# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 1 December 2025 – Friday, 5 December 2025**
**Monday, 8 December 2025 – Tuesday, 9 December 2025**

Virtual Hearing

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| **Name of Registrant:** | **Suzen Chipara** |
| **NMC PIN:** | 00A1029E |
| **Part(s) of the register:** | Registered Nurse - Sub part 1<br>Mental health nurse, level 1 (16 October 2003)<br><br>Recordable qualifications SPMH:<br>Specialist practitioner: Mental health (16 July 2009)<br><br>TCH: Teacher (21 November 2012) |
| **Relevant Location:** | Leicester City Council |
| **Type of case:** | Misconduct |
| **Panel members:** | Derek Artis (Chair, Lay member)<br>Chloe McCandlish-Boyd (Registrant member)<br>Julia Cutforth (Lay member) |
| **Legal Assessor:** | Mark Ruffell |
| **Hearings Coordinator:** | Abigail Addai |
| **Nursing and Midwifery Council:** | Represented by Tessa Donovan, Case Presenter |
| **Mrs Chipara:** | Present and unrepresented |
| **No case to answer:** | Charge 1(e)(ii) |
| **Facts proved by admission:** | Charges 1(d) and 2 |

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| **Facts proved:** | Charges 1(a)(i),1(a)(ii), 1(b)(i), 1(b)(ii), 1(b)(iii), 1(e)(i), 1(f)(i), 1(f)(ii), 1(f)(iii) |
| **Facts not proved:** | Charges 1(c) and 1(e)(iii) |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 months)** |
| **Interim order:** | **Interim conditions of practice order (12 months)** |

**Details of charge**

‘That you, a registered nurse whilst working at the [PRIVATE] Trust;

1) Between 21 January 2021 and 21 May 2021

a) Did not update/evaluate Patient A’s;

i) Collaborative Care Plan
ii) Risk Assessments

b) Did not adequately complete Patient A’s;

i) Care Programme Documentation
ii) Care Programme Approach report
iii) Tribunal Report

c) Did not update Patient A’s status when they were upgraded to informal status

d) On one or more occasions, did not undertake and/or record one to one conversations with Patient A, as his primary nurse

e) On one or more occasion following Patient A absconding from the Trust, did not;

i) Update their care plan

ii) Escalate the absconding to a consultant

iii) Did not schedule a multidisciplinary meeting

f) Did not attend the shifts below at the Trust without providing any explanation;

i) 4 May 2021
ii) 6 May 2021
iii) 10 May 2021

2) Between 1 May 2021 & 2 August 2021, refused to engage with an action plan put into place by your employers

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

**Decision and reasons to adjourn Day 1**

During the course of Witness 1's evidence, you told the Hearings Coordinator that you were experiencing connection issues and were unable to connect to the hearing in the afternoon. The Hearings Coordinator also made attempts to contact you via telephone and email but was unable to get through to you.

Ms Donovan, on behalf of the Nursing and Midwifery Council (NMC), submitted that this is a difficult situation because you were in attendance in the morning. She referred the panel to the proof of service bundle and submitted that there has been good service in this case because you attended the hearing in the morning.

Ms Donovan informed the panel that at this stage, she is reluctant to make an application to proceed in your absence. She submitted that you have engaged with the proceedings thus far and the issue lies in whether you intend to re-engage.

Ms Donovan informed the panel that she asked the Hearings Coordinator to send an email giving you notice that the hearing could proceed in your absence. She submitted that if the panel were inclined to pause proceedings today, Witness 1 is available to give evidence

tomorrow at 9:00AM. This would also give you the opportunity to get in touch with the Hearings Coordinator and explain what has happened and whether you intend to re-engage.

The panel determined that it would be fair to adjourn the proceedings for today to give you sufficient time to reach out to the Hearings Coordinator. You subsequently attended the rest of the hearing.

