NMC registration. You

stated that when Ms Begum had informed you of the interim order hearing, you thought her emails and telephone calls were scams as you had been a scam victim in the past. You asserted that when you became aware of the interim order, you immediately informed your employer at King Edward VII's Hospital and stopped working immediately.

The panel was of the view that based on the evidence of Ms Jones and your evidence, it was clear that you were not aware of the interim suspension order as you had thought that the emails from the NMC were scams. The panel noted that when you became aware of the interim suspension order on 6 July 2023, you immediately informed your employer at King Edward VII's Hospital and stopped working as confirmed by Mr Diokno in his witness statement. The panel also had sight of the WhatsApp Transcript between you and Lorenzo Diokno dated 6 July 2023, in which you had informed Mr Diokno of the interim order.

In this regard, the panel determined that there was no evidence to indicate that you knew your NMC registration had been interim suspended at a hearing on 16 June 2023 prior to taking shifts at King Edward VII's Hospital.

In applying the second limb, the panel was satisfied that your conduct would not be considered as dishonest by the standards of ordinary decent people. The panel therefore found charge 6a not proved.

In respect of charge 6b, the panel was of the view that you would have had a duty to inform King Edward VII's Hospital of the interim suspension order prior to undertaking the shifts if you were aware of the interim order prior to taking those shifts. Given that the panel had earlier determined that there was no evidence to indicate that you knew your NMC registration had been interim suspended at a hearing on 16 June 2023 prior to taking those shifts at King Edward VII's Hospital, the duty to inform King Edward VII's Hospital had not arisen at that time. In this regard, the panel was not satisfied that the NMC had discharged the burden of proof. The panel therefore found charge 6b not proved.

Fitness to practise

Lack of competence and misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved amount to a lack of competence and/or 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 a lack of competence and/or misconduct. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Submissions on lack of competence and misconduct

Mr Joshi submitted that the panel has already found that charges 1a (i), 1b (i), 1b (ii), 1b (iii), 1i (i), and 1i (ii) effectively amounts to lack of competence and that charges 2a, 2b, 3 and 4 are capable of amounting to misconduct if sufficiently serious. He submitted that your actions in charges 2a, 2b, 3 and 4 departed sufficiently seriously from the standards of conduct expected of a registered nurse so as to amount to serious professional misconduct. He submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) are engaged in this case and have been breached. They are sections 8.1, 8.2, 8.3, 13.3, 15.1, 16, 20.1, 20.2, 20.5,

25.1 and 25.2.

In respect of charges 2a, 2b and 3, Mr Joshi submitted that your conduct was particularly serious because it amounted to a conscious decision to disregard an express restriction on your practice that was imposed to protect vulnerable patients. He submitted that, in so far as you knowingly accepted patients that you knew you should not be caring for, your misconduct goes beyond a mere error. He asserted that it involved a deliberate decision to disregard a patient safety restriction. He submitted that your conduct undermined the safeguards that had been put in place by the Trust to protect patients. He highlighted that you failed to inform Ms Hill about your restriction from caring for altered airways patients and you knowingly allowed her to remain under a misapprehension. He asserted that your conduct directly undermined patient safety.

In relation to charge 4, Mr Joshi submitted that the type of behaviour one would expect in a professional work setting was that of mutual respect and understanding but not the threat of violence and bullying. He asserted that threatening violence against a colleague is plainly incompatible with the standards expected of a registered nurse. He submitted that your conduct was not a momentary disagreement nor a situation where just words were being exchanged.

Mr Joshi invited the panel to find that your actions in charges 2a, 2b, 3 and 4, both individually and cumulatively represents a serious departure from the standards expected of a registered nurse and constitute serious professional misconduct. He submitted that they involved disregard of known competence restrictions, exposure of patients to avoidable clinical risk, a failure to communicate patient safety information to colleagues and threat of violence to a colleague which other professionals would find very contemptible.

