Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 29 September – Friday 3 October 2025
Monday, 6 October 2025 – Friday 10 October 2025
Monday, 13 October 2025 – Friday, 17 October 2025

Virtual Hearing

Name of Registrant:	**Rufaro Maringapasi**
NMC PIN:	01C1676E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (05 April 2004)
Relevant Location:	London and Surrey
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant member) Vickie Glass (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Khatra Ibrahim
Nursing and Midwifery Council:	Represented by Bibi Ihuomah, Case Presenter
Mr Maringapasi:	Not present and unrepresented at this hearing
Facts proved:	**Charges 1, 2, 3, 4, 5, 6, 7, 8, 9, 10a, 10c, 10d, 10e, 11b, 11c, 11d, 12 (in respect of charges 10c, 10d and 10e), 13 (in respect of 11b and 11c) and 14 (in respect of charges 2 and 4)**
Facts not proved:	**Charges 10b, 11a, and 12 (in respect of charge 10a)**

Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Maringapasi was not in attendance and that the Notice of Hearing letter had been sent to Mr Maringapasi's registered email address by secure email on 29 August 2025.

Ms Ihuomah, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Maringapasi's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In light of all of the information available, the panel was satisfied that Mr Maringapasi has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Maringapasi

The panel next considered whether it should proceed in the absence of Mr Maringapasi. It had regard to Rule 21 and heard the submissions of Ms Ihuomah who invited the panel to continue in the absence of Mr Maringapasi. She submitted that Mr Maringapasi had voluntarily absented himself.

Ms Ihuomah referred the panel to the documentation from Mr Maringapasi which included an email to the NMC dated 29 September 2025, where he states:

'I got the message. Just go ahead please…'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Maringapasi. In reaching this decision, the panel has considered the submissions of Ms Ihuomah, the representations from Mr Maringapasi, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Maringapasi, and he indicated that he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Mr Maringapasi sent an email dated 29 September 2025 indicating that he has no intention to attend this hearing;
- A number of witnesses are due to give live evidence at this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s), those involved in clinical practice and the patients who need their professional services;
- These are serious charges with a sanction bid of strike-off;
- Any further delay may affect witnesses' recollection of events, with these incidents having occurred in 2022 and 2023; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Maringapasi in proceeding in his absence. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Maringapasi's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Maringapasi.

The panel will draw no adverse inference from Mr Maringapasi's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On 26 December 2022 administered antibiotics intravenously to Patient X without conducting observations.

2. On or around 26 December 2022 falsified records by recording that you had undertaken observations of Patient X when no such observations had been undertaken.

3. On 2 January 2023 administered antibiotics intravenously to Patient X without conducting observations.

4. On or around 2 January 2023 falsified records by recording that you had undertaken observations of Patient X when no such observations had been undertaken.

5. On 5 January 2023 did not visit one or more patients that you were assigned to visit.

6. On or around 5 January 2023 failed to inform the Central London Community Healthcare NHS Trust ("CLCH") that you had not visited one or more patients that you were assigned to visit on 5 January 2023.

7. On 10 August 2022 did not visit the patients that you were assigned to visit.

8. On or around 10 August 2022 failed to inform the CLCH that you had not visited the patients that you were assigned to visit on 10 August 2022.

9. Between October 2022 and 6 January 2023 you failed to practise at the expected standard of a Band 6 nurse in relation to record keeping.

10. Between 6 February 2023 and 28 April 2023 breached conditions 1, 2, 3, 4, and 8 of the Interim Conditions of Practice Order ('ICOPO') imposed on 7 February 2023 by an Investigating Committee of the Nursing and Midwifery Council, in that you:

10a. Did not limit your nursing practice to one substantive employer, namely had NHS Professional as a second employer.

10b. Did not ensure that you were always supervised.

10c. Did not ensure you were supervised by another registered nurse, namely you were employed by Central Surrey Health Ltd (“CSH Surrey”) into a role that required you to work without direct supervision.

10d. Failed to inform your line manager of the existence of the ICOPO and did not meet fortnightly with your line manager.

10e. Did not provide CSH Surrey with a copy of the conditions of the ICOPO.

11. Between 1 April 2023 and 16 August 2023:

11a. Failed to accurately disclose to your employer, CSH Surrey, the circumstances around your resignation from your previous employer, CLCH.

11b. Failed to disclose to CSH Surrey the outcome of the NMC inquiry/investigation into your fitness to practice.

11c. Stated during an employer’s investigation that CLCH did not explain concerns about you doing observations, when this was not correct.

11d. During an employer’s investigation by CLCH regarding an incident on 10 August 2022, you knowingly provided incorrect information regarding your discussions with colleagues, namely you denied having had any conversations with colleagues from the Trust after 3pm on 10 August 2022.

12. Your actions at one or more of charges 10a, and or 10b, and or 10c, and or 10d and or 10e above were dishonest in that you attempted to conceal from your employer(s)that regulatory restrictions had been placed on your practice.

13. Your actions at one or more of charges 11a and or 11b and or 11c above were dishonest in that you attempted to conceal from CSH Surrey concerns raised about your performance in your previous employment with CLCH.

14. Your actions at one or more of charges 2 and or 4 above were dishonest in that you sought to conceal the fact you had not carried out observations on Patient X.

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

Background

Mr Maringapasi was firstly referred to the NMC on 13 January 2023 and secondly, 17 May 2023.

The alleged charges first arose whilst Mr Maringapasi was employed by Central London Community Healthcare NHS Trust (CLCH) as a Band 6 registered community nurse carrying out home visits for patients in the community. Mr Maringapasi's responsibilities included attending patients who required insulin treatments, wound care, intravenous (IV) medication administration and end of life care.

It is alleged that on the dates of 26 December and 2 January 2023, Mr Maringapasi attended the home of Patient X to administer IV medication. Upon arrival, Mr Maringapasi stated that he had carried out observations, and had documented this in Patient X's records. Following concerns raised by Patient X, Mr Maringapasi accepted that he had not undertaken any observations.

During a local investigation into the aforementioned allegations, further allegations were brought to its attention, in that on 10 August 2022, Mr Maringapasi allegedly failed to attend work and to notify management that he would not attend the homes of the patients

allocated to him. It is further alleged that Mr Maringapasi gave a dishonest account of events regarding his communication with colleagues. An investigation was launched by CLCH, and as a result, Mr Maringapasi was placed on an action plan by his employer.

