Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 9 July 2025 – Friday 18 July 2025
Friday, 29 August 2025
Tuesday, 26 November 2025 – Thursday, 27 November 2025

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

Name of Registrant:	James Josh Hartley
NMC PIN	19D1554E
Part(s) of the register:	Registered Nurse – Adult (11 June 2019)
Relevant Location:	Tyne and Wear
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, Lay member) Lesley Foulkes (Registrant member) David Anderson (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Rodney Dennis Dilay Bekteshi (25 – 27 November 2025)
Nursing and Midwifery Council:	Represented by Kir West-Hunter, Case Presenter
Mr Hartley:	Present and represented by Christopher Bealey, Counsel instructed by Thompsons Solicitors
Facts proved by way of admission:	Charges 1b and 1c
Facts not proved:	Charges 1a

Fitness to practise:	**Impaired**
Sanction:	**Suspension order (9 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On or around 21 February 2020:

a) Failed to assist Person A when they were having a seizure.

b) Administered and or assisted Person A to administer themselves an unprescribed saline solution.

c) Obstructed the parents of Person A from attending to him.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms West-Hunter on behalf of the Nursing and Midwifery Council (NMC) to amend charge 1b pursuant to Rule 28 to amend the wording as follows:

That you, a registered nurse:

1) On or around 21 February 2020:

a) …

b) ~~Administered and or assisted Person A to administer themselves an unprescribed saline solution.~~

Amend to

b) Filled a syringe with unprescribed saline solution and left it within the reach of Person A for self-administration.

c) ...

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

Ms West-Hunter submitted that this amendment would correctly reflect the evidence.

Mr Bealey on your behalf did not object to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms West-Hunter under Rule 31, to allow the following documents as hearsay evidence

- Witness Statement from Person A
- Police Statement from Mr 1
- Notes of Meeting [Part 2] dated 4 November 2020

Ms West-Hunter submitted that the written statement from Person A in which they confirm that, due to their medical condition, they suffer from seizures is hearsay. Their seizure has impacted their memory of the entire night. The statement is relevant to charge 1a and charge 1b.

Ms West-Hunter submitted that the police witness statement from Mr 1 who was present at your home on the morning of the incident provides context in relation to charge 1b and the injection of the saline solution by Person A.

Ms West-Hunter submitted the Notes of Meeting (4 November 2020) makes reference to conversations between you and Witness 1 and your communication during the course of the internal investigation.

Mr Bealey opposed the application in respect of the Notes of the Meeting and Mr 1's police statement being admitted as hearsay evidence. Mr Bealey submitted that Witness 1, Mr 1 and you will be giving evidence to the points raised and could therefore be questioned.

The panel heard and accepted the legal assessor's advice on the issues it should consider in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in court proceedings. The panel was referred to the guidance contained in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel's decision to admit Person A's witness statement as hearsay evidence

The panel determined that it would be fair and relevant to accept into evidence the hearsay evidence of Person A's witness statement.

The panel noted that this is not sole or decisive evidence. The panel has been provided with other evidence that goes towards the seizure, these include the three video clips, medical records, and live oral evidence from Parents 1 and 2 and their witness statements.

The panel noted that you will not be able to challenge the statement of Person A, however this will be considered when applying the appropriate weight that should be attached to this evidence.

The panel is of the view that the NMC could have assisted it by providing a more contemporaneous explanation for Person A's non-attendance. However, the panel having been provided with details of Person A's medical history found that it was not wholly unreasonable that they would not be able to attend stressful proceedings such as these.

The panel's decision concerning the admission of Mr 1's Police witness statement and the Notes of Meeting Newcastle Upon Tyne Hospitals NHS Foundation Trust dated 4 November 2020 as hearsay evidence

The panel determined not to consider Mr 1's police witness statement, or the Notes of Meeting dated 4 November 2020 as hearsay evidence.

The panel considered submissions from Mr Bealey and has taken into account that you, Witness 1 and Mr 1 will be giving live evidence. The police witness statement of Mr 1 and the Notes of Meeting on the 4 November 2020 [Part 2] do not need to be considered as hearsay because they will be introduced and considered in live oral evidence.

The NMC will have the opportunity to cross-examine Mr 1 regarding his police witness statement and Mr Bealey will have the opportunity to cross-examine Witness 1 on the Notes of the Meeting on 4 November 2020.

The panel advised Ms West-Hunter that she can renew the hearsay application at a later stage of the hearing if no live evidence is heard from you or Mr 1.

Decision and reason on a further application to admit Mr 1's witness statement as hearsay evidence

At the conclusion of the NMC's live evidence, the panel heard a further application by Ms West-Hunter under Rule 31, to allow the written witness statement of Mr 1 to be introduced at an earlier stage before Mr 1 is due to give evidence.

Ms West-Hunter submitted that this needed to be introduced as hearsay evidence to enable her to question you about its contents as you would be giving evidence prior to Mr 1 and that this would only be regarded as hearsay evidence for a short time until Mr 1 gave evidence.

Ms West-Hunter submitted that Mr 1's statement provides details of some of the conversation that took place during the early hours of 22 February 2020 in which Person A wanted to take drugs. Further conversations took place in regard to the saline solution given to Person A.

Mr Bealey opposed the application submitting that Mr 1 will be giving live evidence. Mr Bealey further submitted that to admit it at this stage would not give you the opportunity to challenge it in any way at all.

The panel's decision to admit Mr 1's Police witness statement

The panel determined to accept this application.

In making its decision, the panel considered that the evidence is relevant and there is no unfairness to you in admitting this evidence at this stage. By admitting Mr 1's police witness statement at this stage, the panel would not regard you as having accepted its contents. It would remain open to Mr Bealey on your behalf to challenge the contents of Mr 1's police witness statement. Similarly it is open to Ms West-Hunter to cross-examine you on the contents of Mr 1's police witness statement should you give evidence. In the circumstances the panel took a pragmatic approach and admitted the statement as hearsay at this stage.

The panel has been assured that Mr 1 will be in attendance. The panel will not make any determination on fact until it has heard the entirety of both cases.

Decision and reasons on application of no case to answer

Having heard the case of the NMC, the panel next considered an application from Mr Bealey that there is no case to answer.

Both Ms West-Hunter and Mr Bealey submitted detailed written and oral submissions in respect of this application. In these circumstances these submissions are only summarised in this determination.

This application was made under Rule 24(7) in respect of charge 1a. In respect of charges 1b and 1c the application was made under Rule 24(8) on the basis that your admitted conduct did not amount to misconduct and therefore your fitness to practise was not impaired.

In relation to this application, Mr Bealey submitted that in regard to charge 1a it is unclear whether Person A was having a seizure.

Mr Bealey submitted that neither Parents 1 and 2 are medical professionals and there has been no medical evidence put forward by the NMC to show that Person A did suffer a seizure.

Mr Bealey submitted that there is no evidence of any delay by you during the evening.

In relation to charges 1b and 1c, Mr Bealey submitted that you accept the underlying facts for charge 1b and accept the factual allegations in regard to charge 1c.

Mr Bealey submitted that Person A was not vulnerable as assessed by a medical professional in the morning of 21 February 2020.

Mr Bealey submitted that the NMC does not allege that you injected Person A. The allegation is that the saline solution in a syringe was made available.

In relation to charge 1c, Mr Bealey submitted that you did not open the door for Person A's parents but that the circumstances surrounding the facts mean the allegation cannot amount to misconduct.

Mr Bealey submitted that charges 1b and 1c cannot amount to misconduct.

In response to the no case to answer application, Ms West-Hunter submitted that in relation to charge 1a, that it is more likely than not that Person A had a seizure.

Ms West-Hunter submitted that evidence from Parents 1 and 2 indicate an intimate knowledge of Person A's medical condition and vulnerabilities.

