Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 December 2025 – Friday, 5 December 2025

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

Name of Registrant:	Elsa Alves De Carvalho
NMC PIN	15F0352E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing RNMH – 5 November 2015
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, lay member) Michelle Wells-Braithwaite (Registrant member) Rachel Cerfontyne (Lay member)
Legal Assessor:	Natalie Amey-Smith
Hearings Coordinator:	Peaches Osibamowo
Nursing and Midwifery Council:	Represented by Harry Piercy, Case Presenter
Ms Carvalho:	Present and represented by Elliott Courcha, instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 2a, 2b, 2c, 2d, 3a, 3b, 4, 5a, 5b, 5c and 6.
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

"That you, a registered nurse:

1) On 13 March 2024 demonstrated poor leadership in your capacity as Nurse in Charge of the shift in that you:

    a) Took an extended break between approximately 00:09 and 02:47 in contravention of your own allocation of duties for the shift and/or a management direction that staff breaks be limited to one hour.
    b) Allowed and/or permitted Colleague A to take a break between approximately 01:07 and 03:56 in contravention of your own allocation of duties for the shift and/or a management direction that staff breaks be limited to one hour.
    c) Your conduct at charge 1a) and/or 1b) resulted in the Ward not having a registered nurse on duty between approximately 01:07 and 02:47.
    d) Did not ensure that a nursing handover took place before Colleague A went on his break at 01:07.
    e) Did not ensure and/or oversee that there was a registered nurse working on shift at all times.
    f) Allowed and/or permitted Colleague B to take a break between approximately 02:56 and 06:00 in contravention of your own allocation of duties for the shift and/or a management direction that staff breaks by limited to one hour.

2) Between 12 and 13 March 2024 failed to safeguard patient safety in that you:

    a) Did not ensure that the keys to the medication cupboard were securely stored on your person.
    b) Did not ensure that you handed over the keys to the medication cupboard before you took your break/s.

c) Did not ensure that the door to the nurse's office where you had left the medication cupboard keys was closed.
d) Created a risk of infection by using and returning cushions and blankets designated for patient use.

3) On 13 March 2024 were asleep whilst on duty as Nurse in Charge between:

a) Approximately 03:00 and 03:40.
b) Approximately 03:52 and 06:22.

Or in the alternative, failed to perform nursing duties adequately or at all between the times set out at charge 3a) and/or 3b).

4) On 13 March 2024 failed to complete twice hourly observations of Patient A between 03:00 and 04:00, as required.

5) On 13 March 2024 inaccurately recorded that you had completed observations of Patient A at:

a) 03:10.
b) 03:35.
c) 04:02.

6) Your conduct at charge 5a) and/or 5b) and/or 5c) was dishonest in that you intended to create a misleading impression that you had completed Patient A's observations when you knew you had not.

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

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

Dr Courcha, on your behalf, made a request that this case be held partly in private on the basis that proper exploration of your case involves references to your health and private life. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Piercy, on behalf of the Nursing and Midwifery Council (NMC), indicated that he supported the application to the extent that any reference to your health or private life 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 determined to go into private session in connection with your health or private life as and when such issues are raised in order to protect your privacy.

Background

The charges arose whilst you were employed by the [PRIVATE] ("the Hospital") bank as a registered RMN. You were employed from 28 April 2023 until 4 April 2024.

The regulatory concerns arise from a referral by the Hospital's Director (Witness 1) who alleged that, whilst acting as Nurse in Charge of the night shift on 12 to 13 March 2024, leading Colleague A (a registered nurse) and Colleague B (a healthcare assistant, HCA):

- You were seen on close-circuit television (CCTV) sleeping for a period of time whilst on shift as nurse in charge of on the Ward;
- You used cushions and blankets from the patient lounge to rest in which presented an infection control risk;
- You allocated yourself, Colleague A and Colleague B three hour breaks contrary to hospital policy;

- You left the medication cupboard keys in the nursing office with the door propped open, making them easily accessible to the Ward's patients;
- You left the HCA on the Ward floor alone on an acute admissions ward; and
- You falsified observations records for Patient A, a patient that was identified by the medical team at the Hospital as being at risk of suicide, who was on twice hourly checks.

