Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 11 December 2025 – Friday, 12 December 2025
Tuesday, 16 December 2025 – Wednesday, 17 December 2025

Virtual Meeting

Name of Registrant:	Iulia Mirela Coseru
NMC PIN:	16H0367C
Part(s) of the register:	Registered Nurse – Adult RN1 – 11 August 2016
Relevant Location:	Shropshire
Type of case:	Misconduct
Panel members:	Paul Grant (Chair, Lay member) Vivienne Stimpson (Registrant member) Karen Naya (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Hamizah Sukiman
Facts proved:	Charges 1a, 1b, 1c, 1d, 2, 3, 4a, 4b, 4c, 4d, 5, 6a, 6b, 7a, 7b, 8a, 8b, 9a, 9b, 10a, 10b, 11 and 12
Facts not proved:	None
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Coseru's registered email address by secure email on 30 October 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the charges, the time, that this matter will be disposed of by way of a substantive meeting, that this meeting will take place on or after 28 November 2025 and that this meeting would be held virtually. The panel noted that the Notice of Meeting also invited Mrs Coseru's response, and that a copy of the Case Management Form ('CMF') was sent to Mrs Coseru but not returned.

In the light of all of the information available, the panel was satisfied that Mrs Coseru has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules').

Details of charge

That you, a registered nurse:

1) On 30 September 2022 failed to adequately respond in an emergency in that upon finding Resident A unresponsive at approximately 01:00 you:
    a) Failed to commence Cardiopulmonary Resuscitation ("CPR").
    b) Failed to ring the call bell for assistance.
    c) Failed to call an ambulance.
    d) Failed to check, adequately or at all, if he had a Do Not Attempt Resuscitation ("DNACPR") and/or RESPECT form in place to ascertain his resuscitation status.

2) On 30 September 2022 at approximately 3:30, inappropriately commenced CPR and/or used the defibrillator in circumstances where you had found Resident A deceased at approximately 01:00.

3) Your commencement of CPR and/or use of the defibrillator at charge 2 failed to respect Resident A's dignity.

4) On 30 September 2022 inaccurately and/or retrospectively recorded in Resident A's notes that:
    a) You administered paracetamol at 02:01.
    b) You conducted observations at 01:52 and/or 01:53.
    c) "*CPR attempted"* at 01:00.
    d) "*Called Ambulance but not answered, and continued with CPR"* at 01:00.

5) Your entries in Resident A's notes at charge 4a) and/or 4b) were dishonest, in that you intended to create a misleading impression that Resident A was not yet deceased.

6) Your entries in Resident A's notes at charge 4c) and/or 4d) were dishonest in that you intended to create a misleading impression that:
    a) You had carried out CPR and/or called an ambulance immediately on finding Resident A unresponsive at approximately 01:00.
    b) You had responded appropriately and/or in accordance with his care plan.

7) On 30 September 2022 in respect of Resident A:
    a) Did not make an entry in his care notes, adequately or at all, to record his presentation and/or actions taken upon finding him unresponsive at 01:00.
    b) Did not complete a verification of death form.

8) On 30 September 2022 in a telephone call to West Midlands Ambulance Service at 03:34:

a) Did not inform them that Resident A was already deceased when you were administering CPR.
b) Inaccurately informed them that a colleague was assisting you in administering CPR to Resident A when this was not the case.

9) Your conduct at charge 8a) and/or 8b) was dishonest in that you sought to create a misleading impression that:
    a) You had carried out CPR and/or called an ambulance immediately on finding Resident A unresponsive.
    b) CPR was being conducted correctly.

10) On 30 September 2022 inaccurately informed police officer/s that:
    a) You had immediately commenced CPR on finding Resident A unresponsive.
    b) You continued CPR until 03:00 with interruptions in between.

11) Your conduct at charge 10a) and/or 10b) was dishonest in that you sought to conceal the fact that you had not administered CPR at the point of finding Resident A unresponsive at approximately 01:00.

12) Failed to comply with your professional duty of candour in that you should have declared your clinical omissions in respect of charge 1.

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

Background

The charges arose whilst Mrs Coseru was employed as a registered nurse at Innage Grange ('the Home') by Coverage Care ('the Employer'). Mrs Coseru was admitted to the NMC register in August 2016, and began employment at the Home in July 2017.

These charges relate to Mrs Coseru's alleged failure to appropriately respond to an emergency involving Resident A on the night shift of 29/30 September 2022 and the subsequent alleged dishonesty associated with the incident. At the relevant time, the Home had 52 residents on the residential side and 30 residents on the nursing side, and Mrs Coseru was the only nurse on shift that night. She was working with three carers and a Night Shift Leader.

It is alleged that, at approximately 00:00, Witness 2 and Witness 3 (both carers) carried out hourly checks on Resident A to assess his breathing and/or carry out repositioning. At this stage, Resident A was alive. Resident A had allegedly eaten very little the day before, and he was displaying symptoms of a chest infection. Mrs Coseru allegedly conducted more regular checks on Resident A than usual (at 21:20, 22:30, 23:25 and 23:50) to monitor his condition.

Resident A's condition deteriorated at some point between 00:00 and 01:00 on 30 September 2022 and it is alleged that in or around 01:00, Mrs Coseru found him unresponsive. On finding Resident A unresponsive, Mrs Coseru failed to carry out a cardiopulmonary resuscitation ('CPR'), or call an ambulance for Resident A. She allegedly did not do so as she incorrectly assumed Resident A had a 'Do Not Attempt Cardio Pulmonary Resuscitation' ('DNACPR') / a Recommended Summary Plan for Emergency Care and Treatment ('RESPECT') Form in place. Resident A did not have this in place.

At approximately 01:10, Witness 2, Witness 3 and a third carer (Ms 1) were informed by Mrs Coseru that Resident A had died. They were allegedly told by Mrs Coseru that Resident A had a DNACPR form in place, and that Mrs Coseru verified his death.

It is further alleged that, upon realising Resident A did not have a DNACPR in place (at around 03:30), Mrs Coseru called an ambulance and attempted CPR and/or defibrillation on him. The Employer alleged that Mrs Coseru subsequently falsified documentation to indicate that she had attempted CPR earlier than she had (at approximately 01:00) and recorded Resident A's observations as well as the administration of paracetamol (at approximately 02:00, after Resident A's death).

The ambulance staff alerted the police that the handling of Resident A's death by the Home was suspicious, albeit the death, in itself, did not appear to be suspicious.

The incident was investigated at a local level.

The matter was also investigated by West Mercia Police. Mrs Coseru attended an interview under caution for Manslaughter by Gross Negligence on 22 December 2022. It is alleged that Mrs Coseru told the police that she immediately commenced CPR upon finding Resident A unresponsive, and that she continued CPR (with interruptions) until 03:00. A post-mortem examination later concluded that Resident A died of natural causes, and consequently, no inquest was required. The police therefore took no further action.

The referral was received by the NMC from the Employer on 26 April 2023.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the written representations from the NMC.

The documentary evidence included the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Night Shift Leader at the Home
- Witness 2: Healthcare Assistant at the Home (at the time of the incident)
- Witness 3: Care Worker at the Home
- Witness 4: Deputy Manager at the Home

- Witness 5: Volunteer Defibrillator Responder for West Midlands Ambulance Service
- Witness 6: Registered Nurse and Executive Director of Nursing at West Midlands Ambulance Service
- Witness 7: Paramedic for West Midlands Ambulance Service
- Witness 8: Officer in Charge of the Police Investigation at West Mercia Police (at the time of the incident)
- Witness 9: Human Resources Officer (at the time of the incident)
- Witness 10: Registered Nurse and Clinical Lead Nurse at the Home

The panel noted it received no evidence from Mrs Coseru in relation to these NMC charges, but it noted that some evidence was provided by her at local level (such as a local statement as well as her responses to the police). The panel further noted that Mrs Coseru has not engaged with the NMC or provided any other information to the NMC to support her case. She has not admitted to any of the charges.

The panel has drawn no adverse inference from Mrs Coseru's lack of response in respect of these charges.

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

She further advised the panel that, in charges alleging a failure, the panel must first be satisfied that there was a duty on Mrs Coseru to act as outlined in the charge, and that Mrs Coseru subsequently failed to do so.

In relation to charges alleging dishonesty, the legal assessor drew the panel's attention to the decision in, and principles derived from, the case of *Ivey v Genting Casinos* [2017] UKSC 67. She advised the panel that, in determining dishonesty, the panel should adopt a two-stage test. She advised that the panel should firstly consider Mrs Coseru's knowledge or belief as to her conduct at the relevant time. There is no requirement for this belief to be reasonable. It is only whether the belief is genuinely held. Upon making its assessment in this regard, the panel should then apply the standards of ordinary, decent people to judge whether the conduct was dishonest.

Further, the panel noted that the outcome of the Home's disciplinary hearing has been made available to it and has been exhibited by Witness 4. The panel bore in mind that the Home's investigation was conducted with a different purpose to these proceedings, and pursuant to *Enemuwe v NMC* [2015] EWHC 2081 (Admin), it determined to disregard this element of the exhibit in its decision-making process. The panel reminded itself to not be consciously or unconsciously influenced by this document.

The panel further noted that the NMC's written representation referenced Mrs Coseru being subject to an interim order. It bore in mind that, at this stage, this information was not relevant. It determined to disregard this element of the representation in its decision-making process. The panel reminded itself to not be consciously or unconsciously influenced by this information.

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

Charge 1a

'That you, a registered nurse:

1) *On 30 September 2022 failed to adequately respond in an emergency in that upon finding Resident A unresponsive at approximately 01:00 you:*
    a) *Failed to commence Cardiopulmonary Resuscitation ("CPR").'*

This charge is found proved.

The panel bore in mind that this charge alleged a failure on Mrs Coseru's part. Accordingly, the panel first considered whether Mrs Coseru had a duty to commence CPR on Resident A after finding him unresponsive at 01:00.

In reaching this decision, the panel had sight of Resident A's care plan, dated 20 July 2022. Under the header '*How to support me'*, the plan stated:

> *'I currently have no ReSPECT form in place, I would like to be hospitalised if needed so that I can received* [sic] *necessary treatment that are not manageable in the care home'*

The panel also considered the Home's Resuscitation Policy document. The panel acknowledged that the policy before it is dated October 2022, and post-dates the incident. However, the panel bore in mind that, the October 2022 version of the policy indicates, under the header '*Version Control*', that there was a policy in place in February 2022. Therefore, the panel was content that, on the balance of probabilities, the Home would have had a resuscitation policy in place at the relevant time. The panel considered that this version of the policy document contained one change, namely that "*Sentence added to Signpost to POLICY Death of Resident – in section 16*". Accordingly, the panel was satisfied that the October 2022 policy was an update on the previous policy in place at the relevant time and there was no material

difference for the purposes of this charge. The panel had sight of the policy outlining the procedure for responding to an emergency.

