Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 1 September 2026 – Monday, 7 September 2026

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Dawn Elaine Sandy**
NMC PIN:	75D0960E
Part(s) of the register:	Registered Nurse Adult Nursing (Level 2) – 1 June 1977 Registered Nurse Adult Nursing (Level 1) – 28 September 1992 Nurse Independent / Supplementary Prescriber V300 – 17 February 2012
Relevant Location:	Wolverhampton
Type of case:	Misconduct
Panel members:	Susan Thomas (Chair, lay member) Daniel Harris (Registrant member) Janine Green (Lay member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Isabella Payne
Nursing and Midwifery Council:	Represented by Naa-Adjeley Barnor, Case Presenter
Ms Sandy:	Not present and represented by Jemma Harding on 1 September 2026 Not present and not represented between 2 – 7 September 2026

Facts proved by way of admission:	Charges 1 and 5(a)
Facts proved:	Charges 2(a)(i)(b), 2(a)(ii)(b), 2(b)(i), 2(b)(ii), 3(a), 3(b), 4, 5(b)(i), 5(b)(ii) (in part)
Facts not proved:	2(a)(i)(a), 2(a)(ii)(a), 5(b)(ii) (in part)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Sandy was not in attendance, and that the Notice of Hearing letter had been sent to Ms Sandy's registered email address by secure email on 28 July 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and information about Ms Sandy's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

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

At the outset of the hearing, Ms Barnor made a request that this case be held partly in private on the basis that proper exploration of Ms Sandy's case involved reference to her [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 Barnor also applied in relation to the [PRIVATE] of one of the witnesses.

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 that it would rule on whether or not to go into private session in connection with Ms Sandy's or the witness's [PRIVATE] as and when such issues are raised in order to protect Ms Sandy's and the witness's right to privacy.

Decision and reasons on proceeding in the absence of Ms Sandy

The panel next considered whether it should proceed in the absence of Ms Sandy. It had regard to Rule 21 and heard the submissions of Ms Barnor who invited the panel to continue in the absence of Ms Sandy. She submitted that Ms Sandy had voluntarily absented herself.

Ms Barnor referred the panel to the documentation from Ms Sandy which included emails which state she is content for hearing to proceed in her absence.

Ms Barnor referred the panel to the email dated 27 August 2026 from Ms Sandy stating she was agreeable for the hearing to continue in the absence of herself and her representation after the first day of the hearing:

> *'I can confirm I am happy for the hearing to continue in mine and Mrs Harding's absence. Just to add after six years the sooner it's over and completed the better.'*

On behalf of Ms Sandy, Ms Harding confirmed that Ms Sandy was not intending to attend any part of the hearing and that she had no objection to the panel proceeding in her absence.

The legal assessor advised the panel to exercise the utmost care and caution before proceeding in Ms Sandy's absence. He referred the panel to the statement of Sir Brian Leveson in *GMC v Adeogba* [2016] EWCA Civ 162:

> *'Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.'*

The panel has decided to proceed in the absence of Ms Sandy In reaching this decision, the panel has considered the submissions of Ms Barnor, the email chain from Ms Sandy and has accepted the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. The main considerations were:

- No application for an adjournment has been made by Ms Sandy:
- Ms Sandy has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- Ms Sandy has made it clear that she wishes for the hearing to continue in her absence and the absence of any representative;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness is due to attend today to give live evidence, and two other witnesses are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events.

The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Balancing the interests of Ms Sandy, the NMC, the witnesses and the wider public interest, the panel concluded that it was fair and appropriate to proceed in Ms Sandy's absence. The panel determined that there was no good reason to adjourn the hearing and no basis to conclude that an adjournment would secure Ms Sandy's attendance at a later date.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Sandy. The panel will draw no adverse inference from Ms Sandy's absence in its findings of fact.

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Barnor, on behalf of the NMC, to amend the wording of charges 1, 2(b)(i), 2(b)(ii), 5(b)(i) and 5(b)(ii).

That you, a registered nurse:

1) In relation to Patient A, **inaccurately** recorded that a risk assessment had taken place on 27 January 2020.
2) In relation to Colleague A:
    (a) between June 2020 and July 2020 encouraged her to:
        (i) in relation to a line competency form;
            a. state that she had received it

b. state that she had forgotten to sign it and/or have it signed;

(ii) in relation to a renal competency booklet:

a. state that she had received it;

b. state that she had left it at home;

(b) between October 2019 and June 2020, failed to ensure that:

(i) she had received appropriate competency training and assessments; **and/or**

(ii) the competency training and assessment she had received was properly recorded.

3) Failed to ensure staff under your management received appropriate:

(a) competency training;

(b) competency assessments.

4) From January 2020, failed to implement an action plan following a serious incident.

5) Your actions at charges 1) and/or 2) (a) were dishonest in that:

(a) In respect of charge 1) you intended others to believe that a risk assessment had taken place on that date, when you knew it had not;

(b) In respect of charge 2(a):

i) You knew Colleague A had not received and/or completed the competency booklet(s) **and/or line competency assessment form;**

ii) You were seeking to hide the fact that you had failed to ensure that Colleague A had received appropriate training and assessments **and/or the training and assessments she had received had been properly recorded.**

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

Ms Barnor submitted that the majority of the proposed amendments were minor, largely cosmetic or served to bring greater specificity to the wording and therefore would not cause any injustice or prejudice to Ms Sandy.

Ms Barnor proposed amendments to charge 1 in the addition of the word “inaccurate” to clarify the nature of the allegation and to make clear what the charge was intended to refer to. The amendment does not materially alter the nature of the case and serves only to provide greater clarity to the charge.