As part of the local investigation, you were interviewed by Witness 1 on 21 March 2024 and you initially denied the allegations, but after being made aware of the CCTV evidence, you made admissions.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Dr Courcha who informed the panel that you made full admissions to charges 1a, 1b, 1c, 1d, 1e, 1f, 2a, 2b, 2c, 2d, 3a, 3b, 4, 5a, 5b, 5c and 6. Dr Courcha clarified that in relation to charge 3 it was not admitted that you were asleep, it was admitted in the alternative, which is that you failed to perform nursing duties adequately or at all, between the times set out in charge 3a and/or 3b.

Mr Piercy submitted that the NMC accepted that position and as the charge was pleaded in the alternative, that was sufficient to find charge 3 proved.

The panel therefore finds charges 1a, 1b, 1c, 1d, 1e, 1f, 2a, 2b, 2c, 2d, 3a, 3b, 4, 5a, 5b, 5c and 6 proved in their entirety, by way of your admissions.

The panel had, in advance of the hearing, received and read the witness statement from Witness 1, the exhibit bundle and your bundle, containing your reflections, training certificates and testimonials. In light of your admissions, the NMC decided that it was not necessary for the panel to view the CCTV, although this was available if required.

Fitness to practise

Having accepted your admissions, the panel moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Piercy invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. Mr Piercy identified the specific, relevant standards which he submitted were breached by your actions and failures.

Mr Piercy submitted that the facts found proved in this case amount to serious professional misconduct and there is no dispute from you on this matter. He

submitted that misconduct is a matter for the panel to decide and NMC guidance states that not all breaches of the Code are a matter for regulatory concern, only conduct that amounts to serious professional misconduct.

Mr Piercy submitted that the case of *Roylance* defines misconduct, and the standards are set out in the NMC Code.

Mr Piercy submitted that you failed to preserve the safety of patients as you took extended breaks, allowed or permitted colleagues to do the same and left the ward understaffed. You did not handover to colleagues, left Colleague B as the only staff member on the ward and left the nurse's office door open with the keys in the office which breached the Hospital's policy. He submitted that your conduct risked serious harm to patients who could have accessed the medication cabinet or locked themselves in the office.

Mr Piercy submitted that you failed to take observations as required and fabricated the observations, a dishonest act with the intention of '*covering up'* your clinical omissions. He submitted that you were dishonest in your investigation interview, did not take responsibility for your actions immediately and only made admissions when presented with CCTV footage. He submitted that your dishonesty was a breach of the Code and fundamental tenets of the profession.

Mr Piercy submitted that you breached the following paragraphs of the Code 3.1, 8.3, 8.4, 8.5, 8.6, 8.8, 10, 13, 18.4, 19.3, 20 and 21.3.

Mr Piercy submitted that your intention in being dishonest was to cover up your clinical failings whilst on a night shift. He submitted that this is directly related to your clinical work and constitutes serious professional misconduct.

Dr Courcha submitted that whilst misconduct is a matter for the panel's judgement, you admit that the facts proved do amount to misconduct, and you recognise it is a serious matter. Dr Courcha submitted that you have expressed your remorse and recognise the error in your ways.

Submissions on impairment

You gave evidence under affirmation.

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

Mr Piercy submitted that there were a series of instances where you put patients at risk of harm and it is fortunate that no such harm arose. He submitted that there is evidence of a deep-seated attitudinal issue which may be more difficult to address.

Mr Piercy submitted that in March 2024 you had been a nurse for nearly 10 years and in oral evidence you acknowledged that you were familiar with the Code and in a position of leadership at the time of the incident. You agreed to staff members taking three-hour breaks, despite knowing that the Hospital policy was to take a one-hour break. You were aware of the rules and the importance of recording observations. You omitted to do some observations and dishonestly fabricated some observations to cover up your mistakes.

Mr Piercy submitted that dishonesty is fundamentally incompatible with the tenets of the profession and gives rise to a risk of repetition. He submitted that there is a risk that you could make errors in the future, cover them up and expose patients to a risk of future harm.

Mr Piercy submitted that you admitted that you lied in your disciplinary interview as you were worried about getting in trouble. He questioned if the panel can be satisfied that you would not repeat this conduct.

