Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 26 August – Thursday, 11 September 2025
and
Monday, 22 December – Tuesday, 23 December 2025

Virtual Hearing

Name of Registrant:	**Aimikpomoyako Hassan**
NMC PIN:	05A1261E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH Registered Nurse - Mental Health (April 2005)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Alan Greenwood (Chair, lay member) Deborah Bennion (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	John Moir (26 August – 11 September 2025) Fiona Barnett (22 December – 23 December 2025)
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Alfred Underwood, Case Presenter (26 August – 11 September 2025) Alex Radley, Case Presenter (22 December – 23 December 2025)
Mrs Hassan:	Present and represented by Onuwa Joe Aniagwu
Facts proved:	Charges 1(a), 1(c)(i), 1(c)(ii), 1(c)(iii), 1(c)(iv), 1(d), 2 in part, and 4
Facts not proved:	Charges 1(b), 3
Fitness to practise:	Impaired

Sanction:	Suspension order (12 months)
Interim order:	**Interim suspension order (18 months)**

Details of charges

That you, a registered nurse:

1. On 13 December 2018 following a ‘rapid tranquilisation’ of Patient A that took place at approximately 05:30:

    a. you failed to carry out the required 15 minute ‘rapid tranquilisation’ observations on Patient A

    b. you failed to conduct or ensure that a staff member conducted Patient A’s intermittent 15-minute observations

    c. you recorded on Patient A’s rapid tranquilisation monitoring chart:
        i. at baseline (0545) that Patient A ‘refused’ observations
        ii. at 15 minutes that Patient A ‘refused’ observations
        iii. at 30 minutes that Patient A was ‘asleep’
        iv. at 60 minutes that Patient A ‘refused’ observations

    d. you recorded on Patient A’s observation record sheet that Patient A was asleep at 0600, 0615, 0630 and 0645.

2. Your conduct at charge 1(c) above was dishonest in that you:

    a. did not conduct or attempt to conduct any of the observations that you recorded on the rapid tranquilisation monitoring chart.

    b. intended to give the impression that you had conducted or attempted to conduct observations on Patient A when you had not.

3. Your conduct at charge 1(d) above was dishonest in that you:

a. did not conduct or attempt to conduct any of the observations that you recorded on Patient A's observation record sheet.

b. intended to give the impression that you had conducted or attempted to conduct observations on Patient A at 0600, 0615, 0630 and 0645 when you had not.

4. Your failure to carry out the required observations of Patient A at charge 1(a) and/or (b) above contributed to Patient A's death.

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

Application for the panel to recuse itself from the hearing.

At the outset of the hearing, Mr Aniagwu made an application for the panel to recuse itself. He submitted that it would not be helpful for you to continue with the hearing while feeling uncomfortable, whether that discomfort was real or perceived. He explained that you had expressed concerns about the composition of the panel and had expected it to be more reflective of today's Britain in terms of ethnic background. He added that you had previously hinted at your unease and that this was the basis for his application.

Mr Underwood opposed the application for the panel to recuse itself. He submitted, firstly, that the Nursing and Midwifery Council (NMC) is not permitted to select its panels based on any protected characteristic under the Equality Act, as doing so would amount to a breach of the law. Secondly, he stated that the basis for the application appeared to be one of apparent bias, as there was no evidence before the panel to suggest actual bias.

Mr Underwood argued that it could not be said that a fair minded and informed observer would conclude that a panel member was biased against you solely because they were of a different race or ethnicity. To suggest otherwise, he submitted, would not be a reasonable or fair submission and might itself be considered discriminatory.

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

The panel considered this carefully, taking into account the legal advice and submissions from both parties. The legal test is whether a fair-minded and informed observer, considering the facts, would conclude that there was a real possibility of bias.

While the panel recognised your feelings and concerns, it concluded that recusing itself solely on the basis of race would, in itself, be discriminatory. To do so would wrongly suggest that white panel members are inherently unqualified to hear cases involving black registrants, which would undermine the integrity and fairness of the regulatory process.

There was no evidence of actual or apparent bias beyond the racial composition of the panel. The panel members confirmed their duty to act impartially and decide the case solely on the evidence.

Applying the objective test, the panel determined that a fair-minded observer would not consider there to be a real possibility of bias. The application was therefore rejected, and the hearing will proceed before the panel as presently constituted.

Abuse of process application

Mr Aniagwu made an application for this hearing to be stayed on the grounds of abuse of process. He submitted that a serious incident review was carried out by senior management following this matter, and it is clear from that review that key individuals, were directly involved in the events that took place on the night in question. These individuals were employed by the East London NHS Foundation Trust (the Trust) and were part and parcel of the running of the ward at that time.

Mr Aniagwu submitted that it would be unreasonable and unrealistic to expect you to call these individuals as your own witnesses. It is not feasible for you, as the registrant, to approach employees of the Trust and secure their attendance to give evidence.

Instead, it is the responsibility of those bringing the case to ensure that key witnesses who were directly involved are included in the process.

Mr Aniagwu submitted that to proceed without the evidence of those present on the ward that night would render these proceedings fundamentally unfair. Instead of relying on statements from individuals who were only remotely connected to the incident, the panel should hear directly from those who were physically present and who can provide first-hand accounts of what occurred. Their testimony is essential to establish an accurate and fair understanding of events, including the ward practices at the time, which go to the heart of assessing your role and level of responsibility.

Mr Aniagwu drew a comparison with the evidence of Witness 3. At the coroner's inquest, Witness 3 gave evidence under oath, just as the Duty Senior Nurse did. Mr Aniagwu stated that if the panel required Witness 3 to attend in person to give evidence, then the same principle should apply to these key witnesses. Their evidence is of similar significance and cannot simply be substituted with statements or indirect accounts.