In relation to impairment, Mr Joshi submitted that your actions indicate a pattern of conduct which demonstrates a risk of repetition. He highlighted that your actions involved repeated failures to recognise and practise within your competence, a repeated disregard

of supervision requirements, repeated patient safety concerns, a failure to accept professional restrictions and hostility towards colleagues who raised concerns. He submitted that your misconduct and lack of competence indicate a recurring theme of you repeatedly placing your own judgement above established clinical safeguards and that pattern is highly relevant when assessing future risk.

Mr Joshi submitted that, throughout the proceedings, you have maintained that your colleagues fabricated allegations, conspired against you and were dishonest. He highlighted that your application to recall witnesses was premised upon allegations that witnesses had lied and fabricated concerns. He submitted that this was highly relevant to insight as a practitioner who denies matters and puts evidence before a panel is in a completely different light from a practitioner who continues to attribute findings to conspiracies or dishonesty on the part of others. He argued that it is because of that such a practitioner may have difficulty in demonstrating a full appreciation of their own responsibility. He submitted that this applies in this case and therefore, there was an absence of meaningful reflection, and this increases the risk of repetition.

Mr Joshi submitted that even if the panel was not satisfied that there remains a significant clinical risk, impairment is still required on public interest grounds. He asserted that members of the public would be concerned if a finding of impairment was not made where a nurse knowingly cared for patients despite being prohibited from doing so and failed to inform colleagues of important competence restrictions. He submitted that any member of the public would be shocked to learn that a nurse threatened violence against a fellow colleague and would expect a regulatory finding of impairment in such circumstances. He submitted that fellow professionals would also be troubled if the regulator did not look at the seriousness of that conduct and if a finding of impairment was not made, it would undermine public confidence in both the nursing profession and the regulatory process.

In conclusion, Mr Joshi invited the panel to find that your fitness to practise is impaired on both grounds of public protection and public interest.

You gave evidence under oath. You told the panel that you were very sorry for the impact of your actions on patients, colleagues and the nursing profession. You stated that you will take steps to prevent the concerns from recurring in future.

In respect of charge 1a (i), you stated that you thought at the time of the incident that what you did was right but having reflected on your actions, you are sorry and you should have followed the Trust policy. You stated that when you were employed at the Hospital, you arrived on the Ward with so much confidence as you had over 10 years of experience as a registered nurse. You highlighted that there was no harm caused to the patient. You stated that the Hospital was short-staffed during the coronavirus pandemic and you only wanted to help. You stated that you regret your actions and you promise that you will never practise contrary to a Trust's policies or act outside the scope of your competence.

In relation to charge 1b (i), 1b (ii) and 1b (iii), you stated that you had adequate knowledge in preparing the Phosphate Polyfusor IV and you were only being "*naughty*" when you had asked Ms Diven on how to prepare it. You stated that Ms Diven may have taken it personally and thought that you did not know what you were doing. You told the panel that you wanted to cross-check with Ms Diven whether she knew what she was doing as it was a general practice among nurses to confirm that during the administration of medication. You attributed your actions to over-confidence on your part, and you apologised for the impact of your conduct on Ms Diven, the patient and the public.

In respect of charges 2a, 2b and 3, you stated that the issues arose from miscommunication among the senior nurses at the Hospital. You stated that the Matron at the Hospital should have sent the email concerning your restriction to all colleagues but some colleagues including Ms Hill did not receive it. You told the panel that, at the time of the incident, you had returned from leave, and you should not have been immediately allocated to another ward. You stated that when Ms Hill had allocated patients with altered airways to you, you had informed her of your restriction, but she told you that she would supervise you. You stated that you should have stood your ground, refused the allocation and contacted the Matron to alert her about the allocation. You told the panel that you only

accepted the allocation out of respect for Ms Hill and due to the fact that Esther ward was short-staffed as it was during the coronavirus pandemic. You highlighted that there was no harm caused to those patients with altered airways and one of them gave positive feedback about your care. You stated that although you knew how to care for patients with altered airways, you were not yet signed off as competent as the nurses who should have signed you off were on sick leave or very busy. You apologised for your actions.