Ms Barnor submitted that it would be appropriate to amend charge 2 by adding a separate sub-charge and an alternative. This was due to the absence of any documentary evidence demonstrating that the relevant competency training and assessment had been undertaken. The alternative charge therefore enables the panel to consider whether the competency training and assessment took place but was not recorded, or whether it did not take place.

Ms Barnor proposed amendments to charge 5(b) which were intended to incorporate matters already set out in charges 2(a) and 2(b), in order to clarify the new allegations. The amendments do not rely upon any new witnesses or evidence, do not materially alter the nature of the case and serve to reflect the NMC’s allegations more clearly.

Ms Barnor acknowledged that Ms Sandy had not been given of the proposed amendments until 27 August 2026. However, during the course of the proceedings, the NMC notified Ms Sandy in relation to the proposed amendments to the charges to provide an opportunity for her to consider and respond to this application. Ms Harding was able to obtain confirmation from Ms Sandy that she accepted the proposed amendments to the charges and admitted to charges 1 and 5(a) in their amended form.

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).

In deciding whether to grant permission for the amendments, the panel had regard to the NMC's guidance 'How a charge becomes final' (reference PRE-2c), which provides that a panel may allow an amendment to a charge at any stage before making its findings, and that in considering whether to do so the panel will consider fairness and the overarching objective of public protection. The panel further had regard to the NMC's guidance 'General approach' to the drafting of charges (reference PRE-2b), which requires that a charge be worded as clearly and simply as possible and contain enough detail to enable both the registrant and the panel to understand the seriousness and extent of the issues to be determined.

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Ms Sandy and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments.

Accordingly, the panel considered it fair to both parties and appropriate to grant the application to amend as requested, in order to ensure the charges are clear, accurate and properly reflect the evidence before it.

Details of charges (as amended)

That you, a registered nurse:

1) In relation to Patient A, inaccurately recorded that a risk assessment had taken place on 27 January 2020.

2) In relation to Colleague A:

(a) between June 2020 and July 2020 encouraged her to:

(i) in relation to a line competency form;

a. state that she had received it

b. state that she had forgotten to sign it and/or have it signed;

(ii) in relation to a renal competency booklet:

a. state that she had received it;

b. state that she had left it at home;

(b) between October 2019 and June 2020, failed to ensure that:

(i) she had received appropriate competency training and assessments; and/or

(ii) the competency training and assessment she had received was properly recorded.

3) Failed to ensure staff under your management received appropriate:

(a) competency training;

(b) competency assessments.

4) From January 2020, failed to implement an action plan following a serious incident.

5) Your actions at charges 1) and/or 2) (a) were dishonest in that:

(a) In respect of charge 1) you intended others to believe that a risk assessment had taken place on that date, when you knew it had not;

(b) In respect of charge 2)(a):

i) You knew Colleague A had not received and/or completed the competency booklet(s) and/or line competency assessment form;

ii) You were seeking to hide the fact that you had failed to ensure that Colleague A had received appropriate training and assessments and/or the training and assessments she had received had been properly recorded.

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

Decision and reasons on application to admit further documentary evidence

The panel heard an application made by Ms Barnor under Rule 31 to admit 'Other evidence and supporting information' into evidence. This comprised:

- Matron's timeline of incident dated 12 June 2020;
- RCA Report Datix dated 15 June 2020;
- Action plan target dates dated 21 July 2020;
- Incident report dated 29 June 2020 and 14 February 2022;
- Inquest file closure note dated 14 October 2020;
- Ms Sandy's local statement dated 6 December 2020 which included her letter of appeal against the local disciplinary decision; and
- Ms Sandy's letter to the Chief Executive of the Trust.

Ms Barnor submitted that these documents are contemporaneous evidence which formed part of the Trust's local investigation. She said that, apart from Ms Sandy's letter to the Chief Executive, these were provided to Mrs Sandy in the NMC's Case Management Form and that she had not objected to these nor commented that the NMC should not rely on these. Therefore, Mrs Sandy had an opportunity to respond, and so there is no procedural unfairness.

Ms Barnor further submitted that these documents are relevant to the charges and therefore invited the panel to admit them into evidence.

Ms Harding, on Mrs Sandy's behalf, did not oppose the application.

The panel accepted the advice of the legal assessor on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered that as Ms Sandy had been provided with a copy of the all the documentation, with the exception of the letter she had written herself to the Chief Executive. There was a public interest in the issues being explored fully, the admission of this evidence into the proceedings was justified.

In these circumstances, the panel decided that it would be fair and relevant to admit all of the documentation into evidence. The panel would decide what weight to give it once it had heard and evaluated all the evidence before it.

Background

The charges arose whilst Ms Sandy was employed as a Band 7 Senior Charge Nurse by Royal Wolverhampton NHS Trust ('the Trust') where she managed two renal units.

Patients are connected to the dialysis machine for three hours, in which the machine takes their blood, processes it through the machine, cleans it and puts the blood back into their body.

An incident occurred in June 2020 when a patient's dialysis line became detached. This patient was known for covering up her line with blankets and/or jumpers when it was connected as she would become cold during the dialysis process. This patient was also said to have been lightheaded during the dialysis as her blood pressure had dropped, but this was considered to be a normal effect during her dialysis. It was stated by the Trust that underneath the patient's blanket, the dialysis line had become disconnected, which meant that the machine was taking blood from her but was not pumping blood back into her body. The patient lost blood and died. However, following the Coroner's Inquest, it was determined this was not the cause of the patient's death.

In January 2020, a serious patient safety incident occurred at an external Trust which identified some learning for the unit. This was communicated by the nurse consultant for renal services.

