

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Hearing
Monday 6 October – Wednesday 15 October 2025**

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

Name of Registrant:	Gifty Sey Mensah-Kirchner
NMC PIN	20D0797E
Part(s) of the register:	Nurses part of the register, sub part 1; Registered Nurse – Learning Disabilities: Nurse, level 1 - 12 August 2020
Relevant Location:	Staffordshire
Type of case:	Lack of competence
Panel members:	Paul Hepworth (Chair, Lay member) Ivan McGlen (Registrant member) Andrea Carman (Lay member)
Legal Assessor:	Graeme Dalgleish
Hearings Coordinator:	Rodney Dennis
Nursing and Midwifery Council:	Represented by Simran Ghotra, Case Presenter
Gifty Mensah-Kirchner:	Not present and unrepresented
Facts proved:	Charges 1(a), 1(b), 1(c), 3, 4, 5
Facts not proved:	Charge 2
Fitness to practise:	Impaired
Sanction:	Suspension order (9 months)
Interim order:	Suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Mensah-Kirchner was not in attendance and that the Notice of Hearing letter had been sent to Mrs Mensah-Kirchner's registered email on 3 September 2025.

Ms Ghotra 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 venue of the hearing and, amongst other things, information about Mrs Mensah-Kirchner's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Mensah-Kirchner 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 Mrs Mensah-Kirchner

The panel next considered whether it should proceed in the absence of Mrs Mensah-Kirchner. It had regard to Rule 21 and heard the submissions of Ms Ghotra who invited the panel to continue in the absence of Mrs Mensah-Kirchner. She submitted that Mrs Mensah-Kirchner had voluntarily absented herself.

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 care and caution.

The panel decided to proceed in the absence of Mrs Mensah-Kirchner. In reaching this decision, the panel considered the submissions of Ms Ghotra 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 Mrs Mensah-Kirchner;
- Mrs Mensah-Kirchner submitted as part of the registrant's response bundle information dated between October 2023 and February 2024, it was noted by the panel that no further information has been received since that date;
- Mrs Mensah-Kirchner has not fully engaged with the NMC and has not responded to any of the letters sent to them about this hearing;
- Mrs Mensah-Kirchner was sent and is deemed to have received the Notice of Hearing dated 3 September 2025;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between October 2022 and June 2023
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Mensah-Kirchner in proceeding in her absence. Although the evidence, upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her 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 Mrs Mensah-Kirchner's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Mrs Mensah-Kirchner. The panel will draw no adverse inference from Mrs Mensah-Kirchner's absence in its findings of fact.

Details of charge

That you, between around October 2022 and around June 2023 failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a band 5 nurse in that:

1. You failed to meet your medicines administration objective in that:
 - a. Around 21 November 2022 while under supervision you were assessed as not safe to administer medications.
 - b. Around 8 April 2023 while under supervision you were assessed as not safe to administer medications.
 - c. Around 25 May 2023 while working under a Performance Improvement Action Plan you were assessed as not safe to administer medications.
2. On one or more occasions failed to carry out effective shift planning.
3. On one or more occasions failed to complete care note entries with sufficient detail.
4. On one or more occasions failed to deliver effective handovers to staff.
5. On one or more occasions failed to contribute to effective teamwork.

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

Decision and reasons on application to disregard parts of the supervision notes dated 16 January 2023, and details of an interim order supplied by the registrant in the Hearing Bundle

The panel heard an application made by Ms Ghotra to disregard some parts of the supervision notes in the hearing document bundle regarding 'inappropriate comments' allegedly made by the registrant, and also details of an interim order supplied by the registrant.

Ms Ghotra submitted that in the interest of fairness, these references should be disregarded as there are no charges relating to this aspect of the behaviour referred to.

The panel heard and accepted the legal assessor's advice.

The panel considered the submissions from Ms Ghotra and advice from the legal assessor. The panel determined that this information should be disregarded as it does not directly relate to any of the charges.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Ghotra under Rule 31, to allow the email dated 4 April 2023 sent to Witness 3, mentioned in Witness 3's statement.

Ms Ghotra submitted that the email is in support of charge 5 of the allegations and this hearsay evidence is admissible.

Ms Ghotra submitted that this evidence is not sole and decisive. Witness 1 has given evidence on how Mrs Mensah-Kirchner failed to contribute to effective teamwork and there is further evidence available from Witness 3.

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 decided that this was not sole or decisive evidence, there was no evidence of fabrication and attendance of a witness to speak to one email would be disproportionate. Further, the statement was not challenged and Mrs Mensah-Kirchner had been given notice of it.

The panel determined that it would be fair and relevant to accept into evidence the hearsay evidence but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

The panel decided to admit the email as hearsay evidence.