In relation to charge 4, you asserted that you never threatened to punch Ms Diven as you were non-violent and would never think of punching anyone especially your boss. You stated that it was not possible for you to punch Ms Diven as she was taller and more physically built than you. You told the panel that, at the time of the incident, you were [PRIVATE] your managers, and your conduct may have been misconstrued to Ms Diven as intimidating to her. You apologised for your conduct and stated that you should have gone to a quiet place to calm yourself. You stated that you were going through difficult personal circumstances at that time and your managers were aware of your situation. You told the panel that you understood the impact of your conduct on your colleague and the picture it would present to the public.

You told the panel that when you resigned from the Trust, you were not informed that a referral would be made against you and you had gone to work in a private hospital. You stated that, at the private hospital, you worked at the intensive care unit (ICU) and there were no concerns raised about your nursing practice. You stated that when you became aware of the interim suspension order, you immediately stopped working at the private hospital. You stated that you were also working for an agency at that time on a temporary basis and when they became aware of the interim suspension order, they were happy to offer you a Band 3 Healthcare Assistant role based on your previous good performances. You stated that they were ready to offer you a permanent role but you told them that you wanted to conclude with your NMC case.

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

Decision and reasons on misconduct and lack of competence

When determining whether the facts found proved amount to misconduct and/or lack of competence, the panel had regard to the terms of the Code.

The panel determined 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, the following sections of the Code:

'Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to....

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

8.2 *maintain effective communication with colleagues*

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

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

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

13.5 complete the necessary training before carrying out a new role

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

To achieve this, you must:

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

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct and/or lack of competence. Therefore, the panel proceeded to make its findings on lack of competence and misconduct.

Lack of competence

The panel bore in mind, when reaching its decision in respect of the charges found proved relating to a lack of competence, that you should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard.

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

The panel first considered whether you were made aware of the concerns raised about your competence. The panel took into account that, on multiple occasions, Ms Cooper, Ms Swaisland, Ms Diven and Ms Potter addressed the concerns raised about your practice with you in numerous 1:1 meetings, feedback emails and capability meetings as documented in the Record of Concern about your practice and the Management Case document. The panel was therefore satisfied that you were made aware of the concerns raised about your competence as a Band 5 nurse at the Hospital.

The panel next considered whether you were given sufficient opportunity by the Trust to strengthen your practice. The panel took into consideration that when you joined the Ward, your one-week supernumerary period was extended for another week. After the second supernumerary week, Ms Cooper informed you on 4 March 2020 that you had not yet achieved some of your basic competencies. Between March 2020 and August 2020, as a result of several concerns raised about your practice, you were placed on a performance improvement plan under the Trust informal capability procedure in August 2020. However, despite the performance improvement plan, several concerns were still raised about your practice.

On 27 July 2021, the first formal stage capability meeting was held when it was reported that you had failed to meet your objectives within an allocated eight week period. As you had not met the outcomes in your action plan, it was extended for another eight weeks to 26 September 2021. In October 2021, you were deemed to have met the objectives of your action plan as Ms Swaisland stated that there was a significant improvement in your performance. You were reverted back to being monitored informally under the capability policy for three months with access and support from the Practice Development Nurse and the Tracheostomy Clinical Nurse Specialist. However, further concerns were raised about your practice in 2022. As a result, you were moved to stage two of the capability process on 20 January 2022 and you were informed that from that day, you could only undertake Band 2 nursing duties and no longer work as a Band 5 nurse.

The panel found that the Trust had endeavoured to assist you in a variety of ways to reach the required level of competency over a considerable period of time but nonetheless, the concerns persisted.

The panel was of the view that there was substantial evidence before it to demonstrate that your failings were not isolated incidents but a pattern of failures between 2 March 2020 and 7 October 2022 whilst employed at the Hospital. The panel determined that, collectively, they demonstrate a pattern of behaviour in which you failed to demonstrate

the required standards of knowledge, skill and judgement in the administration of medication and in basic patient care over a period of two years.