Ms Sandy was the senior charge nurse and was required to ensure that all staff received the training, and that all patient records would be updated to reflect the new procedures. Ms Sandy was alleged not to have implemented this action plan and retrospectively recorded that this had been completed for Patient A and entered these details on all the patient's records. Ms Sandy had also allegedly coerced another member of staff, Rachael Davis, to help falsify the records.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Barnor who informed the panel that Ms Sandy made full admissions to charges 1 and 5(a). Ms Harding confirmed that Ms Sandy admitted those charges in their amended form.

The panel therefore found charges 1 and 5(a) proved in their entirety.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence before it together with the submissions made by Ms Barnor on behalf of the NMC and by Ms Sandy.

The panel has drawn no adverse inference from the non-attendance of Ms Sandy.

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 evidence from the following witnesses called on behalf of the NMC:

- Rachael Davis: Staff Nurse at the Trust, at the time of the incidents, described in the charges as Colleague A;
- Michelle Redding: Matron – Renal at the Trust, at the time of the incidents;
- Samantha Jarvis: Investigating Officer, Matron ED (Emergency Department), at the time of the incidents.

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

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

Charge 2(a)(i)(a)

2) In relation to Colleague A:

a) between June 2020 and July 2020 encouraged her to:

i) in relation to a line competency form:

(a) state that she had received it;

This charge is found not proved.

In reaching its decision, the panel took into account the witness statement from Ms Sandy that stated:

> *'I genuinely believed that she had been given the document from the band 6 and should be at home, when she informed me that she had not been given her booklet I then informed her to call into the unit and pick one up'*

The panel had regard to the evidence before it which included the internal investigation conducted by the Trust dated October 2020:

> *'In an email to Matron Redding SN Davis stated that on 16/6/2020 SSr Sandy told her that her Line assessment competency had been sent to Matron, but that she must have forgotten to sign it. SN Davis stated that she questioned SSr Sandy about this as she had never been asked to sign a Line care assessment document and SSr Sandy clarified that if she was asked, to say that she'd forgotten to sign it.'*

When considering the evidence before it, the panel determined that although there is evidence to suggest Ms Sandy encouraged Ms Davis to say that she had left the

document at home, there is insufficient evidence to suggest that Ms Sandy encouraged Ms Davis to say that she had not received it and that there is a relevant difference. On the basis of these findings, the panel therefore found this charge not proved.

Charge 2(a)(i)(b)

2) In relation to Colleague A:

a) between June 2020 and July 2020 encouraged her to:

i) in relation to a line competency form:

(b) state that she had forgotten to sign it and/or have it signed;

This charge is found proved.

In reaching this decision, the panel took into account an investigation interview with Ms Davis on 20 August 2020 when Ms Davis stated:

> *'I feel awful for Sr. Sandy but I didn't feel comfortable with the position I was in and felt I needed to tell the truth. Sr. Sandy said that if Matron Redding asked me about the paperwork to say that I had it at home, however I didn't have it at home at that time but collected it after a conversation with Sr. Sandy as I also didn't want to be in the position of lying to Matron Redding and saying I had it home when I didn't. I wish I had been strong enough to challenge Sr Sandy at the time and I am annoyed with myself about this.'*

Furthermore, in an email from Ms Davis to the Matron dated 10 July 2020 in relation to the line competency, Ms Davis said:

> *'So Sr Sandy clarified that If I am asked, to say that id forgotten to sign it off'*

The panel also took into account that Ms Sandy denies this allegation and had regard to her witness statement that stated:

> *'I did not coerce the junior staff member who was involved in the serious incident to say that she had forgotten to sign her competency document as I genuinely believed that she had been given the document from the Band 6 and should have it at home'*

However, the panel considered Ms Davis's oral evidence and the NMC guidance on 'Evidence' (reference: DMA-6, last updated 09/06/2025), specifically in relation to assessing credibility. It found that Ms Davis's oral evidence was consistent with all her previous accounts. Her first account was contained in an email sent to Ms Redding on 10 July 2020 which was about four weeks after the incident.

The panel found no reason to doubt her evidence. It appeared from her text messages that she had a good relationship with Ms Sandy. She described her as supportive in her oral evidence. In all the circumstances the panel found Ms Davis's account more reliable than Ms Sandy's.

The panel therefore determined that this charge is found proved.

Charge 2(a)(ii)(a)

2) In relation to Colleague A:

a) between June 2020 and July 2020 encouraged her to:

ii) in relation to a renal competency booklet:

(a) state that she had received it;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence it relied on for its findings in relation to Charge 2(a)(i)(a), which included a statement from Ms Sandy's own account claiming that she believed that Ms Davis had been given the document and that she had left it at home. In an email dated 10 July 2020 from Ms Davis to Matron Redding, Ms Davis stated:

> *'I was then also asked to say that I had the renal competency booklet at home. This made me feel very uncomfortable and I felt in an awkward position so I decided to go to the renal unit and collect a Renal competency booklet so if I was asked did I have it at home, that I would not need to lie'*

The panel also had regard to an email sent to Matron Redding from Ms Sandy dated 16 June 2020 that stated:

> *'I have also added in the renal competency's (sic) for you to see although these are not Rachael's as I presume she has them at home as we do not give them a time limit for completion'*

In considering the evidence before it, the panel determined that although there was evidence to suggest that Ms Sandy encouraged Ms Davis to state that she had left the renal competency booklet at home, there was insufficient evidence to establish that Ms Sandy instructed Ms Davis to state that she had received it. The panel considered that there was an important distinction between the two and the panel therefore found this charge not proved.

Charge 2(a)(ii)(b)

> 2) In relation to Colleague A:

a) between June 2020 and July 2020 encouraged her to:

ii) in relation to a renal competency booklet:

(b) state that she had left it at home;

This charge is found proved.

In reaching this decision, the panel took into account the evidence aforementioned in Charge 2(a)(ii)(a), which included an email from Ms Davis to the Matron stating that Ms Sandy had asked Ms Davis to declare that she had left the renal competency booklet at home. The panel also considered Ms Sandy's own written statement declaring that she had genuinely thought that Ms Davis had left the renal competency booklet at home.