Ms West-Hunter submitted that the video evidence shows Person A having a seizure which raised sufficient medical concern that a viewer decided to send it to Person A's mother.

Ms West-Hunter submitted that Person A's statement reflects both his own assessment that one of the seizures was captured on the Yubo video and that his recall has been impaired in keeping with the impacts seizures can have.

Ms West-Hunter submitted that the panel has heard evidence that you had knowledge of Person A's vulnerabilities prior to the incident on 22 February 2020.

Panel's decision

The panel took account of the detailed written submissions from both parties in respect of this application together with their oral submissions and accepted the advice of the legal assessor who referred the panel to DMA-6 of the NMC Guidance.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved in respect of charge 1a and could find that the matters relating to charges 1b and 1c amount to misconduct.

The panel rejects the application made by Mr Bealey on your behalf.

It took into account all documentary evidence including the witness statements of Person A, Mr 1, Witness 1 and Parents 1 and 2. The panel also took into account live oral evidence and accompanying video footage.

There is evidence that Person A had a history of epilepsy and seizures. Parent 1 and Parent 2 gave evidence that on viewing the video footage, they considered that Person A was having a seizure. In these circumstances the panel considered there was evidence from which it could properly find that Person A had suffered a seizure.

Evidence from Parents 1 and 2 indicate that you had been made aware of Person A's vulnerabilities prior to the incident on the morning of 22 February 2020 and you could have known that Person A was having or had had a seizure. The incident took place in your home where you were present and accordingly, the panel considered that there was evidence from which it could properly infer that you were present at the time or soon after Person A had suffered a seizure and failed to assist him.

The panel next considered charge 1b and whether the evidence presented by the NMC was capable of amounting to misconduct.

The panel had regard to the factors set out in the decision of *Remedy UK Ltd, R (on the application of) v The General Medical Council* [2010] EWHC 1245 (Admin). The panel was of the view that your admission to charge 1b was capable of amounting misconduct in itself and therefore you have a case to answer in this respect regarding your alleged impairment.

The panel had heard evidence from Parent 2 that not only had she previously informed you of Person A's vulnerabilities but also on receipt the Yubo video she had made contact with you alerting you to her concerns about Person A's current health. There is evidence therefore that you knew of Person A's parents' concerns when they arrived at your house and their reason for being there and wanting to check on the welfare of their son.

The panel also heard evidence from Parents 1 and 2 that they had taken recovery medication to your house and had told you that when speaking to you through the door.

In these circumstances the panel finds that there is evidence from which it is capable of properly finding that your obstruction of Person A's parents amounted to misconduct. Accordingly, the panel finds that you do have a case to answer regarding your alleged impairment.

Decision and reasons on application to strike out paragraph nine from the registrant's final hearing bundle [Exhibit 8]

The panel next considered an application by Ms West-Hunter to strike out paragraph nine of the hearing bundle you provided.

[PRIVATE]

Application to exclude your written statement contained within the NMC final exhibit hearing bundle [Exhibit 2, page 56]

During the course of panel questions to you, Mr Bealey submitted that the panel should not ask questions to you about your statement at page 56 of the main exhibit hearing bundle.

Mr Bealey submitted that the basis of his objection was that it had previously been indicated that the statement would be part of a hearsay application by the NMC.

Mr Bealey further submitted that in those circumstances it was not open to the panel to question you about this statement.

Ms West-Hunter did not oppose the application made by Mr Bealey. However, the panel heard and accepted the legal assessor's advice that under Rule 31, subject to receiving legal advice and subject only to the requirements of relevance and fairness, a practice committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would have been admissible in court proceedings.

The panel determined that the written statement formed part of the exhibit bundle presented to the panel from the outset of the hearing.

The panel found that you were available to answer questions regarding this document and were you to have denied the document was yours, that would be the end of the matter.

The panel decided to reject Mr Bealey's application. The written statement formed part of Exhibit Bundle from the outset of the hearing, it is therefore open to the panel to ask you questions relating to the written statement.

Decision and reason on application to strike out paragraph 24 from Mr 1's written statement

Prior to Mr 1 giving evidence, the panel considered an application under Rule 31(1) made by Ms West-Hunter to exclude paragraph 24 from Mr 1's written statement.

Ms West-Hunter submitted that this paragraph does not meet the threshold of Rule 31, and it is unclear on what basis this sentence can assist the panel in relation to the facts in charge 1a.

[PRIVATE].

The panel accepted the advice from the legal assessor.

The panel determined that the statement is not relevant to the charges and should be struck out.

Decision and reason on application to admit paragraph 28 of Mr 1's written statement as hearsay evidence

At this time the panel also considered an application by Mr Bealey to admit paragraph 28 of Mr 1's written statement as hearsay evidence.

The paragraph includes discussions with Person A and Mr 1, including an apology made by Person A to Mr 1's in relation to the incident that took place on 22 February 2020.

Mr Bealey submitted that paragraph 28 should be admitted as it provides context which is essential to the background in this case. It is also fair and relevant to you.

Mr Bealey submitted that it relates directly to this case and is relevant in that the conversation not only took place, but also that the substance of the conversation might impact on the interpretation of what happened that night.

Mr Bealey submitted that Mr 1 will be available for cross examination and the matter relating to this conversation can be considered during his live evidence.

In response, Ms West-Hunter submitted that the paragraph does not have any evidential basis in relation to what happened on the night in question or the morning after the incident.

Ms West-Hunter [PRIVATE]. She further submitted that, in terms of fairness, the paragraph appears to make suggestions about the motivations of Parents 1 and 2 in their response and actions after receiving the video clips of Person A.

Mr Bealey in response to Ms West-Hunter submitted that the panel may feel it is relevant and should therefore appoint the appropriate weight to the evidence.

Panel's decision to admit paragraph 28 of Mr 1's written statement

The panel in reaching its decision has taken into account that Person A has not given live oral evidence. [PRIVATE].

The panel determined that the first sentence in paragraph 28 is not hearsay, it is fact. There are elements of hearsay in the remaining sentences and have potential for unfairness. The panel will apply appropriate weight to this evidence.

Decision and reasons on Facts

At the outset of the hearing, the panel heard from you, that you have made factual admissions to charges 1b and 1c.

The panel therefore finds charges 1b, and 1c, proved in their entirety, by way of your admissions.

It is apparent that there is dispute regarding the context to the facts relating to charges 1b and 1c. The panel having heard the evidence will make a determination concerning those contextual disputes.

Background

At the time of the incident, you were employed as a band 5 staff nurse with the Newcastle upon Tyne, NHS Foundation Trust (Trust) since May 2019.

You advised your employer on 17 September 2020 that a member of the public had made an NMC referral relating to an incident which took place at your home in February 2020 which you had not disclosed at the time.

In the morning of 22 February 2020 an incident occurred where (Person A) was injured at your home.

Following an evening out in Newcastle, you returned to your home with Mr 1 and Person A. Once at home, Person A told you he wanted to take some drugs. It is alleged that, in response to this request you went to your fridge, taking out a bottle before putting a saline solution into a syringe and leaving it in reach of Person A. You indicated to him where to inject the solution.

At approximately 4:45am, whilst you and Mr 1 were upstairs having a private conversation, you heard a noise downstairs. After going downstairs to investigate the cause, you found Person A lying on the kitchen floor bleeding from the mouth.

Person A told you two people had tried to gain access to your home through the back garden and assaulted Person A. You called the police who arrived at your home. They were followed by an ambulance crew who did a welfare check on Person A.

Early that morning, Person A's mother received a link to videos from a friend of Person A. They showed Person A at your home intoxicated and having a seizure. The videos were filmed from a mobile phone, uploaded and live streamed to a social media platform Yubo. It is alleged that Person A's mother contacted you by telephone to ask you what was happening to her son.