Decision and reasons on application to admit Witness 4's written statement as hearsay evidence

The panel heard an application made by Ms Ghotra under Rule 31 to allow the written statement of Witness 4 into evidence.

Ms Ghotra submitted that Witness 4 was not present at this hearing and that several attempts had been made by the NMC to contact the witness.

Ms Ghotra further submitted that there were no known reasons for the witness' non engagement but sufficient efforts to ensure this witness was present had been made but the NMC was unable to secure attendance.

Ms Ghotra submitted that Witness 4's statement is relevant in relation to Charge 1c and Charge 4 before referring the panel to paragraphs 11 and 14 of the witness statement.

Ms Ghotra submitted that Witness 4's statement presented a balanced view as it included reference to Mrs Mensah-Kirchner's assertion that she was being bullied.

The panel heard and accepted the legal assessor's advice on the issues it should consider in respect of this application.

The panel decided to accept this application.

The panel noted that this is not sole or decisive evidence and it has been provided with other evidence that supports Charges 1c and Charge 4.

The panel noted that Mrs Mensah-Kirchner has seen the witness statement from Witness 4 and provided no response with regards to the statement. The panel acknowledged that the NMC has made sufficient attempts to contact the witness and secure their attendance but there has been no engagement with the witness since December 2024.

The panel considered that it is fair and relevant to accept Witness 4's statement, and would give it appropriate weight once it had heard and evaluated.

Background

Ms Mensah-Kirchner was employed at a Band 5 nurse for the Wedgwood Ward (the Ward) at [PRIVATE].

Mrs Mensah-Kirchner joined the Ward in October 2022 and worked shifts until June 2023. Concerns were raised about Mrs Mensah-Kirchner's ability to complete nursing duties effectively. These concerns related to:

- Medication administration
- Shift planning
- Completing handover notes
- Communication with colleagues

During her time on the Ward, concerns were raised about Mrs Mensah-Kirchner's medication competency. There was an organisational requirement that all nurses successfully undertake a medicines administration competency assessment.

Whilst being assessed on a medication round, it was observed that Mrs Mensah-Kirchner was calculating the wrong doses for several medications. It was also observed that Mensah-Kirchner had limited knowledge on the effects of different medications.

Mrs Mensah-Kirchner failed her medication competency on three occasions. To help her address the alleged medicine administration errors she had regular supervision meetings with senior colleagues, shadowed and observed other registered nurses, and received on-going support. Despite this, Mrs Mensah-Kirchner allegedly continued to make errors.

Further concerns were raised about Mrs Mensah Kirchner's care notes lacking detail, also it was alleged that she failed to hand over important patient information to colleagues. There was also concerns about Mrs Mensah-Kirchner not working as part of a team and her inability to complete a shift planner.

On 13 April 2023, Mrs Mensah-Kirchner was put on a performance improvement action plan. The areas for improvement were:

- Medication, administration and calculations
- Taking the lead in clinical management
- Communication to the rest of the team
- Verbal communication in meetings
- Leadership

Mrs Mensah-Kirchner did not successfully complete the first stage of the performance improvement plan.

In June 2023, Mrs Mensah-Kirchner went on sick leave and subsequently handed in her notice in September 2023, and it was not clear if she was aware of the outcome of the plan.

On 11 October 2023, the NMC received a referral from [PRIVATE], her former employer raising concerns about Mrs Mensah-Kirchner.

Decision and reasons on facts

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

- Witness 1: Clinical Team Leader for the Wedgewood Ward at the time of the events
- Witness 2: Clinical Team Leader at Wedgewood Ward at the time of the events
- Witness 3: Clinical Team Leader at Wedgewood Ward at the time of the events

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness statements and all documentary evidence provided by both the NMC and in Mrs Mensah-Kirchner's registrant response bundle.

Charge 1a

You failed to meet your medicines administration objective in that:

- a. Around 21 November 2022 while under supervision you were assessed as not safe to administer medications

This charge is found proved.

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty to administer medications. This was by reference to the requirements of the NMC Code and the Band 5 nurse job description.

The panel also made reference to the Medicines Management Policy. At 8.6.3 of the policy it reads:

'Staff administering medication must be trained and assessed as competent to administer medication.'

Mrs Mensah-Kirchner was under supervision and undertook a medication administration assessment on 21 November 2022 which she failed to pass.

The panel note that Witness 1 gave a clear and detailed explanation of the process involved in the assessment of Mrs Mensah-Kirchner's competency in administering medication. Witness 1 said that, during the assessment, Mrs Mensah-Kirchner could not explain how the dosage was calculated.