In reaching this decision, the panel took into account an investigation interview with Ms Davis on 20 August 2020 when Ms Davis stated:

> *'I feel awful for Sr. Sandy but I didn't feel comfortable with the position I was in and felt I needed to tell the truth. Sr. Sandy said that if Matron Redding asked me about the paperwork to say that I had it at home, however I didn't have it at home at that time but collected it after a conversation with Sr. Sandy as I also didn't want to be in the position of lying to Matron Redding and saying I had it home when I didn't. I wish I had been strong enough to challenge Sr Sandy at the time and I am annoyed with myself about this.'*

The panel considered Ms Davis's oral evidence and the NMC guidance 'Evidence' (reference: DMA-6, last updated 09/06/2025), specifically in relation to assessing credibility. It found that Ms Davis's oral evidence was consistent with all her previous accounts. Her first account was contained in an email sent to Ms Redding on 10 July 2020 which was about four weeks after the incident.

The panel found no reason to doubt her evidence. It appeared from her text messages that she had a good relationship with Ms Sandy. She described her as supportive in her oral evidence. The panel had no reason to conclude that Ms Davis had any motive to fabricate her account of the conversation with Ms Sandy. In all the circumstances the panel found Ms Davis's account more reliable than Ms Sandy's.

Accordingly, the panel found Charge 2(a)(ii)(b) proved.

Charge 2(b)(i)

2) In relation to Colleague A:

b) between October 2019 and June 2020, failed to ensure that:

i) she had received appropriate competency training and assessments; and/or

This charge is found proved.

The panel first considered whether the evidence showed that Ms Sandy had a duty to ensure that Colleague A had received appropriate competency training and assessments during the specified time period. Within the evidence before it the panel did not have any written documentation such as a policy or standard operating procedure explicitly stating that Ms Sandy had this duty. However, the panel bore in mind:

- Ms Sandy was a Band 7 Senior Charge Nurse;
- Her job description which summarises her main duties and responsibilities, including to ensure safe and effective clinical practice and to manage and develop the performance of the team;
- The renal competency document which stated *'competencies should be taken and*

given to the manager so that they can update their records';

- That the request for documentary evidence required for the local investigation was sent to Ms Sandy, suggesting she was the person in charge of these records;
- Within the oral evidence of Michelle Redding, she was asked who was responsible for the training and assessments, and she stated: *'the Band 7'.*

The panel therefore concluded that the duty to provide appropriate competency training and assessments had been established.

The panel heard from Ms Davis in her oral evidence that she received training during her 6-week supernumerary period, which consisted of learning through observations and 'hands on training'. Whilst Ms Davis stated that she felt supported and competent, the panel had to consider whether this amounted to appropriate competency training and assessment.

When asked why the renal competency booklet was important, Michelle Reding stated that:

> *'it was to ensure standardised treatment set against a set of agreed competencies and ensure all staff are assessed to the same level'.*

In Ms Davis's oral evidence, she confirmed that it was only after she had received the renal competency booklet that she became aware that certain competencies applied.

The panel determined that although some training was provided, it was not to the requisite standard.

The panel took into account the witness statement from Ms Davis dated 9 March 2026. Ms Davis stated that she had asked for the relevant competency training booklet on more than one occasion, but she was unable to obtain them from Ms Sandy and she stated that:

> *'I had raised the matter to Dawn a few times, but felt the situation was not being taken seriously enough and that I was causing an annoyance.'*

In her statement, Ms Davis explained how she attempted to obtain the relevant competency training booklets from other staff members. She stated:

> *'Nobody on the unit seemed to know how to locate the correct competency booklet.'*

The panel considered that the completion of these competencies was an integral part of a renal nurse's comprehensive training. The panel found that Ms Sandy had failed to ensure that Ms Davis had received appropriate competency training and assessments.

Accordingly, the panel found Charge 2(b)(i) proved.

Charge 2(b)(ii)

2) In relation to Colleague A:

b) between October 2019 and June 2020, failed to ensure that:

ii) the competency training and assessment she had received was properly recorded.

This charge is found proved.

For the same reasons given in Charge 2(b)(i), the panel found that Ms Sandy was under a duty to ensure that the competency training and assessments Ms Davis received was properly recorded.

In reaching this decision, the panel took into account an undated statement from Ms Sandy as part of the internal investigation, stating she was unaware of where up to date relevant documentation was located. Ms Sandy stated:

> *'The staff Nurse who started new to renal went to New Cross on placement whereby her competency document should have been completed (or at least commenced there). It is my belief that during rotation the professional development nurse who is based at New Cross Renal Unit signs off all relevant competency's. It was also stated that the yearly competency line was not up to date. Both Band 6's had commenced line training for 2020 after being approached by the professional development nurse informing them that they were due. It is true I was unaware of where the documents were at the time that Matron Redding requested to see them.'*

The panel considered what records were required in relation to the renal competency booklet. It had been provided with a copy of Ms Davis's competency booklet. The panel found that it was a live document requiring continuous assessment throughout the assessment period and updated when each competency was achieved. During the 6 months from when Ms Davis started, no recording was made.

Accordingly, the panel found Charge 2(b)(ii) proved.

Charge 3(a) and Charge 3(b)

3) Failed to ensure staff under your management received appropriate:

a) competency training;

b) competency assessments.

These charges are found proved.

For the reasons set out under the previous charges, the panel was satisfied that Ms Sandy was under a duty to ensure that staff under her management received appropriate competency training and assessments.