Further allegations came to light on 5 January 2023 alleging that Mr Maringapasi failed to visit five patients he had been assigned to visit, and to escalate and/or report this. Mr Maringapasi resigned from this position on 6 January 2023. Mr Maringapasi was referred to the NMC on 13 January 2023 and an Interim Conditions of Practice Order (ICOPO) was imposed on his practice on 7 February 2023.

On 1 April 2023, Mr Maringapasi started employment at Central Surrey Health Ltd (CSH Surrey). Mr Maringapasi allegedly failed to inform CSH that he was subject to an NMC investigation, and that an ICOPO had been imposed on his practice. As a result, on 17 May 2023, CSH referred Mr Maringapasi to the NMC, suspended him and a disciplinary hearing was held at a later date. Consequently, Mr Maringapasi was dismissed from his role on 15 August 2023.

Decision and reasons on application for to hear Witness X's evidence in private

Before Patient X attended to give evidence at this hearing, Ms Ihuomah made a request that Patient X's evidence be heard in private on the basis that proper exploration of their evidence will involve reference to their [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there will be reference to [PRIVATE], the panel decided that Patient X's evidence will be heard in private, in order to protect their privacy.

Decisions and reasons on application to amend charge 10a under Rule 28 of the Rules

Upon hearing from the final witness, Ms Ihuomah made an application to amend charge 10a.

> 10. Between 6 February 2023 and 28 April 2023 breached conditions 1, 2, 3, 4, and 8 of the Interim Conditions of Practice Order ('ICOPO') imposed on 7 February 2023 by an Investigating Committee of the Nursing and Midwifery Council, in that you:
>
> 10a. ~~Did not limit your nursing practice to one substantive employer, namely had NHS Professional as a second employer~~. **Applied to secure a second substantive employer, namely NHS Professionals.**

Ms Ihuomah stated that the changes would more accurately reflect the evidence before the panel. Charge 10a was proposed to amend the charge to '*Applied to secure a second substantive employer, namely NHS Professionals*' in the charge to more accurately reflect the fact that Mr Maringapasi attempted to apply for a role with a second employer.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel heard submissions from the NMC in respect of admissions to further amend the charge to ensure clarity and accuracy. It was of the view that such amendments, if accepted, were fair to both parties and in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Maringapasi and no injustice would be caused to either party.

10. Between 6 February 2023 and 28 April 2023 breached conditions 1, 2, 3, 4, and 8 of the Interim Conditions of Practice Order ('ICOPO') imposed on 7 February 2023 by an Investigating Committee of the Nursing and Midwifery Council, in that you:

10a. ~~Did not limit your nursing practice to one substantive employer, namely had NHS Professional as a second employer~~. **Did not limit your nursing practice to one substantive employer by applying to secure a second substantive employer, namely NHS Professionals.**

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Maringapasi. 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:

- Patient X: Patient under the care of Mr Maringapasi
- Witness 2: Locality Manager at the Trust
- Witness 3: District Nurse Team Lead at the Trust at the time of the allegations

- Witness 4: Band 7 Team Leader at the time of the allegations

- Witness 5: Locality Manager at the Trust at the time of the allegations

- Witness 6: Locality Manager at the Trust at the time of the allegations

- Witness 7: Senior Manager within Community Services at the time of the allegations

- Witness 8: Clinical Lead at the time of the allegations

Application to adduce an NMC email under Rule 31

Ms Ihuomah made an application to admit an NMC email under Rule 31 of the Rules. She submitted that an email had been sent by the NMC to Mr Maringapasi on 8 September 2025, informing him that the NMC is seeking to admit the email into evidence for the panel to consider. She submitted that the email was sent to the same email address at which the Notice of Hearing for this substantive hearing was sent to. Further, she stated that Mr Maringapasi's email address used in this instance is the same email address he used to communicate with the NMC.

Ms Ihuomah submitted that the NMC gave Mr Maringapasi notice that it was their intention for Witness 9's statement to be read into the record and considered by the panel, without the witness attending this hearing to give live evidence. She submitted that the email statement merely confirms to Mr Maringapasi that he is subject to an ICOPO and to let the NMC know if he has any objections to this. She also submitted that similar to other communications sent to Mr Maringapasi, he has not to date, responded to the NMC, but that it is the NMC's view that he has had sufficient notice. She further submitted that the bundles for this hearing were sent to Mr Maringapasi some time ago, which included

Witness 9's statement and therefore it would be fair and proper to admit Witness 9's statement.

The panel accepted the advice of the legal assessor.

The panel decided to accept the application made. It determined that it would be both fair and relevant to admit the email into evidence.

The panel considered the evidence of Witness 2, Patient X and Mr Maringpasi's response in relation to charges 1-5. It gave due consideration to Mr Maringapasi's assertions that these charges had arisen in a "*malicious and vindictive*" manner, as outlined in his registrant's response to the NMC regarding the allegations.

Charge 1

1. **On 26 December 2022 administered antibiotics intravenously to Patient X without conducting observations.**

This charge is found proved.

In reaching its decision, the panel considered the documentary and oral evidence of Mr Maringapasi, Patient X and Witness 2. In addition, it also considered the response by Mr Maringapasi in an email to Witness 2 dated 5 January 2023:

> *'I documented that I did some observation all the time I visited the patient, some but not in every visit due to workload.'*

The panel were of the view that Witness 2's evidence was consistent with their live evidence heard by the panel and was further corroborated by Patient X's oral evidence. It considered both Patient X and Witness 2 to be consistent throughout their evidence. The panel also determined that Mr Maringapasi provided inconsistent answers in his meeting

with Witness 2. The panel noted that Mr Maringapasi denied all charges in his registrant's response bundle to the NMC.

The panel took into account that Mr Maringapasi's evidence provided both at the local investigation level and in his response to the NMC's allegations, and concluded these accounts were both unclear and inconsistent. On the balance of probabilities, it is more likely than not that Mr Maringapasi administered IV antibiotics without carrying out observations on Patient X. It therefore found this charge proved.

Charge 2

2. **On or around 26 December 2022 falsified records by recording that you had undertaken observations of Patient X when no such observations had been undertaken.**

This charge is found proved.