Taking all the above into account, the panel determined that there was a duty on Mrs Coseru, as the nurse in charge who found Resident A unresponsive, to commence CPR, as Resident A's care plan did not indicate that he had a DNACPR in place.

The panel next considered whether Mrs Coseru failed to do so.

In reaching this decision, the panel considered Mrs Coseru's interview notes in the local investigation. It stated:

> *'[Witness 9] - So you verified the death at 1 o'clock?*
> *IC - Yes*
> *[Witness 9] - And you didn't attempt CPR at that point?*
> *IC – No'*

The panel noted Mrs Coseru had completed her Basic Life Support Training on 12 October 2021, and was therefore qualified to conduct CPR at the relevant time. The panel considered that Mrs Coseru accepted she did not attempt CPR at 01:00.

Further, the panel had sight of Witness 1's witness statement, which stated:

> *'… I saw Mrs Coseru, [Ms 1] and [Witness 2] walk past the open duty office door. [Ms 1] looked back at the open door and told me that "someone has apparently died." The emergency bell had not been rung. It is policy to ring the emergecy* [sic] *bell in the event of discovering that a service user has been unexpectedly found dying or dead. …When I did go down to the Cherry Unit, although I do not recall at what time, Mrs Coseru had verified Resident A's death. Mrs Coseru had instructed [Witness 2] and [Witness 3] to lay down Resident A, which they had.'*

The panel also considered Witness 2's witness statement, which stated:

‘At approximately 01:10, myself, [Witness 3] and [Ms 1] (HCA) were in the Windsor Lounge on the ground floor of the Home when Mrs Coseru came down to the Windsor Lounge and said to us that “ Resident A has died, he is dead.” Myself, [Witnes 3] and [Ms 1] followed Mrs Coseru back upstairs to where she had come from to Resident A’s room. I could see that Resident A had clearly died because he was not breathing. I asked Mrs Coseru whether Resident A had a ReSPECT Form in place to which she replied that he did. Mrs Coseru further responded by saying that she had verified the death.’

The panel determined that both Witness 1’s and Witness 2’s statements, both of which were signed and contained statements of truth, indicated that Mrs Coseru did not attempt to conduct CPR at approximately 01:00. In particular, the panel considered that Witness 2 was in Resident A’s room in and around 01:00, and did not witness Mrs Coseru attempting CPR. The panel bore in mind that both witnesses indicated that Mrs Coseru’s actions – namely to instruct healthcare assistants to lay down Resident A as well as informing them that Resident A did have a DNACPR – indicated that Mrs Coseru was aware that Resident A had passed away, and did not attempt to conduct CPR as, at this stage, she believed Resident A had a DNACPR or RESPECT agreement in place to not be resuscitated.

Taking all the above into account, the panel was satisfied that Mrs Coseru did not attempt CPR on Resident A at approximately 01:00.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 1b

‘That you, a registered nurse:

1) *On 30 September 2022 failed to adequately respond in an emergency in that upon finding Resident A unresponsive at approximately 01:00 you:*
    b) *Failed to ring the call bell for assistance.’*

This charge is found proved.

The panel bore in mind that this charge alleged a failure on Mrs Coseru's part. Accordingly, the panel first considered whether Mrs Coseru had a duty to ring the call bell for assistance after finding Resident A unresponsive at approximately 01:00.

The panel considered the Home's Resuscitation Policy document, which outlined the steps taken in responding to an emergency. The panel noted its observations in charge 1a above in respect of the policy post-dating the charge. The policy stated:

> *'Step 1 – the person who discovers the emergency situation will assess for immediate danger and then raise the alarm and request help. Within the realms of their competence, they should begin to assess the severity and nature of the emergency.'*

The panel also had sight of Witness 4's witness statement. In respect of call bells, she stated:

> *'A call bell is located in every area of the Home including in each resident's bedroom and in communal areas which both staff members and residents can use at any time. … Mrs Coseru did not use the call bell upon finding Resident A dead. … the process is to call for assistance. As Resident A died unexpectedly, Mrs Coseru should have used the call bell to ring for assistance. This is set out at section 14 of the policy … Even if Resident A did have a DNACPR (Do Not Attempt CPR) in place, this would still be considered a medical emergency…'*

Taking all the above into account, the panel determined that there was a duty on Mrs Coseru to ring the call bell in an emergency situation. The panel next considered whether Mrs Coseru failed to do so.

In reaching this decision, the panel considered Mrs Coseru's interview notes in the local investigation. It stated:

‘[Witness 9] – Can you recall what you did then? Did you ring the emergency bell?
IC - No
[Witness 9] - Is that normal that you wouldn’t ring the emergency bell?
IC - Because I was already there and I checked him and I went to get my kit, I checked him for vital signs. I called, actually, I was a bit confused, I don’t know …’

The panel considered that Mrs Coseru accepted she did not ring the call bell at approximately 01:00.

Further, the panel had sight of Witness 3’s witness statement, which stated:

‘At approximately 01 :30 on 30 September 2022, I overheard Mrs Coseru saying to [Witness 1] that "Resident A was not responding." Mrs Coseru came into the main office and said this whilst I was sat in the office. Mrs Coseru and [Witness 1] went to see Resident A and myself and [Witness 2] followed behind. In this situation, usually the emergency bell would be rung to alert all members of staff available to go to a specific area of the Home for assistance with a resident. However, the emergency bell was not rung , although I do not recall why not.’

The panel also considered Witness 1’s witness statement, which stated:

‘[Ms 1] looked back at me whilst walking past the office and said “someone has apparently died.” At the time [Ms 1] said this, I thought that this particular resident that had died was on the nursing unit and that it was an ‘expected death’ because no emergency call bell had rung through to the office. The Home’s policy is to ring the emergency call bell when a resident is found dead on either the residential or nursing unit.’

In Witness 1’s local statement, dated 30 September 2022 at 01:15, she stated:

‘I became aware that a resident had passed away. I was talking to Shrop Doc, on the phone, concerning another service user.

(The emergency bell hadn’t been rung)’

The panel also bore in mind the interview notes from Ms 1, as taken by Witness 9 on 12 January 2023 at the local investigation, which stated:

‘[Witness 9] asked [Ms 1] what the normal procedure was when someone passed away. [Ms 1] stated that IC should have rung the emergency bell but that she has made a mistake and didn’t do this. [Ms 1] stated that he didn’t have a respect form in place but that she did ask IC this but that IC had already verified his death.

[Witness 9] asked [Ms 1] if in normal circumstances the emergency bell should have been rung. [Ms 1] stated yes and said that they would check the person and the death can then be verified.’

The panel determined that Witness 3, Witness 1 and Witness 9’s evidence are consistent, and all indicated that Mrs Coseru did not ring the call bell at approximately 01:00. The panel further bore in mind that Witness 1 provided a contemporaneous statement of the incident, and it determined that the local statement was consistent with her witness statement in Mrs Coseru’s failure to ring the call bell. The panel determined that this is consistent with Mrs Coseru’s admission of her failure to ring the call bell in the local investigation.

The panel also had sight of the call bell log for Room 31, which was Resident A’s room at the relevant time, which contained no record to a call bell being rung.

Taking all the above into account, the panel was satisfied that Mrs Coseru did not ring the call bell at approximately 01:00.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 1c

'That you, a registered nurse:

1) *On 30 September 2022 failed to adequately respond in an emergency in that upon finding Resident A unresponsive at approximately 01:00 you:*
    c) *Failed to call an ambulance.'*

This charge is found proved.

The panel bore in mind that this charge alleged a failure on Mrs Coseru's part. Accordingly, the panel first considered whether Mrs Coseru had a duty to call an ambulance after finding Resident A unresponsive at approximately 01:00.

In reaching this decision, the panel considered Witness 10's witness statement, which stated:

> *'This was not Mrs Coseru's first dealing with a resident's death. … Staff are expected to call 999 or ask someone to help call 999 whilst the trained staff or nurse is doing CPR. In the past, Mrs Coseru had verified a resident's death. I cannot recall if she has verified unexpected death before, however, I can remember that she did verify expected death in the past and, for example, on 3 January 2022 and 2 February 2022.*
>
> *[…]*
>
> *Even if there is a change in the resident's colour and there is no breathing, you have to check the observations, check the pulse, check whether the resident is warm to touch, check their breathing and start resuscitation, and, as above, call the paramedic (as per Basic Life Support Training …'*

The panel considered the Home's Resuscitation Policy document as referred to by Witness 10 in her witness statement, which outlined the steps taken in responding to

an emergency. The panel noted its observations in charge 1a above in respect of the policy post-dating the charge. The policy stated:

> *'Step 2 – As colleagues attend in response to the alarm, the most competent member of staff will stay with the resident and continue the assessment and management, whilst sending another member of staff to telephone 999 or the GP or collect equipment.*
>
> *Step 3 – Staff will inform other appropriate staff that an incident is taking place and return'*

The panel also considered Witness 1's interview notes with Witness 9 as part of the local investigation, dated 12 January 2023, which stated:

> *'[Witness 9] – What is the procedure then for a death that is unexpected?*
>
> *[Witness 1] – first thing is too* [sic] *look on the care plan but I know we have purple hearts now but someone goes to them and assess them. Get care plan, read respect form and see what it says, and then call 999 regardless as we are not medically able to say that it is a cardiac arrest or something. I would ring 999 straigt* [sic] *away and take their instruction and do what they tell me. If its exected* [sic] *death its different but 999 will always ask you if there is a respect form in place.'*

Taking all the above into account, the panel determined that there was a duty on Mrs Coseru to call an ambulance in these circumstances, as it is an unexpected death, per the Home's policy and evidence from Witness 1 and Witness 10. The panel next considered whether Mrs Coseru failed to do so.

The panel considered Witness 1's witness statement, which stated:

> *'Furthermore, at this time, I recall the First Responder asking Mrs Coseru at what time did she phone the emergency services. Mrs Coseru told them that she had called them when she found Resident A dead. […]*

In front of me, the Ambulance crew checked their emergency call logs and confirmed that Mrs Coseru did not call them when she found Resident A had died. The call came in some time after around 03:00 although I do not recall when. This time would have been logged on the Ambulance call log as they could see at what times she called them.'