Mrs Mensah-Kirchner successfully completed parts of the assessment but was assessed as not safe on administering medicines in a way that would ensure patient safety. The panel had sight of the completed assessment and found Witness 1's explanation cogent, clear, credible and reliable.

The panel acknowledge that there was no guidance presented in evidence in how to complete the assessment. However, the witnesses in oral evidence were able to explain in detail how the assessment should be administered and what should be assessed.

In addition, the assessors, Witnesses 1 and 3 were both clinical leads and had undertaken mentorship training. Witness 1 was Mrs Mensah-Kirchner's supervisor and had carried out two of the assessments and for consistency had also reviewed the third.

In their live oral evidence, Witness 1 confirmed to the panel the failure of this assessment on 21 November 2022 and the rationale as to why Mrs Mensah-Kirchner failed.

The panel also took into account of Witness 1's live oral evidence where she confirmed that Mrs Mensah-Kirchner was at the time of the assessment employed as a Band 5 nurse. The panel noted Mrs Mensah-Kirchner was supernumerary for two weeks when she commenced in the role as part of her induction. She remained supernumerary after that period due to the initial concerns raised.

All three witnesses outlined that Mrs Mensah-Kirchner had been given opportunities for training in preparation for the assessment. This included observing and shadowing other more experienced colleagues with regards to medication administration.

The panel therefore concluded that Mrs Mensah-Kirchner failed to meet her medicines administration objective in that around 21 November 2022 while under supervision she was assessed as not safe to administer medication.

The charge is found proved.

Charge 1b

Around 8 April 2023 while under supervision you were assessed as not safe to administer medications.

This charge is found proved.

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty to safely and effectively administer medication. This was by reference to the requirements of the NMC Code and the Band 5 nurse job description.

The panel also made reference to the Medicines Management Policy. At 8.6.3 of the policy it reads:

‘Staff administering medication must be trained and assessed as competent to administer medication.

A second assessment was undertaken on the 8 April 2023 by Witness 3 in which Mrs Mensah-Kirchner failed. The failures were:

- Inability to identify any information missing from a prescription card and knows what action to take.
- Inability to select the correct medicine, dose, and route based on the patient’s drug card.
- Incorrect answers in the dosage calculations.

The panel noted that these failures were different from the first assessment.

Witness 3 provided supervision to Mrs Mensah-Kirchner on the same day of the assessment on 8 April 2023. Witness 3 in written supervision notes and live evidence confirmed that Mrs Mensah-Kirchner had failed the assessment and was not competent in calculating the correct medication dosage.

In their witness statement and oral evidence, Witness 3 explained that Mrs Mensah-Kirchner was offered support and advice in the administration of medication but that she appeared uninterested in accepting this support.

The panel found the evidence from Witness 3 cogent, clear and credible and measured and was supported by the oral evidence given by Witness 1 and 2 and the documentary evidence.

The panel also noted that Mrs Mensah-Kirchner had supervised medication administration followed by a supervision meeting on 27 March and 3 April 2023 prior to the assessment taking place. In addition, Mrs Mensah-Kirchner remained supernumerary and had the opportunity to further observe medication rounds to assist her learning.

The panel as set out above also heard live oral evidence from Witness 1, 2 and 3 who each explained their ongoing concerns about Mrs Mensah-Kirchner's ability to safely administer medications.

The panel accepted the evidence of all three witnesses, which it found to be clear, credible and reliable.

The panel accordingly found this charge proved.

Charge 1c

Around 25 May 2023 while working under a Performance Improvement Action Plan you were assessed as not safe to administer medications

This charge is found proved.

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty to administer medications. This was by reference to the requirements of the NMC Code and the Band 5 nurse job description.

The panel also made reference to the Medicines Management Policy at 8.6.3.

The panel heard live oral evidence from Witness 1, 2 and 3 and gave consideration to the exhibit bundles in reference to this assessment in particular;

- Medication assessment dated 25 May 2023

- Mrs Mensah-Kirchner's medication calculation returned on 7 June 2023
- Medication assessment correct answers
- Supervision meeting notes dated 8 June 2023

A third assessment was undertaken on the 25 May 2023 in which Mrs Mensah-Kirchner failed. The failures were:

- Unsafe to administer medicines in a way to ensure the safety of the patient
- Incorrect answers in the dosage calculations

The panel considered Witness 1's live evidence and supervision notes in response to the assessment, where she states that Mrs Mensah-Kirchner had made incorrect calculations and that she had demonstrated a lack of knowledge of medication commonly used in this clinical area, mental health documentation, and how this related to the Mental Health Act 1984. The panel found Witness 1 to be clear, cogent and credible.