Later that morning, Person A's parents arrived at your home as they were concerned about their son's medical condition after watching the video and believing him to have had a seizure. They arrived at your home with rescue medication which they believed Person A might require.

It is alleged that you refused them access and said they were being aggressive. Person A's father told you he had Person A's rescue medication. They contacted the police to assist them in gaining access to your home and check on their son's welfare.

The police arrived and entered your home with Person A's parents. Person A was later taken to [PRIVATE] Hospital by his parents.

You were questioned by the police, and a referral was later made to the NMC by the parents of Person A on 22 February 2020.

Decision and reasons on facts

In reaching its decision on the disputed facts of charge 1a, the panel took into account all the oral and documentary evidence in this case together with submissions made by Ms West-Hunter on behalf of the NMC and by Mr Bealey.

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: Matron for Community Nursing at the Trust.
- Parent 2: Mother of Person A
- Parent 1: Father of Person A

The panel also heard evidence from you under oath and evidence from your witness.

- Mr 1 Friend present on the night of the incident

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 your representative Mr Bealey.

Due to the stark differences in fact between the evidence provided by the witnesses relied upon by the NMC and you and your witness Mr 1, the panel carefully considered the evidence given by each witness and considers that it would be useful for it to set out its assessment of the reliability of the evidence given.

Witness 1

Witness 1 gave evidence concerning the contents of a community nurses' standard equipment bag. She also gave her account of the incident as she understood it from her conversations with you.

In oral evidence she confirmed paragraph five of her witness statement where she says:

"Mr Hartley told me about this a few months after this had taken place. I found that Mr Hartley was evasive about the truth and would not inform us about issues unless he absolutely had to. There always seems to be partial truths in what he told you."
"The story varied".

In her oral evidence she said*:*

"He never told the truth he was always changing his story"

The panel found Witness 1 to be a reliable witness who had no reason to fabricate or exaggerate her evidence.

Parent 2

The panel next heard from Parent 2

Parent 2 told that panel that she is the prime carer for the Person A who lived with her.

The panel found her to be very open in her oral evidence and told the panel that she was *'an over protective mother'* and she said she was "*very emotional"* during the incident as you would expect.

She also told the panel throughout her oral evidence that she continued to be emotional during the incident and at times had to be calmed down by Parent 1.

The panel considered that the emotional effect upon Parent 2 may have impacted upon her evidence in regards to some of the detail that happened. But overall the panel was satisfied that she was consistent and a reliable witnesses and gave evidence truthful to her memory of the events.

In his written and oral submissions, Mr Bealey set out seven matters which he submitted undermined Parent 2's credibility. The panel has carefully considered each of these matters and does not consider that they undermine Parent 2's credibility on the factual matters it has to determine, especially as she was giving evidence on an incident that happened five years ago.

Parent 1

Parent 1 told the panel that he was the father of Person A but not the prime carer [PRIVATE]. [PRIVATE].

He gave evidence of a detailed knowledge of his son's medical conditions. He said:

"My son's had many, many seizures and has had lots of hospital admissions and spent long months in hospital as an inpatient……. I had seen him have many, many seizures over the years, so I recognised exactly the signs and symptoms of a seizure on that video."

He told the panel he was initially angry but by the time he reached the property he was the calmer of the two and understood the importance of the need to remain calm. He was consistent with Parent 2 in that he at times had to calm Parent 2 down.

The panel recognised an error in his evidence surrounding timings in taking his son to hospital but recognised that he was quick to acknowledge errors and the panel found his openness to enhance his reliability.

In his written and oral submissions, Mr Bealey set out fourteen matters which he submitted undermined Parent 1's credibility. The panel has carefully considered each of these matters and does not consider that they undermine Parent 1's

credibility on the factual matters it has to determine, especially as he was giving evidence on an incident that happened five years ago.

Parent 1's evidence was consistent that his sole interest was in ensuring the wellbeing of his son and getting rescue medication to him. The panel found Parent 1 to be a reliable witness.

Your evidence

The panel found your evidence to be inconsistent in both your oral evidence and between your oral and documentary evidence. Your account was also inconsistent with the evidence of Mr 1.

In the summary of your interview under caution you said that Person A searched the kitchen for your kit bag. However during your oral evidence you said he was looking at the kit bag.

In the same police interview, you said Person A injected himself two to three times but in your oral evidence to the panel you asserted that you were not present when Person A injected himself you were very clear in your evidence to the panel that you had left the kitchen and gone into the garden.

You told the panel that when Person A was left alone in the kitchen he was playing loud music and frequently changing tracks you could hear the music from upstairs, however no music could be heard on any of the videos provided to the panel.

In your statement on page 56 of the exhibit bundle you said that you and two friends went upstairs leaving Person A in the kitchen, yet during your evidence you said it was just you and Mr 1.

Concerning the saline solution, Mr 1 told the police that you had taken the bottle of saline solution from the fridge. He gave the same account in the witness statement dated the 2 July 2025. You told the panel it was from your bag.

Mr 1

The panel had concerns about the reliability of Mr 1's evidence.

Mr 1 told police in his statement that the you had taken the bottle of saline solution out of the fridge and said the same in paragraph 9 of his statement contained in the Registrant's final hearing bundle. However, in his oral evidence to the panel he said that the bottle of saline solution may have come from the fridge or may have come from your grab bag. He gave this evidence when about to be asked by Mr Bealey about paragraph 9 in his witness statement, seemingly pre-empting Mr Bealey's question. The panel considered that this was clear evidence that Mr 1 and you had discussed what evidence Mr 1 should give. This undermined not only Mr 1's credibility but also your credibility.

Mr 1 gave evidence that he had joined you in the garden when Person A picked up the syringe, this contradicts your evidence where you said you went into the garden on your own having filled up the syringe and leaving Mr 1 and Person A together in the kitchen. It also contradicted what he had stated in his statement to the police.

Mr 1 gave evidence that you and he went upstairs and he heard Person A shout how long they would be, he said he said not long and when you both came down to the kitchen you found Person A bleeding. Had the music been loud as you asserted, the panel find it was inconceivable that he would have heard him call up. Mr 1 made no reference to hearing the bang that you asserted that you heard.

The panel also found discrepancies in the evidence given by you and Mr 1 as to where Person A was when you came downstairs.

In Mr 1's statement to the police shortly after the incident, he said:

"Josh filled the syringe with this saline, put it on the bench and when Person A asked what he did with it, Josh said put it here" and indicated his arm. Person A has picked up the syringe and injected it into his arm. He did this two maybe three times…after

injecting himself, Person A leant back and let out a long breath like he had inhaled something good…"

In oral evidence this was contradicted when he asserted that he had left the kitchen and did not see Person A inject.

The panel then considered the disputed charge and made the following findings

Charge 1a

1) On or around 21 February 2020:

a) Failed to assist Person A when they were having a seizure.

The charge is found NOT proved

In reaching this decision, the panel considered the totality of the evidence including: the three video clips which were live streamed on the social media platform Yubo, the documentary evidence provided by the police and the Hospital Trust. The panel further considered the oral evidence from Witness 1, Mr 1, Parent 1 and Parent 2 alongside your evidence.

The panel found there were inconsistencies between your oral evidence given at this hearing and your witness statement on your recollection of events.

The panel first considered whether Person A suffered a seizure.

The panel carefully considered the live oral evidence of Parent 1 and 2 who both revealed their extensive experience and knowledge of Person A's medical history, in particular their history of suffering seizures.

The panel considered the three video clips of Person A and evidence from Parent 1 who told the panel they heard a male voice with a Newcastle accent. The police report of the incident stated:

"Yubo streaming footage showing inebriated IP and male voice can be heard saying 'PASS IT HERE AND I'LL PUT IT IN' while watchers are heard saying 'ARE THEY GIVING HIM MORE".

