Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday, 4 September – Friday, 5 September 2025

Virtual Meeting

Name of Registrant:	Agnes Cobbina
NMC PIN:	69Y0860E
Part(s) of the register:	Nursing, Sub part 2 RN2, Registered Nurse - Adult (30 May 1969)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, Lay member) Carson Black (Lay member) Rosalyn Mloyi (Registrant member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	John Kennedy
Facts proved:	Charges 1a, 1b, 1c, 1d, and 1e
Fitness to practise:	Impaired
Sanction:	**Suspension order, with review (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Ms Cobbina's registered email address by secure email on 6 August 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, and that this meeting would be held on or after 4 September 2025.

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

Details of charge

That you, a registered nurse,

1. On 3 April 2020, in respect of Resident A,
    a. Failed to communicate effectively the seriousness of Resident AM's condition in the 999 call to London Ambulance Service ('LAS').
    b. Failed to notify the LAS of the worsening condition of Resident AM.
    c. Failed to monitor Resident AM's condition with sufficient regularity or at all.
    d. Failed to administer cardiopulmonary resuscitation ('CPR') in the absence of a do not attempt cardiopulmonary resuscitation ('DNAR') order.
    e. Failed to recognise in a timely manner that Resident AM's condition had become critical.

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

Background

The charges arose whilst Ms Cobbina was employed as a registered nurse by the nursing agency Invicta 24 Plus. On the night of 2 April into 3 April 2020 Ms Cobbina worked a shift at Villa Maria Nursing Home (the Home), she was the only nurse on duty. During this shift Resident AM experienced difficulty breathing and required an ambulance and urgent medical care.

Ms Cobbina called 999 to request an ambulance but it was delayed in arriving by nearly two hours. While waiting on the ambulance it is alleged that Ms Cobbina failed to adequately check on Resident AM, and did not perform cardiopulmonary resuscitation (CPR) despite there being no do not attempt resuscitation (DNAR) order in place.

The local authority carried out a safeguarding investigation and concluded that Ms Cobbina should be referred to the Nursing and Midwifery Council (NMC).

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the written documentation from Ms Cobbina.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Worked at the Home, after the relevant time.

- Witness 2: Care Assistant who worked the night shift at the relevant time.
- Witness 3: Advanced Social Worker at London Borough of Croydon who carried out the Section 42 enquires.
- Witness 4: General Practitioner at Haling Park Medical Practice

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

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

Charge 1a

> "1. On 3 April 2020, in respect of Resident AM,
> a. Failed to communicate effectively the seriousness of Resident AM's condition in the 999 call to London Ambulance Service ('LAS')."

This charge is found proved

In reaching this decision, the panel took into account the transcript of the 999 call and the report of the safeguarding investigation into the call. The panel noted that Ms Cobbina's responses to the call handler were unclear and not as structured or comprehensive as would be expected from a registered nurse. The panel noted that in order to place the call Ms Cobbina was in the clinical room, and therefore some delayed responses would be expected as she was not in the room with Resident AM. However, the panel determined that Ms Cobbina did not give all the pertinent information that she had access to.

The panel concluded that as a registered nurse Ms Cobbina should have known how to explain how serious the situation was to the 999 call handler in a clear and concise way, which she did not. Therefore, the panel found this charge proved.

Charge 1b and 1c

> "1. On 3 April 2020, in respect of Resident AM,
> b. Failed to notify the LAS of the worsening condition of Resident AM.
> c. Failed to monitor Resident AM's condition with sufficient regularity or at all."

These charges are found proved

The panel considered these charges together as they are closely related to the monitoring of Resident AM's condition. The panel considered the statements of Ms Cobbina and Witness 2 which both stated that at least one of them monitored Resident AM at all times from when the ambulance was called. However, there are no clinical notes of observations and checks being carried out. The panel considered that given that paramedics had been called there was a need to maintain a regular observations and record them so that once the ambulance arrived a full handover could be given.

The panel noted that the Home was short staffed with only one nurse and two carers on duty and that one of those carers was normally allocated to 1 to 1 care with another resident. Therefore, there would potentially be periods when Ms Cobbina and/or Witness 2 were attending to other resident's needs, leaving no one with Resident AM. The panel noted that while there were some notes in the care record, there was no record of the specific observations or monitoring of Resident AM's condition, as would have been expected for a resident in this serious condition.

The panel therefore concluded that Ms Cobbina did not monitor Resident AM's condition with sufficient regularity and as a result of this was unable to notify the LAS of the worsening condition of Resident AM. Both charges are found proved.