The panel also noted that Mrs Mensah-Kirchner had a Performance Improvement Action Plan in place from the 13 April 2023 which included actions for her to shadow and observe medication rounds. In addition Witness 3 carried out medication observation and follow up supervision on 20 May 2023 in advance of this assessment taking place. The panel noted that the hearsay evidence from Witness 4 supported the live oral evidence of Witness 1.

The panel found this charge proved.

Charge 2

On one or more occasions failed to carry out effective shift planning.

This charge is found NOT proved.

The panel carefully considered all the documentary evidence available to it, alongside the NMC Code for professional standards of practice and behaviour for nurses and midwives and nursing associates

In finding this charge not proved, the panel determined that Mrs Mensah-Kirchner had no duty to complete the shift planner. It was not part of Mrs Mensah's Kirchner's job description and the panel could not find a policy or document by the hospital that stated such a duty existed in respect of a role for a Band 5 nurse. The panel considered that whilst there may have been an expectation of this function, it could find no basis for concluding that it was a duty, a necessary precursor to a finding of 'failure' as alleged.

Charge 3

On one or more occasions failed to complete care note entries with sufficient detail

This charge is found proved.

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty to complete care note entries with sufficient detail as set out in the NMC Code, specifically Standard 10.

Keep clear and accurate records relevant to your practice

The panel considered the live oral evidence from Witness 1, 2 and 3 and the written statements of each witness. The panel noted the statement from Witness 1 confirmed concerns raised about Mrs Mensah-Kirchner's communication and handovers. Witness 1 states:

'Mrs Mensah-Kirchner would read directly off the handover notes, rather than providing her own knowledge to explain what had happened on the shift.'

In addition, supervision on the 16 January 2023 carried out by Witness 1 with Mrs Mensah-Kirchner highlighted the need to make more detailed care notes. Alongside this, Witness 2 presented a written summary to Witness 1, which outlined omissions contained in the handover by Mensah-Kirchner on 26 May 2023.

Further, the panel noted that a Band 7 nurse expressed concerns by email to Mrs Mensah-Kirchner, copied in to all three witnesses regarding omissions in a care plan which required a correction by the Band 7 nurse.

The panel also took into account the hearsay evidence of Witness 4 in the witness statement which supported the evidence made by Witness 1 and 2.

Witness 2 in their live oral evidence said:

‘This is a standard for all nurses and it is expected that a Band 5 nurse would have hand over experience as it is a crucial skill.’

In finding this charge proved, the panel noted the consistency and detail in the evidence from all three live witnesses which was supported by the documentary evidence provided to the panel.

The panel found this evidence credible and reliable and found this charge proved.

Charge 4

On one or more occasions failed to deliver effective handovers to staff

This charge is found proved

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty to deliver effective handovers to staff. The panel made reference to the NMC Code specifically Standards 7 and 8 as well as Mrs Mensah-Kirchner’s job description which sets out the communication and relationship skills that were expected.

The panel had regard to Mrs Mensah-Kirchner's job description under the title: Communication and Relationship Skills, which states as a key accountability:

'Provide a high level of communication with internal and external providers'

'Communicate all relevant issues pertaining to individuals within our care'

The panel heard from all three witnesses that concerns were raised about Mrs Mensah-Kirchner's verbal and written communication with colleagues. In particular, concerns were raised about the effective delivery of handovers.

The panel heard live oral evidence from Witness 1 and 2 who both explained the importance and significance of providing handovers to colleagues.

The panel gave consideration to the statement of Witness 1. In that statement she said:

'Mrs Mensah-Kirchner would read directly off the handover notes rather than providing her own knowledge to explain what had happened on the shift. It was important to know what had happened that day and Mrs Mensah-Kirchner in her professional handovers had not provided enough detail.'

The panel gave particular weight to the evidence of Witness 2 who stated clearly in their live oral evidence why delivering a handover was important and something which Mrs Mensah-Kirchner should have been able to do. Witness 2 said:

'It's a skill you should have wherever you work, it is a crucial skill'

As set out in charge 3 above, there were a number of omissions in the care notes and as a direct consequence there were omissions in the handover delivery by Mrs Mensah-Kirchner.

In addition on the 6 April 2023 an email was sent from Dr Gore to Witness 1 outlining concerns that Mrs Mensah-Kirchner needed to prepare for meetings beforehand and

be aware of the content of the information she is sharing rather than just reading out.
Dr Gore stated that Mrs Mensah-Kirchner:

'...needs to be able to share her professional views and opinions, not just be present to read off the page.'

In addition, supervision conducted by Witness 1 on the 8 June 2023 highlighted improvements to be taken at handover.