The panel found that you acted outside the scope of your competency and in breach of Trust policy by administering medication without the required competency and adequate supervision. The panel determined that your conduct in not reading the Trust's Medication Administration Policy and proceeding to administer a medication despite knowing that you lacked the required competency was evidential of both a cavalier approach to patient safety and an underlying attitudinal issue at play. You also failed to conduct regular observations on a patient, failed to escalate failed medical equipment and take reasonable steps to obtain an alternative equipment for a patient.

The panel rejected your explanations that your failings arose from the context that you were working during the coronavirus pandemic, that the Hospital was short-staffed and your over-confidence as an experienced nurse. The panel found that despite this being a difficult period, the Trust afforded you considerable support, in its endeavours to help you achieve the competencies required over a significant period of time. However, your misplaced confidence in your abilities impeded your ability in achieving the competencies required. The panel found that your failings posed a risk of serious harm to patients and demonstrated failings in basic knowledge, skills and judgement expected from a registered Band 5 nurse.

Overall, the panel concluded that your failings, both individually and collectively, formed a pattern of failures in fundamental areas of nursing practice. It was satisfied that the evidence before it provided a fair sample of your work between 2 March 2020 and 7 October 2022 and demonstrated an unacceptably low standard of performance as a registered nurse, particularly one who has been practising for some ten years.

The panel determined that your failings in charges 1a(i), 1b(i), 1b(ii), 1b(iii), 1d(i), 1i(i), 1i(ii), 1i (iii) fell significantly below the standards expected of a registered Band 5 nurse and demonstrated a lack of competence.

Misconduct

Charges 2a, 2b and 3

The panel considered these charges together as they arose from the same incident. The panel noted that you knew that you were not yet signed off as competent to care for patients with altered airways and you had also been expressly informed by Ms Bright on 12 January 2022 that you were not allowed to care for those patients in a face to face meeting. However, you made a deliberate decision to care for patients who had altered airways on 15 January 2022. You further failed to inform Ms Hill that you could not be allocated patients who had altered airways. The panel rejected your explanations that you had told Ms Hill that you could not be allocated patients who had altered airways, you cared for those patients out of respect for Ms Hill as the allocating nurse and the fact that the ward was short-staffed. The panel bore in mind that it had already found the charge proved that you failed to inform Ms Hill and that you had a duty as a registered nurse to work within the scope of your competency.

The panel was of the view that your conduct demonstrated a wilful disregard for the restriction imposed on your practice by the Trust in undermining the critical safeguards placed to protect vulnerable patients from harm. Further, your conduct demonstrated an underlying attitude of disregard towards Trust policies, patient safety and constituted authority.

The panel noted that Ms Bright stated in her evidence that patients with altered airways were highly vulnerable and if they were not managed by competent staff, the implications could be catastrophic as life-threatening complications could arise in such situations. The panel therefore determined that your conduct in charges 2a, 2b and 3 posed a significant risk of harm to those patients with altered airways that you cared for on 15 January 2022.

The panel therefore found your conduct to be extremely concerning and that it constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. The panel determined that your conduct amounted to a failure to uphold the standards and values of the nursing profession. Therefore, the panel determined that your conduct in charges 2a, 2b and 3 were sufficiently serious to amount to misconduct.

Charge 4

The panel found your conduct towards Ms Diven to be deeply concerning, unprofessional and unacceptable behaviour in a professional work setting, especially in a clinical setting. The panel rejected your explanations that you never threatened to punch Ms Diven as you were in tears during that meeting and that it may have been misconstrued as intimidating. The panel noted that it had already found the charge proved and it was of the view that there was no justification for your conduct towards Ms Diven. The panel found your conduct would be unacceptable in any circumstances and additionally would amount to disrespect for constituted authority as Ms Diven was a senior nurse and deputy Ward Sister at the Trust. The panel noted that your conduct was intimidating to Ms Diven, and she feared for her safety.

The panel therefore determined that your behaviour in charge 3 fell significantly short of the standards of professional conduct and behaviour that a registered nurse is expected to maintain. The panel found your conduct towards Ms Diven to be extremely serious and that it would be seen as deplorable by other members of the profession and members of the public. Accordingly, the panel determined that your conduct in charge 3 was sufficiently serious to amount to misconduct.