**Background**

The NMC received a referral from [PRIVATE] Trust ('the Trust'), where you were employed as a band 5 staff nurse from 2004 until 12 October 2021.

You were the named nurse for Patient A from 21 January 2021.

Patient A was an inpatient at [PRIVATE] Trust residing on [PRIVATE] since January 2021. In February/March 2021 it was identified during an internal monthly audit that the Care Plans and Risk Assessment for Patient A were not adequate. These were the responsibility of you as his named nurse.

In April 2021, Patient A took his own life and findings in the serious incident report provided some further recommendations in regard to the Care Plans and patient records. Steps were taken to engage with you on an informal performance plan to address the areas where the serious incident report evidenced support was required. The Trust asked you to undertake an improvement plan, however you did not agree that your competence or performance was compromised, and you refused to engage. Due to your refusal to engage with your informal performance plan, the Trust began disciplinary proceedings against you. You resigned from the Trust in October 2021 before the conditions of the performance plan were addressed.

**Decision and reasons on application of no case to answer**

After the NMC closed its case, Ms Donovan submitted that the panel have heard sufficient evidence to make a factual determination in respect of all charges apart from Charge 1(e)(ii). This application was made under Rule 24(7) which states:

> *'**24.**— (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*
>
> *(i) either upon the application of the registrant, or*
> *(ii) of its own volition,*
>
> *the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.'*

Ms Donovan referred the panel to Witness 1's witness statement which reads:

> *'There was an incident where Patient A absconded, and the Registrant should have reviewed and updated Patient A's care plan and risk assessment and communicated with the consultant psychiatrist by arranging a Multidisciplinary Team ("MDT") meeting.'*

Ms Donovan submitted that the panel have heard evidence in respect of the expectation to review and update Patient A's Care Plan and Risk Assessment. With regards to the latter half of Witness 1's witness statement, Ms Donovan sought to seek further clarification from Witness 1. However, when asked about whether or not you had responsibility for alerting the consultant, Witness 1 said the consultant was already aware, but you had the responsibility to coordinate the meeting.

Ms Donovan submitted that whether the evidence enables the panel to reach a factual conclusion in respect of charge 1(e)(ii) is the sole matter she suggests the panel to consider and invited the panel to continue to hear the case in respect of the other charges.

You indicated that you supported Ms Donovan's submissions.

The panel heard and accepted the advice of the legal assessor who directed the panel to *R v Galbraith [1981] 1WLR 1039*.

The panel had regard to the test set out in the case of *R v Galbraith.* In *Galbraith*, Lord Lane set out the following test:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> > *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
> >
> > *(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses' reliability or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury…There will of course as always in this branch of the law be borderline cases. They can safely be left to the discretion of the judge.'*

The panel determined that limb (a) of the test set out in *Galbraith is* engaged because there is insufficient evidence to support the charge. The panel did not hear evidence regarding your requirement to escalate the matter, and this was not forthcoming from any of the witnesses.

The panel concluded, having regard to its assessment of the evidence, that a properly directed panel could not find the facts of charge 1(e)(ii) proved. The panel therefore determined there was no case to answer in respect of this charge.

The panel next considered whether there was a case to answer in respect of the other charges. Having looked at the evidence before it, the panel considered that there is a case to answer at this stage.

**Decision and reasons on facts**

At the outset of the hearing, you made admissions to charges 1(d) and 2.

The panel therefore finds charges 1(d) and 2 proved in their entirety, by way of your admissions.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Ward Manager at the Trust at the time of the concerns;

- Witness 2: Ward Sister at the Trust at the time of the concerns;

- Witness 3: Deputy Ward Sister at the Trust at the time of the concerns;

The panel also heard evidence from you under oath.