It is the panel's view that there were other videos which were not available for it to view as the panel could not hear the male voice referred to in the police report in the three clips that they had been provided with.

The video clips viewed by the panel show Person A in different states of dress and behaviour. Video clip two appears to have been taken shortly after Person A had injected the saline solution as Person A appeared to have indicated he had injected into his arm. However, the panel could not determine the gap in time between clip two and clips one and three due to the different states of dress and demeanour of Person A which is in significant contrast to video clip two to the other two clips.

In giving evidence, Parent 1 said they recognised that Person A was having a seizure in the video clip played before the panel. They confirmed that the triggers for Person A experiencing a seizure can be caused by alcohol and a lack of sleep which the panel note were factors on the night of the incident. Parent 1 in their oral evidence was clear that they recognised that Person A was having a seizure in the video.

Parent 2 in their evidence, believed that Person A was intoxicated by both drugs and alcohol following their viewing of the video clips. The panel noted that Parent 2 took the decision to go to your home address with seizure rescue medication.

The panel took into account evidence from Parents 1 and 2 that Person A had epilepsy and has had frequent seizures over a long period of time.

You and Mr 1 confirmed in evidence that you both witnessed Person A in a disorientated state and mumbling, at the time you discovered that Person A had an injury to their mouth.

The panel believe this injury is consistent with evidence from Parents 1 and 2 that the symptoms of post seizure can include the possibility that during a seizure a person could bite down on their mouth or lips.

The panel is of the view that Person A did experience a seizure in your kitchen during the morning of the 22 February 2020.

However, the panel cannot be satisfied that you were present or at the scene soon after. You are not seen in the video clips and on the evidence before it the panel is unable to say how long after clip 2 you re-entered the kitchen or how Person A appeared when you did so.

The panel has insufficient evidence before it to prove that on the balance of probabilities that you were present at the time that the seizure was taking place or very soon afterwards. Therefore, the panel find this charge not proved.

Contextual findings

In regard to charge 1b you have admitted that you filled a syringe with unprescribed saline solution and left within the reach of Person A.

The panel found that the medical bag was in your kitchen and there was some justification in what was in the bag, notwithstanding the evidence from Witness 1.

The panel found that there was no good reason to supply a syringe full of unprescribed saline to an intoxicated and untrained vulnerable person.

The panel rejects your explanation that it was done as a last resort in response to demands for drugs from Person A. In the NMC's closing submissions, Ms West-Hunter outlined numerous alternative courses of action that you could have taken all of which the panel found to be reasonable options and none of which you took.

The panel found that the supply of the saline syringe was a casual continuation of a night out where large quantities of alcohol had been and were being drunk. The

panel also found that this was a reckless use of medical equipment that you had been entrusted with to keep safe at home.

The panel rejects your account that you were not physically present when the saline was injected into Person A soon after you filled and supplied the syringe to Person A. The panel considers that you were trying to distance yourself as far as possible from what you recognise to be a reckless use of medical equipment.

In regard to charge 1c, which is the obstruction of the parents from attending to Person A, the panel find that you did obstruct the parents from seeing to the welfare of their son in the full knowledge of Person A's medical vulnerabilities.

The panel accept the evidence of Parent 2 in that she had had contact with you when Person A first became friends with you. She had explained to you his vulnerabilities and his medical condition. The panel also accept Parent 2's account that on seeing the videos she made contact with you to check on Person A's condition and therefore you were fully aware of her concerns.

In the circumstances, when Parent 1 and 2 arrived at your address you would have been aware of their concerns and the reason for their attendance. [PRIVATE].

The panel determined that this is confirmed by the entry on the police incident log that appears at page 46 of the registrant response bundle. The incident log records that at 10:02 you told the police that Person A *'has not had a fit or any medical issues'.* This was 19 minutes before you made a call to the police reporting that Person A's parents were outside your home. This sequence of events indicates that prior to attending your home Person A's parents had contacted the police because they believed their son had suffered a fit and you were aware.

The panel found that you took no steps to reassure them as to the welfare of Person A, instead choosing to distance yourself from the situation.

Interim order

On Friday 18 July 2025, the hearing was adjourned part heard at the facts stage after the panel had orally announced its findings. The panel therefore considered whether an interim order was required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests.

Submissions on interim order

The panel took account of the submissions made by Mr Bealey. He submitted that five years have passed since the incidents took place, you have continued to practise as a nurse unrestricted and that no further concerns have been raised in relation to your nursing practice. Mr Bealey submitted that in these circumstances, an interim order was not necessary.

Ms West-Hunter submitted that the NMC takes a neutral view and to impose an interim order is a matter for the panel to consider.

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

Decision and reasons on interim order

The panel was satisfied that in the light of its findings of fact an interim order is necessary for the protection of the public and is otherwise in the public interest as the public would be concerned if you were allowed to continue practice unrestricted.

The panel concluded that the only suitable interim order would be that of a conditions of practice order. It was of the view that to impose an interim suspension order would be disproportionate in the circumstances, noting that you have worked unrestricted without any further concern for the past five years and that the panel had not yet considered the misconduct and impairment stages of this case.

The panel decided that there were workable conditions that could be formulated that would address the public interest and public protection concerns in this case. As

such it has determined that the following conditions are proportionate and appropriate:

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

1. You must only be employed by the Newcastle Upon Tyne Hospitals NHS Foundation Trust and not undertake any agency or bank work.

2. You must not be in possession of any medical equipment or supplies outside of the workplace.

3. 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.

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

5. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.

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

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

The panel decided to make this interim order for a period of eighteen months.

Fitness to practise (heard and considered on 25 November 2025)

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.

Your evidence

You gave evidence to the panel under affirmation.

You stated that the night itself was unique and a one-off event that would not happen again. One action you would change is the amount of alcohol consumed. You indicated that although, at the time, you thought having the medical bag in the house rather than the car was a good idea, in hindsight, it may have been better to keep it in a different part of the house, perhaps locked in a cupboard. You believe the Trust now has an updated policy regarding this matter. You said you would have asked management to clarify the medication storage policies and where that equipment is expected to be kept. You said you acknowledged there were errors in your judgement.

You said that all your friends now are either registered nurses, physiotherapists, doctors, or more recent acquaintances, and you are strengthening your inner circle, where there is a mutual agreement of values and beliefs. You told the panel that you are now in a stable relationship.

You stated that when you are outside of work, you are considerate of your actions and recognise that your shortcomings were not up to the standard expected at all times, both in and outside of work.

You referred to “Big Market,” which is a drinking area where you socialise in Newcastle. You stated that you would only act in life-threatening emergency situations if you felt competent at the time. You provided two examples where you previously provided assistance to others.

When asked what you have learned from these proceedings, you explained that since the investigation, you have done a lot of reflection on how your conduct did not meet the necessary standards and how you could have acted differently. You have reread the Code several times, pinpointing specific sections. You have undertaken training, sought support from your workplace, and engaged in self-reflection. You acknowledged the importance of maturing yourself and recognised the significant responsibility that comes with NMC registration. You said that you would not want to

jeopardise it in any way. You said you gained deeper insight into how things went wrong and have engaged in reflection.

You made reference to the NMC Code, identifying the areas where you felt there were shortfalls. You said you reflected on what went wrong and how to rectify those issues.

You said that your current role is not that of a registered nurse, but you are working alongside registered social workers, adhering to many safeguarding policies aimed at keeping people safe. You said the NMC Code is still applicable, but on a personal level rather than a registered one. You explained that starting a new role with openness and honesty, ensuring that your employer is aware of the facts surrounding your case, is a better approach for you. You emphasised the importance of this transparency from the outset. You said you have been in your role since 4 August 2025, and it is ongoing. Your current job title is Community Well-being Officer with Adult Social Care in one of the local authorities near you. You said your responsibilities include being part of a Gateway Team, which is a new team being established within the local authority to improve the speed at which social services can assist individuals who are struggling with personal care, have had a fall at home, are socially isolated, or are at risk of harm from perpetrators, among other issues. You mentioned conducting DASH (Domestic Abuse, Stalking, Harassment and Honour-Based Violence) assessments, which are questionnaires that aid in safety planning for individuals and provide them with options.