Mr Aniagwu submitted that unless these witnesses are compelled to attend, you will be denied the opportunity to challenge crucial evidence and to present a fair defence. This, he argued, would amount to an abuse of process and undermine the fairness of the entire hearing.

Mr Underwood opposed the application to stay the proceedings as an abuse of process. He explained that the application was based on the NMC's decision not to obtain witness statements from certain individuals who were on duty at the time.

Mr Underwood submitted that the wider conduct of other staff is not central to the case against you. The NMC's case is straightforward: you administered Lorazepam to Patient A at around 05:30, assumed responsibility for carrying out 15-minute observations, failed to complete them, and later inaccurately recorded that they had been done. Patient A ingested illicit drugs before being found unresponsive at 07:50. Had the required observations been completed, the effects of those drugs would have been detected and emergency treatment provided.

Mr Underwood explained that the decision not to obtain certain witness statements was made because the documentary evidence, CCTV footage, and your own admissions during the Trust investigation and at the inquest were considered sufficient to establish the facts.

Mr Underwood concluded that these are regulatory proceedings, not court proceedings, and the panel has wider powers to manage evidence. The absence of these witnesses does not prevent a fair hearing, and there is no basis to stay the proceedings as an abuse of process.

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

The panel reminded itself that the threshold for abuse of process is a very high bar. A stay of proceedings will only be granted in exceptional circumstances where it would be impossible for the registrant to have a fair hearing, or where proceeding would bring the regulatory process into disrepute.

Mr Aniagwu submitted that further disclosure and investigation were required and that certain evidence, including statements from other staff members, should be obtained before the case proceeded.

The panel accepted that, while it may be helpful for additional information to be gathered, the absence of this material at this stage does not, in itself, prevent the hearing from being fair. The charges before the panel are narrow and focused specifically on your conduct, in particular your admitted incorrect observation records.

The panel also considered the argument that issues relating to wider ward practices, or the actions of other staff, might affect the case. While these matters may be explored during the hearing, they do not prevent the panel from considering the evidence already available or from giving you a fair opportunity to respond to the allegations.

The panel concluded that there was no evidence at this stage to show that continuing with the case would be fundamentally unfair or that it would amount to an abuse of process. While further disclosure may arise as the case progresses, nothing before the panel currently meets the very high threshold required to justify halting the proceedings. Should new evidence emerge that could affect the fairness of the hearing, you remain free to make a further application at that time.

For these reasons, the panel rejected the application. The hearing will therefore continue.

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

In the course of your evidence you mentioned [PRIVATE]

The legal assessor reminded the panel that while Rule 19(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel decided to hold parts of the hearing which refer to [PRIVATE] in private because it concluded that this was justified by the need to [PRIVATE] and that this outweighed any prejudice to the public interest in holding those parts of the hearing in public. However, where there is no reference to [PRIVATE], the hearing would be held in public.

Background

The charges arose whilst you were employed as a registered nurse by the Trust.

The background to this case goes back to December 2018, when you were working as a Band 5 mental health nurse on Ivory Ward at the Newham Centre for Mental Health, part of East London NHS Foundation Trust. Ivory Ward is a 15-bed acute admission

ward for mental health patients. You had been registered with the NMC since April 2005 and worked for the Trust from 2005 until 2019.

On 11 December 2018, Patient A was detained by police under section 136 of the Mental Health Act and brought to the Newham Centre. He had a known diagnosis of bipolar affective disorder and was later detained under section 2 for up to 28 days. Initially, he was admitted to Ruby Ward but was transferred to Ivory Ward on the morning of 12 December 2018.

Patient A displayed chaotic and aggressive behaviour throughout the day of 12 December 2018. At around 14:00, he was given 2mg of Lorazepam by intramuscular (IM) injection following a physical altercation with another patient. That evening, he was also given his prescribed medication and 2mg of Clonazepam.

You were working the night shift on Ivory Ward, alongside another Band 5 nurse (Mr 1), and other staff. The night shift ran from 19:30 on 12 December 2018 to 08:00 on 13 December 2018. There is conflicting evidence about whether you were the shift coordinator, but you were one of the two qualified nurses on duty. Patient A retired to his bedroom at around 22:15 and woke at around 05:00.

At around 05:20 on 13 December 2018, Patient A became very agitated and verbally threatening, particularly towards Mr 1. He was restrained, searched, and a small phial containing liquid, later suspected to be gamma-hydroxybutyrate/gamma-butyrolactone (GHB/GBL), was found in his sock. At 05:30 it is alleged that you administered 2mg of Lorazepam to Patient A by IM injection. Shortly after, staff left the room, and by 05:45 there were no staff present outside his door. You stated that you were not aware of these drugs being found or that he had ingested these drugs.

CCTV footage shows that no one entered the room again until 07:40 when a staff member saw Patient A lying in bed. Ten minutes later, at 07:50, he was found lying on the floor and unresponsive. Cardiopulmonary resuscitation (CPR) was attempted, but he was pronounced dead at 08:45. Further drug paraphernalia was later found hidden in his underwear.

Trust policy required that, following a rapid tranquilisation injection, a patient's vital signs, including pulse, blood pressure, respiratory rate, temperature, oxygen saturation level and consciousness level, be monitored every 15 minutes for a minimum of 60 minutes and to continue until the patient was ambulatory and stable. It is alleged that these observations were not carried out. Instead, it is alleged that you filled in the rapid tranquilisation monitoring (RTM) chart, recording that Patient A was either asleep or had refused observations, despite no actual monitoring being done.