Mr Piercy submitted that nurses must be honest, open and truthful in all dealings with patients and the public. He submitted that you were dishonest and, in your

investigation interview you denied the allegations until faced with the CCTV evidence. At which point you had little choice but to admit to the allegations. He submitted that the panel should consider the relevant weight to attach to your admissions.

Mr Piercy submitted that your dishonesty was serious and directly linked to your clinical practice with the intention of '*covering up'* your clinical errors. He submitted that you had full knowledge of the Hospital policies but made a deliberate decision to discard them. Mr Piercy submitted that the panel should consider the relevance of re reading policies and the Code, given that as an experienced nurse you were already aware of these policies and principles of nursing. He submitted that there are public protection concerns.

Mr Piercy submitted that your misconduct constitutes multiple serious breaches and departures from the Code from a senior nurse in position of leadership that led to risk of harm. He submitted that an informed member of the public would be deeply concerned if the panel did not find impairment as the conduct is incompatible with the tenets of the profession.

Mr Piercy submitted that in March 2024 your fitness to practise was impaired and there is not sufficient evidence to show that this position has changed. He submitted that impairment should be found on the public protection ground and in the wider public interest.

Dr Courcha submitted that the panel must decide whether your fitness to practise is currently impaired. He submitted that you understand the gravity of what has happened, however, your position now is significantly different than it was in March 2024. He submitted that your conduct does not represent a fundamental underlying problem, this was a one-off event in an otherwise unblemished career since 2015.

Dr Courcha submitted that you were able to provide many testimonials which show that you '*always put patient care at the forefront'* and '*always demonstrated leadership'.*

Dr Courcha submitted that your insight shows that your conduct will not be repeated.

Dr Courcha submitted that your oral evidence was open and candid, though you sought to give some context, you have not tried to excuse what happened. It is clear you recognise the risk of patient harm caused by your actions, which means you will not repeat this behaviour. You stated that *'looking back even though nothing happened it could have caused serious harm to a patient. especially the patient on 30 minute observations'*. Dr Courcha submitted that this shows you recognised the risks present due to your actions, which is clear recognition of what went wrong and how poorly your actions have reflected on the profession.

Dr Courcha submitted that you have been clear about each of the allegations, the risks and impact of your actions, what you could have done differently and what you will do differently in future. You have stepped back and looked at the incident objectively.

Dr Courcha submitted that your remediation efforts have been complete and successful. You have followed the principles of good practice before and since the event. He submitted that you have complied with your conditions of practice order and received exemplary reports. Your current manager stated that they have '*no concerns'* with your practice which demonstrates that you are no longer impaired and can practise kindly, safely and professionally.

Dr Courcha submitted that your training specifically addresses all the allegations. You have taken your training seriously as seen by your reflective statements. In oral evidence you stated '*I now recognise the critical importance of accountability*'. Dr Courcha submitted that your action plan shows your insight and commitment to remediation. You are now safe to practise.

Dr Courcha submitted that you are not likely to put a patient at risk of harm and you are not liable to bring the profession into disrepute as you have demonstrated this by working safely since the incident.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *CHRE v NMC and Grant* [2011] EWHC 927 (Admin), *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin). *GMC v Armstrong* [2021] EWHC 1658 (admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically: 1.2, 1.4, 8.2, 8.3, 8.5, 8.6, 10.3, 18.4, 19.1, 20.1, 20.2, 25.1 and 25.2.

> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

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

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.

In relation to charge 1, the panel considered that your conduct put vulnerable patients at significant risk of serious harm. You were the nurse in charge of the shift leading a newly qualified nurse and a healthcare assistant on an acute ward with vulnerable patients, including one who required twice hourly observations, as they were at risk of self-harm or suicide. You allowed Colleague A and Colleague B to neglect their duties by taking prolonged breaks of around 3 hours. You knew the Hospital's policy that breaks should be for a maximum of 1 hour and you had attended a Hospital meeting on 26 February 2024 where this policy was reiterated. By permitting staff to take extended breaks, there was not always a registered nurse present on the ward. This put vulnerable patients at serious risk of harm. Therefore, the panel determined that this was a breach of standards 1.2, 1.4, 8.2, 8.3, 8.5, 8.6, 25.1 and 25.2 and amounted to misconduct.