You highlighted the value you place on the team and your close collaboration with the Trusts and GP services, noting that it creates a beneficial link between health and social services.

You said you have been successful in gaining promotion to be the Assistant Reablement Manager, which is in a support service used for hospital discharge, assisting patients as they transition back into the community. You explained that this service is free for six weeks and focuses on enabling individuals to achieve their goals and regain independence after discharge from hospital. You said that this role is aligned with the NMC’s Code of Conduct, even in a non-registered post.

Additionally, you are considering pursuing an apprenticeship at university for an undergraduate degree in social work or embarking on a master's course in social work to become dual registered as both a nurse and a social worker. This is your long-term ambition.

In your current role, you have weekly meetings and have provided the panel with your supervision records dated from August 2025 to October 2025. These records are completed by your line manager and include columns for your workload, progress, successes, challenges, and reflections and learning. You also said that you have maintained a log of Continuing Professional Development (CPD) between August and October 2025.

You expressed the importance of receiving regular supervision in your new role, stating that if there are any shortfalls or reflections, these are discussed weekly to ensure that you uphold the standards expected of you. You said that any issues related to practice are flagged to you, which has consequently improved your professional practice. Although you felt nervous about transitioning into a new role due to the regulatory proceedings underway, you said this experience has provided valuable insight, and you feel you are doing well, receiving regular support to ensure everything is on track.

You said you have ensured that your training is current and that all documentation is compliant with regulatory standards and the expectations of the local authority. You said you want the public to feel confident in your assessments and to trust you, as you are well-acquainted with the Code. You have undergone training and completed revalidation twice before. You believe you can earn the public's trust and aspire to be a good role model, aware of how your behaviour can influence others.

You said you reflected on these incidents that occurred when you were 23 or 24 years old, noting that you are now 30. At that time, you were relatively newly qualified and you were unsure of what was expected of you. Now, with your nursing experience, ongoing supervision, reflective practice, and two revalidations, you have gained a clearer understanding of your responsibilities. You said that you have made positive changes, such as moderating your alcohol intake and [PRIVATE].

You indicated that the ongoing supervision in your current work environment is beneficial. You wish to return to nursing and practise in a way that upholds the required standards and revalidation processes. You said you are committed to regularly seeking feedback while remaining aware that you would want to treat others as you wish to be treated.

You said that you would explain to the public the changes you have made, the revalidation process, and reflect on how this will hopefully change the public's perception of who you were compared to who you are now. You said that the incidents at the time would have damaged the reputation of nursing, but you believe you have strengthened your practice.

You stated that the regulatory process has allowed you to reflect. Although there are many stressors and negative effects associated with the NMC, you have also recognised the positives of the process, and you have learned to be open and honest in your reflections. You said that your responsibilities as a nurse and your NMC registration are at the forefront of your mind. The experience you have gained since this began is significant, and you feel that you have grown as a person.

You said that being able to practise as a nurse means being caring and compassionate, and you would love the opportunity to continue to do so. You also mentioned your aspiration to continue as a registered nurse while going to university to study adult social work, wanting to maintain a high level of knowledge and clinical skills.

You acknowledged that, as your past self, you were not open and honest when the NMC sent you the initial letter. You said that you should have gone straight to your employer regarding the incident, recognising the importance of immediate openness and honesty with your employer and how that relates to ensuring the safety of patients and members of the public.

You said you have since read about seizures and attended training on managing the initial effects of someone critically ill, covering areas such as breathing, circulation,

and what to do in emergency situations. You stated that while Person A may have had a seizure, the paramedic evidence does not confirm this. You said that this is not detrimental to you or the NMC hearing, as there is no expert evidence available. You said you have not focused on whether it was a seizure or not; rather, you have concentrated on what you would do differently and reflected on how the situation could have changed. You have considered whether it was a seizure and how that might have affected Person A's parents.

You said that you can recall going through the NHS pathways on the phone with the emergency services, and that the appropriate assistance arrived. You said that the consequences were not at the forefront of your mind during those situations.

You stated that you did not understand the ramifications at the time due to your age and immaturity. You said that you have informed your current employer of the situation, engaged in a thorough conversation about it, and sent the NMC documentation to your line manager.

In response to the panel's questions, you said that those affected by your actions included the immediate individuals, yourself, and your friend (Mr 1). Following this, the parents were also affected due to their worry. The trust and confidence in you as a registrant was also impacted. You indicated that it impacted you and the parents, as well as your employer, the NMC, your wider circle of friends, and the public perception of nurses. You said that the public expects nurses to act in a manner that is in their best interests. You said that this may affect their access to services and have a negative impact on their health and well-being. You stated that the public trusts that medical equipment is kept in a secure location, and it should not be used outside of working hours. You also said there is an expectation that nurses can respond urgently when required. You said that your actions were not in anyone's best interests, and various aspects of the night could have been handled differently with more preventative measures in place.

Regarding the recent training that you have undertaken and its relevance to the incident, you explained that it covers basic life support and how to manage emergency situations and identify a deteriorating patient. In your current role, you

told the panel that you have undergone extensive training in vulnerable adults, domestic abuse, and mental health capacity assessments, which has provided you with a deeper understanding of adult vulnerabilities and safeguarding procedures. You said that this training is delivered through an online portal funded by Newcastle Upon Tyne Hospitals. The mandatory training in the first week of August is provided by the local authority and is signed off by Social Work England. Although you conducted research and reading concerning seizures, you mentioned that you could not find training specifically focused on seizures.

You said that you should have spoken to Person A's parents to inform them that you had contacted the police, who advised you to wait for their arrival. You believed this communication would have helped de-escalate the situation and offered more reassurance to the parents. In your current role, you said you have engaged in conflict resolution and de-escalation skills training, which has equipped you to handle various scenarios more effectively.

Submissions on misconduct and impairment

Ms West-Hunter provided the panel with written submissions outlining the legal framework and referred to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* She also referred the panel to the NMC guidance on 'misconduct' (FTP-2a), relating to '*concerning outside professional practice'.* She also referred to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

In her written submissions, Ms West-Hunter states that your conduct fell significantly short of what would be expected of a registered nurse for the following reasons:

a. *Despite knowing Person A's particular vulnerabilities and medical condition, the registrant chose to engage in reckless and dangerous behaviour by giving him access to an unprescribed saline solution. The*

risks associated with this were heightened by Person A being untrained and heavily intoxicated.

b. *When police and paramedics attended the scene, the registrant omitted in telling them about Person A's vulnerabilities or the saline injection, again highlighting the registrant's priority was to protect himself as opposed to ensuring Person A could receive the best treatment.*
c. *Throughout the course of the incident, and indeed these proceedings, rather than take responsibility for the dangerous circumstances that arose, the registrant sought to distance himself from the situation precisely because he was aware of the risks involved. His actions throughout the incident, and particularly his treatment of Person A's parents, demonstrate a failure to prioritise the safety of Person A and the well-being of his parents who were clearly distressed. There was a clear lack of compassion for Person A and Person A's parents.*

Ms West-Hunter submitted that your actions represent a significant departure from the fundamental principles of the Code in prioritising people, preserving safety and promoting professionalism and trust in the professions.

In respect of impairment, Ms West-Hunter made reference to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She stated that limbs (b) and (c) of Grant are engaged.