In reaching its decision, the panel considered the evidence of Witness 2, and that of Patient X. The panel noted in Exhibit CD/04, one set of observations for Patient X was recorded as having been carried out. Having determined no such observations had been undertaken, the panel concluded the recordings had been falsified. The panel also had regard to an excerpt from Patient X's witness statement, where he stated:

> '*On both occasions that Mr Maringapasi administered my medication he would simply come into my house and without doing any of the pre-treatment observations on me he would set up the drip bag and administer my antibiotics…'*

and

> *'..and then would leave without doing any post treatment observations on me…'*

The panel had regard to the meeting minutes between the Trust and Mr Maringapasi, which took place on 5 January 2023, where when asked why he had falsified records, it was recorded that he *'paused for a long period and stated "Pressure"'.* The panel determined that on the balance of probabilities, it is more likely than not that Mr Maringapasi falsified records by recording readings and that he had carried out observations on Patient X when in fact he had not. It therefore found this charge proved.

Charge 3

3. **On 2 January 2023 administered antibiotics intravenously to Patient X without conducting observations.**

This charge is found proved.

The panel, in reaching its decision, considered Witness 2 and Patient X's oral and documentary evidence.

The panel heard in Witness 2's oral evidence that they heard from Patient X's wife that Mr Maringapasi had administered IV antibiotics without conducting observations before or after administering the medication. The panel took into consideration that this was hearsay evidence, as Patient X's wife is not a formal witness in these proceedings. However, it was of the view that the call was described in both Witness 1's oral and documentary evidence, and that Patient X also concurred with the assessment and confirmed in the telephone call to his wife that the observations had not taken place. It noted that in Witness 2's statement, they stated:

> '*…She was also confident that the Registrant did not do any of the observations. She confirmed that the Registrant did not take any observations of Patient X during his most recent visit on 2 January 2023 and that he did not communicate with Patient X during the visit…'*

The panel determined that more weight could be attached to this recollection of events, as Patient X also corroborated this event in his evidence. The panel also took into consideration the documentation from the home visit on 2 January 2023, and determined that having heard the evidence from the witnesses, that Mr Maringapasi failed to carry out the observations. The panel also had sight of an email dated 5 January 2023 from Mr Maringapasi to Witness 2, where he stated:

> '*I documented that I did some observation all the time I visited the patient, some but not in every visit due to workload'.*

Having considered all of the evidence before it, the panel determined that on the balance of probabilities, it is more likely than not that Mr Maringapasi administered IV antibiotics to Patient X without carrying out observations, and therefore found this charge proved.

Charge 4

4. **On or around 2 January 2023 falsified records by recording that you had undertaken observations of Patient X when no such observations had been undertaken.**

This charge is found proved.

The panel, in reaching its decision, considered the evidence of Witness 2 and that of Patient X. The panel also heard in Witness 2's oral evidence that they heard from Patient X's wife that Mr Maringapasi had administered IV antibiotics without conducting observations before or after administering the medication. The panel took into consideration that this was hearsay evidence, as Patient X's wife is not a formal witness in these proceedings. The panel also considered Patient X's witness statement, in which he states:

'*The first time Mr Maringapasi attended my home he did not introduce himself and the first thing both my wife and I noticed was that he wasn't carrying a bag like all of the other nurses would.*

All of the other nurses could arrive with a bag that contained all of the equipment that they needed in order to complete the required pre and post treatment observations but Mr Maringapasi never had a bag with him…'

This was further confirmed in Patient X's oral evidence.

The panel considered the assertion that these charges arose maliciously and vindictively, as stated by Mr Maringapasi in his response to the NMC's allegations, but concluded that there was no evidential basis to these claims. In contrast, it found the evidence of Witness 2 and Patient X to be clear and consistent.

The panel was of the view that there was no evidence before it from Mr Maringapasi to explain why he took this action. It concluded that on the balance of probabilities, it is more likely than not that Mr Maringapasi falsified records by recording that he had undertaken observations of Patient X when no such observations had been undertaken. It therefore found this charge proved.

Charges 5 and 6

5. On 5 January 2023 did not visit one or more patients that you were assigned to visit.

6. On or around 5 January 2023 failed to inform the Central London Community Healthcare NHS Trust ("CLCH") that you had not visited one or more patients that you were assigned to visit on 5 January 2023.

These charges are found proved.

In reaching its decision on charges 5 and 6, the panel took into account records of patient visits, telephone calls with patients and meeting minutes at the local Trust investigation, Mr Maringapasi's resignation via email was sent on the evening of 5 January 2023 after 19:00, and that the email was not picked up until the next day. It also heard from Witness 2, who stated in their live evidence that the workload given was in keeping with normal limits, and that it would have been a reasonable and normal workload on that particular day.

The panel also considered Witness 2's oral and documentary evidence, in particular an excerpt from Witness 2's witness statement:

> '*..I then spoke to my manager, … and escalated what had happened. It was decided that the Registrant should continue with his patient visits for that afternoon and that we would meet in the office the following day so that I could review the patient notes of these visits. I called the Registrant at 16:50 that afternoon to inform him of this and the Registrant agreed that he would continue his patient visits.'*

The panel further heard from Witness 2, who confirmed in their oral evidence that they understood from the telephone conversation that Mr Maringapasi would continue his patient visits as scheduled for that day. However, the panel noted that Mr Maringapasi completed patient visits for 7 out of the 12 patients he was scheduled to visit, and that he failed to notify the Trust that he had not visited the remaining five patients on his list.

The panel determined that on the balance of probabilities, Mr Maringapasi did not visit one of more patients that he was assigned to visit and further failed to inform his employer, CLCH that he had not visited one or more patients that he was assigned to visit on 5 January 2023. It therefore found both charges 5 and 6 proved.

Charge 7 and 8

> **7. On 10 August 2022 did not visit the patients that you were assigned to visit.**
> **8. On or around 10 August 2022 failed to inform the CLCH that you had not visited the patients that you were assigned to visit on 10 August 2022.**

These charges are found proved.