The panel also considered Witness 6's witness statement, which stated:

'On 30 September 2022, WMAS received a telephone call from Mrs Coseru at Innage Grange ("the Home") at 03:34:19 […] Mrs Coseru confirms her name when asked 'what's your name please caller?' This call ended at 03:48:50, lasting for 14 minutes and 32 seconds. I did not receive this call. […] The data shows the time the call started and ended. I can see that two calls were received. The first call was made at 03:33:41 from a Night Nurse who identified herself as "Iulia," whom I now know to be Mrs Coseru. The second call was made at 03:57:32 from [Witness 5] (Community First Responder).'

The panel considered Witness 4's witness statement, which stated:

'There were discrepancies between when Mrs Coseru recorded that she telephoned the ambulance to when she actually telephoned them. Mrs Coseru recorded … that she telephoned the ambulance just after she found Resident A dead which would have been just after 01:00. However, the Lead Paramedic told me that they checked with their call handling station and that the only telephone call that was logged from the Home that night was at 03:20. I did not have access the call log at the Home to check the outgoing call.'

The panel had sight of the transcript of the call between Mrs Coseru and the emergency services. The panel took into account that this call was made at 03:34, more than two hours after 01:00, per the wording of the charge. No evidence – such as call logs or transcripts – are before the panel indicating that an emergency call

was made by Mrs Coseru prior to 03:34, or at approximately 01:00 as would have been expected, had the call been made.

The panel noted Mrs Coseru's response in the local investigation, where she accepted that this was an unexpected death and that she attempted to telephone the emergency services but could not get through.

Taking all the above into account, the panel determined it was more likely than not that Mrs Coseru did not telephone the ambulance at approximately 01:00. The panel noted that Mrs Coseru said she attempted to, but the panel had no evidence of this attempt. Further, the panel considered that Mrs Coseru, at this stage, thought that Resident A had a DNACPR, had verified his death and instructed healthcare workers to prepare his body for the undertakers. It would therefore be contradictory for her to take all these steps had she attempted to ring the ambulance at the point of finding Resident A unconscious and not been able to get through to them.

The panel was therefore satisfied that Mrs Coseru did not call the ambulance at approximately 01:00.

Accordingly, this charge is found proved on the balance of probabilities.

Charge 1d

'That you, a registered nurse:

1) *On 30 September 2022 failed to adequately respond in an emergency in that upon finding Resident A unresponsive at approximately 01:00 you:*
    d) *Failed to check, adequately or at all, if he had a Do Not Attempt Resuscitation ("DNACPR") and/or RESPECT form in place to ascertain his resuscitation status.'*

This charge is found proved.

The panel bore in mind that this charge alleged a failure on Mrs Coseru's part. Accordingly, the panel first considered whether Mrs Coseru had a duty to check if Resident A had a DNACPR and or RESPECT form to ascertain his resuscitation status after finding him unresponsive at approximately 01:00.

In reaching this decision, the panel considered the Home's Resuscitation Policy document as referred to by Witness 10 in her witness statement, which outlined the steps taken in responding to an emergency. The panel noted its observations in charge 1a above in respect of the policy post-dating the charge. The panel was satisfied that the policy outlined an obligation for practitioners to recognise whether a DNACPR or RESPECT plan was in place as part of their assessment in the appropriate response to a medical emergency. The panel also considered this to be the fundamental duties of a nurse in an emergency situation.

Taking all the above into account, the panel determined that there was a duty on Mrs Coseru to check if Resident A had a DNACPR and or RESPECT form to ascertain his resuscitation status. The panel next considered whether Mrs Coseru failed to do so.

The panel had sight of Resident A's care plan, as outlined in full in charge 1a above, which indicated that he did not have a RESPECT form in place and in the event of serious illness, wished to be hospitalised to receive the necessary treatment.

In reaching this decision, the panel considered Mrs Coseru's interview notes in the local investigation. It stated:

> *'IC – […] I checked him, all vital signs were off and I couldn't accept actually this thing because when I checked on his care plan I saw he didn't have the respect form […]*
>
> *[Witness 9] - And you didn't attempt CPR at that point?*
> *IC - No*
> *[Witness 9] - And why was that? Because you thought he had a respect form?*
> *IC - Yes (starts to get a little upset)*

[Witness 9] - I'm sorry I have to ask these questions.
IC - After that I was really shocked, I couldn't believe I, because I actually……...when someone is not well, you normally give them help. I have the basic life support training, its 3 hours training, but I saw after that actually that it is in the mandatory trainings list that it is to do the respect training as well, it is a 3 days training and we did not receive that training.

[…]

[Witness 9] - DNAR is not to do CPR and with you thought he had a respect form in place?
IC - Yes, there was some discussion with the family to do the respect form, I knew they wanted to do a respect form.
[Witness 9] – ok but it hadn't actually been formalised that he had one? Is that why you might have thought
he had one?
IC - Yes'

The panel noted that Mrs Coseru indicated that she thought Resident A had a RESPECT form, which informed her decision to not attempt resuscitation.

The panel also considered Witness 2's witness statement, which stated:

'I asked Mrs Coseru whether Resident A had a ReSPECT Form in place to which she replied that he did. Mrs Coseru further responded by saying that she had verified the death.'

Further, the panel considered Witness 4's witness statement, which confirmed that Resident A did not have a DNACPR in place. She further stated:

'Mrs Coseru kept repeating "I'm sorry" and "I have made a mistake." When I questioned Mrs Coseru what she meant by 'making a mistake,' she told me "I thought the resident had a respect form with a DNACPR in place" and that "it wasn't until I came to doing the documentation that I realised he did not have

this documentation in place." This led me to think that the notes were taken retrospectively after finding Resident A.'

The panel considered that Mrs Coseru's account to Witness 2 indicated that she thought Resident A had a RESPECT plan in place, and therefore did not attempt resuscitation. However, her later account to Witness 4 suggested that she retrospectively checked his care plan and discovered her error.

The panel also considered Witness 1's interview notes with Witness 9 as part of the local investigation, dated 12 January 2023, which stated:

'[Witness 9] showed [Witness 1] the handover form - says is for resus. '

[Witness 9] – is this the handover form?
[Witness 1] – that one looks like the nursing one, but anyway the sheet is the same more or less.
[Witness 9] – showed another handover form which states Res A was not for resus. [Witness 1] confirmed that this handover sheet was the residential form and the other one was nursing, but [Witness 1] stated that this Is why you should always check the care plan in the first instance.'

The panel acknowledged that there appeared to be some inconsistency about whether there was a DNACPR or RESPECT form in place for Resident A. However, the panel accepted Witness 1's evidence in her local interview notes, indicating that where there is any doubt or discrepancy, the resident's care plan should be checked in the first instance. The panel noted that Resident A's care plan clearly stated that there was no RESPECT plan in place.

The panel therefore determined that, had Mrs Coseru adequately checked whether Resident A had a DNACPR or RESPECT form in place, she would have identified that he did not, based on his care plan. The panel was therefore satisfied that, if in fact Mrs Coseru did carry out any checks of Resident A's documentation, these checks were inadequate as she did not check Resident A's care plan, which should have been checked in the first instance.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 2

'That you, a registered nurse:

2) *On 30 September 2022 at approximately 3:30, inappropriately commenced CPR and/or used the defibrillator in circumstances where you had found Resident A deceased at approximately 01:00.'*

This charge is found proved.

In reaching this decision, the panel considered Mrs Coseru's interview notes in the local investigation. It stated:

> *'[Witness 9] - OK. So talk me through the point then, that you went to get the defib and what happened and what your reasons for that were, because if he was quite clearly dead at 1 o'clock, and you got the defib at around 3 o'clock, what your reasons for going to get the defib at that time?*
> *IC - That's why I said it is quite…….I couldn't accept that I didn't follow the procedure before. I knew I couldn't do more for him, he was you know, dead. He passed away peacefully in his sleep, but anyway I didn't follow the procedure. It was very ironical because you know the staff told me I was the only nurse, I was checking every time and was doing everything like you know the procedures, all the things right, but that night I didn't. I knew it was no point actually, you know for him because anyway he was passed away for quite a long time. What can I say.*
>
> *[Witness 9] - And after the defib, you attempted CPR?*
> *IC – Yes*
> *[Witness 9] - Can you recall if it was full CPR ? Can you explain to me how you did it? Was he on the bed, was he on the floor?*
> *IC – No, he was on the bed.*

[Witness 9] - You left him on the bed?
IC - Yes.
[Witness 9] - And did you do full hands or fingers?
IC - With hands yes, I did not hurt him anyway.'

The panel considered that Mrs Coseru accepted she commenced CPR and used the defibrillator on Resident A at approximately 03:30, two and a half hours after his death. She accepted that she '*couldn't do more for him'.*

The panel also took into account Witness 1's witness statement, which stated:

'At approximately 03:25, Mrs Coseru came back down to the resident unit and myself, [Ms 1] and [Witness 2] saw her walk past the window of Windsor. […] Momentarily after seeing Mrs Coseru walk past, she was then seen walking back towards the main lounge. [Ms 1] went outside of Windsor (which is opposite the duty office) and she asked me to come out of Windsor and have a look at the wall where the defibrillator is usually kept. The defibrillator had gone from the wall. I told [Ms 1] and [Witness 2] that I was going to see what Mrs Coseru was doing. I went onto the Cherry Unit, as it leads up to the nursing unit, and I heard the automated voice from the defibrillator coming from Resident A's room. When I went to Resident A's room, I saw Mrs Coseru starting to use the defibrillator on Resident A. At this point, the defibrillator was being prepared by Mrs Coseru and the automated voice was explaining the instructions on how to commence Cardiopulmonary Resuscitation ("CPR") and use the defibrillator which it automatically does when it is switched on. The defibrillator was attached to Resident A. I saw Mrs Coseru place her two fingers on Resident A's chest and start chest compressions […]

I immediately asked Mrs Coseru what she thought was doing. Mrs Coseru asked me to help her. Mrs Coseru said "we need to do this." Mrs Coseru said that the paramedics were coming and that she needed to do this. Mrs Coseru was very panicked and distressed. […] Mrs Coseru then continued to carry out CPR on Resident A, using two fingers. I was shocked that Mrs Coseru continued to carry out CPR on Resident A, despite verifying his death hours

before. I could visibly see that Rigor Mortis, which is post-death rigidity of the body had already started in Resident A because he was physically rigid and that he had been dead for a few hours.'