Charge 5

The panel bore in mind that it had earlier determined that when you worked at King Edward VII's Hospital on those dates outlined in this charge, you were not aware that you

were under an interim suspension order and therefore your conduct was not dishonest. In this regard, the panel determined that your conduct in charge 5 was not so serious as to amount to misconduct.

Consequently, having considered the proven charges individually and in totality, the panel determined that your actions in charges 2a, 2b, 3 and 4 did fall 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 your misconduct and lack of competence, 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) 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.’

Registered 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* [2011] EWHC 927 (Admin) 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)'*

The panel first considered whether any of the limbs of the Grant test were engaged as to your past conduct. The panel determined that although there was no evidence of actual harm caused to patients, your significant level of general incompetence in fundamental areas of nursing practice, your misconduct in acting outside the scope of your competence

as well as your disregard for local restrictions on your practice, placed patients at unwarranted risk of harm. The panel also determined that your inappropriate and intimidating behaviour towards a colleague caused her to feel unsafe at the Hospital and this could have affected staff morale with its consequent impact on patient safety.

The panel determined that your misconduct and lack of competence amounted to a serious breach of fundamental tenets of the nursing profession in that you failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. It determined that you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that limbs a, b and c of the Grant test were engaged in respect of your past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) in which the Court addressed the issue of impairment with regard to the following three considerations:

- a. *'Is the conduct that led to the charge easily remediable?*
- b. *Has it in fact been remedied?*
- c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (FTP-16).

The panel first considered whether your misconduct is capable of being addressed. In the NMC Guidance – Can the concern be addressed (FTP-16a), the panel noted the following paragraph:

‘...In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate’s attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice...’

The panel considered the context of the charges found proved, the totality of your behaviour during the time of the incidents, the nature of your responses towards the concerns and your submissions in these proceedings.

The panel noted that although you had over ten years of nursing experience, you had not previously worked in this particular specialty. The panel recognised that whilst some of your existing nursing knowledge, skills and experience were transferable, you were nonetheless required to adhere to the Trust policies and to develop new skills and successfully complete the relevant competencies’ assessments before being able to practise independently in this area of nursing.

The panel found that despite the various concerns raised about your nursing practice and your failure to pass your competencies, there was a consistent pattern of you feeling that some of the competencies’ assessments were unnecessary. The panel noted that Ms Bright stated during her oral evidence that you failed to attend all the training sessions scheduled towards completing your tracheostomy competencies and this was part of the problem. The panel took into account that Ms Cooper stated in her witness statement that:

‘When I spoke with Roselyn about completing her medication competency and concerns with her administering medication during her one-to-one meetings she would talk about how she should not have to complete her competencies in medication administration as she had been a nurse for many years. Roselyn would also say that the standards of assessment were too high and that she was frustrated by having to do her competencies again...’

The panel noted that despite the extensive support provided to you by the Trust for over two years, the concerns persisted and, on several occasions, you chose to act on your own accord, following a path you believed was the right one rather than to adhere to Trust policies, local restrictions on your practice and instructions from senior nurses. In this regard, you placed your interests above patient safety and the interests of the Trust. The panel also noted that you threatened to punch your colleague who was the Deputy Sister of the Ward. The panel determined that the totality of your conduct was suggestive of serious deep-seated attitudinal behaviour that prevailed over a sustained period of time and therefore, the concerns are more difficult to address/remediate.

The panel considered whether the concerns have been addressed and remedied. It had regard to the NMC Guidance – Has the concern been addressed? (FTP-16b). The panel took into account your oral evidence, your various training certificates, your work appraisal form and the testimonial made on your behalf. The panel also considered that there had been no previous or subsequent concerns raised about your character to the NMC.

The panel also considered the context of the misconduct. It noted that you stated that, at the time of the incidents, you were facing difficult personal circumstances, the Hospital was short-staffed and it was during the coronavirus pandemic. It also noted that you have raised allegations of bullying and collusion of staff against you at the Trust.