In reaching its decision on charges 7 and 8, the panel considered the evidence before it, including Witness 3's witness statement, where it states:

'*The allegations I was asked to investigate were that: -*

- *On 10 August 2022, Mr Maringapasi was scheduled to be at a training day in the morning and to be on clinical duties between 1pm and 8pm. It was alleged that Mr Maringapasi had instead gone home to be with his daughter who was in labour, without having reported this to the management team. When contacted by managers later in the day, Mr Maringapasi gave the impression that he was planning to return to work and understood that he had a number of high priority clinical visits to undertake. Mr Maringapasi did not undertake these visits and it was alleged that he did not inform anyone that this was the case so that alternative plans could be made for those patients.'*

The panel considered Witness 3's documentary and oral evidence and determined that it remained clear and consistent throughout. It also noted the disciplinary meeting at the Trust where Mr Maringapasi told Witness 6 that his '*head all over the place that day*' [sic] and that he:

> '*…agrees with the witness testimonies and due to personal stress relating to daughter in labour, unable to remember the exact sequence of events and who and when spoke to. RM sorry for this.'*

The panel took account of his acceptance of the witnesses' accounts made at the Trust's disciplinary investigation, as well as the other evidence in support of this charge. The panel therefore found both charges 7 and 8 proved.

Charge 9

> **9. Between October 2022 and 6 January 2023 you failed to practise at the expected standard of a Band 6 nurse in relation to record keeping.**

This charge is found proved.

The panel, in reaching its decision, had sight of the Band 6 Registered Nurse job description, and the witness statement of Witness 5, which details that there were some concerns identified and consequently raised about Mr Maringapasi's clinical practice throughout this period. The concerns surrounding Mr Maringapasi's clinical practice included that he failed to work to the standards expected of a Band 6 registered nurse, including the expected standard for record keeping. The panel considered Witness 5's evidence and found them to be consistent and reliable. It also considered Mr Maringpasi's letter of resignation, dated 5 January 2023, and the Trust's request for outstanding patient notes in a letter dated 6 January 2023, which had not been fulfilled at the time:

> '*…Please can you provide documentation either by email or handwritten covering your outstanding visits by the end of Monday 9th January 2023…'*

The panel also had sight of the Trust's record-keeping policy, and determined that Mr Maringapasi did not meet the expected standards of a Band 6 registered nurse.

The panel, having considered all of the evidence before it, determined that on the balance of probabilities, it is more likely than not that Mr Maringapasi failed to practise at the

expected standard of a Band 6 nurse in relation to record keeping. It therefore found this charge proved.

Charge 10

The panel considered charge 10 collectively and noted the contents of Exhibit SR/04, in that it explained what the conditions of practice order imposed were. Additionally, the panel considered Witness 9's NMC witness statement, which was exhibited during these proceedings.

10. Between 6 February 2023 and 28 April 2023 breached conditions 1, 2, 3, 4, and 8 of the Interim Conditions of Practice Order ('ICOPO') imposed on 7 February 2023 by an Investigating Committee of the Nursing and Midwifery Council, in that you:

10a. Did not limit your nursing practice to one substantive employer by applying to secure a second substantive employer, namely NHS Professionals.

This charge is found proved.

In reaching its decision, the panel considered the evidence of Witness 7.

Mr Maringapasi confirmed that he was not aware that NHS Professionals was a separate and second employer. The panel considered the evidence before it, but concluded that there is an expectation that a registered nurse would be aware of any restrictions imposed on their practice by their regulator, and who NHS professionals, as an employer, are. The panel also considered an excerpt from the local Trust's investigation in which it states:

- *'RM reported he did join NHS P but was not aware they were a separate employer. Once he was aware of this, he stated he informed the NMC and he informed* [Witness 8] *of his ICOP.'*

The panel, having considered the evidence before it, could not be satisfied that Mr Maringapasi understood that NHS Professionals was a separate employer to the Trust, rather than an internal staff bank. However, the panel found the charge proved in that he did apply for a role knowingly, whilst an ICOPO was imposed on his practice.

Charge 10b

10b. Did not ensure that you were always supervised.

This charge is found not proved.

In reaching its decision, the panel considered the evidence of Witness 9, who provided the framework around the imposition of the ICOPO, specifically the conditions pertinent to charge 10. It further considered the witness statement of Witness SR, where they state:

'Mr Maringapasi was under a 6-week induction period and under the supervision of a registered clinician…'

The panel bore in mind the evidence of Witness 7 that Mr Maringapasi was under the supervision of a registered clinician. The panel also took into account the witness statement of Witness 8, in that Mr Maringapasi was supervised during his induction period. The panel also considered:

'…*informed that the induction period was being extended after discussion with team members who had supervised RM in practice as RM was slow at picking up the processes within the team, e.g. EMIS documentation, understanding different parts*

of the role, triage, following the assessment templates on EMIS, but there were no concerns raised in relation to clinical tasks such as taking clinical observations.'

The panel determined that Mr Maringapasi was always supervised during this period. Furthermore, it concluded that the NMC had not advanced evidence that Mr Maringapasi had failed to ensure that he was always subject to supervision, and therefore determined that the NMC had not satisfied the burden of proof. It therefore found this charge not proved.

Charge 10c

10c. Did not ensure you were supervised by another registered nurse, namely you were employed by Central Surrey Health Ltd ("CSH Surrey") into a role that required you to work without direct supervision.

The panel found this charge proved.

In reaching its decision, the panel considered Witness 7's witness statement, particularly the conditions of the ICOPO:

'Mr Maringapasi was under a 6-week induction period and under the supervision of a registered clinician. However, the service is multidisciplinary led and therefore Mr Maringapasi was not always supervised by a registered nurse. As the interim conditions of practice were not disclosed, the team were unaware of this condition, and it was breached.'

The above excerpt was corroborated further by the meeting minutes, which took place on 8 June 2023, where Mr Maringapasi recognised and accepted that he did not comply with the conditions imposed by an NMC panel on 7 February 2023, and was therefore in breach of his ICOPO:

'*Rufaro recognised that he did not comply with this ICOP'*

The panel took Mr Maringapasi's recognition of the breach as an acceptance of this fact at the time of the Trust's investigation, and found this charge proved.

Charge 10d and 10e

> **10d. Failed to inform your line manager of the existence of the ICOPO and did not meet fortnightly with your line manager.**
> **10e. Did not provide CSH Surrey with a copy of the conditions of the ICOPO.**

These charges are found proved.