The panel was satisfied that Ms Sandy considered Ms Davis to be a competent and trained nurse. However, completion of the required training and assessments was dependent upon accurate records being completed and recorded by a senior member of staff. The panel had regard to the evidence before it, including the statement from Matron Redding, dated 8 November 2024, which highlighted the competency training must be recorded:

> *'I also asked for a Renal Competency Booklet to be forward to me to show that the nurse involved had been properly trained and that there were no concerns surrounding her competency. These booklets should be issued to all new nursing staff'*

The panel also had regard to the witness statement from Ms Davis, dated 13 September 2024:

> *'However, for the training to be evidenced, I should be given a competency booklet. This would allow for my mentors to record which skills and competencies had been completed and when.'*

Having found Ms Sandy failed to ensure Ms Davis received appropriate competency training and competency assessments, the panel next considered whether this failure extended to other members of staff under Ms Sandy's management.

Ms Davis said in her witness statement dated 13 September 2024:

> *'A colleague Nurse… had been at Cannock Renal Unit for several months before me. She approached me stating that she'd also been given the wrong booklet'.*

Ms Sandy stated in her undated statement during the internal Trust investigation:

> *'I failed to check if staff had completed their competencies and returned the documents to their personal files'*

The panel noted that Ms Sandy did not admit this charge. She stated that new starters should have competency booklets completed. In a statement from Ms Sandy on 6 December 2020, Ms Sandy stated that:

> *'I dispute this allegation due to the fact that all the time I have managed Maurice Jackson Unit all new starters apart from one have come from the main Renal Unit at New Cross these staff members should have already had competency documents in place.'*

The panel took into account the evidence from the statement from Ms Sandy to the NMC and the witness statement of Ms Davis and her oral evidence. Ms Davis stated:

> *'Dawn gave me a booklet a few days later, but this booklet was aimed towards student nurses or newly qualified nurses. There was nothing in the booklet which related to renal competencies. The booklet in question only referred to the basic skills such as taking a patient's blood pressure which I didn't need training for as I was an experienced nurse and therefore, already competent at doing this. I told Dawn that I believed she had given me the wrong booklet as it didn't cover the appropriate competencies. Dawn then provided me with another booklet a short while later. However, this booklet only included two pages and was more of a*

statement. It didn't include any competencies. I had raised the matter to Dawn a few times, but I felt like the situation was not being taken seriously enough and I was causing an annoyance.'

The panel also had regard to Ms Sandy's account, when reflecting on whether Ms Davis had received the appropriate competency booklet, Ms Sandy stated:

'I now understand that New Cross Renal Unit allow 12 month for these to be completed. I failed to check if staff had completed their competency's and returned the document to their personal file'

The panel determined that Ms Sandy's account was consistent with the documentary evidence and the witness statement from Ms Davis. The panel therefore determined that on the balance of probabilities, there is clear and consistent evidence, including Ms Sandys own admission, that she had failed to ensure that staff under her management had received the appropriate competency training and assessments.

The panel took into account the statements from Ms Sandy, Ms Redding and Ms Davis and determined that it is clear that, although Ms Davis may have been competent and trained, Ms Sandy failed to ensure that Ms Davis and other members of staff had received appropriate competency training and competency assessments.

Accordingly, the panel found Charge 3(a) and 3(b) proved.

Charge 4

From January 2020, failed to implement an action plan following a serious incident.

This charge is found proved.

In reaching its decision, the panel took into account email correspondence between Ms Sandy and senior colleague.

Following an external serious incident, Ms Sandy was made aware that actions were required to be implemented on the ward. This was set out in an email from Helen Spooner (Ms Spooner) dated 21 January 2020 which stated:

> *'Dear All*
>
> *Following on from an investigation that I have been involved in into a fatality of a HD patient at another trust we need to ensure that all vascular access connections are visible at all times (lines and AVF needles). In order to monitor this I am in the process of altering the comfort round chart to include a column stating that the access is visible. However as this is a change to documentation it has to go through the trust group which will take a little· time to sort. In the meantime can I please ask that you ensure that this is incorporated into your current patient checks and that access is checked and documented hourly. Any patient that insists on covering up their access must have a documented discussion and sign a disclaimer In the same way as they do for cutting their time short. They will also need a risk assessment and consideration of a blood detection advice;*
> *There will be some recommendations around this topic and particularly around line disconnection incidents coming out from the renal association patient safety group shortly but in the meantime please ensure that this is actioned as a matter of urgency.*
> *Any queries please give me a call*
> *Thanks*
> *Helen'*

The panel considered this email included an action plan, given there was specific tasks and timescales attached to them.

Ms Sandy replied to Ms Spooner on 22 January 2020:

> *'Thanks for the update – this is a practice we do follow at both the satellite units therefore it will cause no change in practice for us. Nice to see the documentation for it though.'*

Having found this to include an action plan, the panel then went on to consider whether it was Ms Sandy's duty to implement it. The panel had regard to the wording within the email and considered the use of the word '*ensure*' meant that the actions were mandatory. This email was sent to a number of people including the Band 6 nurse working on the same unit. The panel was satisfied that Ms Sandy accepted the responsibility to implement the action plan on the units for which she was responsible. In her undated account, she said:

> *'I forwarded this email to all the band 6's on both units (Cannock and Maurice Jackson) and informed staff at handovers. The error I made at this point was not ensuring the Band 6's from both units had carried out the instructions from the email I forwarded'.*

Therefore, the panel were satisfied that Ms Sandy was aware that an action plan was to be implemented and that she had not fulfilled her duty to ensure that the action plan had been implemented.

Accordingly, the panel found Charge 4(b) proved.