The panel also considered Witness 1's interview notes with Witness 9 as part of the local investigation, dated 12 January 2023, which stated:

'I went to have a look what was going on and left [Ms 1] and [Witness 2] on Windsor, I went down to Cherry unit and when I got to the corner of room 31 where resident Resident A was I could hear the defib going off from inside his room but the door was closed. I opened the door, went in, IC was there with the defib, she had positioned Resident A and the pads were on him. The defib was going and she was doing a 2 fingered attempt of CPR. I asked her what she was doing, she said we must do this, I replied with we must not do this.'

The panel had sight of the transcript of the call between Mrs Coseru and the ambulance service. The panel took into account that this call was made at 03:34. The transcript stated:

'[Ambulance Service] – Ambulance service is the patient breathing?
[Care Home Nurse] – No, no, he's not breathing, we are attempting CPR.'

The panel was satisfied that "*Care Home Nurse*", as identified in the transcript, was Mrs Coseru, as she identified her name later in the call.

The panel determined that Witness 1 provided a contemporaneous statement of the incident, and it determined that the local statement was consistent with her NMC witness statement which indicated that Mrs Coseru commenced CPR on Resident A at approximately 03:30, when he was deceased. This was consistent with Mrs Coseru's conversation with the ambulance service, at 03:34, indicating that she was "*attempting CPR*", as well as Mrs Coseru's admission in the local investigation that she attempted CPR on Resident A at this time.

Taking all the above into account, the panel was satisfied that Mrs Coseru commenced CPR and used the defibrillator at approximately 03:30. The panel was satisfied that this course of action was inherently inappropriate, as Resident A had passed away by 01:10, and Mrs Coseru acknowledged this.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 3

'That you, a registered nurse:

3) *Your commencement of CPR and/or use of the defibrillator at charge 2 failed to respect Resident A's dignity.'*

This charge is found proved.

In reaching this decision, the panel bore in mind the evidence from Witness 1 and Witness 2 regarding how they were preparing Resident A's body following his death, and the respect they showed in performing this task. The panel determined that this was reflective of the dignity Resident A should be shown after his death.

The panel also considered Witness 10's witness statement, which stated:

> *'It would be undignified if Resident A did actually pass away at 01:00 and if hours had already passed before Mrs Coseru attempted CPR or used the defibrillator.'*

The panel accepted Witness 10's evidence above. The panel considered that, by 03:30, Resident A had been deceased for more than two hours. The panel determined that beginning a CPR two and a half hours after Resident A had died was not a true resuscitation (i.e: an attempt to save his life), and Mrs Coseru would have known this, as she knew he had died by 01:10. The panel was of the view that subjecting Resident A's body to this resuscitation, when Mrs Coseru knew it would not have changed the outcome of Resident A's death, was a breach of his dignity. Further, the panel had evidence that, at this stage, rigor mortis appeared to have set

in. The panel considered that treating patients with dignity is a fundamental element of nursing care, and this extends to the treatment of patients after they have died.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charges 4a and 4b

'That you, a registered nurse:

4) On 30 September 2022 inaccurately and/or retrospectively recorded in Resident A's notes that:

a) You administered paracetamol at 02:01.

b) You conducted observations at 01:52 and/or 01:53.'

These charges are found proved.

Whilst the panel considered charges 4a and 4b separately, its reasoning is the same in respect of both.

In reaching this decision, the panel considered Resident A's patient notes. Within it, there was an entry made by Mrs Coseru on 30 September 2022, stating that, at 02:01, she administered Paracetamol Soluble 500mg Dispersible Tablet. Further, an entry by Mrs Coseru was made on 30 September 2022 stating that, at 01:52, Resident A's pulse was at 79 and his blood pressure was 124/79. Further entries on the same day stated that, at 01:53, Mrs Coseru took readings of Resident A's O2 saturation as well as respiration rate.

The panel also bore in mind Mrs Coseru's interview notes in the local investigation. It stated:

> *'[Witness 9] - The medication system states that you administered paracetamol and took observations for at 2am, can you explain this?*
> *IC - I did a couple of recordings later because it was very very busy and it was actually for the hour before, 11 or something I don't know. But I done a couple of recordings later in the morning, after midnight anyway.*

[Witness 9] - Is this normal procedure?
IC - No, usually I was doing it exactly at that time, but it was so busy
[Witness 9] - So you did give him paracetamol, but that was earlier on in the night?
IC - Earlier in the night yes.
[Witness 9] - And it wasn't at 2 o'clock?
IC – No'

The panel noted that Mrs Coseru does not deny making the entries, but alleges that the entries were made for observations and medication administration which occurred earlier in the evening. She therefore accepted that the entries were made retrospectively.

The panel also considered Witness 4's witness statement, which stated:

'From looking at Resident A's notes … from the material shift, it is evident that Mrs Coseru made retrospective notes on the night as original times were scribbled out. Between the time I went to check on Mrs Coseru at approximately 05:00, to when I collected the notes at approximately 05:30 to give them to the police, Mrs Coseru had unsupervised access to the notes.

Although there is no blanket prohibition on making retrospective notes, it is not usual to do this and it would certainly not be acceptable to do this when completing Verification of Death and Death of a Resident documentation. The Verification of Death and Death of a Resident forms must be done at the time a resident has died or been found dead and there cannot be a delay in completing this particular documentation because the funeral directors require this information

[…]

Mrs Coseru had signed for the administration of Paracetamol for Resident A at 02:00 … However, Resident A had been found dead by Mrs Coseru one hour before this entry was recorded on his medication chart. I understand

from the records … that the Paracetamol had been in fact been administered to Resident A at 21:00 on 29 September 2022 instead.'

The panel further considered Witness 10's witness statement, which stated:

'The emar record shows that the Paracetamol soluble 2 tablet was given at 02:01 and the reason given next to this is recorded as observations Mrs Coseru did at 21:20 ... There is also a recorded pulse and blood pressure at 01:52 … I do not understand why there were observation and paracetamol recorded if the resident was noted to have passed away at 01:00 as per Mrs. Coseru's record on the nurse intervention sheet

I do not know if Mrs Coseru's notes were made retrospectively. The nurse needs to attend to the resident first, provide intervention and document as soon as she available so the nurse can accurately describe the information. There are times where providing the intervention needed for a resident can last an hour or so and then sometimes, we have a number of emergency residents to check on afterwards so the notes can be done as soon as after the intervention provided to that specific resident. If it can't be help as the nurse is very busy and notes are made late, you would be expected to put the date and time on the side for when the entry is being made and then add as much information as possible to describe the event or incident.'

Further, Witness 2 stated in her witness statement:

'Furthermore, although I do not recall when Mrs Coseru said this, she mentioned that she had given Resident A paracetamol. When I checked on our electronic patient record system later that morning, I saw that Mrs Coseru had signed for paracetamol for Resident A at 02:00.'

Taking all the above into account, the panel was satisfied that the entries made by Mrs Coseru which were timed at 01:52, 01:53 and 02:01 respectively were inaccurate and made retrospectively. The panel bore in mind Witness 10's evidence that, in the event entries are made retrospectively, the entries should reflect the

correct time. The panel noted that the relevant entries on Resident A's notes did not indicate that they were made retrospectively, despite Mrs Coseru's indication that they were. The panel, having taken all the evidence into account, was therefore of the view that it was more likely than not that Mrs Coseru had inaccurately and retrospectively recorded in Resident A's notes that she administered paracetamol at 02:01 and conducted observations at 01:52 and 01:53.

Accordingly, the panel found charges 4a and 4b proved on the balance of probabilities.

Charges 4c and 4d

'That you, a registered nurse:

4) *On 30 September 2022 inaccurately and/or retrospectively recorded in Resident A's notes that:*
    c) *"CPR attempted" at 01:00.*
    d) *"Called Ambulance but not answered, and continued with CPR" at 01:00.'*

These charges are found proved.

Whilst the panel considered charges 4c and 4d separately, its reasoning is the same in respect of both.

In reaching this decision, the panel considered Resident A's patient notes. Within it, there was a handwritten entry made at 01:00 on 30 September 2022, which stated:

> *'CPR attempted for Resident A'*

Further, within the '*Nurse Intervention'* document for Resident A, a handwritten entry was made at 01:00 on 30 September 2022. The entry reads:

> *'CPR attempted for Resident A. Called Ambulance but not answered, and contributed with CPR'.*

The panel determined, on the balance of probabilities, that Mrs Coseru had made the above entries in Resident A's notes.

The panel considered its decision in respect of charges 1a and 1c above. The panel considered that Mrs Coseru accepted she did not commence CPR on Resident A at approximately 01:00. Further, the panel reminded itself that it has already found that Mrs Coseru did not call the ambulance at this stage.

Taking all the above into account, the panel therefore determined that Mrs Coseru inaccurately and retrospectively recorded in Resident A's notes that *"CPR attempted"* at 01:00, and *"Called Ambulance but not answered, and continued with CPR"* at 01:00.

Accordingly, the panel found charges 4c and 4d proved on the balance of probabilities.

Charge 5

'That you, a registered nurse:

5) *Your entries in Resident A's notes at charge 4a) and/or 4b) were dishonest, in that you intended to create a misleading impression that Resident A was not yet deceased.'*

This charge is found proved.

In reaching this decision, the panel took into account of its decision in respect of charges 4a and 4b above. The panel further considered the two-stage test, pursuant to *Ivey*, in determining these charges.

The panel first considered Mrs Coseru's state of mind at the relevant time. The panel bore in mind that by 02:00, Resident A was deceased for approximately one hour. The panel considered that Mrs Coseru, in her own account at the local investigation, was aware that Resident A had died by this stage. Despite this, Mrs Coseru continued to note observations and administration of paracetamol.

The panel determined that, as she knew Resident A was deceased by 01:10, Mrs Coseru falsely made the notes at some time between 02:01 and 05:00, when Witness 4 checked on her, to create the impression that observations and the administration of medication were conducted by her prior to Resident A's death. Consequently, this created the impression that Resident A was still alive. The panel determined that this was an attempt to conceal that Resident A died at approximately 01:00, which Mrs Coseru knew to be inaccurate and dishonest.

The panel noted that, in her local interview with Witness 4, Mrs Coseru remarked that she had been feeling unwell on the shift. The panel determined that, whilst illness may have some impact on her clinical practice, it had no evidence to suggest that her illness led or contributed to her making clinical notes she knew not to be accurate. The panel was of the view that, irrespective of Mrs Coseru's health, she was aware, at the time of making the notes, that Resident A was deceased, and that the notes were an inaccurate record of the care he received, implying that he was alive later in the night beyond 01:10.