However, the panel noted that it had found that you were provided with considerable support by the Trust to strengthen your practice. It noted that you were supported with supervision meetings, trainings, a performance improvement plan and additional 1:1 sessions to enable you to complete your competencies. The panel also noted that you were provided with support by the Trust during the period you were facing difficult personal circumstances, and despite working with several managers over two years, the same concerns persisted. Having considered these factors, the panel determined that there were no reasonable contextual justifications for your actions, and it could not find any evidence to support your allegations of bullying and collusion of staff against you at the Trust.

Regarding insight, the panel considered that you made admissions to one of the charges, you apologised for your actions, and you set out some steps you would take to prevent the concerns from recurring in the future.

However, the panel found that despite its findings on facts, you have continued to deflect responsibility, blame others for your actions, and provided justifications or excuses for your misconduct and lack of competence. The panel was very concerned that you failed to demonstrate any understanding of the seriousness of your misconduct and lack of competence, and the risk of harm posed by your actions to patient safety. The panel noted that you failed to demonstrate sufficient insight into the impact of your conduct on patients, your colleagues, the nursing profession and the wider public. The panel was therefore not satisfied that you have demonstrated genuine remorse and sufficient insight into your misconduct and lack of competence, take responsibility and accountability for your own actions and recognise the risk of harm posed to patient safety.

In considering whether you have strengthened your nursing practice, the panel considered your various training certificates, your work appraisal form and the testimonial made on your behalf. The panel took into account that no further concerns were raised about your clinical practice before you were placed under an interim suspension order and that you are currently working as a Healthcare Assistant. However, the panel noted that you did not provide any details about the lessons you had learnt from the training courses and how you will apply your training into your nursing practice. The panel was of the view that despite your positive testimonial and work appraisal form, your failure to demonstrate insight into your actions and your deep-seated attitudinal behaviour raises concerns about your ability to practise safely and effectively as a registered nurse.

The panel was therefore not satisfied that the misconduct and lack of competence concerns have been addressed/remediated. Accordingly, the panel determined that there is a high risk of repetition, and limbs a, b and c of the *Grant* test are engaged in the future.

The panel therefore concluded 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 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 had regard to the serious nature of your misconduct, lack of competence and the public protection issues it had identified. In this case, where there are concerns of wide-ranging failings in fundamental aspects of nursing practice involving highly vulnerable patients, disregard for local restrictions, intimidating behaviour towards colleagues and serious deep-seated attitudinal behaviour, the public would expect the regulator to take action. The panel determined that public confidence in the profession would be seriously undermined and damaged if a finding of impairment were not made.

For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the professional misconduct and your lack of competence, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

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

Sanction

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

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

Submissions on sanction

Mr Joshi submitted that the most appropriate and proportionate sanction in this case is a striking-off order. He highlighted that the purpose of a sanction is not intended to be punitive but to protect the public, maintain public confidence in the profession, and uphold proper professional standards. He noted that the findings in this case are serious and they involve a combination of a persistent lack of competence, repeated patient safety failings, deliberate disregard of a restriction placed upon practice, conduct that posed a risk of serious harm to vulnerable patients and threatening behaviour towards a colleague. He highlighted that there has been limited insight, a lack of remediation and a high risk of repetition.

Mr Joshi submitted that the aggravating features of this case were:

- A persistent pattern of failures between 2 March 2020 and 7 October 2022 and an unacceptably low standard of performance over a prolonged period.
- The failings related to core nursing functions, including medicines management, competency, patient observations, escalation of medical equipment and care of highly vulnerable patients.
- A wilful disregard for the restriction imposed on your practice which was a deliberate undermining of safeguards intended to protect vulnerable patients.
- Serious deep-seated attitudinal issues.
- An underlying attitude of disregard towards trust policies, patient safety, and constitutional authority.