You also allegedly signed a general observations chart at 06:00, 06:15, 06:30, and 06:45, indicating that Patient A was asleep. CCTV evidence and witness statements allegedly confirm you did not make these checks yourself.

During the Trust investigation and at the coroner's inquest, you admitted you had not carried out the required observations. You said you were afraid to approach Patient A because of his earlier aggressive behaviour and imposing stature.

Medical evidence later concluded that Patient A likely ingested illicit drugs, including Ketamine and GHB/GBL. These, combined with the Lorazepam you allegedly administered, caused his death by severely depressing his nervous system. The expert evidence was that if proper observations had been taken, signs of distress would have been likely detected, and emergency treatment could have been provided, potentially saving his life.

The case against you is that by failing to carry out the required observations, and by making false entries in both the general observation and RTM charts, you acted dishonestly and contributed to Patient A's death.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you that you made full admissions to charges 1(c)(iii), 1(d). Immediately prior to giving your evidence at the commencement of your case, you made further admissions to charges 1(a), 1(c)(i), 1(c)(ii), 1(c)(iv).

The panel therefore found charges 1(a), 1(c)(i), 1(c)(ii), 1(c)(iii), 1(c)(iv), 1(d) proved by way of your admissions.

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

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

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

- Witness 1: Employed by the Trust as the Borough Lead Nurse for Newham Centre for Mental Health.
- Witness 2: Registered Psychiatric Nurse and was the Borough Lead Nurse for Hackney, London at the time of the incident.
- Witness 3: Employed by University Hospital of Leicester NHS Trust as a Consultant in Acute Medicine and Clinical Pharmacology and Therapeutics.
- Witness 4: Employed by the Trust as a Life Skills Recovery Worker and Unit Floater at the Ivory Ward at the

Newham Centre for Mental Health
London.

The panel also heard evidence from you under affirmation.

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

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

Charge 1

1. On 13 December 2018 following a 'rapid tranquilisation' of Patient A that took place at approximately 05:30:

   b) you failed to conduct or ensure that a staff member conducted Patient A's intermittent 15 minute observations.

This charge is found NOT proved.

It was a matter of common ground between the parties that you did not personally conduct Patient A's 15-minute observations. Accordingly, the panel focused its consideration on whether you had failed to ensure that another member of staff conducted these observations.

In its deliberations, the panel carefully considered the evidence of Witness 4, who gave clear and detailed testimony. During cross-examination, Witness 4 was specifically asked:

- *"Were you reporting to her about the observations?"* to which he replied, *"I mentioned them to the whole team."*
- When asked, *"Was your intention to report to Aimi?"* he confirmed, *"Yes."*

- He further confirmed that he was assisting you, stating, *"Yes, I was helping her,"* and agreed that you expected him to inform you of what he had observed.

Witness 4 also stated that he carried out some observations during the first hour, explaining, *"I did my best and the times are there as shown."* He confirmed that this was done to fulfil your observations and to help, emphasising, *"We were working as a team. If someone is busy, you would step in. For example, if someone cannot do observations, I would do the task for them."*

When asked whether he had carried out the observations but had not personally signed for them, Witness 4 responded, *"Unfortunately yes. A lot of staff would have done so in the past."* He further confirmed that this practice was customary on the ward.

Having weighed this evidence, the panel was satisfied that you relied on Witness 4 to conduct Patient A's intermittent 15-minute observations and that this was in keeping with the established team-based practice on the ward. The precise manner in which Witness 4 conducted the observations was a matter for him, and the evidence indicated that he did, in fact, carry out the observations, albeit without signing for them.

The panel noted your evidence that you had delegated the task of making 15-minute observations in respect of Patient A to Witness 4.

The panel concluded that the burden of proof had not been discharged by the NMC. There was insufficient evidence to establish that you failed to ensure that Witness 4 conducted the necessary observations.

Having taken all of the above into consideration, the panel determined that this charge is found not proved.

Charge 2

Your conduct at charge 1(c) above was dishonest in that you:

a. did not conduct or attempt to conduct any of the observations that you recorded on the rapid tranquilisation monitoring chart

b. intended to give the impression that you had conducted or attempted to conduct observations on Patient A when you had not

This charge is found proved in part.

In respect of 2(a) the panel found that proved on the basis of your admissions in evidence. However, 2(b) is proved only in respect of 1(c)(i), (ii) and (iv) and not in respect of conduct at 1(c)(iii).

The panel noted the NMC's submissions that, while your actions were not particularly sophisticated or premeditated, and may have been carried out without full appreciation of the seriousness of the circumstances, you made false records that gave others a misleading impression about the actions you had taken and the conscious state of Patient A.

The panel took into account your evidence about the entries that you admitted making. These entries were those listed under 1(c). At 1(c)(i), the entry recorded was *'refused'*; at 1(c)(ii), the entry recorded was also '*refused*'; and at 1(c)(iv), the entry recorded was again '*refused*.' The entry at 1(c)(iii), however, was recorded as '*asleep*.' In considering your evidence, the panel also bore in mind that you are a person of good character. The panel accepted the legal advice that your good character was relevant both to your credibility and to the likelihood of you acting dishonestly.