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

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

**Charge 1(a)(i) and Charge 1(a)(ii)**

1) Between 21 January 2021 and 21 May 2021
   a) Did not update/evaluate Patient A's;
   i) Collaborative Care Plan
   ii) Risk Assessments

**This charge is found proved.**

The panel had regard to the evidence and noted that two entries in respect to Patient A's Collaborative Care Plan, were made on 2 February 2021 and 17 February 2021. However, the respective entries were not completed by you and there is no evidence before the panel that you updated or evaluated Patient A's Collaborative Care Plan at any point during his admission on the [PRIVATE] Ward.

Similarly, in respect of Patient A's Risk Assessments, the panel had regard to an entry made on 29 January 2021. However, this was not completed by you and there is no evidence before the panel that you updated or evaluated Patient A's Risk Assessments at any point during his admission on the [PRIVATE] Ward.

The panel next had regard to the email from the clinical supervisor dated 11 July 2021 which reads:

> *'I have done clinical and management supervision to Sue Chipara on 22/2/21 whilst I was working from home via telephone I did collaborative care plan and risk assessment audit to all patients on [PRIVATE] This patient was admitted on 29/1/ 21 during my clinical supervision I have requested Sue to do collaborative care plan and update risk assessment to her patient On 21/3/21 I had a telephone supervision with Sue because I was working from home I asked her why collaborative care plan and risk assessments have not been updated since patient has been on [PRIVATE] since 29/1/21 Sue replied patient goes to bed about 7 pm and she is on night shift most of the time but I do the Rota Sue is on one flexi day shift every week has the opportunity to see patient Sue asked me to swap a patient I have asked her to speak to Witness 3 and Witness 2 as both of them are working on [PRIVATE]'*

The panel also considered the witness statement of Witness 1 where he states:

> *'It has been identified in relation to Patient A's records, the registrant failed in the following areas of care planning, risk assessments, 1:1 primary nurse conversation, CPA reports and tribunal paperwork.'*

Witness 1 also confirmed this in his oral evidence which the panel found to be consistent and credible.

You also told the panel that you did not complete Patient A's Collaborative Care Plan and Risk Assessments, stating that you were unable to do so because Patient A was asleep and your shift pattern conflicted with your ability to complete the documents. However, the panel was of the view that there was sufficient opportunity for you to engage with Patient A, in order for you to then update and review Patient A's documentation, including during the early evening, on flexi day shifts, and whilst giving Patient A night time medication.

Having regard to the above, the panel determined that you did not update/review Patient A's Collaborative Care Plan and Risk Assessment and found charges 1(a)(i) and 1(a)(ii) proved.

**Charge 1(b)(i)**

1) Between 21 January 2021 and 21 May 2021
   b) Did not adequately complete Patient A's;
   i) Care Programme Documentation

**This charge is found proved.**

The panel considered Witness 1's oral evidence in making its decision. It noted that Ms Donovan asked Witness 1 a question about Care Programme Documentation. Witness 1 said the Care Programme Documentation involves a review form which includes patient details, diagnosis, services they are under, risks, Care Plan details, their progress on the rehabilitation pathway, barriers to discharge and patient voice.

Witness 1 was also clear that it was the named nurse's responsibility to oversee this. Witness 1 also said although the named nurse gathers information from other professionals, it is still the named nurse's responsibility to ensure the documentation is up to date. Witness 1 said this was not done by you.

The panel found Witness 1's evidence credible and heard nothing to undermine his evidence. The panel therefore determined that between 21 January 2021 and 21 May 2021, you did not adequately complete Patient A's Care Programme Documentation and found charge 1(b)(i) proved.

**Charge 1(b)(ii)**

1) Between 21 January 2021 and 21 May 2021

b) Did not adequately complete Patient A's;

ii) Care Programme Approach report

**This charge is found proved.**

The panel directed itself to the witness statements of Witness 1 and Witness 3. It also had regard to Witness 1 and Witness 3's oral evidence.

