Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 1 September 2025 – Tuesday 16 September 2025

Virtual Hearing

Name of Registrant:	Joyce Efuah Babowa Mensah
NMC PIN:	00I6851E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – 25 August 2003
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, Lay member) Patience McNay (Registrant member) Robin Barber (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Charis Benefo
Nursing and Midwifery Council:	Represented by Simran Ghotra, Case Presenter
Ms Mensah:	Present and not represented
Facts proved by admission:	Charges 1, 2 and 3
Facts proved:	Charges 4a, 4b, 4c, 5a, 5b, 5c, 5d, 5e, 6 and 7
Facts not proved:	Charge 8
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

Ms Ghotra, on behalf of the Nursing and Midwifery Council (NMC), made an application to amend the wording of charges 5e and 6.

Ms Ghotra submitted that the proposed amendment to charge 5e would reflect the evidence of Witness 1 and accurately reflect the misconduct alleged. She submitted that the proposed amendment to charge 6 would allow more clarity on what is to be proved. Further, that the proposed amendments would provide clarity and more accurately reflect the evidence.

The proposed amendments are as follows:

"That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
   e. failed to ensure and/or communicate Patient A's medical history to the ambulance personnel **in a timely manner**

6. Your actions at **any or all of** charge 5a-e led Patient A to lose a significant chance of survival."

Ms Ghotra referred the panel to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), as well as the NMC guidance on 'How a charge becomes final' (reference: PRE-2c). She said that you were put on notice of this application prior to the hearing on 29 August 2025. Her submission was that the proposed amendments did not present undue unfairness to you, and it would be in the interests of justice to amend the charges as proposed.

You indicated that the application appeared to be fair, and you did not oppose it.

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

The panel determined that such amendments were in the interests of justice. It was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. The panel therefore allowed the amendment to ensure clarity and accuracy.

Details of charge [as amended]

That you, a registered nurse

1. Between 31 July and 1 August 2020 in relation to Patient A failed to undertake 15-minute physical observations between 23:45 and 03:00 as required.

2. Your actions at charge 1 led Patient A to lose a significant chance of survival.

3. Between 31 July and 1 August 2020 on one or more occasions between 2345 and 0300 recorded observations within Patient A's clinical records, that they were asleep.

4. Your conduct in charge 3 above was dishonest in that you:

    a. knew you had not observed Patient A sleeping.

    b. sought to conceal that you had not undertaken the observations.

    c. intended any reader of Patient A's records to believe, you had undertaken the observations.

5. On 1 August 2020 in relation to Patient A

    a. failed to use the radios and/or alarms to alert colleagues to a medical emergency.

b. failed to communicate to colleagues adequately or at all, that Patient A was suffering from cardiac arrest and/or a medical emergency.

c. on discovering Patient A on or around 0300 hours failed to commence and/or instruct others to commence cardiopulmonary resuscitation ('CPR')

d. failed to use the automated external defibrillator on Patient A

e. failed to ensure and/or communicate Patient A's medical history to the ambulance personnel in a timely manner.

6. Your actions at any or all of charge 5a-e led Patient A to lose a significant chance of survival.

7. Permitted Colleague A to have an extended break putting patients at significant risk of harm.

8. Failed to keep your immediate life support training up to date.

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

Decision and reasons on application to admit Colleague B's hearsay evidence

Ms Ghotra made an application under Rule 31 to allow the hearsay evidence of Colleague B, namely his investigation interview notes. She also reminded the panel of its power under Rule 22(5) which states that:

'*22.—(5) The Committee may of its own motion require a person to attend the hearing to give evidence, or to produce relevant documents.*'

Ms Ghotra provided a background to the allegations involving Patient A. She submitted that Colleague B was in Patient A's room during your call with a 999-call operator after Patient A was discovered unresponsive in his room. Ms Ghotra submitted that you had allegedly sent Colleague B to bring a defibrillator to Patient A's room and before it could be used, the ambulance crew arrived and assisted Patient A before pronouncing Patient A deceased at 03:46.

Ms Ghotra referred to the principles set out in the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *El Karout v NMC* (2020) EWHC 3079.

Ms Ghotra submitted that Colleague B's investigation interview notes were not the sole or decisive evidence in support of the charges. She submitted that it provided a picture of what happened and was supportive evidence in respect of charges 5b, 5c and 5d. Ms Ghotra submitted that Colleague B had also given evidence at the Coroner's Inquest, and his statement and transcription of evidence was already before the panel.