Mr Joshi submitted that these aggravating features indicate that this case is beyond remediable clinical shortcomings and the NMC Sanctions Guidance specifically identifies insight and remediation as central considerations. He submitted that given the panel's findings on current impairment, the high risk of repetition and the serious misconduct, taking no action or a caution order would be wholly inappropriate in this case. He submitted that the concerns were neither isolated nor minor and the panel had found both a continuing risk of repetition and significant public protection concerns. He asserted that a caution order would provide no protection to the public.

In relations to a conditions of practice order, Mr Joshi submitted that such a sanction would not be workable or sufficient to protect the public and uphold public confidence in the nursing profession. He highlighted that you have already been provided with substantial support over a prolonged period and that included competency programmes, additional supervision, action plans, performance improvement measures, 1:1 support and specialist training opportunities. He submitted that despite those interventions, the concerns persisted. He noted that the panel had identified attitudinal concerns, and the NMC Sanctions Guidance indicates that conditions are unlikely to be appropriate where concerns involve attitudinal problems, lack of insight, unwillingness to comply with professional requirements, or persistent failings despite support. He submitted that this case regrettably has all those features and therefore a conditions of practice order would not be an appropriate sanction in this case.

Mr Joshi noted that a suspension order may be appropriate where there is a realistic prospect of remediation. He submitted that the panel's findings demonstrate that there is no prospect of remediation as despite the long period since the concerns arose, there has been no real meaningful insight or remediation that's been demonstrated. He submitted that a fully informed member of the public would rightly be concerned if a practitioner who knowingly ignored patient safety restrictions and threatened a colleague were permitted to return to unrestricted practice following a period of suspension alone.

Mr Joshi submitted that this is a case where a striking-off order is both necessary and proportionate in view of the serious misconduct, the extensive lack of competence, the attitudinal issues, the limited insight, the lack of remediation, the high risk of repetition, the ongoing public protection and public confidence concerns. He asserted that there was no other appropriate sanction that could address the seriousness of the concerns and meet the overarching objective of public protection.

You submitted that the panel's findings were unfair on you as you have been working with NHS for many years. [PRIVATE]

You submitted that you had worked so hard at the university to be a nurse, you are passionate about the nursing profession and you want to return to your nursing career. You asserted that you have worked very hard as a nurse in various healthcare settings where you have been appreciated by many people. You submitted that there may have been concerns in the past, but you have been a good nurse. You stated that you have had positive feedback from several patients and based on their feedback, you do not pose a risk of harm to the public.

You invited the panel to consider imposing a conditions of practice order as you would be able to update yourself and you can work under supervision.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct and failings over a sustained period of time.
- Your repeated wilful disregard for Trust policies, local restrictions on your practice and instructions from senior nurses.
- Your failings and misconduct placed highly vulnerable patients at unwarranted risk of harm.
- Your threat of violence to a colleague.
- Your failure to demonstrate sufficient insight into the seriousness and impact of your misconduct and lack of competence on patients, your colleagues, the nursing profession and the wider public.
- You have continued to deflect responsibility, blame others for your actions, and provide justifications or excuses for your misconduct and lack of competence.
- Your conduct was suggestive of serious deep-seated attitudinal behaviour that prevailed over an extensive period of time.
- Your unwillingness to complete the competencies at the Trust.
- Your failings and misconduct amount to deliberate breaches of the Code.
- Your lack of competence relates to failing in basic areas of nursing practice.
- Your failure to work collaboratively with your colleagues at the Trust.

The panel also took into account the following mitigating features:

- You were facing difficult personal circumstances at the time of the incidents.
- A positive testimonial made on your behalf.
- You have completed several training courses in basic areas of healthcare.

The panel noted that you apologised several times for your actions during your submissions on impairment. However, these apologies were made whilst you continued to blame others for your actions and accuse your colleagues of conspiring against you. Therefore, the panel did not consider your apologies as a mitigating factor.