Witness 1's witness statement reads:

> *'Within Patient A's records I can see that the CPA reports were copied and pasted from a previous document when there has been noticeable change in Patient A'*

Witness 3's witness statement reads:

> *'The CPA documentation was not submitted on time and if they were they were not done to a standard that we would expect…In relation to the CPA Report, our admin team was initially requesting from the Registrant for the report to be submitted and then when that did not happen, I had received an email from the team. I sent a general email to the team to let them know of the processes when undertaking these sorts of tasks and if they were encountering any difficulties to let me know so then support could be made available. The Registrant did not respond to this email to indicate they were having difficulties in any way.'*

Witness 1 and Witness 3 confirmed and expanded on this in their oral evidence and the panel found them consistent on this point. The panel also looked through the documentary evidence and noted that there is no evidence of a Care Programme Approach report written by you. It therefore found nothing to undermine Witness 1 and Witness 3's evidence.

Witness 3's statement also highlighted that she requested that you send the preparation of the CPA report through email. Witness 3 also highlighted the process to you and what was expected from the named nurse. However, you did not respond to her nor expressed any difficulties. The panel found Witness 3's oral evidence credible and consistent with her written evidence.

The panel noted your acknowledgement that your Care Programme Approach documentation was incomplete, both in your written and oral statement.

Having looked at the evidence before it, the panel determined that it was more likely than not that you did not adequately complete Patient A's Care Programme Approach report. Accordingly, the panel found charge 1(b)(ii) proved.

**Charge 1(b)(iii)**

1) Between 21 January 2021 and 21 May 2021
    b) Did not adequately complete Patient A's;
    iii) Tribunal Report

**This charge is found proved.**

The panel directed itself to the witness statement of Witness 3. It also had regard to Witness 3's oral evidence.

Witness 3 told the panel that requests for tribunals would come to her and if the named nurse was not rostered on in time to complete the report, another nurse would be allocated. It also noted from Witness 3's witness statement that the Tribunal reports were not submitted on time and if they were, they were not completed to the standard expected.

Witness 3's statement also highlighted that she requested that you send the preparation of the Tribunal report through email. Witness 3 also highlighted the process to you and what

was expected from the named nurse. However, you did not respond to her nor expressed any difficulties. The panel found Witness 3's oral evidence credible and consistent with her written evidence.

The panel noted your acknowledgement that your Tribunal Report documentation was incomplete, both in your written and oral statement.

The panel having considered Witness 3's evidence, determined that it was more likely than not that you chose not to engage with the correct procedure. It found nothing to undermine Witness 3's evidence and concluded that there was sufficient evidence to determine that you did not adequately complete Patient A's Tribunal Report.

Therefore, the panel found charge 1(b)(iii) proved.

**Charge 1(c)**

1) Between 21 January 2021 and 21 May 2021
c) Did not update Patient A's status when they were upgraded to informal status

**This charge is found NOT proved.**

The panel had no evidence before it to determine what updating a clinical status would look like. It also was of the view that the NMC did not provide a full picture of your shift pattern from the informal status being changed on 20 April 2021, to the subsequent death of Patient A on 26 April 2021.

The panel took into account your evidence, namely that it was not your responsibility to update Patient A's status because you were not on shift during this time. The panel carefully considered the evidence before it and concluded that there is insufficient evidence to show you were there at the time. It also noted that there is no email, directive or policy to say what you should have done in respect of Patient A's changing status. As

such, the panel did not believe that the NMC have discharged its burden in determining that you did not update Patient A's status when they were upgraded to informal status. Therefore, the panel found charge 1(c) not proved.

**Charge 1(e)(i)**

1) Between 21 January 2021 and 21 May 2021
    e) On one or more occasion following Patient A absconding from the Trust, did not;
    i) Update their care plan

**This charge is found proved.**

The panel noted that Patient A had absconded on multiple occasions between 11 March 2021 and 2 April 2021. Patient A also absconded for an extended period which triggered an additional Section 17 leave to be granted.