Ms Ghotra submitted whilst you had denied some of the charges, it was not known whether you had any specific challenges to Colleague B's investigation interview notes. She submitted that no suggestion had been made by you that Colleague B had reasons to fabricate his evidence. Ms Ghotra submitted that the charges in this case were serious and that a finding on the facts would have an adverse effect on your career.

Ms Ghotra submitted that the NMC had made efforts to obtain Colleague B's contact details to no avail. She submitted that the NMC had never had direct contact with Colleague B. Ms Ghotra referred the panel to the email correspondence between Capsticks LLP (on behalf of the NMC) and Witness 2/Colleague A on 12 July 2022, where Witness 2 was asked whether he had received a response after reaching out to Colleague B. Witness 2 indicated that he had contacted Colleague B via his Facebook account and passed on their details to him. He also stated that he did not have Colleague B's personal telephone number and suggested contacting Witness 3 for it.

Ms Ghotra referred the panel to the telephone attendance note dated 8 August 2022 detailing a call to the Coroner's Officer. She submitted that the Coroner's Officer could not provide Colleague B's contact details to the NMC due to General Data Protection Regulation (GDPR) reasons, and it appeared that from that point, no further information was received, and no further attempts were made to obtain Colleague B's contact details.

Ms Ghotra submitted that you were given prior notice that a hearsay application would be made for Colleague B's evidence. She submitted that it was set out in the Case Management Form (CMF) which was sent to you on 2 April 2025, and you were also informed at the case conference on 20 August 2025 with the NMC reviewing lawyer.

Ms Ghotra submitted that it was a matter for the panel to decide whether Colleague B's hearsay evidence could be fairly admitted into evidence.

Ms Ghotra reminded the panel of its power to request that the NMC obtain further evidence if it is concerned that there are any gaps in the evidence which would prevent it from properly performing its function. However, she submitted that the panel had sufficient evidence before it.

You informed the panel that you would like Colleague B's hearsay evidence to be admitted.

The panel accepted the legal assessor's advice on the issues it should take into consideration 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 civil proceedings.

The panel considered the principles set out in paragraph 56 of *Thorneycroft v NMC*:

i. *'whether the statements were the sole and decisive evidence in support of the charges;*
ii. *the nature and extent of the challenge to the contents of the statements;*
iii. *whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
iv. *the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
v. *whether there was a good reason for the non-attendance of the witnesses;*
vi. *whether the Respondent had taken reasonable steps to secure their attendance; and*
vii. *the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

The panel had regard to Colleague B's evidence, which comprised his investigation interview notes. It determined that Colleague B's evidence was relevant to charge 5 and would add more context to the circumstances of the incident.

The panel was satisfied that Colleague B's evidence was not the sole or decisive evidence in respect of any of the charges. The panel had before it, other relevant evidence including the evidence from Witness 1, Witness 2 and Witness 3.

You did not appear to challenge the contents of Colleague B's investigation interview notes, nor did you oppose the application to admit it into evidence, although you had denied many of the charges relating to your conduct during that night.

There was no evidence before the panel to suggest that Colleague B had reason to fabricate his evidence.

The charges were serious, involving allegations that your conduct led to a patient losing a significant chance of survival, and as such, any adverse findings could have an impact on your career.

In determining whether there was a good and cogent reason for Colleague B's non-attendance, the panel had regard to the email correspondence between Capsticks LLP (on behalf of the NMC) and Witness 2, and the telephone attendance note with the Coroner's Officer. It considered that the NMC could have made further enquiries to locate Colleague B or obtain his contact details in order to warn him as a witness. In absence of this, the panel was therefore not satisfied that the NMC had a good and cogent reason for Colleague B's non-attendance as it had failed to take reasonable steps to secure his attendance.

The panel took into account that you had been put on notice about Colleague B's non-attendance as early as April 2025 and then again in August 2025, and you had no objections to Colleague B's evidence being admitted as hearsay.

As a result of Colleague B's non-attendance, the panel and parties would be deprived of the opportunity of questioning and probing his evidence. However, the panel took into account that you did not oppose the application in respect of Colleague B and that his evidence was not therefore contentious. There was also nothing before the panel to suggest that it would be unfair to you to admit Colleague B's hearsay evidence. The panel determined that there was a public interest in the issues being explored fully which supported the admission of Colleague B's evidence into the proceedings.

The panel was mindful of your right to a fair hearing alongside the public interest in these issues being explored fully. Taking all of the above matters into account, the panel concluded that Colleague B's investigation interview notes were relevant to the charges and that it would be fair to admit as hearsay.

In reaching this decision, the panel took into account that it would be able to attach such weight as it deemed appropriate to Colleague B's hearsay evidence once it had heard and evaluated all the evidence at the fact-finding stage.