In her written submissions, Ms West-Hunter stated the facts found proved is clearly behaviour which has brought the medical profession into disrepute. This is demonstrated most by the disappointment expressed by Person A's parents. Parent 2 explained her initial reaction when she found out the registrant was a nurse: "*It made me feel confident that he [the Registrant] would know symptoms and what to look out for*". There was a high level of trust in the registrant's professionalism that was lost because of your behaviour and actions on 22 February 2020.

Ms West-Hunter stated that throughout this incident, you did not demonstrate compassion to Person A or his parents. You inhibited Person A from being attended

to by his parents, when they were equipped with medication that could have been of assistance to him. Perhaps more damning than the actions themselves was the reasoning behind it – you continuously attempted to distance yourself from the ramifications of your conduct. You did not want Person A's parents to see the state Person A was in nor did you want paramedics who first attended to know that you had prepared an unprescribed saline solution for an intoxicated, vulnerable person to inject. Subsequently, you were not open and honest with your employer at the time.

Ms West-Hunter submitted that the purpose of fitness to practise proceedings is not to punish for past behaviour but is forward looking. She submitted that the incident of 22 February 2020, show deep attitudinal issues which suggest a lack of insight and future risk.

Ms West-Hunter made reference to the NMC Guidance '*Has the concern been addressed'* (FTP-15b, reference 29 November 2021).

In her written submissions, Ms West-Hunter stated that you continue to refute the fact that Person A had a seizure, despite it being identified as such by Parent 2 and now equipped with Person A's medical records from the time; continue to refute you had any knowledge of Person A's vulnerabilities and continue to refute that Person A's parents made clear to you at the time of the incident their concerns about their son's seizure activity. These are some of the key aspects of the incident that would undermine public trust in the profession.

Ms West-Hunter submitted that you sought to give examples where you have helped others in public on nights out as a means of showing development, but these are not like for like scenarios. The incident before the panel shows you contributing significantly to a dangerous scenario, subsequently omitting key information from emergency services, failing to allow Person A's parents to attend to him following an emergency, all in an attempt to distance yourself from the scenario at hand. She submitted that this is not something where development can be shown just through doing your job, or assisting people in public, because one of the fundamental failings in this scenario, was a lack of integrity. A lack of owning one's mistakes at a crucial time of emergency. She submitted that not enough has been provided to the panel to

demonstrate insight or that the risk of repetition in such circumstances has been properly mitigated.

Ms West-Hunter submitted that the behaviour demonstrated by you throughout the incident, the internal investigation and the earlier proceedings, demonstrate a lack of insight which increases the risk of repetition of similar incidents occurring in the future and suggests that your fitness to practise remains impaired.

Mr Bealey, on your behalf, provided the panel with written submissions on misconduct and impairment. He outlined the legal framework and made reference to relevant case law.

In his written submissions on misconduct, Mr Bealey stated:

1. *…it is submitted that the following circumstances surrounding the facts of allegation 1(c) mean that the 'obstructing the parents of Person A from attending to him' does not amount to serious misconduct:*

    a) *At all material times for charge 1(c), the evidence shows Person A was well:*
        i) *Person A was discharged at scene by paramedics after first attendance at the registrant's property*
        ii) *Police confirmed to Parent 1 that Person A was '[PRIVATE] during a call on route to the house.*
        iii) *Person A was checked by police on their attendance and no concerns were noted.*
        iv) *Person A was only taken to A&E at 19:40 on Saturday evening. There cannot have been any need for immediate medical assistance.*

    b) *The registrant was demonstrably scared of Parent 1 to the extent of contacting the police. It is reasonable for the registrant to have been scared for his safety by the loud banging and shouting, along with swearing language used by (at least) Parent 2.*

c) *It is submitted that in these circumstances, the registrant cannot be under a duty to make his property available to anyone other than the emergency services (who had been called). This would set a dangerous precedent, especially where an individual is concerned for his own safety.*

d) *In any event, the registrant admitted the police to the property and the parents shortly thereafter.*

e) *There is evidence from the registrant's contact with police that Person A did not want his parents to enter the property.*

f) *The parents' medication was not of any assistance to the situation (and they themselves could not have assisted better than a <u>trained</u> medical professional). Even if the Registrant was aware that Parents 1 and 2 did have Midazolam, Midazolam is for use during or shortly after a seizure lasting 5 minutes. Given the timings of Parent 1, they attended the property at least 2 hours after the videos were received. By that point in time, there was no necessity for this medication.*

g) *Furthermore, Parent 1 stated in evidence that the rescue medication was precautionary. Parent 1 said that there was 'no need to give him anything apart from anti-epileptics but we didn't have those with us'. There was no medication which would have been necessary.*

h) *It is submitted that had the parents actually been concerned about the health of Person A, they would have contacted the ambulance service. Given that their only contact was with police, it suggests the sole concern was gaining entry into the property.*

i) *Parent 1 admitted that the presence of police would make the registrant feel secure. As such, it was reasonable to wait for that to take place. There is no evidence that the police had any concerns on entering the property that Mr Hartley had done the wrong thing.*

2. *Fundamentally, Mr Hartley was acting on Police advice in obstructing the parents from attending the address. Following police advice cannot constitute misconduct.*

3. *The panel's findings suggest concern that there were no steps taken to reassure the parents as to the welfare of Person A, instead choosing to distance himself from the situation. The following observations are made:*
    a) *There is no duty or requirement for Mr Hartley to have done so.*
    b) *Mr Hartley was acting on police advice to wait for the police to attend. Given the aggressive nature of parents 1 and 2, this may have inflamed the situation further.*
    c) *By this point, the father of Person A had disregarded police information confirming that his son was fine. He not only ignored this but drove to pick up his partner and head to the registrant's house. In this context, attempts to reassure the parents would have been futile.*
    d) *In reality, distancing himself meant going upstairs and attending to Person A rather than Person A's parents. It is noted that this is consistent with a duty of care to Person A.*
    e) *The charge is not concerned with what other actions the Registrant could have taken, but with whether the charge found proven could amount to misconduct.*

4. *Given these circumstances, the actions of the registrant cannot be regarded as 'deplorable', falling far below the standard reasonably expected from a registered nurse. It is therefore not misconduct.*

In relation to impairment, Mr Bealey in his written submissions, stated that there is no basis for finding current impairment of fitness to practise. There are no separate clinical concerns relating to you. You have demonstrated that you can practise kindly, safely and professionally.

Mr Bealey stated that you have admitted the charges from the outset and there is a wealth of reflection within the bundles provided to the panel where you have shown

insight into the implications of your actions that evening. You have also given oral evidence on two occasions, and provided an updated bundle. In your evidence, you accepted that you made the wrong decisions that night and conceded there would be other ways of dealing with the incident now. You have shown a willingness to engage with the process and learn from mistakes. There have been no repetition of the concerns and there are no underlying attitudinal concerns. Through engagement in this process, you have been able to reflect on your own immaturity at the time of the incident. Mr Bealey in his written submissions outlined the evidence you have provided in that you have changed your outlook and demeanour.

Mr Bealey in his written submissions stated that the NMC have raised whether you knew it was a seizure and that you may be saying you cannot be definitive because it helped your case if there was not a seizure. He stated the fact is the panel finding only on balance of probabilities and there has not been an expert view. In any event, the panel cannot say you were there during the seizure, and the focus is more on your actions in response to Patient A's presentation when he was discovered. He stated that you have done your own research on seizures and considered what you would have done if it had or had not been a seizure. You were able to point clearly to all parties who suffered an impact and how they suffered, ranging from those present all the way to public perception and understanding. He stated that your insight and reflection surpass what could reasonably have been expected by the panel to show the required level of insight.

Mr Bealey drew the panel's attention to the references provided on your behalf and that you have received a promotion to a managerial role. You have complied with the interim conditions of practice order and have shown commitment to the NMC process.