This is supported by the hearsay evidence of Witness 4 who states that there were times she witnessed Mrs Mensah-Kirchner in operational meetings not giving out the right information saying Mrs Mensah-Kirchner was not able to provide the correct information around incidents and the information was limited.

This charge is accordingly found proved.

Charge 5

On one or more occasions failed to contribute to effective teamwork

This charge is found proved

In reaching this decision the panel determined that Mrs Mensah-Kirchner had a duty in her role to deliver effective teamwork.

The panel made reference to the NMC Code specifically Standard 8: which states:

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.

8.5 work with colleagues to preserve the safety of those receiving care

The panel heard live oral evidence from Witnesses 1, 2 and 3 called on behalf of the NMC.

The panel noted that there were repeated references in the evidence from these witnesses to Mrs Mensah-Kirchner's failure to contribute to teamwork on the ward. In the supervision conducted by Witness 1 on the 3 April 2023, a lack of teamwork in the following areas was highlighted:

- Mrs Mensah-Kirchner not being present in the dining room to support the rest of the team with patient supervision.
- Not appropriately responding to an alarm.
- Not sending staff to support another ward.

Furthermore, an email from a colleague was sent on 4 April 2023 to Witness 3 highlighting concerns about Mrs Mensah-Kirchner's inflexibility in taking breaks and not consulting wider team members or responding to the needs of the ward.

The panel also considered an email from Witness 3 to Witness 1 providing details of an incident with a patient where Mrs Mensah-Kirchner initially wanted to make her own decisions rather than work as part of a team. Witness 3 outlined in their witness statement a further incident where Mrs Mensah-Kirchner withdrew from a patient restraint potentially putting others at risk and did not communicate her actions prior to the withdrawal.

The panel was of the view that there was a level of consistency in the live oral evidence from each of the three witnesses. The panel found this evidence credible and reliable and was consistent with each witness statement.

On the basis of the evidence the panel find this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to a lack of competence and, if so, whether Mrs Mensah-Kirchner'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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether, in all the circumstances, Mrs Mensah-Kirchner's fitness to practise is currently impaired.

Submissions on lack of competence

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Ms Ghotra moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Ghotra stated that the panel should have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the NMC Code) in making its decision.

Ms Ghotra made reference to the case of *Holton v GMC* [2006] EWHC 2960.

Ms Ghotra submitted that Mrs Mensah-Kirchner was a Band 5 nurse and that the standards of competence should be measured against this grade.

Ms Ghotra submitted that Mrs Mensah-Kirchner was aware of and understood the concerns raised about her competence to administer medication. During her time on the Ward, Mrs Mensah-Kirchner was given time to improve her competence.

Ms Ghotra submitted that the facts found relate to basic and fundamental aspects of nursing practice. Ms Ghotra added that the concerns were not an isolated incident and that Mrs Mensah-Kirchner's conduct is a pattern demonstrating a lack of competence and despite Mrs Mensah-Kirchner receiving support, she did not improve her skills.

Ms Ghotra referred the panel to the performance assessment documents, training plan, Mrs Mensah-Kirchner's job description as well as the standards expected of a Band 5 nurse.

Ms Ghotra made specific reference to the following professional standards of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code): 2.1, 6.2, 7, 8.2, 8.3, 8.5, 8.6, 9.2, 10.1, 20.1, 20.8, 22.3.

Ms Ghotra identified the specific relevant standards where Mrs Mensah-Kirchner's actions amounted to a lack of competence. Ms Ghotra submitted that a lack of competence needs to be addressed using a three stage process:

- Is there evidence that Mrs Mensah-Kirchner was made aware of the issues around her competence?

- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

Submissions on impairment

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

Ms Ghotra submitted that Mrs Mensah-Kirchner is impaired by lack of competence and made reference to Dame Janet Smith's "test" in the Grant case 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.'

Ms Ghotra submitted that limbs a, b, c are engaged and that Mrs Mensah-Kirchner has acted and is liable to act in a way that would put patients at risk of harm. There is no evidence that Mrs Mensah-Kirchner has addressed the issues of concern and her actions fell significantly short of what is expected of a registered nurse.

Ms Ghotra submitted that Mrs Mensah-Kirchner's actions bring the nursing profession into disrepute and that she has breached the fundamental tenets of the profession.

Ms Ghotra referred the panel to specific paragraphs of the NMC Code, the NMC's Fitness to Practise Guidance and the judgement in *Cohen v General Medical Council [2008] EWHC 581 (Admin)*.

Ms Ghotra submitted that Mrs Mensah-Kirchner has not shown sufficient insight into her actions. There is no evidence of steps taken by Mrs Mensah-Kirchner to address the concerns, nor is there evidence of any strengthening of practice.