In reaching its decision on charges 10d and 10e, the panel took into consideration the evidence of Witnesses 7 and 8, the local Trust investigation and Witness 9's NMC witness statement. In particular, the panel had regard to Witness 7's assessment:

> *'iv. There was ample opportunity for Mr Maringapasi to disclose this information from the interim order hearing that took place on 7 February 2023 resulting in an interim conditions of practice order being placed upon him and the time he commenced his employment on 1 April 2023 as well as at any time during his induction with CSH Surrey, but Mr Maringapasi did not do this.'*

And

> *'Mr Maringapasi did not inform his line manager, mentor or clinical supervisor of the interim conditions of practice, and as a result of this the required fortnightly progress meetings were not scheduled as indicated and therefore this condition was breached.'*

The panel also took into account the meeting minutes between Witnesses 7 and 8:

> *'*[Witness 7]: *Okay, thank you. And on commencement of his employment, or during his employment, did ~~Refaro~~ Rufaro share with you or any members of the team that he was subject to this Conditions of Practice order by the NMC?*
>
> [Witness 8]: *No, he didn't'*

The panel further took into account Witness 8's evidence from the same meeting, in which she stated:

> [Witness 8]: *… During, after this event I did ask him on a few occasions verbally and via email to send the Conditions of Practice to me. And he wasn't responsive…'*

Consequently, the panel took into account that Mr Maringapasi failed to notify his employer in a timely manner and did not notify them of the ICOPO imposed on 7 February 2023. It therefore found that on the balance of probabilities, it is more likely than not that he did not notify his employer about the ICOPO imposed and further, did not provide his employer, namely CSH Surrey with a copy of the imposed conditions and therefore found charges 10d and 10e proved.

Charge 11a

> **11. Between 1 April 2023 and 16 August 2023:**
> **11a. Failed to accurately disclose to your employer, CSH Surrey, the circumstances around your resignation from your previous employer, CLCH.**

This charge is found not proved.

The panel took into account the evidence of Witnesses 7 and 8, which spoke to the previous charges in relation to the ICOPO imposed on 7 February 2023. However, the panel concluded that the evidence provided in relation to this charge was not sufficient enough to conclude that Mr Maringapasi was under a duty to disclose the circumstances surrounding his resignation from CLCH. Furthermore, the panel considered that the NMC had not advanced sufficient evidence to indicate that Mr Maringapasi was aware of his referral to the NMC. Consequently, the panel determined that the NMC had not discharged its burden of proof and therefore found this charge not proved.

Charge 11b

11b. Failed to disclose to CSH Surrey the outcome of the NMC inquiry/investigation into your fitness to practice.

This charge is found proved.

In reaching its decision, the panel considered the evidence before it, including the witness statement and oral evidence of Witness 7:

'iii. However, one of the conditions of practice imposed on Mr Maringapasi by the interim conditions of practice order on 7 February 2023 was that he had to inform his current employer of this order and therefore Mr Maringapasi should have informed CSH Surrey of this order as soon as he became aware of it.

iv. There was ample opportunity for Mr Maringapasi to disclose this information from the interim order hearing that took place on 7 February 2023 resulting in an interim conditions of practice order being placed upon him and the time he commenced his employment on 1 April 2023 as well as at any time during his induction with CSH Surrey, but Mr Maringapasi did not do this.'

And

> *'Rufaro reflected that she should have informed* [colleagues] *about ICOP pre employment. Rufaro recognised that he did not comply with ICOP…He offered an apology for not overtly declaring the NMC investigation and ICOP.'*

And

> *'Mr Maringapasi did not disclose that he was subject to an interim conditions of practice order on commencement of his employment with CSH Surrey, and he failed to either voluntarily or immediately provide a copy of the interim conditions of practice order to CSH Surrey.'*

The panel determined that Mr Maringapasi failed to disclose to CSH Surrey the outcome of the NMC investigation into his fitness to practise. The panel therefore concluded that on the balance of probabilities, it is more likely than not that Mr Maringapasi failed to disclose to CSH Surrey the outcome of the NMC investigation into his fitness to practise and found this charge proved.

Charge 11c

> **11c. Stated during an employer's investigation that CLCH did not explain concerns about you doing observations, when this was not correct.**

This charge is found proved

The panel, in reaching its decision considered Mr Maringapasi's denial recorded in the minutes from the meeting, and his response to the NMC's allegations. It further noted an excerpt from the meeting which took place on 14 June 2023, where Mr Maringapasi was

asked if his previous employer (CLCH) had explained any of the concerns about carrying out observations, to which Mr Maringapasi said they had not.

The panel considered the entirety of Exhibit CD/05, whereby:

> '*Asked RM to clarify that he was confirming on each visit he undertook, he completed all OB's except BP. RM hesitant and then stated "not all".*
>
> *Asked RM to be clear, was he stating not all Obs or not all visits, as patient information differed to RM account, and I needed him to be clear and honets.*
>
> *RM then stated "Obs not always taken". Asked RM again to be very clear with what he was telling me. Was he confirming that some obs weren't taken at each visit or that non were taken?*
>
> *RM stated "Not always taken"'.*

The panel considered that CLCH did explain their concerns about Mr Maringapasi doing observations.

Furthermore, the panel considered Mr Maringapasi's response:

> *'I documented that I did some observation all the time I visited the patient, some but not in every visit due to workload.'*

The panel determined that this indicated that Mr Maringapasi was aware of the concerns at that time. Consequently, the panel found this charge proved.

Charge 11d

11d. During an employer's investigation by CLCH regarding an incident on 10 August 2022, you knowingly provided incorrect information regarding your discussions with colleagues, namely you denied having had any conversations with colleagues from the Trust after 3pm on 10 August 2022.

This charge is found proved.

The panel had regard to Witness 3's witness statement, namely paragraphs 11-14, and the interview meeting minutes between Witness 3 and Mr Maringapasi, in terms of what had occurred on the day in question. The panel also considered the call log, which indicated that a number of calls were made to the manager post 3pm. The panel considered Exhibit ER/05 and concluded that it further corroborated that Mr Maringapasi was in contact with relevant colleagues after 3pm.

It was clear to the panel that in Witness 3's oral evidence, that all relevant witnesses that she had interviewed during the local investigation were clear and consistent with each other, but that the version of events provided by Mr Maringapasi was conflicting, in that he said that he had been in contact with a number of colleagues after 3pm. The panel noted the chronology provided by Witness 3, and determined that Mr Maringapasi had not in fact been in contact with his colleagues to inform them of any issues.