The panel next considered whether Mrs Coseru's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that her conduct – namely to make medical notes she knew to be false to create an impression that Resident A was still alive – would be regarded as dishonest.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charges 6a and 6b

'That you, a registered nurse:

6) *Your entries in Resident A's notes at charge 4c) and/or 4d) were dishonest in that you intended to create a misleading impression that:*
    a) *You had carried out CPR and/or called an ambulance immediately on finding Resident A unresponsive at approximately 01:00.*
    b) *You had responded appropriately and/or in accordance with his care plan.'*

These charges are found proved.

Whilst the panel considered charges 6a and 6b separately, its reasoning is the same in respect of both.

In reaching this decision, the panel took into account its decision in respect of charges 4c and 4d above. The panel further considered the two-stage test, pursuant to *Ivey*, in determining these charges.

The panel first considered Mrs Coseru's state of mind at the relevant time. The panel bore in mind that, by Mrs Coseru's own admissions at the local investigation, she did not conduct CPR at 01:00 (per charge 1a above), as she was under the impression that Resident A was subject to a DNACPR. The panel determined that, as she knew no CPR was conducted at 01:00, Mrs Coseru knew the entries she made in Resident A's patient notes were false. The panel was satisfied that these entries were made to create the impression that Mrs Coseru responded appropriately to finding Resident A unresponsive at 01:00, by carrying out CPR and calling an ambulance, in accordance with his care plan. The panel determined that this was an attempt to conceal her clinical omissions, which she knew to be dishonest.

The panel next considered whether Mrs Coseru's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that her conduct – namely to make false entries in a resident's patient notes to conceal her clinical omissions – would be regarded as dishonest.

Accordingly, the panel found charges 6a and 6b proved on the balance of probabilities.

Charge 7a

'That you, a registered nurse:

7) On 30 September 2022 in respect of Resident A:

a) *Did not make an entry in his care notes, adequately or at all, to record his presentation and/or actions taken upon finding him unresponsive at 01:00.'*

This charge is found proved.

In reaching this decision, the panel noted that some of Resident A's presentation was recorded by Mrs Coseru at a later time. However, the panel determined that, based on its decision in respect of charges 4a and 4b above, those were false entries. As such, the panel was satisfied that this charge related to whether any true and adequate entries as to Resident A's presentation and/or actions taken upon finding him unresponsive at approximately 01:00 were made.

The panel had sight of Resident A's patient notes. A handwritten entry was made at 01:00 on 30 September 2022, which read:

'Found Resident A on check he has passed away'

The panel therefore accepted that this was a true entry made by Mrs Coseru in respect of Resident A's presentation, as Resident A had passed away by this time.

In considering whether this entry was adequate, per the wording of the charge, the panel took into account Witness 10's witness statement, which stated:

'Nothing in the notes state what she did next or what Resident A looked like at the time she noticed he had passed away. For good record keeping, it is a good practice if a staff nurse documents clearly any intervention provided, assessment/presentation of the resident when he was found dead. The call bell log is not able to indicate whether anything happened in the resident's room or whether Mrs Coseru asked for help.'

Based on the above, the panel determined that Mrs Coseru's entry was inadequate in recording all of the information that would be expected from an entry of this type. The panel noted that, other than recording that Resident A had passed away, Mrs

Coseru made no other observations in respect of his presentation or any further actions taken by her in response to his death.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 7b

'That you, a registered nurse:

7) On 30 September 2022 in respect of Resident A:

b) Did not complete a verification of death form.'

This charge is found proved.

In reaching its decision, the panel considered Witness 10's witness statement, which stated:

> *'We normally complete verification of death following the death of the resident. There was no verification of death form completed by Mrs Coseru. I can only see her note entry on the Nurse Intervention sheet at 1:00am that Resident A had passed away.*

Further, in Witness 4's local statement, dated 6 October 2022, she stated:

> *'Sergeant said their concerns were with Iulia's version of events and her documentation. One entry was scribbled out. I checked with Iulia where the verification death was she said she hadn't completed one.'*

The panel had sight of a blank Verification of Death form, as exhibited by Witness 10.

Taking all the above into account, the panel was satisfied that Mrs Coseru did not complete a Verification of Death form for Resident A. The panel determined that

Witness 10 and Witness 4 were consistent in this regard, and both of their evidence was consistent with the incomplete form before the panel.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charges 8a and 8b

'That you, a registered nurse:

8) On 30 September 2022 in a telephone call to West Midlands Ambulance Service at 03:34:

a) Did not inform them that Resident A was already deceased when you were administering CPR.

b) Inaccurately informed them that a colleague was assisting you in administering CPR to Resident A when this was not the case.'

These charges are found proved.

Whilst the panel considered charges 8a and 8b separately, its reasoning is the same in respect of both.

In reaching its decision, the panel had sight of the transcript of the call between Mrs Coseru and the ambulance service. The panel took into account that this call was made at 03:34. The transcript stated:

> *'[Ambulance Service] – Ambulance service is the patient breathing?*
> *[Care Home Nurse] – No, no, he's not breathing, we are attempting CPR.*
>
> *[…]*
>
> *[Ambulance Service] – Okay. So you said CPR's in progress.*
> *[Care Home Nurse] – Yes it is.*
>
> *[…]*

[Ambulance Service] – Er, how many people are assisting with the CPR?
[Care Home Nurse] – Erm two people.
[Ambulance Service] – Two people, they're taking it in turns are they.
[Care Home Nurse] –Sorry
[Ambulance Service] – Are they taking it in turns?
[Care Home Nurse] – Yes.'

The panel was satisfied that "*Care Home Nurse*", as identified in the transcript, was Mrs Coseru, as she identified her name later in the call. The panel also had regard to Witness 6's witness statement, which stated that the night nurse who called the ambulance services was Mrs Coseru.

In respect of charge 8a, the panel determined that, during the call, Mrs Coseru did not inform the ambulance service that Resident A was deceased. Instead, she told them that she was commencing CPR or that CPR was in progress, and implied that he was still alive, albeit not breathing. The panel considered that two ambulances and a Volunteer Defibrillator Responder (Witness 5) were dispatched to the Home, suggesting that the ambulance service was under the impression that Resident A was still alive at the point when Mrs Coseru telephoned (at 03:34).

In relation to charge 8b, the panel determined that Mrs Coseru confirmed two people were assisting her in the CPR, using phrases such as "*we*", and telling the ambulance service that "*two people*" assisted with the CPR. The panel bore in mind Witness 1's witness statement which confirmed she did not assist with the CPR, and that she *"told Mrs Coseru that [she] was not touching anything*", and the panel determined that it was more likely than not that Witness 1 did not assist Mrs Coseru with the CPR, as Resident A was already deceased. As such, Mrs Coseru's statement to the ambulance service in respect of two people conducting the CPR was inaccurate.

Taking all the above into account, the panel was satisfied that, throughout the telephone call, Mrs Coseru did not inform the ambulance service that Resident A had been deceased for approximately two and a half hours at the time of the call.

Further, the panel was also satisfied that in the course of the call, Mrs Coseru informed the ambulance service that another colleague was assisting her in administering CPR correctly to Resident A, which was inaccurate.

Accordingly, the panel found charges 8a and 8b proved on the balance of probabilities.

Charge 9a

'That you, a registered nurse:

9) Your conduct at charge 8a) and/or 8b) was dishonest in that you sought to create a misleading impression that:

a) You had carried out CPR and/or called an ambulance immediately on finding Resident A unresponsive.'

This charge is found proved.

In reaching this decision, the panel took into account its decision in respect of charges 8a and 8b above. The panel further considered the two-stage test, pursuant to *Ivey*, in determining these charges.

The panel first considered Mrs Coseru's state of mind at the relevant time. The panel bore in mind that the telephone call took place at 03:34, approximately two and a half hours after Resident A's death. At this stage, Mrs Coseru was aware that Resident A had died, and no CPR would therefore be clinically justified. The panel further considered that Mrs Coseru created the misleading impression to the ambulance service that this was an emergency situation, whereby Resident A was found unresponsive and CPR was commenced immediately.

The panel also considered Witness 1's interview notes with Witness 9 as part of the local investigation, dated 12 January 2023, which stated:

> *'she actually fibbed to them because they asked her what time she had been trying to get 999 involved and she said she had been trying since she found*

him. And they told her that they could check but she said that she had been trying for a long, long time and said that the lines were jammed and then when she did get through she was put in a queue.'

The panel determined that Mrs Coseru's remarks to the ambulance service as reported by Witness 1 as well as on the telephone call were designed to create the impression that she began CPR and attempted to ring 999 immediately after finding Resident A unresponsive. Mrs Coseru knew this to be inaccurate and dishonest, as she knew Resident A was deceased by 01:10.

The panel next considered whether Mrs Coseru's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that her conduct – namely creating a misleading impression to the ambulance service that she carried out CPR and called an ambulance immediately on finding Resident A unresponsive – would be regarded as dishonest by those standards.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 9b

'That you, a registered nurse:

9) Your conduct at charge 8a) and/or 8b) was dishonest in that you sought to create a misleading impression that:

b) *CPR was being conducted correctly.'*

In reaching this decision, the panel took into account its decision in respect of charges 8a and 8b above. The panel further considered the two-stage test, pursuant to *Ivey*, in determining these charges.

The panel first considered Mrs Coseru's state of mind at the relevant time. The panel bore in mind that the telephone call took place at 03:34, approximately two and a half hours after Resident A's death. At this stage, Mrs Coseru was aware that Resident A had died, and CPR was therefore inappropriate. The panel further considered that Mrs Coseru created the misleading impression to the ambulance service that there

was another colleague assisting with the CPR, as instructed by the ambulance service over the telephone, and that the CPR was therefore conducted correctly (i.e. two people, in the event one gets physically exhausted). The panel bore in mind Witness 1's NMC witness statement and local interview notes, where she confirmed that she did not assist Mrs Coseru with CPR as she deemed it inappropriate given the circumstances. Mrs Coseru would therefore be aware that her statement to the ambulance service in respect of another colleague assisting her was inaccurate and dishonest.

The panel next considered whether Mrs Coseru's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that her conduct – namely to create a misleading impression to the ambulance service in respect of CPR being conducted correctly, when it was not – would be regarded as dishonest by those standards.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charges 10a and 10b

'That you, a registered nurse:

10) On 30 September 2022 inaccurately informed police officer/s that:

a) You had immediately commenced CPR on finding Resident A unresponsive.

b) You continued CPR until 03:00 with interruptions in between.'