Ms Ghotra submitted that the lack of competence by Mrs Mensah-Kirchner requires a finding of impairment, the lack of competence in skills is serious and without a finding of impairment that would undermine public confidence.

Ms Ghotra invited the panel to make a finding of impairment on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments, including the Holton and Grant cases.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the standards of the NMC Code.

The panel was of the view that Mrs Mensah-Kirchner's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Mensah-Kirchner's actions found proved amounted to a breach of the NMC Code.

Specifically:

1.2 Make sure you deliver the fundamentals of care effectively

2.1 Work in partnership with people to make sure you deliver care effectively

6.2 Maintain the knowledge and skills you need for safe and effective practice

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

9.2 Gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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

18. Advise on, prescribe, supply dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

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

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

22.3 Keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

The panel bore in mind, when reaching its decision, that Mrs Mensah-Kirchner should be judged by the standards of a reasonably competent Band 5 registered nurse and not by any higher or more demanding standard.

The panel determined that Mrs Mensah-Kirchner was aware of the concerns raised. In making this decision the panel had considered all the evidence including the following:

- Three competency assessments including dosage calculations
- Supervision meetings and an appraisal
- Evidence of the formal performance improvement plan
- Live evidence from three witnesses
- Information supplied by Mrs Mensah-Kirchner

The panel concluded that Mrs Mensah-Kirchner worked for a period of eight months and had time to improve her practice. The panel was satisfied that a fair sample of Mrs Mensah-Kirchner's work was considered and this included the three competency assessments. The panel also found that there was a fair and consistent approach from the Clinical Team Leaders, as explained by Witness 1. In addition Mrs Mensah-Kirchner was also supernumerary for the majority of the eight month period providing time to observe, receive support and learn whilst on the Ward.

The panel next considered whether in Mrs Mensah-Kirchner's lack of knowledge, skill and judgement is so lacking that she is unable to practice safely and effectively.

The panel was satisfied that the three assessments were carried out appropriately, fairly and in an objective way. The panel considered that there had been parity between the assessors. Both assessors were Clinical Team Leaders and had mentorship training and the assessment process was designed by Ashton's Pharmacy. Witness 1 carried out two of the assessments and reviewed the third to provide a level of consistency.

The panel determined that Mrs Mensah-Kirchner is currently unable to practice safely and effectively. The medication administration concerns were not a one-off isolated incident but an on-going issue. The panel found that this lack of competence would put patients at risk of harm.

The panel went on to consider Mrs Mensah-Kirchner's failure to complete care note entries with sufficient detail.

The panel concluded that Mrs Mensah-Kirchner had been made aware by colleagues on the Ward about her care note entries, as well as in supervision notes and it was an objective in her appraisal. In their live evidence, Witness 1 and 2 confirmed this to the panel.

The panel determined that there is evidence that Mrs Mensah-Kirchner had sufficient time and opportunities to improve her note taking skills.

In considering whether Mrs Mensah-Kirchner's note entries amount to a lack of competence, the panel found that she received ongoing support and during a sustained period she continued to complete notes entries with insufficient detail.

The panel next considered Mrs Mensah-Kirchner's failure to deliver effective handovers. The panel found that Mrs Mensah-Kirchner had been made aware of these concerns on more than one occasion. In both of their witness statements and live oral evidence, Witness 1 and 2 confirmed that concerns over handovers and her communication had been discussed with Mrs Mensah-Kirchner. Both Witness 1 and 2 told the panel that as a registered nurse, Mrs Mensah-Kirchner should have known the importance of being able to explain to colleagues what had happened on each

shift. Mrs Mensah-Kirchner continued, despite support to be unable to share important information relating to patient care and this was evidenced in the care notes and in handover.

The panel determined that Mrs Mensah-Kirchner's inability to complete handover notes demonstrated a lack of competence, and had the ability to compromise patient safety and the continuity of care by not passing on vital information to the next nursing team who were also caring for the same vulnerable patients.

The panel next considered Mrs Mensah-Kirchner's failure to contribute to effective teamwork. Having heard from witnesses and seen documentary evidence, the panel found that Mrs Mensah-Kirchner had been made aware of this concern in supervision on more than one occasion. Matters discussed were topics such as taking breaks, oversight in the dining room, supporting staff during incidents and supporting other units.

The panel noted that Mrs Mensah-Kirchner did not demonstrate, despite the support given to her, any evidence of improvement over the course of several months. The panel found that this was consistent with her failure to make improvements with the other concerns that had been raised.

The panel therefore concluded that there was a lack of competence in respect of the charges found proved.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mrs Mensah-Kirchner's fitness to practise is currently impaired

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

'The question that will help decide whether a professional's fitness to practise is impaired is:

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”

If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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:

‘...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” as to fitness to practise which is expressed as follows:

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

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

- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) ...*

The panel found limbs a, b and c engaged in this case.