In relation to charge 2a, 2b and 2c, the panel considered the written evidence of Witness 1 who stated that the Hospital's Medication Administration policy provides that:

'the keys to the medication cupboard should always be kept with a Registered Nurse, and be held in their possession. As soon as the keys are not in their possession, there is a risk that a patient could access the medication cupboard'

The panel accepted that that you were aware of this policy and as a nurse with 10-year experience you knew the importance of patient safety in regard to the safe management of medications. Witness 1 stated that:

> *'If a patient obtained the keys, they could lock themselves in the medication room, with access to the medication cupboard. This presents serious risks to the patient's safety.'*

The panel considered that the vulnerability of the patients on the Ward, including Patient A who was at risk of self-harm or death by suicide, increased the seriousness of your conduct in this charge and put patients at serious risk of harm. Therefore, your conduct in charges 2a, 2b and 2c was in breach of standard 18.4 of the Code and amounts to misconduct.

The panel considered charge 2d and although this charge was admitted by you, it found that the cushions and blankets were in a communal area and there was no decisive evidence to confirm that you attended the meeting where staff were informed that the cushions and blankets were designated for patients. The panel determined that it was not best practice for you to use the cushions and blankets, however, this conduct did not amount to misconduct.

In relation to charge 3, the panel found that your failure to perform any nursing duties between approximately 03:00 and 03:40 and 03:52 and 06:22 meant that vulnerable patients were not receiving nursing attention, putting them at the most serious risk of harm. Therefore, the panel determined that this was a breach of standards 1.2, 1.4 and 19.1 of the Code and amounts to misconduct.

In relation to charge 4, you were aware that you were responsible for a seriously vulnerable patient who had been assigned level 2 observations which required twice hourly observations because there was, as stated by Witness 1, a

> '*high risk that the patient would self-harm or commit suicide if they were left alone in their room'*. In your local investigation interview you stated that you

knew the purpose of the observations was '*for safety reasons and to minimise risk'.*

In failing to complete the twice hourly observations you did not assess this vulnerable patient. In the panel's view this is at the most serious end of putting a patient at risk of harm. Therefore, the panel determined that your conduct was in breach of standards 1.2 and 1.4. This amounts to misconduct.

In relation to charges 5 and 6, the panel considered that accurate record keeping is a fundamental nursing skill and a key part of safeguarding and honesty is at the heart of nursing practice. Your dishonest conduct meant that there was no accurate record of Patient A's status between 03:00 and 04:00. If an incident had occurred during the night there would have been false information about how Patient A was or what they were doing within this time period. The panel determined that falsifying records for a seriously vulnerable patient had the potential to be even more harmful than recording no information because another clinician would have based their clinical decisions on false information recorded by you. Therefore, the panel determined that this amounts to a breach of standards 10.3, 20.1 and 20.2. This amounts to misconduct.

In each and every charge the panel found that there was a breach of standards 1.2 and 20.1 which amounted to misconduct.

The panel found that your actions 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 the misconduct, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library DMA-1 Impairment, updated on 3 March 2025, which states:

‘The question that will help decide whether a professional’s fitness to practise is impaired is:
“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

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

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

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

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

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

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

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

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

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

The panel found that your dereliction of nursing duties in an acute ward put vulnerable patients at significant risk of serious harm. The public would expect a nurse to perform their duties professionally and not falsify records. You breached standards in each of the four parts of the Code namely prioritise people, practise effectively, preserve safety and preserve professionalism and trust. Your misconduct breached the fundamental tenets of the profession and, therefore, brought the profession into disrepute. You behaved dishonestly. Therefore, all four limbs of the test are engaged in the past by your misconduct.

The panel next considered whether these limbs would be engaged in the future. The panel noted the NMC Guidance DMA-1 (Impairment) which states:

'*when making a decision on impairment…the Committee will…need to consider whether there is a risk of unwarranted harm to people receiving care in the future. This includes considering whether the concern suggests there may be an attitudinal issue…or knowingly taking unreasonable risks with patient's safety…here are some factors that could potentially support such a conclusion…*

- *whether there were clear, well established and unambiguous processes in place which were not followed;*

- *how obvious the risk of harm was'*

The panel noted the NMC guidance FTP-15A (Can the concern be addressed) which states:

> *'where the behaviour suggests underlying problems with the nurses attitude, it is less likely the nurse…will be able to address their conduct by taking steps, such as completing training courses or supervised practice…Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurses professional practice.'*

In assessing whether the concerns had been addressed the panel had regard to your insight and whether your behaviour had changed. The panel considered your oral evidence and your written reflections.