These charges are found proved.

Whilst the panel considered charges 10a and 10b separately, its reasoning is the same in respect of both.

In reaching this decision, the panel considered the transcript of the body-worn video, as exhibited by Witness 8. It stated:

*'**Female** – He's been sleeping and I said I checked him hourly and at one o'clock I found him…looks like…I've done the obs and I saw him actually….he didn't responded.*
***Male officer** – Okay.*
***Female** – And I have attempted the CPR. Then my staff said they just checked him half an hour ago and they positioned him, they changed the pad and I called for the ambulance but it was….I didn't stay too much, I went back to him. But I mean (inaudible). And there were other emergencies and I went back to him (inaudible).*
***Male officer** – Okay, okay. So you've found him at around about one o'clock yeah?*
***Female** – Yes.*
***Male officer** – And you say you started CPR straightaway did you?*
***Female** – Yes with…yes a little bit with the mask on the….like that.*
***Male officer** – Okay. And then how long did you do CPR for?*
***Female** – It was with one….with gaps, with interruptions actually.*
***Male officer** – Okay with interruptions for how long?*
***Female** – Just to answer the phone and back.*
***Male officer** – Okay but how long were you doing CPR for in total?*
***Female** – In total until three o'clock.*
***Male officer** – Pardon? Until three o'clock?*
***Female** – Yeah.' (bold font added to easily identify speaker)*

The panel was satisfied that "*Female*", as identified in the transcript, is Mrs Coseru.

Taking the above into account, the panel determined that Mrs Coseru answered "*Yes*" when asked by the police whether she "*started the CPR straightaway*" after "*[finding] him around about one o'clock*". The panel was therefore satisfied that Mrs Coseru told the police that she began CPR on Resident A immediately after finding him unresponsive.

Further, the panel also determined that Mrs Coseru answered "*Yeah*" when asked if she was performing CPR on Resident A "*until three o'clock*", and that she told the police that the CPR was conducted "*with gaps, with interruptions*" in that timespan.

The panel was therefore satisfied that Mrs Coseru told the police that she continued CPR on Resident A until 03:00, with interruptions.

Accordingly, the panel found charges 10a and 10b proved on the balance of probabilities.

Charge 11

'That you, a registered nurse:

11) Your conduct at charge 10a) and/or 10b) was dishonest in that you sought to conceal the fact that you had not administered CPR at the point of finding Resident A unresponsive at approximately 01:00.'

This charge is found proved.

In reaching this decision, the panel took into account its decision in respect of charges 10a and 10b above. The panel further considered the two-stage test, pursuant to *Ivey*, in determining these charges.

The panel first considered Mrs Coseru's state of mind at the relevant time. The panel bore in mind that the interview with the police took place after Mrs Coseru's call to the ambulance service, which was approximately two and a half hours after Resident A's death. At this stage, Mrs Coseru was aware that Resident A had died, and no CPR was conducted at 01:00. The panel further considered that within the body-worn video transcripts, the female officer was reassuring to Mrs Coseru, and Mrs Coseru had the opportunity to be honest regarding what had occurred, but chose not to be. The panel determined that, as she knew no CPR was conducted at 01:00, Mrs Coseru provided the police with inaccurate information (which she knew to be inaccurate) to conceal the fact that she had not conducted CPR when she found Resident A unresponsive at 01:00, which she knew to be dishonest.

The panel next considered whether Mrs Coseru's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that

her conduct – namely to conceal the fact that you had not administered CPR at the point of finding Resident A unresponsive at approximately 01:00 – would be regarded as dishonest by those standards.

Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 12

'That you, a registered nurse:

12) Failed to comply with your professional duty of candour in that you should have declared your clinical omissions in respect of charge 1.'

This charge is found proved.

The panel bore in mind that this charge alleged a failure on Mrs Coseru's part. Accordingly, the panel first considered whether Mrs Coseru had a duty to comply with her professional duty of candour and declared her clinical omissions.

In reaching this decision, the panel took into account of Witness 10's witness statement, which stated:

> *'Being honest and factual about what really happened fosters trust and nurses have a professional duty of candour. If there are no clinical signs of life and hours have passed since the resident's death, you would know as a nurse that rigor mortis will be evident and so it is better to be honest and call a doctor to explain the situation.*
>
> *[…]*
>
> *The Home has a Duty of Candour Policy which covers staff conduct wherein we expect our staff to work in line with any professional code of conduct to apply a duty of candour in all their work with residents. […] The policy requires staff to be open and honest, to admit mistakes where they occur, to apologise for them, to put matters right promptly and to follow all applicable reporting*

and recording procedures. Also, as per the Code of Conduct, Section 10.3, it states that nurses must "complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirement.'

The panel also had sight of the Home's Duty of Candour policy, which requires nurses to adhere to The Code: Professional standards of practice and behaviour for nurses and midwives 2015 ('the Code'). The panel noted that this policy was dated June 2024, and post-dates the incident. However, the panel considered that the duty of candour and compliance with the Code is a long-standing obligation which permeates all elements of nursing care, and it was satisfied that the relevant policy on the duty of candour at the time would have placed the same obligations on Mrs Coseru to adhere to the Code.

Further, the panel had sight of the Night Nurse Job Description, which required nurses to *'[have] full knowledge of and to follow the NMC Professional Code of Conduct and to be accountable for [their] professional practice*.'

Taking all the above into account, the panel was satisfied that there was a duty on Mrs Coseru to comply with her professional duty of candour and declared her clinical omissions. The panel next considered whether Mrs Coseru failed to do so.

The panel bore in mind its decision in charge 1 above. The panel determined that Mrs Coseru did not adhere to her duty of candour as she did not admit her clinical omissions, instead embarking upon a pattern of conduct (including providing inaccurate information to colleagues, paramedics and the police) to conceal her clinical failings. The panel noted the possibility that, immediately after Resident A's death, Mrs Coseru panicked and did not declare her omissions. However, the panel considered that, by the time she was in communication with the ambulance service and the police, over two hours had passed which would have given her the opportunity to reflect on her conduct and declare her omissions.

The panel noted that Mrs Coseru did make some admissions in the local investigation. However, the panel determined that, even then, Mrs Coseru was not completely candid about the events.

Accordingly, the panel found this charge proved on the balance of probabilities.

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 Mrs Coseru's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise 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, Mrs Coseru's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

Within its representations, the NMC referred the panel to the relevant case law and submitted that paragraphs 1.1, 1.2, 1.4, 3.1, 3.2, 8.5, 8.6, 10.1, 10.3, 13.1, 14.1, 14.2, 14.3, 15.2, 19.1, 20.1, 20.2 and 20.8 of the Code are engaged in this case. The NMC submitted that the breaches of the Code that amount to misconduct are serious because Mrs Coseru's failings, which involved dishonesty, were a serious departure from the standards expected of a registered professional. The failings are likely to

cause risk to patients in the future if they are not addressed and also undermine trust and confidence in the profession.

In respect of impairment, the NMC drew the panel's attention to the four "limbs", as outlined in the decision of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council and (2) Grant* [2011] EWHC 927 (Admin). The NMC submitted that all four limbs were engaged and invited the panel to find Mrs Coseru's fitness to practise currently impaired on both public protection and public interest grounds.

On public protection, the NMC drew the panel's attention to the considerations as outlined in *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin). The NMC further submitted:

> *'Although Ms Coseru admitted at a local level to the failure to administer CPR, she blamed it on her mistaken belief that there was a DNAR in place; she made no comments or admissions in relation to her attempts to conceal her actions. As such, it is submitted that she has not displayed any insight into her actions; she has not engaged with these proceedings.*
>
> *Ms Coseru has been subject to an interim suspension order since 2023 and she has not had the chance to show strengthened practice. There is no evidence that Ms Coseru has undertaken any relevant training.*
>
> *We consider there is a continuing risk to the public due to Ms Coseru's lack of insight and failure to undertake relevant training, and not having had the opportunity to demonstrate strengthened practice through work in a relevant area.'*

On the public interest, the NMC submitted:

> *'We consider that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.*

Ms Coseru's conduct engages the public interest because members of the public would be appalled to hear of a nurse failing to administer CPR without checking whether the person in her care had a DNAR in place, failing to call for emergency services in the emergency situation, lying about the time of death and making further attempts to conceal her failure to administer the CPR. Such conduct severely damages and undermines public confidence in the nursing profession and the NMC as the regulator.'

The panel noted it received no written representations from Mrs Coseru.

The panel accepted the advice of the legal assessor.

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 Mrs Coseru's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Coseru's 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.

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.

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

8 Work co-operatively

To achieve this, you must:

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 some time after the event.

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

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

To achieve this, you must:

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers.

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly.

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 […]'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore considered each of the charges found proved in turn below.

In respect of charge 1a, the panel determined that a failure to commence CPR following Resident A being found unresponsive is a significant departure from the standards expected of a registered nurse in responding to an emergency situation. The panel considered that CPR is a fundamental element of patient care in an emergency, and the panel determined that her conduct fell well below the standards expected of a registered nurse. The panel was therefore satisfied that this was sufficiently serious to amount to misconduct.

In respect of charge 1b, the panel accepted that Mrs Coseru should have rung the emergency bell, but it went on to consider whether this, in itself, was sufficiently serious to amount to misconduct, bearing in mind her incorrect assumption that Resident A was not for resuscitation. The panel considered the Home's policy required the emergency bell to be rung when there is an unexpected death (which this was, irrespective of any DNACPR). The panel further considered that Mrs

Coseru's failure to ring the emergency bell at this stage prevented other steps which her colleagues could have taken to assist her in responding to Resident A's deterioration (such as contacting the ambulance service). Accordingly, the panel determined that Mrs Coseru's failure was a departure from the standards expected of a registered nurse, and was sufficiently serious to amount to misconduct.

On charge 1c, the panel determined that Mrs Coseru's failure to call the ambulance service and summon help in the moment fell seriously short of the standards expected of a registered nurse responding to an emergency situation. Accordingly, the panel was satisfied that this was sufficiently serious to amount to misconduct.

On charge 1d, the panel considered that Mrs Coseru's failure to adequately check that Resident A was subject to a DNACPR, and proceeding on an assumption that he was, informed the rest of her decision-making that evening. The panel determined that her omission was a serious departure from the standards expected of a registered nurse.