The panel was of the view that the first episode of absconding should have triggered a review within his care plan because you were subsequently on shifts and should have documented those incidents. This is supported by Witness 1 and Witness 2's oral evidence in which they outline it was your duty to update the Care Plan as his named nurse. You also accepted that you did not do this during the course of your oral evidence.

Therefore, the panel found that there is sufficient evidence to support that you did not update Patient A's Care Plan after he absconded from the Trust.

**Charge 1(e)(iii)**

1) Between 21 January 2021 and 21 May 2021
    e) On one or more occasion following Patient A absconding from the Trust, did not;

iii) Did not schedule a multidisciplinary meeting

**This charge is found NOT proved.**

The panel found there was a lack of clarity behind the facts within the charge. The panel was not provided with any procedures or policy outlining the requirement for the named nurse to schedule this meeting. You gave evidence that the Consultant within the Ward would schedule these meetings with support from the medical admin team, and whilst named nurses may contribute to who should be invited, they did not schedule the meetings. The panel also noted that Witness 1, while credible and consistent throughout his evidence, was relatively new to the post. The panel determined that whilst Witness 1 may be describing the ideal and his expectations, it was not clear about the custom and practices of the Ward prior to his arrival.

Therefore, on the balance of probabilities, the panel found charge 1(e)(iii) not proved.

**Charge 1(f)(i), Charge 1(f)(ii), Charge 1(f)(iii)**

1) Between 21 January 2021 and 21 May 2021
   f) Did not attend the shifts below at the Trust without providing any explanation;
      i) 4 May 2021
      ii) 6 May 2021
      iii) 10 May 2021

**This charge is found proved.**

The panel took into account that you admitted that you did not attend the shifts listed in the charge. Your evidence is that you raised issues with the shifts around 28 April 2021, and an email was sent by you stating that you were unable to attend the flexi-shifts.

Having found that you did not attend the shifts, the panel next considered whether you provided any explanation for your absence.

The panel heard in oral evidence that absences were to be reported to the Shift Coordinator. Witness 2 was clear in her oral evidence that there was no record of you calling the Shift Coordinator. Witness 2 told the panel that these records were contained in a book, but the panel was not provided evidence of this.

The panel noted that you raised concerns about the shifts as early as 28 April 2021. However, the panel was of the view that this conflicted with the oral evidence of Witness 2 who was clear there was no record of a call from you to the Shift Coordinator. The panel also noted that your evidence conflicted with the common procedure to report absences in the Trust.

The panel next had regard to the Statement of Witness 2, which is annotated on a statement you originally provided where you outline the steps you took to inform the Ward of your absences. You said that you were given unauthorised leave for the shifts you could not do.

However, Witness 2 was clear that you were given unauthorised leave because you did not attend the shifts. Further attempts were made to contact you by the Coordinator, including leaving '*several answer phones messages'* which prompted you to send the Coordinator a text to say you were not coming. The panel found this evidence supported that you provided no explanation for your absence, given that your absence was marked as 'unauthorised leave'. The panel heard evidence that other types of emergency leave can be granted when notice is given about non-attendance to a shift, and Witness 2 confirmed this had been granted to you on previous occasions. It also found this was agreed by you and Witness 2 in oral evidence and heard nothing to undermine this evidence.

Therefore, the panel found charges 1(f)(i), 1(f)(ii), 1(f)(iii) proved.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to 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.'*

Ms Donovan 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.

Ms Donovan identified the specific, relevant standards where your actions amounted to misconduct.

Ms Donovan submitted that you are a highly experienced mental health nurse and failed to complete patient records of various types over a period of four months. This related to a vulnerable mental health patient who ultimately took his own life. She submitted that the failure to make any effort to engage with Patient A and ensure his records were properly maintained put him at serious risk.

Ms Donovan submitted that you have maintained throughout these proceedings, despite being a mental health nurse of nearly 20 years, that you were awaiting guidance on how to manage this patient. However, there are no records that this was a patient who refused to engage, was aggressive, dismissive or hostile. Witness 2 also refuted this in evidence.