The panel considered your evidence carefully. When questioned about the word '*refused*,' you admitted that it was wrong. When asked directly whether it was true, you accepted that it was not. When it was put to you that you had used the word '*refused*' deliberately to mislead others into thinking that you had carried out observations, you said, *"I was not thinking of that. It was not my intention to mislead anyone, I was just filling out the forms at that time."* Later, when it was suggested again that it was a

deliberate attempt to mislead, you stated, *"I was not thinking to mislead anyone. I never filled the form to mislead. I did not think twice. I had no intention to mislead."*

In relation to the entry at 1(c)(iii), where you recorded that Patient A was asleep, you explained that you wrote this because Witness 4 had told you that Patient A was asleep at that time. The panel considered your evidence about this entry carefully. It noted that this entry was factually correct in that Patient A was asleep at the relevant time. Accordingly, the panel accepted your explanation.

The panel accepted your evidence that you were simply recording what Witness 4 had told you. Your intention in making that entry was to record the truth rather than to mislead. The panel therefore concluded that your conduct in respect of this particular entry was not dishonest.

The panel was satisfied that the entries recorded as '*refused*' were, to your knowledge, untrue. These entries gave the impression that there had been an attempt to carry out observations on Patient A, but that Patient A had refused to engage. The panel considered whether you had the intention, when making these entries, to create that impression, which was untrue. It concluded that you did have that intention.

The panel then considered whether your conduct in making these entries was dishonest. Following legal advice, the panel first considered your state of mind at the time and concluded that you knew the entries marked '*refused*' were untrue, but that you made them anyway with the intention to create a false impression. The panel then applied the objective test and determined that ordinary decent people would consider this conduct to be dishonest.

Accordingly, the panel found that your conduct in making the entries at 1(c)(i), 1(c)(ii), and 1(c)(iv) was dishonest.

Charge 3

Your conduct at charge 1(d) above was dishonest in that you:

a. did not conduct or attempt to conduct any of the observations that you recorded on Patient A's observation record sheet

b. intended to give the impression that you had conducted or attempted to conduct observations on Patient A at 0600, 0615, 0630 and 0645 when you had not

This charge is found NOT proved.

The panel was satisfied, on the basis of your admission, that 3(a) is proved.

At 3(b), the allegation is that you intended to give the impression that you had personally conducted the observations when, in fact, you had not. In its closing submissions, the NMC argued that your actions were dishonest, even though it was accepted that the entries recorded as '*asleep*' were consistent with the evidence given by Witness 4.

The panel carefully considered the NMC's submissions. It noted Witness 1's evidence, which confirmed that, at the time, it was common practice for staff to sign off observations that had actually been carried out by other colleagues. This position was further supported by the investigation report, which highlighted a poor culture surrounding the recording of observations, including staff routinely signing for observations they themselves had not conducted.

Despite acknowledging this widespread culture, the NMC argued that, in this case, by signing the observation chart, your purpose was to give the false impression that you had personally carried out the intermittent observations. It was submitted that this was dishonest conduct.

In your written statement, you addressed this allegation, stating:

'On the night shift of 12-13 December 2018, I did not complete the observation chart with the intention to be dishonest as it now seems and as I am charged. Yes, I filled

the chart based on the reports by [Witness 4], who I had asked to assist me with the observation by looking through the door window. I relied on his feedback.'

I am aware that he has since denied being asked to do it, however, he accepts coming to "inform the team" in the office. I must say that when incidents, like in the case of pt. A happen, everyone's instinct is self-preservation. Many will choose to desperately lie to absolve themselves of all blame. I would always tell the truth. In filling those forms, dishonesty was never the intention; it was just to fulfil the customary practice.'

The panel heard consistent evidence, both from Witness 4 and other sources, about the widespread customary practice that existed at the time. It was standard practice for staff to sign for observations that had been physically carried out by others. The panel considered this context carefully, given that you explained you were merely following this custom. In other words, your position was that you never intended to suggest you had personally carried out the observations but were instead signing to record the observations undertaken by Witness 4, based on the information he provided.

Having carefully weighed all the evidence, the panel concluded that there was insufficient evidence to contradict your account about your intention. There was insufficient proof to meet the burden required to establish that you intended to give the impression that you had personally conducted or attempted to conduct the observations.

Accordingly, the panel found that the allegation at charge 3(b) was not proved.
The NMC also alleged dishonesty in relation to this charge. The panel applied the legal test for dishonesty as set out in the legal advice it received. Taking into account all the circumstances, including the evidence of the prevailing ward culture, the panel concluded that dishonesty had not been proved to the required standard.

In all the circumstances, the panel determined that it would not be fair to disregard the clear evidence of widespread customary practice. Therefore, as both limbs 3(a) and

3(b) are required to prove the charge, the panel finds that charge 3 as a whole has not been proved.

Having taken all of the above into consideration, the panel determined that this charge is found not proved.

Charge 4

Your failure to carry out the required observations of Patient A at charge 1(a) and/or (b) above contributed to Patient A's death.

This charge is found proved.

The panel considered the allegation that your failure to carry out the required observations of Patient A contributed to his death. As the panel had previously found that Charge 1(b) was not proved, the focus is on Charge 1(a), which relates to your failure to carry out the required 15-minute rapid tranquilisation observations of Patient A. The allegation is not that your actions were the sole cause of death, but that your failure to undertake these observations contributed to it.

The panel considered the evidence carefully, including that of Witness 3, who stated that:

> *'With regard to the cause, given the multiple drugs found at post mortem and their interactions I would be of the opinion that the death should not be attributed to a single agent but instead reflect the polypharmacy of the depressant drugs that [Patient A] was experiencing including both the drugs of abuse (ketamine and GHB) and the therapeutic agents with depressive actions (namely lorazepam, clonazepam, aripiprazole, promethazine, and flupentixol).'*

The expert evidence was that any changes in vital signs, such as decrease in respiratory rate, changes in pulse rate or blood pressure readings, decrease in oxygen saturation level, and changes in conscious level would likely have been observable during the period for which you were responsible i.e. from 05:45 to 06:45. The panel accepted that you shared responsibility for patient care with other staff, but the focus of

this fitness to practise panel has to be on the evidence relating to you personally and your responsibilities at that time.