The panel found all the failings are remediable. However, the panel found that as a result of Mrs Mensah-Kirchner being unable to correctly and consistently calculate the correct dosage of medication, along with not being able to keep patient notes up to date with relevant information, and brief the next nursing team with that information about vulnerable patients and their care, linked with a lack of team work, potentially put patients at an unwarranted risk of harm as a direct result of Mrs Mensah-Kirchner's lack of competence.

In considering impairment the pane took account of the information supplied by Mrs Mensah-Kirchner, this included a response to the allegations, two testimonials and training undertaken while in role. However, the panel noted that there was no evidence of strengthened practice, no evidence of training since leaving this role and no reflective statement showing insight. Furthermore, there had been no recent engagement and Mrs Mensah-Kirchner did not attend the hearing and the panel are unaware for the reason for this or her current circumstances.

The panel determined that there is no evidence before it that can demonstrate that remediation or strengthened practice has taken place.

The panel has found there has been a lack of insight demonstrated by Mrs Mensah-Kirchner. Despite the significant level of support and guidance this was perceived by her as bullying, racism and demotion. Mrs Mensah-Kirchner did not appear to accept

the concerns about her practice and asserted in her NMC response that she had done nothing wrong.

The only explanation the panel has received from Mrs Mensah-Kirchner is from the Royal College of Nursing (RCN) in which she says:

‘She hasn’t done anything wrong’

The panel found no evidence of bullying, racism or demotion, indeed all three witnesses appeared shocked by these accusations.

The panel next considered whether the actions of Mrs Mensah-Kirchner were likely to be repeated. The panel referred to Dame Janet Smith's “test” and found that three of the four limbs had been engaged. The panel decided in these circumstances there is no evidence of insight and there is accordingly a real risk of repetition of the failures found proved, and it cannot conclude that those failures are highly unlikely to be repeated. The panel found Mrs Mensah-Kirchner’s fitness to practise impaired on the grounds of public protection.

The panel was mindful of the overarching objectives of the NMC and the expectation of the public for nurses to be competent. Given the seriousness of its findings the panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case. The panel also found Mrs Mensah-Kirchner’s fitness to practise impaired on the grounds of public interest.

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of nine months. The effect of this order is that the NMC register will show that Mrs Mensah-Kirchner’s registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been heard 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 Ghotra advised the panel that the NMC would seek the imposition of a 12 month suspension order in response to the finding that Mrs Mensah-Kirchner's fitness to practise is currently impaired.

Ms Ghotra submitted that the purpose of this sanction is to protect the public and meet the public interest.

Ms Ghotra reminded the panel, that in making its decision the sanction imposed should not be punitive but proportionate.

Ms Ghotra referred the panel to several aggravating factors in this case, that included the lack of insight shown by Mrs Mensah-Kirchner and that her lack of competence in medicine administration potentially puts patients at risk of harm.

Ms Ghotra referred the panel to the relevant paragraphs of the Sanctions Guidance and submitted that due to the nature of the case, no other sanction apart from a suspension is appropriate.

Ms Ghotra made reference to SAN-3 of the Sanctions Guidance and outlined to the panel the sanction orders available.

Ms Ghotra submitted that the panel could take no further action and impose no sanction on Mrs Mensah-Kirchner. Ms Ghotra reminded the panel that this discretion should only be used in rare cases and was not appropriate for this case.

Ms Ghotra next considered a caution order and reminded the panel that this sanction is only appropriate if the panel find there is no risk to the public.

Ms Ghotra submitted that the concerns raised are serious and there remains a risk of repetition. Ms Ghotra added that caution orders should only be imposed if a case is

at the lower end of the spectrum of impaired fitness to practise. She further submitted that this does not apply to Mrs Mensah-Kirchner.

Ms Ghotra next considered a conditions of practice order and submitted that this sanction was not appropriate, proportionate and was insufficient to protect patients and service users.

Ms Ghotra submitted that the areas of concern highlighted are remediable but Mrs Mensah-Kirchner has not shown proper insight or a willingness to respond to training. Ms Ghotra further submitted that during her employment, Mrs Mensah-Kirchner was offered further training in order to meet the basic and fundamental aspects of nursing practice.

Ms Ghotra submitted that Mrs Mensah-Kirchner's lack of competence was not a one-off clinical issue but a pattern of continuing failings.

Ms Ghotra submitted that the panel cannot be satisfied that Mrs Mensah-Kirchner has insight into her lack of competence. Ms Ghotra referred the panel to the three competency assessments that Mrs Mensah-Kirchner failed, despite support from her employer and after being placed on a performance plan.