In the panel's view, you have demonstrated some insight into the risks and potential harm caused by your conduct. The panel accepted that to some extent you have stepped back, acknowledged your failings and taken steps to address them. It noted that you have continued to work as a registered nurse since these events, working as a community nurse, with the same substantive employer you were employed with at the time these concerns occurred. Your current employer is aware of these regulatory concerns which were raised by the Hospital where you were employed as Bank staff.

The panel noted that you have undertaken some on-line training courses including: Attitude and Behaviour dated 23 July 2025, The Ethics of Deception & Dishonesty – Strategies & Insights dated 2 April 2025, Leadership – How to influence, inspire and impact as a leader dated 2 April 2025 and Documentation and record keeping dated 1 April 2025.

You have provided written reflections, outlining what you have learnt from your training, how you behave now and how you would behave in the future. You said that you have re-read the Code and relevant policies.

You have provided positive testimonials from colleagues and your manager and supervisor who confirm that they know about the NMC proceedings. The panel was aware from your evidence, however, that you have been subject to strict restrictions on your practice and have worked under constant supervision by another registered nurse and have not worked on night duty.

The panel noted that you created an action plan, reflecting on your behaviour and considered the areas you needed to work on.

You apologised for your actions to the panel and acknowledged the impact of your behaviour on patients, colleagues and the public. The panel considered that you have shown remorse for your actions and said that you have learnt the hard way. In response to panel questions, you explained that this meant you have considerable restrictions on your practice and this and the regulatory process has all had a significant emotional impact on you. In your oral and written evidence, you recognised that your conduct put patients at significant risk of harm, and you stated that you *'will always follow policies in future'*.

However, the panel considered that it was highly significant that you were an experienced nurse when these events occurred, that you were fully aware of all the relevant policies and the Code and that you had been told two weeks before that you must comply with the one-hour break policy. In the panel's view, your behaviour showed very concerning attitudinal issues; you had deliberately flouted the Hospital's break policy, actively allowing junior members of staff to do so too, leaving vulnerable patients without appropriate nursing supervision. You state that you had a headache, you were fatigued at the time, and your judgement was not good. However, you did not mention this in the local investigation and in the panel's view this would not have explained any of the conduct that occurred that night.

The panel was not convinced that re-reading policies, the Code and taking continuing professional development (CPD) courses was sufficient to demonstrate

that your attitude had changed. You were aware of all these policies in March 2024 but nevertheless deliberately behaved so as to put patients as serious risk of harm.

You knew at the time that Patient A was extremely vulnerable, and it would therefore have been very obvious that failing to carry out the required observations would have put them at real risk of harm. Your attitude, in the panel's view, could not be changed through familiarisation of policies as it is fundamentally at odds with the core principles of kind, safe and professional practice.

Further, the panel found that you have shown limited insight in relation to your dishonesty. Remediation of dishonesty is difficult to demonstrate. You stated that you accept that dishonesty is wrong and that you have undertaken learning and reflection so that you can be honest even in difficult circumstances and that you will be upfront when there are mistakes. However, the panel considered that your conduct did not constitute '*mistakes'*; you deliberately chose not to check on Patient A and deliberately falsified their records to make it look as though you had checked. You did not own up to this immediately when questioned by Witness 1. In the panel's view, your remediation at best extends to acknowledging that you would own up in future not that you fully appreciate the dishonesty in the underlying behaviour of falsifying records which put a patient at serious risk of harm.

In the panel's view, there was an element of pre planning to the falsification of the record. You had Patient A's records with you while you were resting on the sofa in the communal area. In the panel's view this indicated an intention to falsify the record rather than undertake the required observations, which would have necessitated leaving the sofa.

In addition, the panel concluded that in your oral evidence the emphasis was on the impact on you, rather than the impact on patient safety, colleagues and public confidence in the profession.

The panel further considered that although you made admissions to all charges at the outset of the hearing, you did not do so at the outset of the local investigation. After being presented with CCTV footage you stated '*what should I say, there is*

evidence – all I can say is sorry' and only subsequently made admissions to the allegations.