Charge 1d

> "1. On 3 April 2020, in respect of Resident AM,

d. Failed to administer cardiopulmonary resuscitation ('CPR') in the absence of a do not attempt cardiopulmonary resuscitation ('DNAR') order."

This charge is found proved

The panel had regard to the statement of Witness 4 who stated that there was no DNAR in place for Resident AM at the time and therefore CPR should have been attempted. The panel noted that the LAS report indicates that there was no attempt at CPR, and there is no mention of attempting CPR in the notes of Ms Cobbina or of Witness 2. Further the panel noted that in Ms Cobbina's record of events there is no record of CPR being attempted and when she discovered Resident AM had no signs of life she simply called to cancel the ambulance, although LAS were already dispatched.

Therefore, the panel concluded that CPR had not been attempted and that there was no DNAR order in place; therefore this charge is found proved.

Charge 1e

"1. On 3 April 2020, in respect of Resident AM,
e. Failed to recognise in a timely manner that Resident AM's condition had become critical."

This charge is found proved

In reaching this decision, the panel took into account its findings at charge 1c that there had not been sufficient observations completed. The panel concluded that by failing to complete sufficient observations it is therefore more likely than not that Ms Cobbina did not notice the deterioration in Resident AM's condition and that it had become critical.

Therefore, the panel found 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 misconduct and, if so, whether Ms Cobbina'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, Ms Cobbina's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The NMC identified the specific, relevant standards where Ms Cobbina's actions amounted to misconduct and that her actions fell significantly short of what would be expected of a registered nurse and placed Resident AM at real risk of actual harm.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Cobbina's fitness to practise impaired on the grounds that her actions were liable to put Resident AM at unwarranted risk of harm and were a significant failure in the fundamental tenets of care that should be expected of a registered nurse. This would bring the reputation of the nursing profession into disrepute.

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

Decision and reasons on misconduct

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

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

> *'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*
>
> *3.1 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*
>
> *8.2 maintain effective communication with colleagues*
>
> *20.1 keep to and uphold the standards and values set out in the Code'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that by failing to adequately perform her duties of providing care for Resident AM during the last moments of their life Ms Cobbina's actions fell significantly short of the standards expected of a registered nurse. While there was significant mitigation, which the panel will consider below, her actions taken as facts would be considered deplorable by fellow practitioners.

The panel found that Ms Cobbina's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Fitness to Practise Library, and the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant*, particularly paragraphs 74 and 76.

The panel finds that Resident AM was put at risk and was potentially caused physical harm as a result of Ms Cobbina's misconduct. Ms Cobbina's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Ms Cobbina has not been in contact with the NMC since 2022 when she informed that she is no longer working and is unlikely to seek to return to work given her age.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, given the lack of any strengthening of practice, or of developed insight the panel was not satisfied that it has been addressed. Therefore, the panel is of the view that there is a risk of repetition and that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because a reasonable person would expect a registered nurse to be able to perform the required monitoring of a resident in a critical condition to the highest standard of care and would be concerned by Ms Cobbina's actions and lack of action.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Cobbina's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Ms Cobbina that it would seek the imposition of a suspension order for 12 months if it found Ms Cobbina's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Ms Cobbina'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 took into account the following aggravating features:

- Conduct that put Resident AM at risk of actual harm
- Limited insight into failings

The panel also took into account the following mitigating features:

- The actions occurred during the very early days of the COVID 19 Pandemic, shortly after the first UK National Lockdown and this was a highly unusual time
- A lack of understanding how COVID 19 affected patients
- The perceived failings of the 999 call handler
- Low staffing levels on the shift
- Previous exemplary nursing practice over a 60 year career

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Cobbina'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 Ms Cobbina'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 Ms Cobbina'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, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 is of the view that although many of these factors are present in this case there are no practical or workable conditions that could be formulated, given that Ms Cobbina has not engaged with the NMC since 2022 and that she has indicated she will not return to nursing practice.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

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

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register, and Ms Cobbina had shown some insight. The panel considered that this was not an attitudinal concern but a single instance of misconduct that occurred at a highly stressful and uncertain period for nurses.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Cobbina's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece from Ms Cobbina addressing each of the concerns the panel identified

- A statement on Ms Cobbina's intentions on returning to nursing practice

This will be confirmed to Ms Cobbina in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Cobbina's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim suspension order of 18 months is necessary to cover any potential appeal period on the grounds of public protection and otherwise in the public interest.

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 substantive order. The panel therefore imposed an interim suspension order for a period of 18 months on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

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

That concludes this determination.