The panel took into account your explanation that you had been concerned about Patient A's aggression. However, it was noted from Witness 1's evidence that in situations where a patient presents with risk, observations can be carried out safely with the support of a colleague. Certain aspects of rapid tranquilisation monitoring, including checking respiratory rate and oxygen saturation could be conducted without waking the patient. Witness 4's observations of Patient A were noted, but the panel concluded that they were informal and did not include full vital signs monitoring which was required following rapid tranquilisation.

The panel also noted that you retrospectively completed the rapid tranquilisation form yourself. By doing so, you accepted responsibility for ensuring that the rapid tranquilisation observations referred to in the form had been carried out. This was an acknowledgement of accountability and meant that the panel had to consider your failure to act against the standards required. While the care was shared among staff, the panel was satisfied that your failure to carry out the necessary rapid tranquilisation observations contributed to the outcome.

Taking all of the evidence into account, including the expert evidence on the likely effect of the illicit drugs taken and Lorazepam on vital signs, the panel concluded that the rapid tranquilisation observations were not carried out as required. If they had been carried out appropriately, the panel accepted the expert medical evidence that any deterioration in Patient A's condition could likely have been identified, and there could then have been a timely intervention by the emergency care team. According to the evidence, on the balance of probability, had Patient A received the required treatment it is likely that Patient A would have survived the medication he had taken or had been administered.

Accordingly, on the balance of probabilities, the panel found that your failure to carry out the required observations of Patient A contributed to his death. The panel therefore determined that this charge is found proved.

Fitness to practise

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

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

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

You gave evidence under affirmation. You told the panel about your practice as a nurse since these events some seven years ago. You said that there had been NMC revalidations. You also told the panel that you had worked for the NHS Professionals (NHSP) and two different agencies. There had been no concerns raised throughout this period.

Submissions on misconduct

Mr Underwood invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision.

Mr Underwood submitted that the panel must first consider whether your actions, as found proved, amount to misconduct. In relation to Charge 1(a), you admitted failing to follow the Trust's rapid tranquilisation monitoring policy. This failure placed Patient A at an unwarranted risk of harm and breached your fundamental duty under the NMC Code, particularly paragraph 19.1, which requires nurses to take measures to reduce as far as possible the likelihood of mistakes, near misses, harm, and the effect of harm.

Mr Underwood submitted that in relation to Charge 1(c), you breached the requirement to keep clear and accurate records under paragraphs 10.3 and 10.4 of the Code. Paragraph 10.3 requires you to complete records accurately and without falsification, taking immediate and appropriate action if you become aware that others have failed to meet these requirements. Paragraph 10.4 requires that all entries you make are clearly attributed to you, dated, timed, and free from speculation or unnecessary abbreviations.

Mr Underwood stated that no submissions are made in relation to misconduct for Charge 1(d), given the panel's factual findings.

Mr Underwood submitted that in relation to Charge 2, you acted dishonestly by falsifying records. This was a clear breach of paragraph 20.2 of the Code, which requires nurses to act with honesty and integrity at all times. He said that the NMC submits that this conduct amounts to serious misconduct, as it undermines a fundamental tenet of the nursing profession.

Mr Underwood submitted that for Charge 4, your actions and/or omissions were found to have contributed to Patient A's death. This was a serious breach of your duty to preserve patient safety under paragraph 19.1 and also amounts to serious misconduct.

Mr Underwood submitted that these breaches strike at the heart of the nursing profession's fundamental duties to preserve patient safety and to act with honesty and integrity.

Mr Aniagwu submitted that while you fully acknowledge and respect the panel's findings of fact, the context of this case and the limited nature of the dishonesty found must be

carefully considered. He said the dishonesty was not straightforward: in some respects, dishonesty was not proved, and where it was found, it relates to a single, isolated incident after 13–14 years of unblemished practice.

Mr Aniagwu submitted that the events took place on an exceptionally difficult night shift, as confirmed by both managers and colleagues. Patient A was aggressive and challenging, and there was evidence of a poor culture on the ward. Your actions were not for personal gain or to avoid blame. At the time you completed the form, you did not know that Patient A had died, and there was no intention to deceive. He said that your motivation was to reflect what the team collectively ought to have done, not to misrepresent your individual actions. This was an administrative act, not clinical dishonesty.

Mr Aniagwu submitted that there has been some misunderstanding of your role. There is no clear evidence that you were specifically responsible for carrying out observations, or that the medication administration should be attributed to you alone rather than the wider team. For dishonesty to be established, he said the NMC's guidance requires proof of a dishonest state of mind, which is not evident from the evidence.

Mr Aniagwu submitted that even if the panel concludes that your actions amounted to misconduct, it is submitted that the level of misconduct is at the very lowest end of the scale. It would be disproportionate to place full responsibility on you, given the shared responsibilities and the wider systemic issues at play.

Submissions on impairment

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

Mr Underwood submitted that the panel must now consider whether your fitness to practise is currently impaired. The relevant test is set out in the case of *Grant*. This requires the panel to consider whether your past actions, or potential future actions, show that you have placed patients at unwarranted risk of harm, brought the profession into disrepute, breached fundamental tenets of the profession, or acted dishonestly. Mr Underwood submitted that all four parts of this test are satisfied in your case.