The panel was mindful that there were changes to the Home's policy in relation to RESPECT and DNACPR following the incident, such as the introduction of the purple heart symbol as an indication of "*do not resuscitate*". This policy was not in place at the relevant time, and the panel must consider misconduct in the context of Mrs Coseru's omissions at the time of the incident. Despite these subsequent changes, the panel was clear that Mrs Coseru had a duty to adequately check whether Resident A was subject to a DNACPR in place at the time and failed to do so. Therefore, the panel determined that this was a serious failing on Mrs Coseru's part, and was sufficiently serious to amount to misconduct.

In respect of charges 2 and 3, the panel noted Mrs Coseru's assertion, per her local statement, that she had a delayed reaction to her clinical failings given her shock. However, the panel determined that her attempt to commence CPR and use the defibrillator approximately two and a half hours after Resident A's death was entirely unjustified, and fell far below the standards expected of a registered nurse. The panel considered that, given Mrs Coseru's experience, she likely knew that commencing CPR when rigor mortis had begun would not only be in contravention of

his right to dignity, but was done in an attempt to conceal her error. The panel determined that this was a serious departure of the standards expected of a registered nurse, and it was satisfied that the actions as outlined in charges 2 and 3 were sufficiently serious to amount to misconduct.

In respect of charges 4, 5 and 6, the panel determined that attempting to conceal a clinical error by falsifying patient records is a serious departure from the standards expected of a registered nurse. The panel was satisfied that these actions were sufficiently serious to amount to misconduct.

On charge 7, the panel considered that keeping contemporaneous and accurate patient records (including records involving death) is a fundamental tenet of nursing. The panel determined that Mrs Coseru's failure to do so created a misleading picture for all involved parties (colleagues, ambulance service and the police) in respect of Resident A's death. The panel determined that this fell far below the standards expected of a registered nurse in the handling of a patient's death, and was sufficiently serious to amount to misconduct.

In respect of charges 8 and 9, the panel considered that Mrs Coseru created an impression to the ambulance service which she knew to be false. The panel considered that there was a potential for emergency ambulance resources to be needlessly directed to Resident A, as a result of Mrs Coseru's actions. The panel determined that misleading the ambulance service falls far below the standards expected of a registered nurse, and was sufficiently serious to amount to misconduct.

In respect of charges 10 and 11, the panel determined that deliberately misleading the police is extremely serious, and that Mrs Coseru was under a professional duty to provide an honest account to the police. The panel was of the view that Mrs Coseru's actions fell far below the standards expected of a registered nurse, and were sufficiently serious to amount to misconduct.

In respect of charge 12, the panel bore in mind that the duty of candour is a professional duty imposed upon all registered nurses, per the Code. The panel noted

that the events in question occurred over one night shift and Mrs Coseru asserted she was in shock, but it considered that Mrs Coseru had the opportunity, over the night shift, to be open and honest with her colleagues, the ambulance service and the police regarding Resident A's death and her clinical errors. Mrs Coseru chose not to do so. Further, the panel also considered that the local investigation took place approximately four months (from September 2022 to January/February 2023) after the incident, during which time Mrs Coseru had the opportunity to reflect on her duty of candour. Whilst the panel noted that Mrs Coseru admitted to some of her errors in the local interview, she was not fully candid about what took place during the incident. Accordingly, the panel determined that this fell far below the standards expected of a registered nurse in the exercise of her duty of candour, and was sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 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. 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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.'

On limb (a), the panel determined that a failure to conduct CPR on Resident A, when those were his wishes, clearly placed Resident A at a risk of harm. The panel noted that, whilst this was a singular error, this was a very serious, irreversible and catastrophic error.

In respect of limbs (b) and (c), Mrs Coseru's misconduct – a failure to respond appropriately to an emergency and subsequent dishonesty to conceal that failure, in documentation and to other practitioners – breached the fundamental tenets of the nursing profession, namely to prioritise patient safety, respect their dignity and to exercise her duty of candour at all times. Mrs Coseru therefore brought the reputation of the nursing profession into disrepute.

On limb (d), concerning dishonesty, the panel found that Mrs Coseru's actions – namely to conceal her clinical errors by making false patient entries as well as telling colleagues and other healthcare practitioners information she knew to be false – amounted to several instances of dishonesty, albeit in the course of one incident over a few hours. The panel further noted that the dishonesty included dishonest reports to third-parties, such as the ambulance service and the police.

The panel considered that impairment is a forward-looking exercise, and it next considered whether Mrs Coseru is liable, in the future, to put patients at unwarranted risk of harm, bring the nursing profession into disrepute, breach one of the fundamental tenets of the nursing profession and act dishonestly, pursuant to *Grant*. In reaching its decision, the panel also considered the principles derived from *Cohen,* namely:

- Whether the concern is easily remediable;
- Whether it has in fact been remedied; and
- Whether it is highly unlikely to be repeated.

The panel first considered whether the concerns are remediable. The panel was satisfied that some elements of Mrs Coseru's misconduct related to her clinical practice (such as ensuring appropriate responses to an emergency or checking residents' documentation or care plans), and those concerns are remediable.

However, the panel was of the view that her dishonest conduct is very difficult to remedy. The panel noted that dishonesty is on a spectrum, and there are less serious forms of dishonesty which are more easily remediated. However, the panel took into account that Mrs Coseru's dishonesty took place in the course of her professional practice, and involved falsifying patient records as well as deliberately misleading colleagues, other healthcare professionals and the police. The panel considered that Mrs Coseru's dishonesty involved a lack of duty of candour, and her attempts to conceal her clinical error. Accordingly, the panel determined that the nature of Mrs Coseru's misconduct would require the demonstration of a significant degree of insight, evidence of acting with honesty and integrity in a workplace setting, allied to the passage of time, before the panel could be satisfied that it has been sufficiently remedied.

On whether her misconduct has, in fact, been remediated, the panel considered that Mrs Coseru has not engaged with these proceedings, and it has no evidence before it of Mrs Coseru's current insight, remorse or remediation. The panel considered Mrs Coseru's local interview notes, which stated:

> *'[Witness 9] - OK. I don't think I have anymore questions, have you got anything you would like to add?*
> *IC - I'm sorry for all this.'*

The panel also considered the email Mrs Coseru sent to the Home, dated 14 February 2023, as part of the local investigation. Within it, Mrs Coseru described the incident and her response to Resident A's deterioration, and she explained why the shift was "*particularly difficult*" for her. The panel noted that there are inconsistencies between Mrs Coseru's account of her actions in the local interview and within her email, and it was of the view that Mrs Coseru was not fully candid regarding the incident on either occasion, and failed to accept responsibility for what occurred.

Further, the panel considered that, save for the one apology made (above), there is no evidence that Mrs Coseru has demonstrated any remorse or remediation. The panel took into account the lack of evidence of any reflection on Mrs Coseru's part regarding the impact of her actions on Resident A's family, on colleagues and on the wider nursing profession. Further, the panel has no evidence before it that Mrs Coseru has strengthened her practice, or has engaged in continuing professional development.

The panel therefore determined that evidence of Mrs Coseru's insight is limited to what she stated in the course of the local investigation. The panel concluded that there is no evidence that Mrs Coseru has demonstrated meaningful remorse, insight or strengthening of her practice to reassure this panel that the concerns have been remediated.

Consequently, the panel determined that given Mrs Coseru's non-engagement and lack of evidence on her current insight, remorse or strengthened practice, the conduct is likely to be repeated. The panel accepted that mistakes can happen within a practitioner's career, and that this incident was likely borne of Mrs Coseru's initial serious error in not adequately checking whether Resident A was subject to a DNACPR. However, this error was compounded by her subsequent dishonest actions to conceal her failings.

The panel determined that Mrs Coseru's dishonest actions following that initial error was indicative of a deep-seated attitudinal issue. The panel noted the NMC's representations in this regard. The panel considered that, throughout the course of the night shift, Mrs Coseru had ample opportunity between approximately 01:00 and 03:30 to reflect upon her actions. Even if she was initially shocked by the error she had made in respect of Resident A's resuscitation status, she had opportunities to seek advice and be truthful with her colleagues. Instead, Mrs Coseru maintained her position, chose to fabricate clinical records and create misleading impressions to her colleagues, the ambulance service as well as to the police.

Further, the panel considered that Mrs Coseru remained not fully candid when interviewed about the incident several months later. The panel was of the view that, even if the actions on the night were influenced by Mrs Coseru's panicked state, she had approximately four months between the incident and the local investigation to reflect upon her actions and be truthful. The panel bore in mind that Mrs Coseru instead sought to deflect blame upon other colleagues (such as Witness 1, who allegedly would not assist her) and upon the situation she found herself in during the shift. The panel bore in mind that her story shifted (for example, she initially recounted that she performed a two-handed CPR on Resident A, but claimed in her email that this was with two fingers), and that neither document addressed why Mrs Coseru misled the ambulance service or the police.

The panel accepted that the dishonesty on Mrs Coseru's part was borne of one incident, and there is no indication that Mrs Coseru has been dishonest in her nursing practice prior to or following the incident. However, the panel determined that Mrs Coseru, despite being given the opportunity over time, did not comply with her duty of candour. In the absence of her reflection or demonstrating an understanding of her duty of candour in these proceedings, the panel determined that this conduct is likely to be repeated.

Based on the above, the panel determined that Mrs Coseru is liable, in the future, to put patients at unwarranted risk of harm, to bring the nursing profession into disrepute, breach one or more of the fundamental tenets of the nursing profession and act dishonestly, pursuant to *Grant*. Accordingly, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel next considered whether a finding of impairment is necessary on public interest grounds. The panel bore in mind that the overarching objectives of the NMC, namely to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case, particularly given Mrs Coseru's dishonest conduct designed to conceal her clinical failings in the management of a resident's death. It determined that a well-informed member of the public would be shocked if a finding of impairment was not made against a nurse who attempted to conceal her clinical errors to colleagues, other medical professionals as well as the police, and fabricated clinical notes in this concealment. Mrs Coseru also failed to uphold the dignity of a deceased resident in her care. Accordingly, the panel also finds Mrs Coseru's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Coseru's fitness to practise is currently impaired on both public protection and public interest grounds by way of her misconduct.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance ('SG') published by the NMC.

Representations on sanction

The panel had sight of the NMC's representations, which advised the panel that the NMC considers a striking-off order to be the appropriate and proportionate sanction.