Ms Donovan submitted that you maintained throughout these proceedings and during cross examination of the witnesses that your supervisors failed you, and did not provide you with guidance. However, she reminded the panel that the evidence and your own admissions show you had multiple opportunities to engage with this patient, aligning with the panel's findings on the facts.

Ms Donovan referred the panel to the serious investigation report which she submitted the panel may wish to consider. The report outlined that there was no up-to-date nursing care and treatment care plan, with the exception of Occupational Therapy (OT) and psychology. There was also no up-to-date comprehensive risk plan and Patient A's risk assessment and management plans were inadequate for his needs and not updated.

Ms Donovan submitted that the facts found proved with regards to charges 1(a)(i), 1(a)(ii), 1(b)(i), 1(b)(ii), 1(b)(iii) and 1(e)(i), posed a serious risk to the patient himself, and poses a risk to the public's trust and confidence in the profession. She submitted that for there to have been an independent report published following the death of Patient A which set out the failings, undermines the confidence the public ought to have in the nursing profession.

With regards to Charges 1(f)(i), 1(f)(ii) and 1(f)(iii), Ms Donovan submitted you failed to maintain effective communication and failed to keep colleagues informed. She submitted

that the fact this was on three occasions is misconduct because this was a deliberate refusal to attend the shifts. Ms Donovan informed the panel that this is supported by evidence that you gave after panel questions [PRIVATE], highlighting that you could not do these shifts when there was an emergency. However, the panel have also seen evidence that you were able to go back to work as soon as you had another night shift that suited you.

Ms Donovan submitted that this demonstrates that you should have been able to work or notify the ward ahead of time, and your conduct put patients at risk and was evidence of potential attitudinal concerns.

With regards to charge 2, Ms Donovan submitted that the performance management plan was an effort by the Trust to support you and encourage you to update your knowledge and training. Your refusal stemmed from the belief that the lack of records was not your fault or responsibility due to Patient A's sleeping patterns. Ms Donovan submitted that you have to an extent accepted that the responsibility did lie with you as the named nurse. However, in failing to engage with the performance management plan you demonstrated an attitudinal concern which amounts to misconduct.

You gave evidence under oath.

You told the panel that you believe you have insight into what you did wrong and agree with everything. You said that you have learnt a lot in the four years and were fortunate enough to have worked since the incident. You said you have been reflecting throughout and since then your performance has changed significantly.

You told the panel that your practice is different now. You undertook extra training and informed the panel that your competency assessment covers record keeping. You said that your current employer is thorough with regards to training.

You accept that your behaviour was unacceptable. You said that during this time, you [PRIVATE] which contributed to your performance. However, you learnt not to allow your social life to impact your work.

You told the panel that before this, you were maintaining that management should have helped you. You recognised that you should have thought about other means to help you deal with the situation. You also note your communication was not efficient and you have let other people down because you should have spoken up. You said you have improved your communication such as replying to emails.

**Submissions on impairment**

Ms Donovan 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).

Ms Donovan submitted that you are a nurse of some 20 years' experience and have had no previous referrals or issues. However, this was not a one-off incident and was a persistent problem over several months and demonstrated attitudinal concerns.

Ms Donovan submitted that your level of insight is relatively limited at this stage, but has arguably increased over the course of these proceedings. She submitted that you forcefully challenged all three witnesses in cross examination on the basis that you asked for support. Ms Donovan also submitted that you continued to be quite defensive in respect of charge 2 and charge 1(f)(i), 1(f)(ii) and 1(f)(iii).

Ms Donovan submitted that you accept that you could have done things differently when questioned by the panel. You also have worked without any issues being raised in your

practice. Ms Donovan submitted that in respect of remediation, you have supplied a number of training certificates, but none relate specifically to record keeping and the panel may feel that there is not currently any clear evidence of remediation in respect of the primary regulatory concerns.