Mr Bealey stated that there was no harm caused to the individual. Although it is conceded that there may have been a risk of harm, saline was chosen because it had no effect on the body. You have accepted that your actions in not supervising Person A with the syringe could have caused harm. He stated that this is a one-off isolated incident nearly six years ago and that it would be unjust to find that you now pose a risk to patients or others receiving care. As such, there is no risk of future

harm to people receiving care. Mr Bealey stated that it was a one-off isolated incident, with no further incidents reported, and this cannot form a reasonable basis for suggesting that there is a risk of repetition.

Mr Bealey addressed the panel on public confidence and submitted that you have engaged throughout these proceedings and giving evidence. He stated that a fully informed member of the public will not be concerned to find that you are found not impaired as you have shown development, reflection and insight.

Mr Bealey invited the panel to find that the allegations found proved, whilst serious, are not so serious as to amount to misconduct. Alternatively, the conduct is remediable, has been remediated, and through continued training and safe practice is highly unlikely to be repeated. He therefore invited the panel to find that your fitness to practise is not currently impaired.

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

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

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion

4 Act in the best interests of people at all times

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

8.6 share information to identify and reduce risk **(in the context of emergency services)**

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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 … integrity at all times…

The panel determined that your actions in charge 1(b), amounts to serious misconduct. The panel concluded that providing the saline syringe was a reckless continuation of a night out during which excessive amounts of alcohol were

consumed. The panel determined that this constituted an unjustified and reckless use of medical equipment, which you were entrusted to keep safe at home.

Furthermore, the panel found that you did not act in the best interest of a vulnerable intoxicated person. Not only did you provide the syringe that you had filled with saline, but you also indicated to him where it should be injected, displaying a disregard for Person A's well-being. Although you later called emergency services, the panel found that your account was intentionally selective, likely aimed at minimising adverse repercussions for yourself, prioritising your own interests over those of Person A. This was further exacerbated by your failure to give an accurate account of what transpired when emergency services arrived, notably omitting the fact that Person A had been injected with saline.

In relation to charge 1(c), the panel had found that Parent 2 had previously discussed Person A's vulnerability with you, trusting you, knowing that you were a nurse to keep him safe. The parents were clearly distressed, and you could have taken many different steps to reassure them even without affording them entry into your house. Instead, your deliberate actions kept the parents away, potentially causing psychological harm. While you expressed concern about confrontation with Person A's father, the panel found that you were aware of the parents' intent to support their son. By obstructing them, you deprived the parents of the opportunity to ensure their son's safety, which only heightened their anxiety. Any concern for yourself that may have resulted from the parents entering and seeing their son, did not excuse your failure to act compassionately toward Person A or his parents. You inhibited the parents from being able to assess their son to determine whether administering emergency medication was necessary. Your reasoning revealed a continuous effort to distance yourself from the ramifications of your actions, as you seemed more concerned with concealing the state of Person A and what had transpired during the night, from his parents than ensuring his well-being.

For these reasons, the panel found that your actions in charges 1(b) and 1(c) did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the 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 act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel determined that limbs (a), (b) and (c) are engaged in this case. The panel determined that your actions in the past put Person A at risk of harm by enabling him to be injected with an unprescribed saline solution and subsequently failing to act in his best interests. Your actions may have caused psychological harm to Person A’s parents. It determined that your actions breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that the misconduct is such that it can be addressed. The panel had regard to the bundle of documents supplied by you and your oral evidence in determining whether you had in fact addressed your misconduct.

While the panel acknowledged your reflections, it noted that these lacked depth and you failed to recognise the gravity of the incident and through your counsel have not even recognised that your actions amount to misconduct, which demonstrates a significant shortcoming in your insight. Although you demonstrated some insight regarding the issues with your medical bag and the parents, you made no reference to the potential risk of providing Person A with a syringe or its impact on Person A. It noted your evidence that appeared to prioritise the importance of reporting the incident to your employer, rather than the importance of reporting exactly what had happened to the emergency services on the night or how you could have ensured better care for Person A, raising concerns about your ability to prioritise in situations like this.

Furthermore, the panel noted an ongoing reluctance to accept responsibility on your part. Your responses lacked substance and clarity, suggesting a circular reasoning that failed to provide any meaningful insight.

The panel noted that you would now seek guidance as to where to keep a medical bag at home and yet the position of the bag on the night of the incident was not the issue. The issue was that you took a syringe from it, and filled it with saline in response to a vulnerable and intoxicated young man asking for drugs. While you acknowledged immaturity at the time of the incident, stating that you were previously irresponsible and had made poor lifestyle choices, you told the panel that you have matured since then. However, the panel noted that your insight did not extend to taking any personal responsibility for the proven actions. During your evidence, when asked about those impacted by your actions, you identified yourself and your friend first, which further illustrated a lack of awareness regarding the real and potential consequences for Person A, his parents and the wider implications for trust and confidence in the profession.

While the panel acknowledged the steps you have taken so far to reflect and learn from this experience, it was felt that this process is incomplete and you have not yet fully developed insight into the full impact of your actions. The panel also noted that you have been working without concern and have provided positive references.

However, the panel found that there was significant evidence to indicate attitudinal concerns on your part at the time of the incident and during the subsequent investigation. The panel accepted that while these have been addressed to some degree, your evasive and self-serving responses during your oral evidence at the hearing, rather than accepting personal responsibility for your actions, shows that such concerns have yet to be fully remediated. The panel was concerned that due to your limited insight and incomplete remediation, that in future challenging situations you would continue to put your own interests above those of others at the expense of integrity, openness and transparency.

The panel determined that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel was of the view that due to the seriousness of the misconduct found proved, public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Ms West-Hunter provided the panel with written submissions. She outlined the legal framework and NMC guidance including '*Factors to consider before deciding on sanction'* (SAN-1) and '*Available sanction orders'* (SAN-3).

Ms West-Hunter outlined the aggravating factors including: attitudinal concerns; risk of harm to Person A; psychological harm caused to Person A's parents; and the vulnerability of Person A.

Ms West-Hunter took the panel through the available sanctions. She stated that your conduct was not at the lower end of the spectrum and as such a caution order would be inappropriate in view of the seriousness of the case. In relation to a conditions of practice order, she stated that the seriousness of the misconduct and risk of repetition cannot be mitigated by a conditions of practice order. It is not something that be addressed through training, particularly given the charges indicated a lack of integrity. Ms West-Hunter further stated that a suspension order would not adequately address the seriousness of this case, uphold proper professional standards or protect the public.

Ms West-Hunter therefore submitted that this is a serious case where the appropriate sanction is one of a striking-off order.

Mr Bealey provided the panel with written submissions on sanction. He outlined the legal framework and made reference to the NMC guidance.

Mr Bealey stated that the panel found that you have taken steps to reflect and learn from this experience. Although it identified that this is incomplete and does not amount to full insight, this does not negate the volume of work done. He stated that the panel has noted that you have been working without concern and there are no

issues relating to clinical practice. He stated that although a risk of repetition has been identified, there has been no repetition of the misconduct. He drew the panel's attention to the reference which shows that you are a valued colleague able to contribute and work well in a team.

Mr Bealey in his written submissions, outlined personal mitigation in this case, which includes: your age and immaturity at the time of the incidents – you have taken efforts to readjust your lifestyle and friendship group to reduce risks of similar incidents occurring; and you have no other history before the NMC.