The representations outlined the following aggravating factors:

- *‘Concerns relate to fundamental tenets of the nursing profession (responding in an emergency, completing records accurately and without falsification and retaining patient dignity);*
- *Dishonesty which occurred in a clinical context which elevates the seriousness;*
- *Dishonesty is indicative of an attitudinal disposition which is more difficult to remediate.*
- *No insight (she has not engaged);*
- *No evidence of remediation (subject to ISO).’*

The representations outlined the following mitigating factors:

- *‘Contextual factors – Ms Coseru states she had worked overtime, was feeling unwell and the shift was short-staffed;*
- *Ms Coseru erroneously believed Resident A was not for resuscitation and thereafter likely panicked/ was in a state of shock when she realised resuscitation should have been attempted. This may account for her actions and suggest spontaneous dishonesty rather than sophisticated dishonesty;*
- *Admissions at local level to not commencing CPR (although she made no responses in relation to potential dishonesty).’*

On the most appropriate and proportionate sanction, the NMC submitted that neither taking no further action nor the imposition of a caution order would be appropriate, as both would not mark the seriousness of the case, or sufficiently address the public protection concerns identified.

In respect of imposing a conditions of practice order, the NMC outlined the factors for the panel’s consideration, and submitted that Mrs Coseru has not demonstrated a willingness to retrain or any evidence of her insight. The NMC further submitted that there is evidence of harmful, deep-seated personality or attitudinal concerns, and consequently, no workable conditions could be devised to address the concerns.

On a suspension order, the NMC submitted:

*'A **Suspension Order** would not be an appropriate sanction because of*

i. lack of insight and risk of repetition;

ii. although misconduct occurred over the course of a single shift, it cannot be said to be a singles [sic] *instance, as it involved the clinical misconduct of not carrying out the CPR and asking for help, and then the dishonest actions of falsification of the notes, perfunctory administration of the CPR on a corpse.*

iii. as such, there is evidence of deep-seated harmful personality or attitudinal problems.'

In respect of a striking-off order, the NMC submitted:

*'A **Striking-off Order** is the appropriate sanction for the following reasons:*

i. Ms Coseru's actions raise fundamental questions about her professionalism and make her incompatible with remaining on the register;

ii. public confidence in nurses cannot be maintained if Ms Coseru, a nurse who committed a breach of fundamental tenets of nursing profession including serious dishonesty is not struck off from the register;

iii. there has been no engagement, no insight and no attempt at restoration;

iv. The NMC guidance SAN-2 sets out the following:

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'*

The panel noted it received no written representations from Mrs Coseru.

The panel accepted the advice of the legal assessor. She advised the panel to consider sanction in ascending order, starting from the least to the most restrictive. She further referred the panel to the decision in, and principles derived from, *Parkinson v NMC* [2010] EWHC 1898 (Admin). Based on *Parkinson*, the legal assessor advised that a nurse who has been found to have been dishonest is always at a severe risk of being erased from the register, and when the nurse has not appeared before the panel to demonstrate remorse or remediation, they effectively forfeit the small chance of convincing the panel to adopt a more merciful outcome. However, the legal assessor advised that each case should be considered on its individual merits.

Further, the panel was reminded of the NMC guidance on sanctions and the need for proportionality in the imposition of any sanction.

Decision and reasons on sanction

Having found Mrs Coseru's 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 identified and took into account the following aggravating features:

- Conduct which put a resident at direct risk of suffering harm;
- Concerns relating to fundamental tenets of the nursing profession;
- Deliberate breach of the professional duty of candour, in that her actions were intended to conceal her clinical errors;
- Dishonesty which occurred in the clinical context, which were repeated instances on the shift in question, involving fabrication of Resident A's clinical notes as well as dishonesty to colleagues, the ambulance service and the police; and

- No evidence of insight into failings or strengthened practice.

The panel also identified and took into account the following mitigating features:

- Early admissions to some failures at the local investigation;
- Personal mitigation including Mrs Coseru's assertion that she was unwell on the night in question and that she was overworked;
- Contextual factors, such as some evidence that the shift was short-staffed and Mrs Coseru's initial's failure to perform CPR appears to stem from her genuinely-held, but mistaken, belief that Resident A was not for resuscitation;
- Positive comments made regarding Mrs Coseru's previous nursing practice during the local investigation.

Prior to reaching its decision on sanction, the panel considered the NMC Guidance, '*Sanctions for particularly serious cases'* (SAN-2). Under the header, '*Cases involving dishonesty*', the guidance stated:

> *'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*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice*

Nurses, midwives and nursing associates who have behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again. Where the professional denies dishonesty, it is particularly important that they make every effort to attend the hearing so that the Committee can hear at first hand their response to the allegations.'

In considering the factors above, the panel determined that Mrs Coseru did deliberately breach her professional duty of candour by attempting to cover up her error of not adequately checking if Resident A had a DNACPR in place. Further, the panel took into account that her dishonesty did involve placing a vulnerable resident within her care at direct risk of harm.

When assessing the seriousness of her dishonesty, the panel took into account that Mrs Coseru's conduct was not a one-off incident, albeit it noted that it occurred over one night shift. The panel also bore in mind that Mrs Coseru's dishonesty occurred within her professional practice.

Further, the panel was not satisfied that this was opportunistic or spontaneous conduct, as the panel bore in mind that Mrs Coseru had approximately two and a half hours (between Resident A's death and when she spoke to the police) to reflect upon her conduct and be truthful about the incident. In this time, Mrs Coseru also made false entries into Resident A's clinical records. Further, the panel noted that she had approximately four months between the incident and the commencement of the local investigation to be fully candid. The panel determined that this could not be

described as spontaneous conduct, as spontaneous would suggest an unplanned, one-off reaction which would not be repeated over the course of a few hours. Whilst the panel accepted that Mrs Coseru's reaction was initially unplanned (rather than premeditated), its repetition indicated that it was not spontaneous.

The panel accepted that there is no direct personal gain through Mrs Coseru's dishonesty. Having taken account of all the circumstances and context for her actions, the panel determined that Mrs Coseru's dishonesty was at the upper end of seriousness.

Bearing the above in mind, the panel then moved on to consider the appropriate and proportionate sanction.

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 Mrs Coseru's 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 Mrs Coseru's misconduct was not at the lower end of the spectrum and that 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 Mrs Coseru's registration would be a sufficient and appropriate response. The panel noted that some of the instances of misconduct identified are clinical in nature and could be addressed through the imposition of conditions of practice. However, the panel bore in mind that Mrs Coseru has not engaged with the NMC, and it was therefore not

satisfied that she would engage with any conditions imposed upon her nursing practice designed to address these specific elements of her misconduct in any event.

Further, the panel considered that some of Mrs Coseru's misconduct is attitudinal in nature (such as dishonesty and lack of candour), and no workable conditions could be formulated to address these elements of her misconduct and adequately protect the public, given her serious clinical failings. The panel also concluded that a conditions of practice order would not satisfy the public interest, given the seriousness of Mrs Coseru's dishonesty. The panel therefore determined that a conditions of practice order would not be the appropriate or proportionate sanction in these circumstances.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are present:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The panel considered the above factors in turn.

The panel determined that the facts found proved did not constitute a single instance of misconduct, albeit it noted that they stemmed from one incident. The panel determined that Mrs Coseru's misconduct involved several instances of dishonesty, including falsifying clinical records, as well as misleading colleagues, the ambulance service and the police.

On whether there is evidence of harmful deep-seated altitudinal concerns, the panel had regard to its observations in respect of impairment above. The panel determined that Mrs Coseru's subsequent reaction to her initial error was indicative of harmful, deep-seated attitudinal concerns, as she repeatedly sought to conceal her clinical errors despite the opportunities she had (both on the night and in the subsequent months during the local investigation) to be candid about the incident.

The panel accepted that there is no evidence before it of any repetition of the behaviour since the incident. However, the panel noted that Mrs Coseru is currently subject to an interim suspension order and therefore has not had any opportunity to demonstrate safe and effective practice.

On whether Mrs Coseru has sufficient insight, the panel noted that Mrs Coseru has not engaged with the NMC and had demonstrated minimal insight in her admissions during the local investigation, and no remorse or remediation, save for the apology she made at the local investigation. The panel noted its decision on her fitness to practise above, and it determined that Mrs Coseru has not demonstrated any meaningful insight or remediation into her misconduct, and that she does pose a significant risk of repeating the behaviour.

Based on the above, the panel determined that, given Mrs Coseru's lack of meaningful insight and therefore the likely risk of repetition, a suspension order would not be a sufficient, appropriate or proportionate sanction to address her misconduct.

The panel therefore considered whether to impose 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?*

The panel considered the above factors in turn.

Based on the above guidance, the panel was satisfied that Mrs Coseru's actions were significant departures from the standards expected of a registered nurse and raised fundamental questions about her professionalism. In particular, the panel considered that her dishonesty in her concealment of her clinical errors to colleagues, the ambulance service as well as the police raised such fundamental questions.

Further, the panel determined that public confidence in nurses could not be maintained if Mrs Coseru remained on the register following the panel's findings on her misconduct. The panel was of the view that a member of the public would be dismayed to learn that a nurse who has failed to appropriately conduct CPR on a resident and subsequently falsified clinical notes and relayed misleading information to other medical professionals and the police to conceal their error, was allowed to remain on the register. The panel accepted the legal advice it received including reference to the case of *Parkinson*. Whilst considering this case on its individual merits, the panel was mindful that Mrs Coseru has not engaged with the NMC. Therefore, the panel has no evidence before it to suggest that she has developed any further insight into her failings or has since remediated these concerns surrounding her dishonesty and lack of candour, even if the initial error (the presumption of Resident A having a DNACPR plan in place) was a mistake.

In considering whether a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards, the panel noted its earlier findings that Mrs Coseru's clinical failings were irreversible, and that her dishonesty was at the upper end of the scale. Therefore, it determined that nothing short of a striking-off would be appropriate, proportionate or adequately protect the public in the circumstances. Further, having regard to the effect of Mrs Coseru's actions in bringing the profession into disrepute by adversely affecting the

public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

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

This will be confirmed to Mrs Coseru in writing.

Interim order

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

The panel accepted the advice of the legal assessor.

Representations on interim order

The panel had sight of the NMC's representations, which stated:

> *If a finding is made that Ms Coseru's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that Ms Coseru's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with*

continued registrant [sic] *we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

The panel noted it received no written representations from Mrs Coseru.

Decision and reasons on interim order

The panel determined that not to impose an interim suspension order would be wholly incompatible with its earlier findings.

The panel considered the guidance on interim orders (SAN-5). 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 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 suspension order is consistent with its findings on impairment and sanction.

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 any relevant appeal period and allow any appeal, if made, to conclude.

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

That concludes this determination.