You did not provide any submissions regarding whether your fitness to practise is impaired.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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 Treat people as individuals and uphold their dignity***

*To achieve this, you must:*

*1.1 Treat people with kindness, respect and compassion.*

*1.2 make sure you deliver the fundamentals of care effectively*

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

*'**2 Listen to people and respond to their preferences and concerns***

*To achieve this, you must:*

*2.1 work in partnership with people to make sure you deliver care effectively.*

*2.3 encourage and empower people to share in decisions about their treatment and care*

*2.5 respect, support and document a person's right to accept or refuse care and treatment*

*'**8 Work co-operatively***

*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:*

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

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

***24 Respond to any complaints made against you professionally***

*To achieve this, you must:*

*24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel next went on to consider whether the facts found proved amounted to misconduct. In doing so, it considered the charges in turn.

Charges 1(a)(i), 1(a)(ii), 1(b)(i), 1(b)(ii), 1(b)(iii), 1(e)(i).

The panel was of the view that your actions fell short of what was expected of a registered nurse. It noted that you were the named nurse of Patient A, who as a vulnerable patient subsequently took his own life. During the course of his care, you failed to update and record his Risk Assessments and Care Plan. You did not attempt to offer a 1:1 with Patient A despite this being your responsibility as his named nurse. You also did not follow up concerns raised by management or communicate effectively.

The panel determined that you had limited insight into how your conduct impacted colleagues and how your conduct put Patient A at risk of harm. As such, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 1(f)(i), 1(f)(ii), 1(f)(iii) and Charge 2.

The panel determined that your failure to attend your shifts had serious implications because it put your colleagues and patients at risk of harm. It noted that you worked for the Trust for a period of 18 years and were aware of the protocols and steps colleagues needed to take to inform the Ward of absences. Your failure to do so put patients at risk of receiving insufficient care and put further strain on your colleagues.

The panel also noted that your failure to engage with an improvement plan raises serious concerns about your professionalism as a nurse, and demonstrates a lack of insight into

your failings. In light of this, 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, whether your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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 and to maintain professional boundaries. 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) *...'*

The panel found limbs (a), (b) and (c) are engaged in your case.

The panel determined that your actions put Patient A at risk of unwarranted harm due to your failure to engage with him and update/evaluate his Care Plan and Risk Assessments. Further, your failure to communicate with colleagues regarding his care, despite several

requests asking you to provide this information, means your actions are liable in the future to put patients at risk of harm.

With regards to remorse, the panel noted that you have accepted your failings and made admissions. However, the panel was not satisfied that you understand the impact of your failings, including not sharing an understanding around the impact of missing your shifts.

The panel was of the view that you understood your failings from a procedural perspective, noting how you would do things differently if faced with a similar circumstance. But there was minimal address by you to demonstrate your insight into the safety risks presented to Patient A through the communication and record keeping concerns found proved. The panel also noted a limited insight into the safety concerns presented to the Ward staff and patients through your absence from shifts on three occasions.

The panel had regard to your training but determined that there is no training about different engagement styles. It noted that a lot of your understanding has been about process and documentation but none has been focused on how Patient A was put at risk by your lack of action.

The panel also noted that you are currently working at an agency and recognised that you removed yourself from an environment you found challenging. It also took into account that since the incident, you have practised without any further concerns, are someone with good character and have had no previous regulatory findings against you.

Regarding insight, the panel considered that at this stage, your insight is developing. It noted that you identified what you would do at a procedural level, namely by responding to emails and communicating effectively. However, the panel determined that your understanding of the impact of your actions is still largely missing.

The panel is of the view that there is a risk of repetition which has lowered by the training you have completed and the fact that the conduct has not been repeated. However, the panel found your insight is still developing and you have not sufficiently addressed the regulatory concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because members of the public would be shocked that the named nurse for a vulnerable patient did not adequately document or update his records for a period of four months.

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 conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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.