Background

The NMC received a referral in respect of you on 18 August 2020. You first entered onto the NMC's register on 25 August 2003.

The allegations arose when you were employed by Whitepost Healthcare at [PRIVATE] (the Hospital) as an agency mental health nurse. You started working at the Hospital on 27 June 2011.

At the time of the concerns, Patient A was an in-patient on the [PRIVATE] Ward (the Ward). The Ward was a 10-bedded admission and assessment ward for men aged between 18 and 65 undergoing mental health rehabilitation for complex mental health problems.

Patient A was a 35-year-old male and he had been known to the mental health services since 2009. He was admitted to the Hospital with a diagnosis of paranoid schizophrenia and was detained under Section 3 of the Mental Health Act 1983. Patient A was also diagnosed with a number of medical conditions such as obesity and diabetes, and he had breathing problems.

At the material time, Patient A was on 15-minute observations under the recommendation of the multidisciplinary team. The observations were to monitor Patient A when he slept, and the Hospital policy was that members of staff were required to enter the room of the patient they were observing.

During the night shift between 31 July 2020 and 1 August 2020, you were working on the Ward as the nurse in charge, and you were supported by Witness 2, a support worker. Witness 2 went on break at around 00:15, leaving you as the only staff member on the Ward, and he returned at around 03:00. It is alleged that you had permitted Witness 2 to have an extended break, putting patients at significant risk of harm.

It is alleged that you failed to undertake the 15-minute physical observations of Patient A between 23:45 and 03:00 as required. You had allegedly recorded observations in Patient A's clinical records that he was asleep between 00:00 and 02:45, when the CCTV of the Ward showed that you did not undertake any observations. It is alleged that by doing so, you acted dishonestly, and that your conduct in failing to undertake the observations of Patient A led to a significant loss in Patient A's chance of survival.

You reported that at around 02:45, you did not hear Patient A's usual heavy breathing or snoring, and so you entered his room and found that his lips were blue, and his left hand was hanging off the side of the bed. You went to the nursing station and telephoned different wards at the Hospital to request for assistance for an emergency. However, you allegedly did not use the radio or alarm to alert colleagues to a medical emergency as required, or communicate to colleagues adequately or at all, that Patient A was suffering from cardiac arrest and/or a medical emergency.

You called the [PRIVATE] Ward and spoke to Registrant A, who was working as a nurse on that ward, and you allegedly told her that you thought you had lost a patient which Registrant A had allegedly interpreted to mean that a patient had absconded. When Registrant A and other colleagues arrived on the Ward, you allegedly did not start or instruct others to commence CPR. It is alleged that there was approximately a 12-minute delay in starting cardiopulmonary resuscitation (CPR), and this was only commenced after you were prompted by the 999-call operator. You also allegedly failed to use the automated external defibrillator on Patient A.

The paramedics arrived at the Hospital at around 03:00 and they allegedly saw Patient A laying on the floor with a member of staff performing CPR ineffectively, and the paramedics then took over. It is alleged that it took 45 minutes for Patient A's medical records to be provided to the paramedics and you allegedly failed to ensure and/or communicate Patient A's medical history to the ambulance personnel in a timely manner.

Patient A died during the shift in question.

It is further alleged that you failed to keep your immediate life support training up to date, as it was three years out of date at the time.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made admissions to charges 1, 2 and 3.

The panel therefore found charges 1, 2 and 3 proved, by way of your admissions.

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 Ghotra on behalf of the NMC, and by you.

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 evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Paramedic who attended the Ward following Patient A's cardiac arrest;
- Witness 2/Colleague A: Support Worker who was working on the Ward during the night shift in question;
- Witness 3: Clinical Lead Nurse at the Hospital; and

- Witness 4: Consultant Cardiologist who produced an independent medical report for the Coroner's Inquest in respect of Patient A.

The panel also took into account the hearsay evidence of the following witness:

- Witness 5/Colleague B: Support Worker who came to assist you from another ward on the night in question.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. The panel also took into account the NMC guidance relevant to the issues in this case.

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

Charge 4

That you, a registered nurse

4. Your conduct in charge 3 above was dishonest in that you:
    a. knew you had not observed Patient A sleeping.
    b. sought to conceal that you had not undertaken the observations.
    c. intended any reader of Patient A's records to believe, you had undertaken the observations.

This charge is found proved.

In reaching this decision, the panel took into account its finding, by way of your admission, that between 31 July and 1 August 2020, on one or more occasions between 23:45 and 03:00, you recorded observations within Patient A's clinical records, that they were asleep.

The panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 in which the Supreme Court, giving judgment, stated as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel first considered your state of mind as to the facts, i.e. whether you knew that you had not observed Patient A sleeping, whether you sought to conceal that you had not undertaken the observations, and whether you had intended any reader of Patient A's records to believe you had undertaken the observations.

The Hospital's '*Observation Policy*' stated that:

> '*…For night-time observation, the allocated nurse will enter the patient's room and do a physical check to establish safety and presence before signing the form.*'

You told the panel that you were mainly in the office between 23:45 and 03:00 reading through patient records and that you did not carry out the 15-minute observations required for Patient A in line with the policy. When carrying out observations, it would be usual not

to go into Patient A's room because staff would rely on the sound of Patient A's loud snoring to indicate that he was asleep, and therefore there was no need to go into his room. As Patient A's room was opposite the clinical room, he could be heard snoring. You explained that this was a common practice among you and your colleagues. Whilst you accept that you did not carry out 15-minute observations on Patient A, you denied that your observation entries were dishonest.

The panel was mindful that such records are subject to inspection by clinical audits, so it is vital that a true account of patient observations are documented. In addition, the '*Observation Policy*' stated:

> '*The overall aim of any observation is to reduce risk to the vulnerable patient and/or others by promoting their safety. It is hoped that the patient observations will contribute to the clinical assessment and treatment of patients, thereby assisting in their overall treatment and care.*'

The panel also accepted Witness 3's evidence that instead of making false entries, you could have left the clinical records blank and completed an incident form about the circumstances or challenges you were facing, i.e. that you were the only member of staff on the shift and Witness 2 was on a break.

The panel found that by completing the 13 observation entries in the clinical records that Patient A was asleep/appeared to be asleep, you knew that it would look as though the observations in line with the policy had been carried out. You accepted this in evidence. The panel determined that your entries in the clinical records concealed the fact that you had not actually carried out the observations and by doing so, you intended any reader to believe that you had undertaken them.

The panel next considered whether, in the context of what you knew, you were dishonest by the standards of the ordinary decent person. The panel was satisfied that by the objective standards of ordinary decent people, your actions at charge 3 were dishonest.

An ordinary decent person would expect a registered nurse to make truthful and accurate entries in the clinical records of patients.

The panel therefore determined that your conduct at charge 3 was dishonest in that you knew you had not observed Patient A sleeping, sought to conceal that you had not undertaken the observations, and intended any reader of Patient A's records to believe you had undertaken the observations. It found charge 4 proved in its entirety.

Charge 5a

That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
    a. failed to use the radios and/or alarms to alert colleagues to a medical emergency.

This charge is found proved.

In reaching this decision, the panel first took into account the '*protocol for panic alarms activation and staff actions*' which stated:

> '*When the panic alarms are activated, the staff or colleagues on that ward/ area must also broadcast the emergency using the radios.*
> *When broadcasting you must use the following CODES; FALSE ALARM, CODE BLUE, CODE RED*'

The panel therefore found that there was a duty on you to use the radios and/or alarms to alert colleagues to the medical emergency involving Patient A. You also agreed that you had a duty to use the alarms and/or radios as per Hospital policy.

You admitted in evidence that you did not use the radio and/or alarms after you discovered Patient A unresponsive but acted immediately to obtain the help required by using the telephone. You said that it was uncommon for radio's to be used during the

nightshift and that on previous occasions when using the radio help had not arrived immediately. You also said that "*half the time, there were no batteries and they were not working*". You could not recall whether you had an alarm on you at the time of the incident but said that an alarm would have been inside Patient A's room.

The Hospital's investigation report stated:

> '*Joyce admits to not triggering the panic alarm based on her belief that no one would respond and a quicker response being gained by calling wards individually which she states she knew had male staff. She did not call [PRIVATE]. There were male staff and experienced RMN staff on this ward who was not summoned until the paramedics had declared the casualty deceased. Joyce did not activate the emergency alarm or escalate this by radioing the wards to escalate the emergency in accordance to hospital policy. Staff contacted said the information they were given did not indicate to theme that this was a medical emergency. Joyce has informed the wards "I think I may have lost a patient and I need some help" This did not alert staff to the need for an urgent response and therefore resulted in a delay in staff arriving as some staff waited to be relieved in order for to leave to support staff…*
>
> *…*
>
> *Joyce admits to never having had to use the walkie talkie radio before and stated that using this didn't come to her mind at the time once the incident was underway and she prioritized calling the wards and emergency services instead.*'

The panel had in mind that after discovering Patient A, you had used the telephone in the office to contact other wards including that of Registrant A to request for assistance, but there was at least one other ward that you did not contact.