Mr Bealey submitted that a caution order is the most appropriate sanction available. It would mark that the behaviour was unacceptable and must not happen again. He stated that a caution would be entirely suitable in this case given the following factors:

i) *"There was only one isolated incident which took place nearly 6 years ago.*
ii) *Although the panel have found a risk of repetition, it is submitted that this must be low. No repeat incidents have occurred in over half a decade.*
iii) *The registrant has shown some insight within his statement and in his oral evidence. This includes, but is not limited to, acknowledging his errors, and an understanding of the negative impact on public confidence through his actions.*
iv) *The registrant has undertaken some appropriate remediation such as reading around the topic and personal reflection.*
v) *The registrant has not had any complaints since the incident."*

Mr Bealey submitted that you have been practising for a period of approximately five years since the incident without further concern. He stated that during and after this period, you have demonstrated your ability to work well in a number of different challenging environments including the following factors:

i) *"Promotion to Discharge Specialist Nurse which involved overseeing patient flow throughout the hospital alongside two others and senior management.*

ii) *His current role involves safeguarding and vulnerable individuals in an isolated community context, often as first point of contact.*
iii) *Both these jobs demonstrate skills working with and contacting wider agency groups."*

Mr Bealey submitted that a caution order will mark your record for a long period and give you motivation to continue the positive reflection. He stated that if the panel is not satisfied that a caution order is appropriate, the next consideration is whether a conditions of practice order is appropriate and proportionate. However, Mr Bealey submitted that you are not currently practising in a registered position. As such, any conditions of practice would not apply until a change in job role. In his written submissions, Mr Bealey stated:

"It is difficult to conceive of any conditions which are necessary in these circumstances, given:

i) *Given that these conditions would not apply unless and until a registered role is taken, which could be some time into the future.*
ii) *The incident took place outside of work. The majority of conditions in the NMC bank apply to the workplace. Others are not appropriate.*
iii) *The previous conditions that were imposed are no longer suitable"*

Mr Bealey submitted that if the panel do impose conditions of practice, then you would seek the opportunity to address the panel on each condition.

Mr Bealey stated that a suspension and striking-off order are wholly disproportionate given the following:

i) *"The registrant practised for 5 years since the allegation without any referrals.*
ii) *Strike off would mean that Mr Hartley would likely not be able to continue in his social care role. His work have made it clear that he would have to go through an internal HR process to consider if he could work in that position with that decision on his record (regardless of whether or not he is registered). This would cease a promising career which the panel have*

seen positive references and Mr Hartley's clear passion. This would be extremely disproportionate at this stage.

iii) *Strike-off would prevent Mr Hartley undertaking his future career plans to positively contribute to his local community*

iv) *Mr Hartley has never been subject to restrictions in clinical practice (as he was not using his registration when interim conditions were imposed).*

v) *The Registrant is clearly capable of providing a good quality of clinical work. To remove him entirely from practice would sacrifice the career of an otherwise competent and useful nurse.*

vi) *It would be disproportionate to prevent the Registrant from practising at this stage, when the Registrant has been practising without restriction and without incident for the past 5 years.*

vii) *The registrant has shown insight, remorse, and reflection.*

viii) *This is the registrant's first finding before the regulator."*

Mr Bealey therefore invited the panel to impose a caution order for a period of twelve months.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Whilst a single incident, it occurred over several hours providing multiple opportunities to take a different course of action.
- Person A was vulnerable.

- There was a breach of trust in that the parents of Person A had trusted you due to your position as a nurse to take care of Person A given his vulnerabilities.
- You prioritised your own interests over those of others, particularly Person A, by withholding vital information from the emergency services.
- You recklessly misused medical equipment from your medical bag outside of your professional duties. You were expected to use this only for justified clinical purposes.
- Attitudinal concerns in that you have continuously sought to minimise the gravity of the incident.
- There was a risk of harm to Person A and a significant emotional impact on their parents.
- There has been an absence of remorse or apology for your actions.

The panel also took into account the following mitigating features:

- You have been working without further issue since the incident, and have provided positive references to support this.
- You have taken some steps to develop insight.
- You have recently been promoted to a managerial position indicating employer's trust in the workplace.

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

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate:

"…*if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted,*

meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again."

The panel considered that your misconduct was a long way from the lower end of the spectrum and that a caution order would not reflect the seriousness of the concerns identified and would not provide an opportunity to reassure your regulator that you have fully developed insight. The panel determined that it would not protect the public nor uphold the public interest to impose a caution order as you have shown insufficient insight into the gravity of your misconduct.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel determined that no practical or workable conditions can be formulated, considering the nature of the charges in this case. The misconduct identified cannot be addressed through retraining, as it does not relate to your clinical practice. Although the panel imposed an interim conditions of practice order before the hearing went part-heard in July 2025, it had not then heard your oral evidence regarding your insight and remediation at that time. Following its assessment of your insight, the panel found that you demonstrated only superficial insight and have taken only limited responsibility for, or acknowledgement of the severity of the incident. The panel therefore found that there is a risk of repetition, albeit, outside of your clinical practice and a risk of harm to the public. Therefore, the panel concluded

that your misconduct cannot be adequately mitigated by conditions, would not address the seriousness of this case, and would not adequately protect the public and satisfy the public interest in this case.

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

The panel concluded that while this case involves a single instance of misconduct, it comprises a series of behaviours occurring over an extended period during one night. The panel determined that your actions were attitudinal in nature and found your insight to be superficial, failing to address the impact your actions had and could have had on Person A, his parents and the wider trust and confidence in the nursing profession. The panel found that there was a risk of repeating this behaviour. However, the panel acknowledged that you are a competent clinician and it noted that there have been no concerns regarding your performance at work, and that the positive testimonials you have supplied do not indicate any further issues.

Considering all of these factors, the panel concluded that imposing a suspension order would mark the seriousness of your misconduct whilst allowing you the opportunity to reflect and further develop your insight and provide evidence to reassure a future panel that there is no risk of repetition of this behaviour. The panel considered that a period of suspension would be sufficient to protect patients, maintain public confidence in the nursing profession and uphold professional standards and public confidence in the regulator.

The panel was satisfied that in this case, your misconduct, whilst serious, was not fundamentally incompatible with remaining on the register should you be able to

develop full insight. The panel balanced the public interest of marking the seriousness of the misconduct with a striking-off order with the effect of denying the public the services of an otherwise competent nurse. A well-informed member of the public would consider the public confidence in the profession is maintained as a suspension from the register is a significant and proportionate sanction.

The panel did go on to consider whether a striking-off order would be proportionate and seriously considered such sanction. However, taking account of all the information before it, the panel concluded that at this stage, without giving you the further opportunity to further reflect in light of the panel's findings, it would be disproportionate. It determined that it would be unduly punitive in your case to impose a striking-off order at this stage.

Taking into account all of the information before it, the panel concluded that a suspension order is appropriate and the least sanction necessary to protect the public and satisfy the public interest. Whilst the panel acknowledges that a suspension may have a punitive effect, this is outweighed by the public protection and public interest concerns as described above.

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

The panel determined that a suspension order for a period of nine months was appropriate in this case to mark the seriousness of the misconduct. This will provide an adequate opportunity for you to fully develop your insight.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A comprehensive written reflection on the incidents that occurred that night, detailing the impact on Person A and his parents, as well as the public's perception of the profession and its reputation.
- Demonstrate a clear understanding of the factors that contributed to the incident, including insight into how and why it unfolded and what alternative actions you could have taken.
- Your full engagement and in person participation in these proceedings.
- Up-to-date testimonials from your employer.

Interim order

As the 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 in your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Ms West-Hunter invited the panel to impose an interim suspension order for a period of eighteen months to provide for the gap between the making of any substantive order and closure of the statutory appeal window or any actual appeal. She submitted that an interim suspension order is necessary for the protection of the public and otherwise in the public interest.

Mr Bealey submitted that, as you are not practising as a nurse, the interim order would not directly affect your current job. He submitted that an interim order's efficacy means it is not necessary, given you will not be practising as a registered nurse within the next eighteen months.

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 also noted that you had previously informed the panel of your intent, should you be able, to work shifts as a bank nurse whilst you are currently employed in an unregulated role.

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 eighteen months to allow for the possibility of an appeal to be made and determined.

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.

This will be confirmed to you in writing.