The panel also considered the evidence of Witness 6, and determined that on the balance of probabilities, it is more likely than not that Mr Maringapasi failed to inform his employer and therefore found this charge proved.

Charge 12

12. Your actions at one or more of charges 10a, and or 10b, and or 10c, and or 10d and or 10e above were dishonest in that you attempted to

conceal from your employer(s)that regulatory restrictions had been placed on your practice.

This charge is found proved in respect of charges 10c, 10d and 10e.

In reaching its decision, the panel took account of the legal assessor's advice, including the case of *Ivey v Genting Casinos* [2017] UKSC 67, which sets out the two stage test for dishonesty:

1. What was the registrant's actual state of knowledge or belief as to the facts?
2. In view of that knowledge or belief, was the registrant's conduct dishonest by the standards of ordinary decent people?

In regard to charge 10a, the panel was of the view that Mr Maringapasi had discussed his desire to apply for a role within NHS Professionals with his manager. He had overtly raised this and had not sought to conceal it, and so the panel determined he was not acting dishonestly, as he openly spoke to his manager. It further determined that the NMC has not provided sufficient evidence that Mr Maringapasi was aware that NHS Professionals was a separate employer.

Having considered the evidence before it, the panel determined that by the standards of ordinary decent people, Mr Maringapasi did not act dishonestly Therefore, the panel found charge 12 in respect of charge 10a not proved.

In regard to charge 10b, the panel did not consider this charge, as it found charge 10b not proved.

In regard to charges 10c, 10d and 10e, the panel considered the evidence before it, and determined that Mr Maringapasi was dishonest in that he did not ensure he was supervised by another registered nurse, attempted to conceal the ICOPO in that he failed to inform his manager and further failed to inform CSH Surrey. The panel determined that

by the standard of ordinary decent people, this was dishonest and therefore found charge12 proved in respect of charges 10c, 10d and 10e.

Charge 13

13. Your actions at one or more of charges 11a and or 11b and or 11c above were dishonest in that you attempted to conceal from CSH Surrey concerns raised about your performance in your previous employment with CLCH.

This charge is found proved in respect of charges 11b and 11c.

The panel did not consider charge 11a, as it found this charge not proved.

In regard to charges 11b and 11c, the panel found Mr Maringapasi's conduct to be dishonest. The panel was of the view that Mr Maringapasi attempted to conceal from his employer, namely CSH Surrey the outcome of the NMC investigation into his fitness to practise, and stated that CLCH did not explain concerns around Mr Maringapasi carrying out observations, when this was not correct. The panel concluded, from the evidence before it that Maringapasi would have been in the knowledge that the ICOPO had been imposed. It concluded that by the standards of ordinary and decent people, Mr Maringapasi's conduct was dishonest and therefore found charge 13 proved in respect of charges 11b and 11c.

Charge 14

14. Your actions at one or more of charges 2 and or 4 above were dishonest in that you sought to conceal the fact you had not carried out observations on Patient X.

This charge is found proved.

The panel considered the evidence before it, including Patient X's oral and written evidence. It was of the view that Mr Maringapasi sought to conceal that he did not carry out observations and falsified records. The panel determined that Mr Maringapasi did record false observations and by the standards of ordinary decent people, his conduct was dishonest.

The panel considered that this was an example of dishonesty in clinical practice, involving the care of a vulnerable patient, namely Patient X. The panel therefore found this charge proved in relation to both charges 2 and 4.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Ihuomah invited the panel to find the facts found proved amounted to misconduct.

Ms Ihuomah referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, which defines misconduct as:

> '*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances'*

Ms Ihuomah also referred the panel to the following cases: *Calhaem v GMC* [2007] EWHC 2606 (Admin), and *Nandi v GMC* [2004] EWHC 2317 (Admin) and submitted that the facts found proved amount to misconduct both individually and collectively. She submitted that the panel have found that Mr Maringapasi's actions were dishonest and related to his clinical practice. She submitted that Mr Maringapasi's actions both individually and cumulatively fell well below the standards expected of a registered nurse.

Ms Ihuomah submitted that failing to complete observations before and after a treatment could put a patient under Mr Maringapasi's care at risk of harm. She submitted that observations are an indicator of deterioration, and if not completed, a patient could become unwell. She also submitted that medical treatment could be delayed, and could have led to detrimental consequences to a patient.

Ms Ihuomah submitted that a failure to carry out visits to vulnerable patients also puts them at a risk of harm. She submitted that if a visit was missed, then a patient may not

receive the treatment they require, which could also have had a detrimental effect on their health and wellbeing.

Ms Ihuomah submitted that Mr Maringapasi's actions would not be expected from a nurse who works with such a wide variety of patients, members of the public, and other nurses. She submitted that the charges found proved is not the behaviour expected of a registered nurse, and that his conduct was found by the panel to be dishonest and in breach of his ICOPO.

Ms Ihuomah referred the panel to the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives 2015*' (the Code). She identified the specific, relevant standards where she submitted Mr Maringapasi's actions amounted to misconduct and fell well below the standards expected of a registered nurse. In particular, she submitted that Mr Maringapasi had breached the following sections of the Code:

8. Work co-operatively
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

10. Keep clear and accurate records relevant to your practice
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event
10.3 complete records accurately and without any falsification…

20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty (and integrity) at all times…

23 Cooperate with all investigations and audits

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body

Ms Ihuomah invited the panel to find the facts found proved individually and collectively amount to misconduct.

Submissions on impairment

Ms Ihuomah addressed the panel on the issue of impairment and reminded the panel to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She referred the panel to questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant* [2011] EWHC 927 (Admin):

> *"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:*
>
> *(i) Has in the past, and/or is liable in the future to act as so as to put a patient or patients at unwarranted risk of harm;*
> *(ii) Has in the past, and/or is she liable in the future to bring the profession into disrepute;*
> *(iii) Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the profession;*
> *(iv) Has in the past, and/or is she liable in the future to act dishonestly."*

Ms Ihuomah also referred the panel to paragraph 74 of Grant and submitted that if the panel wish to do so, it should '*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'.

Ms Ihuomah submitted that limbs a, b, c and d are all engaged in this case. She submitted that Mr Maringapasi's failures placed patients at unwarranted risk of harm. She also submitted that, considering the facts found proved by the panel, the reputation of the nursing profession would be damaged if Mr Maringapasi were permitted to practise without restrictions. She submitted that the public have an expectation that nurses provide adequate care to all patients under their care.