In light of your admission, the panel found that on 1 August 2020, you failed to use the radios and/or alarms to alert colleagues to a medical emergency. This charge was therefore found proved.

Charge 5b

That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
    b. failed to communicate to colleagues adequately or at all, that Patient A was suffering from cardiac arrest and/or a medical emergency.

This charge is found proved.

In reaching this decision, the panel found that as the nurse in charge of the Ward, there was a duty on you, as a basic nursing skill, to communicate to colleagues that Patient A was suffering from cardiac arrest and/or a medical emergency.

The panel had in mind that after discovering Patient A, you had telephoned some of the other wards at the Hospital, instead of using the alarms and/or radios. It determined that your method of communicating the emergency was inadequate, because you were not communicating to as many colleagues as you could have done, in light of the seriousness of the incident.

You stated that you were in a panicked state and were not aware of how you were communicating with colleagues.

Registrant A's evidence in the investigation interview was that when you called her ward and said, "*I think I've lost a patient and I need your assistance*", she had assumed that a patient had absconded as you did not give any other details. She stated that when she arrived on the Ward, you were on the phone to emergency services, and she was '*waiting for [you] to give [her] instructions as it was not immediately clear what the emergency was*'. Registrant A stated that she did not receive any instruction from you, '*apart from to go and let the emergency services in*'.

In addition, the CCTV footage of the corridor outside Patient A's room showed members of staff, including Registrant A, standing around after they had arrived on the Ward.

In the notes of Colleague B's investigation interview, he stated that he was working on a different ward when he was told that '*[PRIVATE] called and requested assistance for "an emergency" and if someone could come to the ward.*' He stated that when he arrived on the Ward, you were on the phone to emergency services, and he was waiting for instructions to find out what to do and how to help. The notes stated:

> '*Yes I asked [Witness 2] what was going on and he said we "lost" a patient. [Witness 2] carried on doing observations. There did not appear to be any plan to manage the situation and as I did not know what was going on I was waiting for instructions from the Nurse in charge. In hindsight I know now we should have waited with the patient and started the CPR sooner but I was waiting for instruction.*'

Witness 2's witness statement dated 7 October 2022 stated that:

> '*At roughly 02:55, I entered Patient A room after [Colleague B] telling me about Patient A. I saw Patient A on their bed unconscious and the Nurse on the phone to the paramedics which I believe was on loudspeaker. The Nurse told me that Patient A was in cardiac arrest.*' [sic]

However, in oral evidence, Witness 2 told the panel that he could not remember if you gave him instructions or informed him about what was happening to Patient A.

The panel determined that had you communicated adequately to your colleagues that Patient A was suffering from cardiac arrest and/or a medical emergency, then their actions and responses to the incident after arriving on the Ward would have been better informed that Patient A was suffering from a cardiac arrest and/or there was a medical emergency. It found that on the balance of probabilities, on 1 August 2020, you had failed in your duty to communicate to them adequately, and it therefore found charge 5b proved.

Charge 5c

That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
    c. on discovering Patient A on or around 0300 hours failed to commence and/or instruct others to commence cardiopulmonary resuscitation ('CPR').

This charge is found proved.

In reaching this decision, the panel took into account the Hospital's '*Managing Medical Emergencies*' policy, which stated that:

> '*A cardiac arrest is the ultimate medical emergency - the correct treatment must be given immediately if the person is to have any chance of surviving. The interventions that contribute to a successful outcome after a cardiac arrest can be conceptualised as a chain - Chain of Survival…*
>
> *Early recognition and call for help – to prevent cardiac arrest*
> *Early CPR – to buy time*
> *Early defibrillation – to restart the heart*
> *Post resuscitation care – to restore quality of life*'

The panel therefore found that on discovering Patient A at or around 03:00, there was a duty on you to commence and/or instruct others to commence CPR.

You told the panel that when you discovered Patient A, you did the "*ABCs*" but could not commence CPR because you were unable to turn him over onto his back due to his size. You said that you went to the office to call other wards in order to request assistance, before calling the emergency services. You accepted that you did not commence CPR until you were instructed to do so by the emergency call handler.

In the recording of your call with the emergency call handler, the panel found that you did not commence CPR until you were instructed to do so by them.

Based on Witness 4's assessment of the CCTV footage and your telephone calls to the emergency call handler, it took you around 12 and a half minutes to commence CPR on Patient A, and you did not deny this evidence. Witness 4 stated that in the circumstances, the important thing was to commence CPR and do your best, irrespective of whether you could move Patient A onto the floor. He highlighted that it was vital that CPR commenced as soon as possible, within seconds or minutes of the patient being found.