Ms Ghotra submitted that Mrs Mensah-Kirchner has provided certificates of continuing professional development and certificates of achievement but these predate the concerns of the case. Mrs Mensah-Kirchner has provided no evidence of remediation or strengthening of practice.

Ms Ghotra submitted that Mrs Mensah-Kirchner is not safe to practise.

Ms Ghotra submitted that a suspension order was the most appropriate and proportionate sanction.

Ms Ghotra moved on to consider a striking-off order. She reminded the panel that this sanction is not available as a registered nurse cannot be struck off at this stage due to a lack of competence.

Decision and reasons on sanction

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

The panel accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- Competence issues raised have the potential to put patients at risk of harm
- No evidence of strengthening of practice or reflection
- No recent engagement with the NMC or the fitness to practise process
- A lack of competence demonstrated, despite support and undertaking learning activities over the course of several months
- An absence of evidence of any insight

The panel also took into account the following mitigating features:

- Limited level of experience as a nurse in this particular specialism

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 determined that taking no action would bring the profession in disrepute and undermine public trust and confidence. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that due to the seriousness of the case, and the public protection issues identified, an order that

does not restrict Mrs Mensah-Kirchner's practice would not be appropriate in the circumstances.

The panel determined that the risk of repetition and that of patient safety remains. The panel referred to the SG that states a caution order is only appropriate if there is no risk to the public or patients.

The panel considered that Mrs Mensah-Kirchner's lack of competence was not at the lower end of the spectrum given the lack of competence across fundamental nursing skills 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 Mrs Mensah-Kirchner's 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. The panel decided that there are no practical or workable conditions given the evidence heard, that could be formulated.

Although the lack of competence identified is remediable, the panel has no evidence that Mrs Mensah-Kirchner has shown no understanding of the seriousness of the concerns raised regarding her competence or that she has taken steps to address these concerns.

The panel concluded that it is unknown whether Mrs Mensah-Kirchner would be willing or able to respond or comply with any conditions of practice placed on her registration.

The panel found that conditions of practice are not appropriate. Mrs Mensah-Kirchner has not sufficiently engaged with the NMC or the fitness to practice process and the panel note that it not known whether she has worked since the incident in 2023 and in what capacity. She has provided no evidence of strengthening of practice, and no reflective piece that set out what actions or further learning she has undertaken to address the concerns relating to her lack of competence.

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:

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel concluded that Mrs Mensah-Kirchner's lack of competence puts patients and the public at risk. The risk of repetition remains and there has been a lack of engagement by Mrs Mensah-Kirchner in response to the concerns. The panel has no evidence that Mrs Mensah-Kirchner has reflected on the failings identified during her employment. There is no evidence of remediation by which the panel can measure any improvement and there is a proven lack of competence and in particular with regards to medication administration.

The panel determined that a suspension order is the only appropriate sanction that can be imposed.

In considering whether a striking-off order would be appropriate, the panel took into the account the Sanctions Guidance, reference SAN-3e which states:

'A striking-off order can't be used if the nurse, midwife or nursing associate's fitness to practise is impaired due to:

- *Lack of competence*

Until they have been on either a suspension order, a conditions of practice order for a continuous period of two years.'

In taking these factors into account, a suspension order is the most serious sanction the panel has the power to impose at this stage. The panel was mindful that they did

not have the power to strike-off at this stage given the absence of a continuous period of two years of suspension or conditions.

In making this decision, the panel carefully considered the submissions of Ms Ghotra in relation to the 12 month suspension sanction the NMC was seeking.

However, the panel determined that a suspension order for a period of nine months is appropriate in this case to mark the seriousness of the lack of competence shown by Mrs Mensah-Kirchner. The time period would also give Mrs Mensah-Kirchner sufficient opportunity to demonstrate strengthening of practice and insight at the review stage.

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 may be assisted by:

- Mrs Mensah-Kirchner's attendance at the hearing
- Engagement with the fitness to practise process
- Written reflections which clearly address the charges proved
- Evidence of strengthened practice which address the charges proved
- Evidence of relevant training and development

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, and or is otherwise in the public interest or is in the registrant's own interest until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Ms Ghotra invited the panel to consider imposing an Interim 'Suspension order to protect the public and the wider public interest and to cover Mrs Mensah-Kirchner's 28 day statutory appeal period and/or the duration of any appeal that may be lodged.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

An Interim Order may only be made on one or more of three grounds, namely:

- It is necessary for the protection of the public and/or
- It is otherwise in the public interest and/or
- It is in your own interest

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 substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to Mrs Mensah-Kirchner in writing.

That concludes this determination.