The panel first considered whether to take no action but concluded that this would be inappropriate and not proportionate in view of the seriousness of the case. It had earlier

decided that there is a high risk of repetition, that you breached fundamental tenets of the nursing profession, and that your misconduct and lack of competence would undermine the public confidence in the nursing profession if you were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel next considered the imposition of a caution order and had regard to the NMC Guidance on '*Caution order*' (Reference: SAN-2b) 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 noted that it had found that your misconduct and lack of competence pose a risk of harm to patients. In view of its findings on your lack of competence, misconduct and impairment, the panel decided that your case was not at the lower end of the spectrum of impaired fitness to practise. Given the seriousness of the case, the public protection and public interest considerations identified, the panel determined that an order, that does not restrict your nursing practice, would not be appropriate nor proportionate in the circumstances. The panel therefore concluded that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel was 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) 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 had earlier found that despite the extensive support provided to you by the Trust for over two years, the concerns persisted and, on several occasions, you chose to act outside your competence, following a path you believed was the right one rather than to adhere to Trust policies, local restrictions on your practice and instructions from senior nurses. The panel determined that there was no evidence that you have taken responsibility for your actions and demonstrated the potential and willingness to respond positively to retraining. Therefore, the panel was not satisfied that there was any evidence to demonstrate that you would comply with any conditions of practice order imposed on your nursing practice.

Furthermore, the panel had earlier determined that the totality of your conduct was suggestive of serious deep-seated attitudinal behaviour, which are more difficult to address with a conditions of practice order. The panel therefore determined that given the seriousness of the concerns, the deep-seated attitudinal issues and your insufficient insight into the severity and the impact of your failings and misconduct, there were no proportionate, workable and measurable conditions that could be formulated to address

the high risk of repetition and the consequent risk of harm. Therefore, the panel determined that a conditions of practice order would not protect the public nor uphold professional standards and 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.'*

The panel noted that the lack of competence and misconduct concerns in this case were extremely serious and they were at the higher end of the spectrum. The panel determined that your significant level of general incompetence in fundamental areas of nursing practice, your misconduct in acting outside the scope of your competence, your disregard for local restrictions on your practice and your threat of violence towards a colleague seriously calls into question your suitability to continue practising as a registered nurse.

The panel noted that although you have been under an interim suspension order since 2023, you have failed to demonstrate any meaningful insight into the seriousness and impact of the concerns, you have continued to blame others and deflect responsibility for your actions. The panel further noted that there was no evidence that you had developed further insight into your failings and misconduct since the commencement of these proceedings one year ago nor that you had sufficiently strengthened your nursing practice. The panel therefore concluded that there was no realistic prospect that you would address the concerns to such a level where you could return to practice safely if a suspension order was imposed on your nursing practice given the deep-seated attitudinal concerns and your insufficient insight. This poses a serious risk of harm to patient safety and the public.

The panel also determined that given the seriousness of the concerns and your lack of insight and accountability for your actions, a suspension order would also not be sufficient to uphold public confidence and maintain professional standards in the nursing profession.

The panel concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the following considerations as set out in the NMC Guidance entitled '*Striking-off order*' (SAN-2e):

- *'Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?'*

The panel determined that the serious breach of fundamental tenets of the nursing profession, evidenced by your lack of competence and misconduct, is fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case raise serious and significant questions about your professionalism and to allow you to continue practising would not protect the public and would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

Given the serious nature of the concerns, the deep-seated attitudinal issues, your misconduct in acting outside the scope of your competence, your disregard for local restrictions on your practice and your threat of violence towards a colleague, the panel determined that there was no realistic possibility of you demonstrating sufficient insight

and reflection in this case which could keep patients safe, maintain public confidence in the profession, and uphold professional standards.

Balancing all of these factors and after considering all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the nursing profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient and proportionate in this case and this is the only sanction which would be sufficient to protect the public.

The panel determined that this order is necessary to maintain public confidence in the nursing profession, and to uphold the professional standards of behaviour expected and required of a registered nurse.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Joshi. He submitted that, given the seriousness of the concerns and the panel's findings on sanction, an interim suspension order for a period of 18 months is necessary in order to protect the public and

otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

You submitted that you intend to seek legal advice.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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 its decision to impose an 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 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 in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.