The panel determined that your lack of immediate action and the subsequent approximately 12-and-a-half-minute delay in commencing CPR was significant enough that you had failed in your duty to do so immediately upon discovering Patient A at or around 03:00.

In relation to whether you had instructed others to commence CPR, you told the panel that you had learnt from the Coroner's Inquest that you had instructed Colleague B to commence CPR. However, in the recording of the call with the emergency call handler, you had only instructed him to assist you in administering CPR after the call operator had instructed you to commence it.

In addition, the transcript of your evidence at the Coroner's Inquest stated that:

'*[Question]: Inaudible, you can see halfway down erm, the ambulance service, says is anyone doing CPR at the moment and you say oh hold on and it says talking in the background can't hear, can you start CPR. Who were you speaking to?*

[You]: Oh, it was at that time that I realised that [Colleague B] had come into the ward so I inaudible because inaudible

[Question]: What, did you ask [Colleague B] to start CPR?

[You]: *No because I, I knew he was going to have the same problem trying to turn him onto his back*

…

[Question]: *… I'm asking you did you ask anybody to start CPR?*

[You]: *No, I did not*'.

The panel therefore found that you had also failed to instruct others to commence CPR on Patient A.

In all the circumstances, the panel determined that on 1 August 2020, upon discovering Patient A on or around 03:00, you failed to commence and/or instruct others to commence CPR on him. It therefore found charge 5c proved.

Charge 5d

That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
    d. failed to use the automated external defibrillator on Patient A.

This charge is found proved.

In reaching this decision, the panel took into account the Hospital's '*Managing Medical Emergencies*' policy, which stated:

'*Automated External Defibrillator (AED)*
The AED is used for a patient who is unconscious, and non-breathing. This needs to be attached and utilised within 4 minutes of the victim collapsing to be most effective.'

The panel therefore found that there was a duty on you to use the automated external defibrillator on Patient A after you had discovered he was unresponsive.

Witness 3's witness statement dated 28 October 2022 stated:

> '*I asked the Nurse if they had used an AED and they confirmed that this had not been used until the paramedics arrived, as they had asked [Colleague B] to obtain the AED but they had brought the bag without the AED.*'

You told the panel that you had completed your basic life support (BLS) training and the use of an automated external defibrillator was part of that training. You also admitted that you did not use the automated external defibrillator on Patient A. You stated that after you had called 999, you went to get the defibrillator and were in the process of attaching it when the paramedics arrived to attend to Patient A.

In light of your admission and the evidence before it, the panel found that on 1 August 2020, you failed to use the automated external defibrillator on Patient A. This charge was therefore found proved.

Charge 5e

That you, a registered nurse

5. On 1 August 2020 in relation to Patient A
    e. failed to ensure and/or communicate Patient A's medical history to the ambulance personnel in a timely manner.

This charge is found proved.

In reaching this decision, the panel found that as the nurse in charge of the Ward, there was a duty on you to ensure and/or communicate Patient A's medical history to the ambulance personnel or paramedics in a timely manner, in order for them to provide the most appropriate medical assistance to the patient.

Witness 1 told the panel that it was important for the paramedics to find out Patient A's medical history at an early stage, as conditions like diabetes and sleep apnoea might have changed the treatment provided, although it may not have changed the outcome. He stated that in his experience, he usually received medical history within five minutes of attending the scene of a medical emergency, but when he attended the Ward, it took approximately 45 minutes for a member of staff to provide Patient A's medical history in the form of medical records.

Witness 4's evidence was that it was important for medical history to be communicated to paramedics in a timely manner, as it could assist in confirming the possible cause of the emergency.

You told the panel that you were aware of Patient A's medical conditions, and you accepted that you could have passed this on to the paramedics if they had asked you. You stated that you could not remember if you had conversations with the paramedics about Patient A's medical history because "*so much was going on*".

You said that you were having difficulties finding the relevant information on Patient A's electronic medical records. Another nurse was contacted from a different ward to help access the information, which took around 45 minutes to provide.

There was also no evidence that you had asked anyone else to communicate Patient A's medical history to the paramedics in a timely manner, or before the paramedics received the medical records.

The panel therefore determined that on 1 August 2020, you failed to ensure and/or communicate Patient A's medical history to the ambulance personnel in a timely manner, and so charge 5e is found proved.

Charge 6

That you, a registered nurse

6. Your actions at any or all of charge 5a-e led Patient A to lose a significant chance of survival

This charge is found proved in respect of your actions at charges 5b, 5c and 5d.
This charge is found NOT proved in respect of your actions at charge 5a and 5e.

In reaching this decision, the panel took into account its findings at charges 5a, 5b, 5c, 5d and 5e.