Mr Underwood submitted that by the panel's findings on Charges 1 and 4, your actions placed Patient A at unwarranted risk of harm. He said while you have shown some insight during these proceedings, there remain concerns. You have, at times, sought to shift blame to colleagues or suggested, without supporting evidence, that you were treated in a discriminatory manner by management. You also stated that you did not see the need to follow the rapid tranquilisation policy at the time of the incident. This demonstrates a lack of full insight and increases the risk of repetition.

Mr Underwood submitted that dishonesty of any kind is serious and brings the nursing profession into disrepute. Your actions were publicly scrutinised during the coroner's inquest, which was heard before a jury, compounding the reputational harm caused. By both placing a patient at unwarranted risk of harm and acting dishonestly, you breached two fundamental tenets of the profession: the duty to preserve patient safety and the duty to act with honesty and integrity. He said the panel must focus on your actions, rather than the tragic outcome of Patient A's death, as these proceedings are concerned with public protection and professional standards, not punishment.

Mr Underwood reminded the panel that it had found that you acted dishonestly when falsifying records. Whether you are likely to act dishonestly again depends on the degree of insight and responsibility you have demonstrated. It is noted that you admitted the falsification to Witness 1 at the start of the investigation and repeated this admission at the inquest. This suggests that your dishonesty was not premeditated or sophisticated. However, it was still a deliberate attempt to cover up the fact that you had failed to carry out the required observations, and dishonesty of this nature remains very difficult to remediate.

Mr Underwood submitted that there are additional factors for the panel to consider. You had a previously unblemished 15-year career and were regarded as a very good nurse. The panel has heard that there was a poor culture within the Trust at the time, particularly around the signing off of observations, but he submitted that this only marginally mitigates your responsibility. It is also relevant that you were candid about your actions from an early stage and that you have practised unrestricted for seven years since the incident without further concerns. These are matters that the panel may take into account when considering the risk of repetition.

Mr Underwood submitted that dishonesty, especially in the context of a patient's death, remains serious and difficult to remediate. While the panel may recognise the steps you have taken to improve your practice and the time that has passed, he submitted that your fitness to practise is currently impaired.

Mr Aniagwu submitted that you have demonstrated genuine remorse and deep reflection on these events. Throughout these proceedings, you have been open and truthful, even when this honesty has worked against you. You have expressed regret not only for your lapse in judgment but also for its impact on public and professional confidence. This reflection shows clear insight into why your actions were wrong and how they undermined professional standards.

Mr Aniagwu submitted that since the incident, you have taken proactive steps to improve your practice, including undertaking training courses and successfully completing two revalidations approved by the NMC. He said you have continued to work as a nurse for seven years without any further concerns or incidents. In the 13 to 14 years prior to this matter, you also had a completely unblemished record. Employers who have employed you since 2018 have provided positive feedback, and there is no evidence that you pose any ongoing risk to patients.

Mr Aniagwu submitted that the incident itself has had a profound emotional impact on you, and the experience has been both sobering and transformative. You have shown yourself to be a diligent, compassionate, and capable nurse who has learned from this tragedy and is determined never to repeat such mistakes.

Mr Aniagwu submitted that given your long history of safe practice, the significant reflection and remorse you have demonstrated, and the absence of any ongoing risk, a finding of current impairment is not required. Removing you from the register or imposing a lengthy suspension would be disproportionate when all the circumstances are considered. Your misconduct has been fully addressed and remediated, and you remain a safe and valuable member of the nursing profession now and in the future.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

In coming to its decision, the panel had regard to the case of *Roylance v GMC* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

> *'**10 Keep clear and accurate records relevant to your practice***
> *This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.*
>
> *To achieve this, you must:*

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

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

The panel recognised that breaches of the Code do not automatically result in a finding of misconduct. However, having carefully considered all the evidence and submissions, it determined that the charges found proved in this case amounted to serious misconduct and significant breaches of the standards expected of a registered nurse.

The panel concluded that your actions represented serious departures from accepted nursing practice, involving numerous breaches of the Code. It referred to the NMC's guidance, which emphasises the importance of nurses acting with transparency and integrity. In this case, you failed to meet those fundamental professional expectations.

The panel found that you breached the fundamental tenets of the nursing profession and brought its reputation into disrepute. It was particularly concerned by the dishonesty found proved under Charge 2. Honesty and integrity are core requirements of nursing practice. You falsified important clinical records, namely the rapid tranquilisation monitoring chart, intending to mislead by giving the impression that you had attempted to conduct observations on Patient A when you had not. This was a clear and serious breach of paragraph 20 of the Code, which requires nurses to act with honesty and integrity at all times.

In addition to the dishonesty, the panel considered your failure to carry out the required 15-minute rapid tranquilisation observations. This placed Patient A at unwarranted risk of harm and was found to have contributed to his death. Such a failure to protect a vulnerable patient also amounts to serious misconduct.

Accordingly, the panel found that your actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

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

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

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

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

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

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

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

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

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

The panel determined that all four limbs are engaged.

The panel considered carefully whether your fitness to practise is currently impaired. In doing so, it had regard to the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing profession and upholding proper professional standards.

The panel applied the three-stage test from *Cohen v GMC*. It first considered whether the misconduct is easily remediable. While some aspects of clinical failings may be remediable, dishonesty is inherently difficult to remediate. The panel found that there was insufficient evidence that you had fully addressed or remedied the concerns arising from your dishonest conduct and failures in patient care.