Charge 5(b)(i)

> 5) Your actions at charges 1) and/or 2) (a) were dishonest in that:
>
> b) In respect of charge 2)(a):

i) You knew Colleague A had not received and/or completed the competency booklet(s) and/or line competency assessment form;

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Ms Davis who stated that she was not provided with a renal competency book to complete and was instead encouraged to say that she had forgotten to sign it or that she had left it at home. Within her witness statement dated 9 March 2026, Ms Davis stated

> *'if matron asked, that I should say that I left the competency booklet at home. This was because Dawn knew that I didn't have a competency booklet, so by saying I'd left it at home, I would not be able to show it to matron when asked. The trueful answer would've been to inform matron that multiple staff members, possibly all of us, had never been given the correct competency booklet in the first place… I do believe that she was panicking due to the investigations which were taking place. This is why she was determined to have the individual line competency form, competency booklets and the documentation… in place'.*

Ms Davis stated that she was not provided with a renal competency booklet to complete and was instead encouraged to say that she had forgotten to sign it or that she had left it at home.

The panel also had regard to an email from Ms Davis to the Matron sent on 10 July 2020.

> *'so Sr Sandy clarified that if I am asked, to say that id forgotten to sign it. I was then also asked to say that I had the renal competency booklet at home. This made me feel very uncomfortable and I felt in an awkward position so I decided to go to the renal unit and collect a Renal competency booklet so if I was asked did I have it at home, that I would not need to lie. I advised Sr Sandy that I would do that.'*

During an internal investigation with the trust dated 2 September 2020, in relation to Ms Sandy having given Ms Davis the relevant renal competency documentation, Ms Sandy stated:

> *'To be honest I don't remember I thought I had given her the competency booklet, I do not recall the conversation with Rachel'*

The panel found Ms Davis to be a credible witness, and it was satisfied that this conversation had taken place. Ms Davis in her written and oral evidence detailed requesting the renal competency booklet from Ms Sandy on a number of occasions. The panel therefore concluded that at the time Ms Sandy encouraged Ms Davis to say that she had her renal competency booklet at home when Ms Sandy knew that this was untrue.

The panel was satisfied, applying the standards of ordinary and decent people, that Ms Sandy's actions were dishonest.

Accordingly, the panel found Charge 5(b)(i) proved.

Charge 5(b)(ii)

> 5) Your actions at charges 1) and/or 2) (a) were dishonest in that:
>
> > b) In respect of charge 2)(a):
> >
> > > ii) You were seeking to hide the fact that you had failed to ensure that Colleague A had received appropriate training and assessments and/or the training and assessments she had received had been properly recorded.

This charge is found proved in respect of the second limb of Charge 5(b)(ii).

The panel found that it is unlikely that Ms Sandy considered that Ms Davis had not received appropriate training and assessments. The evidence suggests that Ms Davis had received hands on training on the unit and the important omission was that she had not worked through the competency booklet. From Ms Sandy's perspective, it is likely that she viewed Ms Davis as having received appropriate training and that she was competent to work on the renal unit. Accordingly, the panel considers it unlikely that Ms Sandy was seeking to conceal a failure to provide appropriate training and assessments. Accordingly, the first limb of Charge 5(b)(ii) is found not proved.

However, the panel was satisfied that Ms Sandy was seeking to conceal the training and assessments that Ms Davis had received had not been properly recorded. The relevant training records would have been found within the competency form or renal competency booklet. Had those records been provided to Ms Davis, Ms Sandy would have appreciated that these competency booklets had not been received.

In reaching its decision, the panel took into account a series of text exchanges between Ms Davis and Ms Sandy from 6 July 2020. Ms Davis stated:

> *'I think you should know Dawn, the matron knows that I've only just been given my competency booklet and that I didn't know about the line one. She asked me some questions and i felt I'd better be truthful with it going to court. It says on the rcn it can be made criminal if you lie about paperwork and I already feel under so much [PRIVATE] and pressure so I felt I should be honest. I did tell her though that i was 100% trained properly and I was supernumerey* (sic) *for 6 weeks etc. And what has been signed so far in the book is what i was competent at. She might ask you so I don't want you to be caught out.'*

By encouraging Ms Davis to state that she had forgotten to sign the competency book and that she had left the booklet at home, Ms Sandy was seeking to hide the fact that she had failed to ensure that the training and assessments had been properly recorded. The panel

was satisfied that her attempt to hide this fact was dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 5(b)(ii) proved in part.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Sandy's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Representations on misconduct and impairment

Ms Barnor invited the panel to take the view that the facts found proved amount to misconduct. The panel should have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015)' ('the Code') in making its decision.

Ms Barnor submitted that Ms Sandy's conduct fell significantly short of what is expected of a registered nurse as her actions put patients at risk by falsifying documents, encouraging

nurses to give false information, and failing to implement the required training. She also submitted that Ms Sandy's dishonesty, which was her attempt to cover up her errors, was a serious departure of the fundamental tenets of the Code.

Ms Barnor identified the following specific, relevant standards in the Code where in her submissions, Ms Sandy's actions amounted to misconduct: 8.2, 8.5, 10.3, 14.1, 20.1, 20.2, 20.3, 20.5, 25.1 and 25.2.

Ms Barnor submitted that Mrs Sandy's fitness to practise is impaired. She referred the panel to on NMC's guidance on *'Impairment'* (Reference: DMA-1) and the case of Council for *Healthcare Regulatory Excellence* v (1) Nursing and Midwifery Council (2) *Grant* [2011] EWHC 927 (Admin) to answer the following questions:

a. *has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
b. *has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
c. *has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
d. *has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.*

Ms Barnor submitted that limbs a to d can be answered in the affirmative in this case. Ms Barnor submitted that Ms Sandy's conduct created concerns around patient safety, public confidence, professional standards, and dishonesty.

Ms Barnor submitted that record keeping is a fundamental nursing skill and that inaccurate information on patient records could have consequences for the patient's future care. She further submitted that honesty and integrity are important qualities for a nurse and the seriousness of the misconduct lies in the fact that the patient's record had been fabricated to make it appear that a risk assessment had taken place when it had not.