Charge 5a

The panel did not find that your actions at charge 5a led Patient A to lose of significant chance of survival.

The panel took into consideration the culture and practices of the Hospital in relation to the use of radios and alarms during a night shift.

Witness 2 told the panel that he understood that radios were available, but he did not know where they were kept on the Ward, and he had not seen anyone use them at the Hospital. He stated that the common practice was that if an alarm from another ward went off during a shift, members of staff would only attend if their own wards were sufficiently staffed.

You also provided an example of a previous experience, where you used an alarm during a night shift, but colleagues from other wards were reluctant to attend your ward if they were alone in manning their own wards. You maintained your evidence that after discovering Patient A, you had prioritised telephoning the other wards because you really

wanted to speak to someone for assistance. You felt that obtaining help immediately was best done if you spoke to people directly.

The panel determined that there was a poor culture on the Ward during the night shift which led members of staff not to comply with Hospital protocol in relation to the use of radios and alarms. In its view, if you had attempted to communicate via radio or raise the alarm on the night in question, based on your previous experience, there was no guarantee that help would have arrived any sooner than alerting your colleagues over the telephone. Accordingly, this charge is not found proved in relation to charge 5a.

Charge 5b

The panel determined that your actions at charge 5b led Patient A to lose of significant chance of survival.

Witness 4's evidence was that everyone should know that communication during a medical emergency where a patient has suffered a cardiac arrest is essential and time is of the essence. He told the panel that any delay would reduce a patient's chance of survival exponentially. The panel therefore concluded that your lack of communication or instruction to colleagues resulted in a lack of action being taken as soon as it could have been, causing a delay and a significant reduction in Patient A's chance of survival.

Charge 5c

The panel determined that your actions at charge 5c led Patient A to lose of significant chance of survival.

In his independent medical report, Witness 4 stated:

'*The outcome in terms of survival at any timepoint as has been clearly highlighted depend on the nature of the initial rhythm and gap between onset of cardiac arrest and delivery of prompt and effective and definitive CPR and early defibrillation.*

Immediately at the onset of cardiac arrest due to VF/VT up to 5 minutes I consider there would have been >50% chance of successful resuscitation.

Between 5 – 10 minutes there would have been an exponential decline in chances of successful resuscitation (achieving ROSC) to 10 – 20%.

Beyond 10 minutes if had a shockable rhythm then chance of ROSC would drop further to below 10%.'

Witness 4 confirmed this in oral evidence and stated that over time, survival rates decrease exponentially for patients who suffer cardiac arrests.

Upon discovering Patient A, you failed to commence and/or instruct others to commence CPR, and it took you a subsequent 12 and a half minutes to commence it, which based on Witness 4's evidence reduced his chance of survival to below 10%; a significant loss.

Charge 5d

The panel determined that your actions at charge 5d led Patient A to lose of significant chance of survival.

In his independent medical report, Witness 4 stated:

'*Defibrillation within 3–5 min of collapse can produce survival rates as high as 50–70%. This can be achieved by public access and onsite AEDs. Each minute of delay to defibrillation reduces the probability of survival to discharge by 10–12%. The links in the chain work better together: when bystander CPR is provided, the*

decline in survival is more gradual and averages 3–4% per minute delay to defibrillation.'

Witness 4 told the panel that the early use of the defibrillator was the only way of securing the survival of a patient who has suffered a cardiac arrest, and by not using it, the patient's chance of survival is zero.

The panel had found that you failed to use the automated external defibrillator on Patient A at all, and so your omission in this regard resulted in a significant reduction in Patient A's chance of survival

Charge 5e

The panel did not find that your actions at charge 5e led Patient A to lose of significant chance of survival.

Witness 4 told the panel that whilst you might have made the job more difficult for the paramedics, your failure to ensure and/or communicate Patient A's medical history to them in a timely manner did not result in a loss of a significant chance of survival for Patient A. He stated that your failure took Patient A's small chance of survival to an even smaller chance of survival. However, the panel determined that the outcome would not have changed significantly had you ensured and/or communicated the information to them in a timely manner.

Notwithstanding its decisions in respect of charge 5a and 5e, the panel determined that each one of your actions at charges 5b, 5c and 5d cumulatively increased Patient A's loss of a significant chance of survival. The panel therefore found charge 6 proved.

Charge 7

That you, a registered nurse

7. Permitted Colleague A to have an extended break putting patients at significant risk of harm

This charge is found proved.