The panel then considered whether the misconduct has been remedied. It acknowledged that you admitted some of the charges, were truthful during the investigation and before the coroner, and demonstrated some remorse and insight. However, your insight does not go far enough to provide reassurance that the misconduct will not be repeated. The panel was particularly concerned that you have not demonstrated full understanding of the impact of your actions on Patient A, their family, colleagues, and the wider public.

Finally, the panel considered whether it could be said that the misconduct is highly unlikely to be repeated. It concluded that this was not the case. Although you have demonstrated some insight, it was limited. There remains a risk of repetition, both in terms of putting patients at risk of harm through a failure to carry out essential observations and in respect of dishonest record-keeping.

The panel was encouraged by your evidence that you have been practising as a nurse since these events. The panel noted, however, that you did not provide any independent workplace references about your nursing practice.

In the light of the panel's findings, it could not be satisfied that you are currently able to practise safely and professionally. Although you deserve credit for your openness,

admissions, and some degree of remorse, this was not sufficient to demonstrate that you have the necessary level of insight to practise.

The panel also considered the public interest. Honesty and integrity are fundamental tenets of the nursing profession. The panel determined that a finding of impairment is necessary to maintain public confidence in the profession and its regulator. The public must be reassured that nurses will act honestly and with integrity and that patients will be protected from harm. Failing to make a finding of impairment in this case would seriously undermine public confidence in the profession and the NMC as its regulator.

Accordingly, the panel determined that your fitness to practise is currently impaired on the grounds of both public protection and the wider public interest.

Interim conditions of practice order under Article 31(2) of *The Nursing and Midwifery Order 2001.*

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing role.'

1. You must limit your nursing practice to working for NHSP in one designated NHS Trust.

2. You must not be the nurse in charge of any ward, shifts or setting.

3. You must meet with your supervisor at least once a month. The supervisor must be a registered nurse.

4. Prior to 12 December 2025, you must send to your NMC case officer a report from your supervisor, commenting on your:
    - Record keeping
    - Safeguarding patients
    - Following protocols
    - Clinical practice

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

6. You must immediately give a copy of these conditions to any organisation or person you work for.

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

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with your current employer.

This determination will be sent to you in writing.

That concludes this determination.

The hearing resumed on Monday, 22 December 2025.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

At the end of the 12-month suspension period, the case will be reviewed by another panel. At the review hearing, the panel may decide to revoke the suspension, confirm the order, or replace it with another sanction.

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

Submissions on sanction

Mr Radley submitted that the panel must strike a fair balance between your rights and the need for public protection, as outlined in the case of *Huang v Secretary of State for the Home Department* [2007] UKHL 11. The NMC's position is that the panel should justifiably restrict your right to practise in light of the findings made in this case. The panel must carefully consider whether the least restrictive sanction would be enough to safeguard the public and serve the wider public interest, taking into account both the reasons for your current unfitness to practise and any aggravating or mitigating factors.

Mr Radley further submitted that the panel should consider the gravity of your actions and the consequences of the proven misconduct. He highlighted that registered nurses occupy a position of trust and must adhere to professional standards, as the public would not expect a nurse to practise following proven misconduct. The aggravating factors include the direct harm caused to a patient, dishonesty, and a breach of fundamental nursing tenets. The panel must also consider the lack of insight you have

shown and the risk to patient safety, as these factors are directly linked to your clinical practice.

Mr Radley acknowledged that you have no prior regulatory or disciplinary findings, and your age and experience could be considered in your favour. Additionally, your engagement with the NMC was noted. However, he argued that these factors are outweighed by the seriousness of your misconduct, particularly given the Panel's findings regarding dishonesty, lack of insight, and the serious risk to patient safety.

Mr Radley submitted that striking you off the register is the most appropriate and proportionate sanction. He stated that less severe sanctions, such as a caution, conditions of practice order, or suspension, would not sufficiently protect the public or restore confidence in the profession. He submitted that your actions represent a significant departure from the required standards of care, with devastating consequences, and that permanent removal from the register is necessary to maintain public trust in the nursing profession.

Mr Aniagwu submitted that many of the propositions in this case arise from findings that are not fully supported by the evidence presented throughout the proceedings. He expressed disappointment that a finding of dishonesty was made.

Mr Aniagwu also questioned the finding of impairment, stating that the current guidance and case law, including the *Grant* case, do not support the conclusion of current impairment. He referred to legal precedents which emphasise that impairment should be based on current fitness to practise, not historical incidents. The incident in question occurred in 2018, and since then, you had no disciplinary issues and have continued to practise without incident. Mr Aniagwu stated that this shows that you are a competent and safe practitioner, and the finding of impairment should not stand, as it contradicts the guidance and the facts.

Mr Aniagwu highlighted that the incident leading to these charges involved unclear responsibilities, particularly regarding the monitoring of the patient in question. The

evidence did not show that you had sole responsibility for the patient's care, and the actions taken were in line with standard practice at the time.

Mr Aniagwu submitted that the consideration of a striking-off order is disproportionately harsh. He argued that you have been a safe and competent practitioner for the last seven years, with no issues or complaints against you. Given this, he felt that a striking-off order is unnecessary and that a less severe sanction, such as conditions of practice for a limited period, would be more appropriate. He also noted that you have successfully revalidated several times, further demonstrating your fitness to practise. Mr Aniagwu concluded that there is no ongoing risk to public safety, and therefore, a lenient approach should be taken, with no need for a striking-off order.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose 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 first considered the seriousness of the finding of dishonesty. It took into account that instances of dishonesty are not all of the same level of seriousness. The panel had regard to the NMC guidance SAN-2, 'Cases Involving Dishonesty'.