Ms Ihuomah submitted that these factors, alongside others, substantially affect Mr Maringapasi's ability to practise, and consequently, he has failed to demonstrate that he is currently able to practise kindly, safely and professionally. She further submitted that Mr Maringapasi has not provided sufficient evidence that he has addressed the concerns raised, no evidence of strengthening his practice and submitted that as a result, the risk of repetition remains high.

Ms Ihuomah submitted that Mr Maringapasi's conduct was dishonest, and that he risked the public's trust and confidence in the nursing profession being damaged. She also submitted that it may be difficult for Mr Maringapasi to remediate his practice, as the some of the charges found proved relate to dishonesty and a lack of abiding by the interim conditions of practice order imposed on his practice. She invited the panel to find Mr Maringapasi's fitness to practice impaired on the grounds of public protection and also in the wider public interest.

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

Decisions and reasons on misconduct

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

The panel was of the view that Mr Maringapasi's actions fell significantly short of the standards expected of a registered nurse, and that Mr Maringapasi's actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

8 Work cooperatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times…

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively as well as the circumstances of the case as a whole.

The panel next considered each charge, and if it was so serious to amount to misconduct.

The panel took into account the NMC's guidance on seriousness – FTP-3, dated 27 February 2024.

The panel considered the following areas of misconduct:

1. Disregard for patient safety, which evidenced that Mr Maringapasi was prioritising his needs over that of his colleagues and care of his patients;
2. A disregard for the ICOPO imposed and the limitations on his professional practice;
3. A disregard of professional accountability and oversight;
4. Falsification of clinical records; and
5. Dishonest conduct, in particular in regard to Mr Maringapasi's professional clinical practice

In relation to charges 1 to 9, the panel determined that Mr Maringapasi failed to appropriately carry out observations and care for Patient X, who was a vulnerable patient. The panel took into account that Mr Maringapasi did not inform his colleagues that he had failed to visit patients. It determined that given Patient J was vulnerable and receiving end of life care, the risk of harm was significantly higher. The panel further considered that actual harm was caused to Patient J and their family, as the patient experienced distress, pain and laboured breathing. Furthermore, this likely would have caused distress to the

family as well, and furthered the risk of reputational damage to the nursing profession. The panel noted that some of the patients under Mr Maringapasi's care were also diabetic patients, who were in need of insulin, and were not visited by him. It therefore concluded that there was a risk of serious harm, as they did not receive this prescribed medication.

In relation to charge 10a, the panel considered its decision on the facts in relation to this charge, and determined that on balance, Mr Maringapasi did not know that NHS Professionals would be considered a second employer, and that he had been overt to his manager about this matter. The panel therefore concluded that his conduct was not so serious as to amount to misconduct.

In regard to charges 10c, 10d and 10e, the panel considered that Mr Maringapasi was aware of the imposition of his ICOPO, and he did not take any formal steps to ensure he was not in breach of the restrictions imposed. The panel also noted that he did not inform his manager that he was required to be supervised by another registered nurse, failed to inform his line manager of the existence of the ICOPO and did not provide CSH Surrey with the copy of the conditions. The panel found that charges 10c, 10d and 10e was so serious as to amount to misconduct.

In regard to charges 11b, 11c and 11d, the panel determined that Mr Maringapasi should not have concealed from his employer, CSH Surrey, the outcome of the initial NMC investigation into his fitness to practise and given a false response to CLCH in regard to carrying out observations which led to the interim order. The panel further determined that Mr Maringapasi knowingly provided incorrect information regarding conversations with his colleagues after 3pm on 10 August 2022. The panel determined that Mr Maringapasi's conduct at these charges was so serious as to amount to misconduct.

In regard to charges 12 to 14, the panel considered NMC guidance DMA-8. It was of the view that Mr Maringapasi demonstrated deep-seated attitudinal behaviours throughout the timeframe of these allegations, as he was dishonest in his practice in that he attempted to conceal the ICOPO imposed on his practice, attempted to conceal from CSH Surrey

concerns that were raised by CLCH regarding his performance in his previous role and that he sought to conceal that he had failed to carry out observations on Patient X. The panel determined that Mr Maringapasi breached the professional duty of candour, in that he was responsible for the care of vulnerable patients, and was dishonest about aspects of his practice. The panel concluded that the charges found proved was so serious as to amount to misconduct.

The panel was of the view that honesty and integrity are fundamental to the nursing profession, and Mr Maringapasi's actions fell seriously short of the conduct and standards expected of a registered nurse. It therefore found that the charges found proved, bar charge 10b, amounted to serious misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust,

nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

The panel found that limbs a, b, c and d are all engaged in this case. In relation to the test of Grant, the panel determined that there is a risk of harm to patients. Further, it determined that Mr Maringapasi's misconduct brought the nursing profession into disrepute, and that he had breached the fundamental tenets of the nursing profession. Furthermore, Mr Maringapasi was dishonest to both his employer and in the course of his clinical practice. Consequently, the panel found limb d, relating to dishonesty, engaged in this case. There was nothing before the panel to demonstrate that he would not repeat this conduct in the future.

The panel considered whether the misconduct in this case was capable of being remedied. It determined that in principle the misconduct was potentially capable of being remedied. However, it was of the view that Mr. Maringapasi's dishonest conduct was prolonged, repeated and related to his clinical practice, and as such it determined it was at the higher end of the spectrum of dishonesty. Furthermore, the panel considered that his dishonesty had involved vulnerable patients. Consequently, the panel determined that any remediation would be extremely difficult.

The panel next considered whether Mr Maringapasi had taken any steps to remediate his misconduct, while it found it was potentially capable of remediation. For example, the panel had no evidence before it that Mr Maringapasi had demonstrated any insight and understanding of the risk of harm via reflections into the impact of his actions upon patients, colleagues or the wider nursing profession. The panel considered that Mr Maringapasi had only demonstrated minimal remorse for his failures.

Having considered the questions identified in Cohen, the panel determined that Mr Maringapasi would be liable in the future to engage all of the limbs of Grant. The panel also determined that in light of the above, Mr Maringapasi is not capable of practising kindly, safely or professionally as a registered nurse.

The panel therefore concluded in light of Mr Maringapasi's liability to place patients at an unwarranted risk of harm in the future, that his fitness to practise is impaired on the grounds of public protection.