The panel made reference to NMC guidance FTP-15B (The duty of Candour) '*nurses should never allow personal interest to outweigh the duty to be honest, open and truthful'.* In the panel's view your initial response, where you were not honest, open or truthful, compounds the severity of your previous dishonest actions.

The panel took into account that you have worked in a clinical environment without concern since the incident. However, the panel noted that you have been subject to restrictions on your practice, including being supervised by a registered nurse at all times, not being the nurse in charge and not working night shifts. You have not, therefore, been able to demonstrate that you can practise safely without supervision.

You have provided reflective pieces; however, you have not convinced the panel that you have genuinely changed your attitude. The panel considered that your conduct involved a level of premeditation. You allowed other staff members to take extended breaks, despite being in a leadership role, suggesting a collusive culture of rule breaking. The panel decided that your behaviour appeared to be conscious and deliberate and you showed no insight into this aspect.

The panel is of the view that there is a risk of repetition because it was not satisfied that you had provided sufficient evidence that you would not behave dishonestly in the future. You were the nurse in charge and there is no evidence that the behaviour in question arose in unique circumstances. You knew the Hospital policies and deliberately did not follow them, knowing that your conduct would put vulnerable patients at risk of harm. 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.

Whilst it accepted that you have engaged with the regulatory process and taken some steps to address your misconduct, the panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession and the NMC as regulator would be severely impacted if there was no finding of impairment on the public interest ground, as your misconduct goes to the heart of the fundamental tenets of the profession. An informed member of the public would be shocked to hear that you were dishonest within your clinical practice relating to a high-risk mental health patient and that you compounded this dishonesty by denying the conduct until you were told about the CCTV evidence, at which point you had little option but to accept it. The public would also be significantly concerned that you completely neglected your nursing role to meet your own needs and in doing so put vulnerable patients at risk of harm. Your misconduct must be marked by the regulator so as to not undermine public confidence. Therefore, the panel also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you 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 careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

You gave evidence under affirmation.

Mr Piercy informed the panel that in the Notice of Hearing, dated 28 October 2025, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Mr Piercy submitted that a striking off order is the only sanction that would properly protect the public and uphold public confidence in the profession. He submitted that you have breached fundamental tenets and shown limited insight particularly into dishonesty. These elements are fundamentally incompatible with you remaining on the register. He submitted that the panel should remember that the sanction should be proportionate and not go further than it needs to.

Mr Piercy submitted that the aggravating factors are that you were a senior nurse with 10-year experience, in a position of responsibility as the nurse in charge. Your actions involved a degree of premeditation and put vulnerable patients at risk of harm. He submitted that your dishonesty included deliberately covering up your decision to not take observations, only admitting to the charges when presented with the CCTV evidence, when you had no choice but to make these admissions.

Mr Piercy submitted that the mitigating factors in this case are that it was a single incident, there is some evidence of remorse and positive testimonials. There is some evidence of personal mitigation, though he submitted that personal mitigation should be of limited weight to the panel's decision on sanction.

Mr Piercy referred the panel to NMC guidance SAN-2 which states that *'honesty is of central importance*' to a nurse's practice. He submitted that it was serious because you had been dishonest in not taking the observations and then you had lied in your interview. He submitted that the panel should consider sanctions in ascending order of seriousness.

Mr Piercy submitted that taking no action or imposing a caution order would be wholly inappropriate in this case as the panel found there was a risk of repetition, a risk to patient safety and public confidence in the profession would not be maintained by taking no action.

Mr Piercy submitted that conditions of practice orders are appropriate in cases where clinical errors need to be amended to strengthen a nurse's practice. The concern in this case is attitudinal as despite knowing the Code and the Hospital policies, you chose to disregard these. This cannot be addressed with a conditions of practice order. He submitted that you may not comply with conditions as you did not comply with hospital policies.

Mr Piercy submitted that the panel has the power to impose a suspension order of up to 12 months. Whilst these events took place on one day, there were multiple varied and distinct incidents of misconduct. He submitted that dishonesty is by definition a harmful deep seated attitudinal issue, and the panel is not satisfied that you have changed your attitude. He referred the panel to its finding that there remains a risk of repetition. Therefore, a suspension order of 12 months would not be sufficient to protect the public or uphold public confidence in the profession.