The panel found that whilst your falsification of records relating to Patient A's observations were intended to give the impression that there was an attempt to conduct the observations which were required, they were not premeditated but more a spontaneous reaction to the circumstances at the time. The panel concluded that this was all done in the course of a one off incident and that the dishonesty was not at the highest level of seriousness.

The panel considered the following aggravating features:

- Dishonesty in the course of your practice
- Lack of sufficient insight into the impact your actions had on the patient and their family

The panel also considered the following mitigating features:

- Described by Witness 1 as a kind and good nurse whom he would trust with the care of his loved ones
- There have been no concerns raised with the NMC in respect of 15 years of your practice before these events nor in the seven years since these events
- [PRIVATE]
- Significant admissions you made at an early stage

The panel first considered whether to take no action, but concluded that such an approach would be inappropriate given the seriousness of the case. The panel determined that taking no action would not be sufficient to address the misconduct or serve the public interest, particularly given the seriousness of the aggravating features identified.

The panel then considered the imposition of a caution order. However, the panel concluded that a caution order would not be appropriate in this instance. 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 misconduct did not fall within the lower end of the spectrum of impaired fitness to practise.

The panel considered whether any conditions could be formulated to address the nature of the misconduct. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

Given the nature of the dishonesty and patient risk involved, the panel determined that no conditions could be appropriately imposed that would address these issues. The misconduct was not something that could be remediated through retraining or conditions. Furthermore, placing conditions on your practice would not sufficiently protect the public or address the seriousness of the case.

The panel concluded that this case was particularly serious because it involved not only dishonesty which was found proved in charge 2 but also very serious consequences which are dealt with in charge 4, namely that your failure to carry out the required observations of Patient A contributed to their death. The panel referred to SG SAN-3(d) which provides the following guidance:

> *'will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?'*

The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *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; and*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel considered that the charges found proved all arose from a single event during which the misconduct took place.

- There was no evidence of harmful deep-seated personality or attitudinal problems.
- There was no evidence of repetition of the behaviour since the incident seven years ago.
- The panel is satisfied that you do not pose a significant risk of repeating the behaviour.

Having regard to the level of seriousness involved, when weighed against the mitigation, the panel concluded that this case requires your temporary suspension from the NMC register.

The panel considered that a suspension order for 12 months was the most suitable and least restrictive measure to ensure public protection, provide you time to reflect on your practice, and allow you to demonstrate your commitment to upholding professional standards.

The panel did consider the possibility of a striking-off order but determined that such an outcome would be disproportionate in this case. The panel had regard to SG SAN-3(e) as follows:

- Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?
- Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not struck off 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 bore in mind the seriousness of the misconduct found and the aggravating features outlined above. However, against this, it took account of the mitigation outlined and on balance, decided that the mitigation was sufficient to enable the panel to conclude that your misconduct was not fundamentally incompatible with continued registration.

The panel concluded that in the circumstances there are currently no fundamental questions about your professionalism and public confidence in nurses can be maintained if you are temporarily suspended from the NMC register. The panel concluded that a striking-off order is not the only sanction which will be sufficient to protect patients, members of the public and maintain professional standards.

The panel considered that a suspension order would be a sufficient response to the seriousness of the misconduct and would allow you time to reflect and address any shortcomings in your practice. In contrast, striking you off would be an excessively punitive measure, given the circumstances of the case.

The panel recognised the hardship a suspension order will cause the registrant. However, it concluded that this hardship is outweighed by the need to protect the public and maintain public confidence in the profession. The panel noted that the suspension order would serve to reinforce the importance of upholding the standards expected of registered nurses, both to the registrant and the wider public. This would send a clear message about the seriousness with which the nursing profession views breaches of trust, dishonesty, and the risk to patient safety.

After considering all factors, the panel concluded that a suspension order for a period of 12 months was the appropriate and proportionate sanction. A shorter period would not reflect the seriousness of this case. The suspension period would allow you the opportunity to reflect on the case and demonstrate that you have learned from the experience, while ensuring public protection in the interim.

Any future panel reviewing this case would be assisted by:

- Written reflections from you addressing the following points:
    - The reasons why patients, such as Patient A, require continuous and accurate observations
    - The importance of accurate record-keeping, including the recording of vital signs and drug administration
    - Reflection of the impact of your misconduct on the patient, their family, and the public's confidence in the profession
- Any relevant testimonials, whether from paid or unpaid employment, that speak to your character and work performance
- Evidence of any steps taken to keep your knowledge and skills up to date, including any professional development activities or training.

At the end of the 12-month suspension period, the case will be reviewed by another panel. At the review hearing, the panel may decide to revoke the suspension, confirm the order, or replace it with another sanction.

At the end of the suspension period, you will have an opportunity to demonstrate that you can return to practice in a manner that ensures patient safety and maintains public trust in the profession.

This decision will be confirmed to you in writing.

Interim order

As the substantive suspension 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 is in your own interests until the substantive suspension order takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that an interim suspension order is necessary to cover the period until the substantive suspension order comes into effect having regard to the panel's findings. He submitted that if you appeal the decision of the panel, then you would be able to practise without restrictions until the appeal process is finished and this can take up to 18 months. He therefore invited the panel to impose an order for a period of 18 months to cover the whole of the appeal period.

Mr Aniagwu submitted that an interim order could result in unfairness if as a result of it a registrant is suspended for a period of 18 months instead of the 12 months period ordered by the panel.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be a suspension order, as to do otherwise would be incompatible with its earlier findings. The interim suspension order will be for a period of 18 months to cover the appeal period and any appeal.

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

That concludes this determination.