In addition, Ms Barnor submitted that Ms Sandy was in a position of power and influence and had abused her position of authority. She submitted that members of staff should be able to expect their manager to ensure that systems are implemented and maintained appropriately, and that competency of staff was necessary to ensure safe practice. Ms Sandy's actions resulted in nurses not having the correct skills recorded for the unit, which represented a failure and created a potential risk to patient safety. Ms Barnor submitted that some nurses had been permitted to work without their competencies being appropriately recorded, thereby creating a potential risk of harm. Ms Sandy's failure to take accountability for her actions were of a serious nature.

In relation to future risk, Ms Barnor referred the panel to paragraph 16 of the NMC's Fitness to Practise guidance and submitted that the panel should have regard to the approach in *Cohen v General Medical Council* [2008] EWHC 581 (Admin). Ms Barnor submitted that the panel should consider whether the concerns were capable of remediation, whether they had been remedied, and whether there was a risk of repetition. The misconduct had not been remediated and, consequently, remained capable of being repeated.

Ms Barnor accepted that Ms Sandy had received positive testimonials from her current place of work. However, these testimonials related to an entirely different workplace in which Ms Sandy did not have managerial responsibilities or comparable responsibilities. Furthermore, the Ms Barnor submitted that, in her reflections, Ms Sandy had demonstrated limited accountability and little insight into her conduct. Ms Barnor therefore submitted that there remained a risk of repetition.

Ms Barnor submitted that Ms Sandy's conduct has brought the nursing profession into disrepute, breached fundamental tenets of nursing, and involved dishonesty. Whilst Ms Sandy had made some admissions to the charges, and had provided some reflections, Ms Barnor submitted that this was insufficient insight into the concerns. She said that there is no evidence of meaningful remediation, training, or strengthened practice, and therefore submitted that there remains a risk of repetition.

Ms Barnor submitted that a finding of impairment is required on both public protection and public interest grounds, to protect patients, uphold professional standards, and maintain public confidence in the nursing profession.

The NMC reminded the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

The panel accepted the advice of the legal assessor. This included reference to *Council for Healthcare Regulatory Excellence* v (1) Nursing and Midwifery Council (2) and *Grant* [2011] EWHC 927 (Admin) *(Grant)* and Dame Janet Smith's test as set out in the '*Fifth Report from the Shipman Inquiry'*.

Decision and reasons on misconduct

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

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

> ***'8 Work co-operatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*

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

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

To achieve this, you must:

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver

is maintained and improved, putting the needs of those receiving care or services first.
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered the NMC Guidance *'Misconduct'* (Reference: FTP-2a Last Updated: 20/05/2026) and recognised that serious professional misconduct is more likely to arise where concerns occur within professional practice and when conduct falls far below the standards expected of a registered professional.

The panel considered that, in Ms Sandy's role as a Band 7 nurse and manager, she failed to fulfil the responsibilities and duties expected of her at that level. The panel was of the view that the charges found proved constituted misconduct.

The panel was of the view that the conduct in this case involved fundamental breaches of the Code. Across the charges found proved, the panel identified failures engaging the core requirements of nursing practice, including prioritising people, preserving safety, maintaining accurate records, acting with honesty and integrity, and upholding professional standards.

The panel considered the record-keeping concerns to be particularly serious. Accurate records are essential to safe patient care. Where records are inaccurate or misleading, there is a risk that other healthcare professionals may make decisions based upon incorrect information, potentially placing patients at risk and unknowingly undermining their professional practice.

The panel was of the view that the charges are serious and include dishonesty. A registered nurse is expected to act with honesty, integrity and candour. The panel found that conduct involving falsification of records and an attempt to mislead

colleagues represents a serious departure from the standards expected of a nurse. Furthermore, the panel considered that encouraging junior members of staff to falsify their own records and to provide false information to colleagues is an abuse of power and fell significantly below the standards expected a Band 7 nurse and manager.

The panel considered that the concerns were wide-ranging and involved different areas of nursing practice, including failures implement appropriate systems, failures in record keeping, inaccurate documentation, encouraging other nurses to also falsify records and a failure to demonstrate openness and honesty when concerns arose.

The panel found that Ms Sandy's actions did fall seriously short of the conduct and standards expected of a nurse and therefore found that all the charges found proved amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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 Grant in reaching its decision. At 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.'*

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

For reasons already set out above, the panel considered that limbs a, b, c and d were engaged by your misconduct in this case.

The panel finds that patients were put at risk of harm due by falsifying documentation and failing to implement and record appropriate training and competencies. It was satisfied

that Ms Sandy's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Furthermore, Sandy was dishonest.

The panel recognised that it must make an assessment of Ms Sandy's fitness to practise as of today. It had regard to *Cohen* and considered whether the concerns identified in her nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Ms Sandy had provided evidence of insight and remorse.

In considering Ms Sandy's level of insight the panel bore in mind that she did not provide any evidence today of any steps she has taken to address the concerns. The statement given by Ms Sandy's representative on the first day of the hearing did not provide the panel with any new evidence that challenged the allegations put before her. The panel considered Ms Sandy's responses to the allegations in the bundle and the emails sent to senior colleagues in the panel's judgement Ms Sandy took limited accountability for the failings and showed only very limited insight into the misconduct.

The panel concluded that patients were put at risk of harm by falsifying documents, encouraging nurses to give false information and failing to implement appropriate training. It was satisfied that Ms Sandy's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel is of the view that there is a risk of repetition based on Ms Sandy's lack of accountability and insight. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

standards for members of those professions. The panel therefore found Ms Sandy's fitness to practice impaired.