Mr Piercy submitted that a striking-off order is appropriate when the conduct is fundamentally incompatible with being a nursing professional. He submitted that nurses must preserve safety and promote trust, and your dishonesty is inconsistent with you remaining on the Register.

Mr Piercy submitted that a well-informed member of the public would be deeply concerned if you were allowed to remain on the Register as you have shown a willingness to behave dishonestly which gives rise to a serious concern that you could do so again in the future. He submitted that the panel cannot be satisfied that this would never happen again, which would put the public at risk of harm. Consequently, the only sanction can be a striking-off order.

Dr Courcha submitted that a suspension order or a conditions of practice order would be the most appropriate sanction. He referred to NMC guidance SAN-1.

Dr Courcha submitted that you have been a nurse since 2015 and a highly respected healthcare assistant since 2003. He submitted that there have not been any previous disciplinary issues nor any complaints about your practice.

Dr Courcha referred the panel to a testimonial from a registered Band 6 nurse which stated that the *'removal of Elsa from register would be a significant loss to the profession'* and that they *'firmly believe'* you are *'fit to practise without restriction'*. He submitted that this addresses some of the public interest issues and the panel should give some weight to your contribution to the profession.

[PRIVATE].

Dr Courcha submitted that the mitigating factors in this case include your efforts to recognise and remedy your shortcomings. In your reflective piece, you stated that you acknowledge that your '*dishonest actions were unacceptable'*. Dr Courcha submitted that this shows that you do have insight into your dishonesty.

Dr Courcha submitted that the panel noted that you have been working safely but that it was subject to stringent conditions. He submitted that when your supervisor stated that they were no longer able to supervise you, you chased them up. This is a testimony to your efforts in addressing the regulatory concerns.

Dr Courcha submitted that there are numerous extremely positive testimonials.

Dr Courcha submitted that your personal mitigation is relevant in providing some context. [PRIVATE].

Dr Courcha submitted that you are passionate about nursing and would suffer significant reputational hardship if you were removed from the Register. He referred to your oral and written evidence in which you stated that being a nurse is a core part of your identity.

Dr Courcha submitted that you have deep remorse for your actions and highlighted that, in oral evidence, you stated that you feel '*ashamed*'.

Dr Courcha submitted that although no patient came to harm the fact that your actions put patients at risk of harm must be balanced against the absence of any other factors. You did not deny the allegations, you complied with the investigation

and NMC proceedings, it was a one-off event, and it represents a one-off issue in an otherwise unblemished career.

Dr Courcha referred to the case of *Watters v Nursing and Midwifery Council* [2017] EWHC 1888 (Admin) in which it was determined that, despite the allegation not being admitted, a striking off order was found to be a disproportionate sanction. He highlighted that factors including remorse and insight, long standing good character, no harm being caused to patients, appropriate training and the impact on the nurse should be considered. He submitted that this case falls squarely into this category as you have significant mitigation, you have provided many testimonials, it was a one-off incident, you have corrected the errors and there would be a significant impact on you if a striking off order were imposed. He submitted that panel ought to come to the decision that a striking-off order is not appropriate in this case.

Dr Courcha submitted that the NMC need not go further than it needs to. He referred to the case of *Macleod v The Royal College of Veterinary Surgeons* [2006] UK PC 39 and submitted that the panel must consider the overarching principle of public protection. He submitted that a sanction of erasure from the Register must be proportionate and that a striking-off order would be disproportionate in this case.

Dr Courcha referred to the case of case of *Wisniewska v Nursing and Midwifery Council* [2016] EWHC 2672 (Admin) which highlighted that mitigation must be considered at each step.

Dr Courcha submitted that your behaviour is not incompatible with remaining on the Register especially considering the significant insight and remorse you have shown. He submitted that public protection should not be a concern due to your remediation and that you are of value to the profession.

Dr Courcha submitted that you have been working since the incident and there is no evidence of repeated dishonesty or any other misconduct.

Dr Courcha submitted that there are two proportionate options. A conditions of practice order, in similar terms to what you are already subject to, or a suspension

order. He submitted that confidence in the profession can be maintained with the imposition of either of these sanctions. He submitted that a well-informed member of public would not be shocked by this due to your remediation and low risk of repetition.