The panel accepted the advice of the legal assessor.

**Submissions on sanction**

Ms Donovan submitted that the least restrictive and most proportionate sanction that can be appropriately imposed in this case is a conditions of practice order for a period of 12 months. She submitted that by finding you impaired, the panel has indicated that further work needs to be done to demonstrate insight and remediation.

Ms Donovan submitted that a conditions of practice order will enable you to demonstrate true remediation and insight, particularly in respect of the impact and the potential impact of your conduct. It will also ensure work relating to record keeping such as Care Plans and Risk Assessments is supervised or overseen for that limited period. The order would also ensure that any risk posed to patients and the reputation of the profession would be appropriately addressed.

Ms Donovan invited the panel to consider a term which requires you to develop and submit a Personal Development Plan (PDP), which addresses the regulatory concerns around record keeping. She submitted that your adherence to such a requirement would show your commitment to addressing your attitudinal concerns and help develop insight.

In conclusion, Ms Donovan submitted this would also assist a future reviewing panel to see the work and training undertaken by you to remediate, and help a future panel in assessing the risk going forward.

You told the panel you understand what Ms Donovan said. You accept there is a need to keep patient's safe by addressing these concerns as a nurse and you should be there to protect patients and gain the public's confidence in care. You recognise that you did not do this in the four months in 2021.

You told the panel you are willing to remedy your actions and are willing to undertake retraining and work under supervision. You also told the panel that you fell short of the NMC's standard of practice and will work hard to remedy where you failed.

**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:

- A pattern of misconduct over a period of four months.
- Conduct which put patients at risk of suffering harm.
- Lack of fully developed insight into the impact of your behaviour regarding patient care and documentation

The panel also took into account the following mitigating features:

- Experienced nurse of over 20 years
- The incidents occurred over four years ago and there are no other regulatory concerns raised from your employment.
- You made some admissions at the outset of the hearing.
- Previous good character and history.

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.

It 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 and that a caution order would be inappropriate in view of the issues identified. 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 mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, you have had an unblemished career of 20 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse. It was pleased to see that

you were willing to engage, noting that you were committed to the process, represented yourself and thought about your questions.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order. It determined that the conditions of practice order will give you the opportunity to strengthen your practice and demonstrate insight into your failings.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case, especially in light of your genuine commitment and engagement throughout the process. It also noted that you have demonstrated remorse and developing insight. There have also been no further regulatory concerns from your employment in the four years since the misconduct occurred.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must work with a registered nurse to create a personal development plan (PDP). Your PDP must address the concerns

about your misconduct. You must send your case officer a copy of your PDP within one month.

2. You must undertake clinical supervision with a registered nurse every two months. You must send your case officer signed notes of your clinical supervision every two months. Your clinical supervision should focus on the following aspects:
   a) Safe and effective practice
   b) Documentation responsibilities
   c) Following policy and practice which ensures patient safety
   d) Your progress towards your aims within your PDP

3. You must send the NMC evidence of further training regarding the following. You must give evidence of your training prior to any review:
   a) Therapeutic relationships
   b) Record keeping

4. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

5. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.
b) Any agency you apply to or are registered with for work.
c) Any employers you apply to for work (at the time of application).
d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

7. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Positive testimonials from colleagues and managers
- Any written reflections to demonstrate your progress and insight
- Evidence of any additional training undertaken

This will be confirmed to you in writing.

**Interim order**

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

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Donovan. She invited the panel to impose an interim conditions of practice order for a period of 12 months with the same terms as the sanction order. This would ensure that you are subject to those conditions from today and cover the outcome of any appeal lodged.

You asked the panel if the interim order could start on Monday because you wanted to fully consider the terms of the order and what they meant for you and your practice.

**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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The panel acknowledged your request for the interim order to start on Monday. However, given the findings of the panel, it was necessary to impose it immediately. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 12 months to cover the appeal period.

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

That concludes this determination.