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

The panel determined that public confidence in the profession would be seriously undermined if a finding of impairment were not made in this case, particularly given the nature of the charges found proved and that Mr Maringapasi had acted dishonestly. The panel determined that a reasonable and well-informed member of the public would be concerned if Mr Maringapasi's fitness to practise was not found impaired, given the panel's decisions on the charges found proved and misconduct.

Accordingly, the panel also finds Mr Maringapasi's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Maringapasi's fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

Ms Ihuomah submitted that the NMC had advised Mr Maringapasi in the Notice of Hearing that it would seek the imposition of a striking off order if the panel found his fitness to practise impaired.

Ms Ihuomah invited the panel to consider the Sanction Guidance (SG) and submitted that a striking off order is proportionate and fair and would adequately address the public protection and the public interest concerns in this case.

Ms Ihuomah referred the panel to the NMC guidance, and submitted that there remains a risk of repetition and therefore a risk of harm. She submitted that the charges found proved are wide-ranging, and relate to failing to follow an interim order, informing his employers of that order and the subsequent NMC investigation, falsifying patient records on more than one occasion, failures in fundamental nursing care and not visiting patients as scheduled.

Ms Ihuomah submitted that Mr Maringapasi deliberately breached the professional duty of candour by attempting to conceal the imposition of the ICOPO from his employer. She further submitted Mr Maringapasi's actions raise fundamental questions about his professionalism and public confidence cannot be maintained if Mr Maringapasi were not removed from the register. She submitted that these are matters of dishonesty, and that honesty is of central importance to a nurse's practice.

Ms Ihuomah submitted a striking-off order is the only appropriate and proportionate sanction in order to protect patients, Mr Maringapasi's colleagues and members of the public.

Ms Ihuomah invited the panel to consider one sanction: a striking-off order. She submitted that when considering the charges found proved, a striking off order is the most proportionate order to impose. She submitted that Mr Maringapasi's misconduct occurred over an extended period of time and there is clear evidence of deep seated attitudinal issues.

Ms Ihuomah submitted that given this additional dishonesty and disregard for the NMC's previous ICOPO, a striking off order is the only appropriate sanction as Mr Maringapasi's actions raise fundamental questions about his professionalism and public confidence cannot be maintained if he was not removed from the register.

Therefore, Ms Ihuomah's submission was that the only appropriate order in this case was a striking-off order.

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

Decision and reasons on sanction

Having found Mr Maringapasi's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG.

The panel took into account the following aggravating features:

- Mr Maringapasi's conduct involved a number of vulnerable patients, where actual harm was caused, and risk of harm was high;
- Dishonesty was related to clinical practice;
- Minimal evidence of remorse into the effect his actions had on patients, colleagues and confidence in the nursing profession;

- No evidence of insight and/or remediation, compounded by a fundamental disregard for patient safety; and
- Repeated misconduct over a period of time.

The panel identified the following mitigating factor:

- Some evidence of high workload in the team at the time of the incidents.

The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel had regard to NMC guidance, namely SAN-2 and determined that the misconduct was serious, and paid particular attention to:

> *'If a nurse, midwife or nursing associate deliberately doesn't comply with an interim or substantive order this will be taken very seriously. This is because it is likely to show a disregard by that person for the steps the NMC has put in place to keep the public safe or uphold confidence in the professions.'*

It accepted Ms Ihuomah's submissions and concluded that Mr Maringapasi's dishonesty on more than one occasion was at the higher end of the spectrum, in that he breached his interim conditions of practice order, failed to take observations and was dishonest about his communications with colleagues.

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 not be appropriate or proportionate, protect the public or be in the wider public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Maringapasi's practice would not be appropriate in the circumstances. The SG

states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Maringapasi's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Maringapasi's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be appropriate, proportionate, measurable and workable. The panel took into account the NMC guidance, namely San 3-c, and that a conditions of practice order would only be appropriate where there was:

- *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;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel noted that Mr Maringapasi has not engaged with this process, has previously breached his interim conditions of practice order in a number of significant respects, and that he has deep-seated attitudinal issues. As Mr Maringapasi's dishonesty was at the higher end of the spectrum, the panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the concerns in this case, and that he would not adhere to any conditions the panel could impose.

Furthermore, the panel concluded that the placing of conditions on Mr Maringpasi's registration would not be proportionate, nor adequately address the seriousness of this case and would not protect the public or satisfy the wider public interest.

The panel then went on to consider the NMC guidance (San 3-d) and 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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel considered that the matters found proved relate to the care of vulnerable patients and that there remains a direct risk of harm to patients under Mr Maringapasi's care. It further considered that Mr Maringapasi has demonstrated little remorse, no remediation, there is evidence of harmful and deep seated attitudinal problems, and a significant risk of this behaviour being repeated.

The panel also considered the lack of engagement from Mr Maringapasi, his dishonesty, lack of caring for patients and significant number of breaches of the Code. It therefore concluded that a suspension order would not sufficiently protect the public or meet the public interest. It therefore concluded that a suspension order is not appropriate or proportionate in this case.

The panel had regard to NMC guidance SAN-3e. It determined that Mr Maringapasi's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with Mr Maringapasi remaining on the register. The findings in this particular case demonstrate that Mr Maringapasi's misconduct was very

serious and dishonest, and to allow him to continue practising would put patients at risk of harm and undermine public confidence in the nursing profession and in the NMC as its regulator.

After taking into account all the evidence before it during this case, the panel determined that the most appropriate and proportionate sanction is that of a striking-off order. The panel had regard to the effect of Mr Maringapasi's serious actions, which included deliberate dishonesty, the breach of an existing interim order and falsifying records. It considered that Mr Maringapasi has brought the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves when caring for vulnerable patients. The panel concluded that nothing short of a striking off order would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of protecting the public, 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.

Accordingly, the panel decided to strike Mr Maringapasi off the NMC register.

Submissions on interim order

Ms Ihuomah invited the panel to impose an interim suspension order for a period of 18 months. She submitted that an interim suspension order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest. Further, she submitted that this was required to cover the 28-day appeal period and, if Mr Maringapasi wishes to appeal the decision, the period for which it may take for that appeal to be heard.

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

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day appeal period and any period which an appeal may be heard.

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

This will be confirmed to Mr Maringapasi in writing.

That concludes this determination.