Dr Courcha submitted that you have been working with conditions imposed on your practice in the interim period and you have followed the conditions. He submitted that you have not been able to show you can practise unsupervised but that over a period of 18 months you could have repeated your misconduct but you have not done so.

Dr Courcha submitted that in the round the panel should consider a short suspension order or a conditions of practice order as a striking off order would deprive the profession of a good nurse who simply made a mistake.

The panel took 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 in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. 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 as the nurse in charge in that you used this to allow yourself and junior colleagues to take extended breaks for three hours contrary to Hospital policy, putting vulnerable patients at significant risk of serious harm as there were times when there was no registered nurse on duty.

- You put your own needs above the safety of your patients, disregarding the potential for consequential harm this may have had. You prioritised taking a rest over ensuring patient safety, including the safe management of the medication cupboard keys and providing nursing duties. You knew this was wrong and therefore sought to cover this up with the falsification of records and your subsequent denial of this.

- Conduct which put patients at risk of suffering harm in that you deliberately chose not to observe a seriously vulnerable patient, who was subject to twice hourly observations and at risk of self-harm or death by suicide, then falsified records, fabricating details of what you alleged you had observed.

- There was an element of pre planning to your conduct. You took Patient A's records with you while you were resting on the sofa in the communal area. In the panel's view this indicated an intention to falsify the record rather than undertake the required observations.

- Limited insight into failings in relation to the dishonesty aspect in that you have not demonstrated that you have grasped the seriousness of your unacceptable attitude, in particular in the way that you denied the allegations until confronted with unequivocal CCTV evidence.

The panel also took into account that there are some mitigating features:

- You have been a nurse since 2015 with no regulatory or disciplinary concerns. You have worked in the healthcare profession since 2003 without known incident.

- You have worked as a registered nurse since the incident under an interim conditions of practice order with no concerns.

- Positive testimonials including from professionals who have known you for a long time.

- Some limited insight in as much as you recognise that you put patients at serious risk of harm. You have apologised for this.

- You have also completed CPD courses relevant to the issues identified.

The panel also had particular regard to NMC Guidance SAN-2 (sanctions for particularly serious cases). It noted under cases involved in dishonesty that:

> *'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception'*

The panel found that you had deliberately breached the professional duty of candour, you had misused your power, your behaviour had a direct risk to vulnerable

patients receiving care and was premeditated or planned. The panel found that the dishonesty in your case was extremely serious.

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 then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum because it involved dishonesty and put vulnerable patients at risk of serious harm. Therefore, a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The dishonesty identified in this case was considered an attitudinal concern and one that cannot be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate '*in cases where the misconduct isn't fundamentally incompatible with the nurse continuing to be a registered professional'.*

In the panel's view your conduct on that shift was totally incompatible with remaining as a registered nurse because of the severity of the neglect of your duties that evening and your dishonesty, individually and collectively.

- There were multiple instances of misconduct, each putting patients at risk of serious harm;

- There is significant evidence of attitudinal problems which led to taking unacceptable risks with patient safety in cases where the risks were obvious; and

- There is a significant risk of repetition given the attitudinal concerns and limited insight.

The panel was concerned that your dishonesty amounts to an attitudinal issue because despite all your knowledge and years of experience in the profession, you made conscious decisions which you knew would result in vulnerable patients being put at significant risk of serious harm, throughout the shift. Further, as the nurse in charge you were in a position of trust and you were expected to be a good role model to more junior staff. Therefore, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel considered that on the shift in question multiple aspects of your professional practice, across all four areas of the Code, fell below the standards of what would be expected of a registered nurse. The panel found that you were dishonest and breached the professional duty of candour by firstly falsifying clinical records and then denying the allegations until presented with the CCTV evidence. Your actions were premeditated, and you prioritised your personal gain in having a rest during a night shift, over the safety of your vulnerable patients.

The panel was of the view that the findings in this particular case demonstrate that your actions, in particular your dishonesty, was serious and to allow you to continue practising would put patients at risk of harm and 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 your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel has concluded that nothing short of this would be sufficient in this case.

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

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific

circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public and is otherwise in the public interest until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Piercy. He submitted that the striking-off order will not take effect until the expiry of the 28 day appeal. He submitted that the panel have the power to impose an interim suspension order of 18 months to cover this appeal period.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.