Having regard to all of the above, the panel was satisfied that Ms Sandy's fitness to practice is currently impaired.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

In the Notice of Hearing, dated 28 July 2026, the NMC had advised Ms Sandy that it would seek the imposition of a striking-off order if Ms Sandy's fitness to practise were found to be impaired.

Ms Barnor submitted that the aggravating features include:

- Abuse of position of trust;
- Absence of insight;
- Deliberate breaches of Code which recklessly put a patient at risk of harm; and
- Attempt to cover up when things went wrong to her own benefit.

Ms Barnor submitted that the mitigating features include:

- Long standing career of 45 years with no Fitness to Practice history; and
- Early admissions into some of the charges, charge 1 and charge 5(a).

However, Ms Barnor submitted that Ms Sandy has demonstrated an attitudinal concern which has not been addressed, and therefore her fitness to practise history should not be relevant.

In relation to no order and a caution order, Ms Barnor submitted that these sanctions would be wholly inappropriate, would not reflect the seriousness of the misconduct, and would not protect the public or meet the public interest.

In relation to a conditions of practice order, Ms Barnor submitted that whilst some charges can be addressed through conditions, the attitudinal concern and the dishonesty are so serious that conditions would not be appropriate, workable or measurable. She said that honesty is a fundamental tenet of the Code and to monitor honesty would be difficult for any employer. Furthermore, Ms Sandy has told the NMC that she no longer wishes to practise as a registered nurse. Therefore, it can be inferred that she will not engage with the conditions.

In relation to a suspension order, Ms Barnor submitted that Ms Sandy's misconduct was so serious that anything less than a striking-off order would not be appropriate, protect the public or meet the wider public interest. She submitted that the panel, in its decision, had found that Ms Sandy has limited insight and has taken no accountability for her failings. Therefore, a suspension order would not be appropriate.

In relation to a striking-off order, Ms Barnor submitted that Ms Sandy's misconduct does raise fundamental questions about her professionalism, and that it was so serious that the public's confidence in the nursing profession could not be maintained if she was not removed from the Register. Furthermore, Ms Barnor submitted that Ms Sandy has not demonstrated a sufficient amount of insight and/or reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards. Ms Sandy has indicated to the NMC that

she no longer wishes to practise as a registered nurse. Therefore, there is not a realistic prospect that, after suspension, Ms Sandy will have gained insight and strengthened her practice such that the risk she poses will have reduced.

Ms Barnor therefore invited the panel to impose a striking-off order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Abuse of a position of trust;
- Deliberate breaches of the Code which recklessly put people receiving care at risk of suffering harm;
- Dishonesty;
- Limited insight into her failings; and
- No evidence of remediation or retraining to address the concerns.

The panel took into account Ms Sandy's 'impact statement' and case management form, in which she demonstrated very limited insight into her misconduct.

The panel also took into account the following mitigating features:

- Long standing career – 45 years with no Fitness to Practise history;
- Early admissions to some of the charges in this case; and
- The impact and [PRIVATE] of the Covid-19 pandemic.

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

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

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

The panel considered that Ms Sandy's actions were not at the lower end of the spectrum, and it found that there is a risk to patient safety. The panel therefore determined that a sanction that does not restrict Ms Sandy's practice would not protect patients. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on Ms Sandy's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). Having found two charges relating to dishonesty proved, and having regard to the nature and seriousness of Ms Sandy's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last

Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could be managed by Ms Sandy being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the

seriousness and nature of the facts found proved. Given Ms Sandy's limited insight, lack of remorse, together with no evidence of relevant training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely. The panel determined Ms Sandy's intention to leave the register and lack of insight into her failings, suggests that she would not utilise the suspension to remediate her misconduct. Furthermore, the panel considered that given the nature of the misconduct, which involves dishonesty and attitudinal concerns, there is limited scope for remediation to address concerns related to dishonesty.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

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

Having had regard to the evidence before it, the panel could not be assured that a period of suspension would in fact satisfactorily reduce the risk to the public from Ms Sandy's practice. It noted that Ms Sandy has indicated that she no longer wishes to practise as a registered nurse. Further, the panel did not consider that a period of suspension would be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and wide-ranging nature of the facts found proved.

The panel also considered that Ms Sandy had been unable to demonstrate an understanding of the risk of harm she posed to patients and members of staff. Whilst it acknowledged she had admitted some of the charges, there would have been considerably more pressure managing the unit at that time due to Covid-19, and positive testimonials from subsequent employers, it had no evidence there has been any strengthening of practice, remediation or sufficient insight into her misconduct. Furthermore, the panel considered charges of dishonesty to be of the most serious and least remediable.

In light of her extremely limited insight, lack of remorse, and insufficient evidence of learning from training, remediation, and professional development, the panel concluded that there was no realistic prospect that Ms Sandy would address the concerns to the extent necessary to return to safe and unrestricted practice.

Ms Sandy's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Sandy's actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Sandy's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse

should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Ms Sandy in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Barnor. She submitted that an interim suspension order is necessary and proportionate in order to protect the public and maintain the public interest over any appeal period. She submitted that this order should be imposed for a period of 18 months so as to allow sufficient time for any appeal to take place.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel has decided that there was a risk to the public arising from Ms Sandy's practice which required her to be struck off the register. 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. For the same reasons the panel was satisfied that an interim order suspending her from practice was required in order to protect the public. The panel also considered that an interim suspension order was required in order to maintain the reputation of the profession, and the NMC as its regulator because of the nature of the misconduct found proved.

This order will cease either 28 days after service if there is no appeal, or at the conclusion of the appeal if one is lodged. As an appeal may take up to 18 months to come to a conclusion, the panel decided on an interim order for 18 months.

The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and maintain public confidence over any appeal period.

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

That concludes this determination