In reaching this decision, the panel took into account Witness 2/Colleague A's witness statement dated 7 October 2022 which stated:

> '*I went on my break at 00:15 on 1 August 2020, leaving the Nurse as the only staff member on the ward and returned at 02:55. A normal night shift break was two hours but I am not sure where this was set out but I had travelled a 156 miles that night to get to the Hospital so the Nurse verbally agreed that I could have extra time to rest as was also not feeling well. Due to COVID guidance, we could not take breaks on the Ward and had to go downstairs to my car.*'

In his evidence to the panel, Witness 2 maintained that you had agreed to his extended break during the shift.

You told the panel that you did not recall making an agreement with Witness 2 for an extended break. You stated that had you agreed to this, you would have asked him about a return time.

The panel had heard from Witness 3 that staff members working the night shift were entitled to a two-hour break. On this basis, Witness 2's break would have ended at around 02:15. However, there was no evidence to suggest that you had made an attempt to contact him after that point, nor did you seek to find out why he had not returned from his break. The panel therefore found that you had at the very least provided implicit permission for Colleague A to have an extended break.

Due to the extended break, Witness 2 was not on duty at the time you discovered Patient A unresponsive. The panel considered that had Witness 2 not taken an extended break,

he would have been on the Ward and able to assist you in responding to the emergency. In light of this, the panel decided that patients were put at significant risk of harm when you permitted Witness 2 to have an extended break. It therefore found charge 7 proved.

Charge 8

That you, a registered nurse

8. Failed to keep your immediate life support training up to date

This charge is found NOT proved.

In reaching this decision, the panel took into account the Hospital's '*Managing Medical Emergencies*' policy, which stated:

> '*All staff will be trained to administer Adult Basic Life Support (BLS) and the use of AED (automated external defibrillator).*
>
> *Registered Nurses and Medical Staff working in services where Rapid Tranquilisation (RT) may be used will also be trained to administer Immediate Life Support (ILS).*'

This policy indicated that there was a duty on staff at the Hospital to have completed basic life support (BLS) training as a mandatory requirement, whereas immediate life support (ILS) training was only for staff working in services where rapid tranquilisation may be used. There was no evidence that you were working in a department where rapid tranquilisation might have been used.

You told the panel that your BLS training was mandatory, and you kept it up to date. You stated that you were not aware of any duty to keep your ILS training up to date since it was not a mandatory training course.

Witness 4's evidence was that, in any event, the BLS training was sufficient for you to have carried out the first steps of treatment after Patient A's cardiac arrest, and the ILS training was not essential.

The panel could not find that there was a duty on you to keep your immediate life support training up to date. It therefore found charge 8 not proved.

Fitness to practise

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

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

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

Your evidence on misconduct and impairment

The panel heard evidence from you under oath.

You told the panel that you have always acknowledged the seriousness of the lapses in your practice on the night of the incident. You stated that you have always questioned how

much of a difference it would have made to Patient A's survival and that the thought would "*plague you until the end of your days*". You said that you have considered all the things you would have done differently, from just carrying out the 15-minute observations as you should have; documenting them accurately; getting Colleague A back from his break earlier; and communicating accurately and precisely to your colleagues.

[PRIVATE], but you still see the importance of communicating clearly and following best practice by ensuring the radios were in use and not just joining the culture as you had found it. You said that you appreciated how much difference that would have made. You stated that you could acknowledge the significant delay in commencing CPR or the use of the defibrillator and you accepted how much of a difference that would have made. You stated that you fully accepted your shortcomings and deeply regretted them.

You told the panel that at your initial NMC interim order hearing in September 2020, when you received no interim order, you were surprised because until the hearing, you had judged yourself as incompetent to practise as a nurse. You stated that after you were given the opportunity to continue working, you made a promise to yourself to ensure that every patient in your care received "*the full interventions and beyond*", according to care plans, organisational procedures and practices. You said that you promised to work hard to redeem yourself.

You said that you have consciously removed yourself from in-ward environments because you knew it would take you a long time to get the events of the night shift involving Patient A out of your head. You stated that you also stopped doing any extra work or work within areas you were not familiar with.

You stated that in the last five years, you have ensured that all your mandatory training courses are up to date. [PRIVATE]. You stated that you recognise that observations are a key skill of a mental health nurse and although you have not worked on an in-patient ward to improve this skill, it remains one of the main skills that you have used in the past five years. You said that it has helped you to interpret signs of mental disorder and you have

been able to make recommendations for interventions. You stated that in all the areas you have worked, you have made yourself accountable to your line managers and supervisors, and you ensure that you talk about the incident in your supervisions, ask how you're improving in the area that you lapsed in and take the learning forward to every new environment.

You said that you have used the negative and painful experience to caution and teach students in your role as a practice assessor and practice supervisor, and also to help newly qualified nurses in their preceptorship months. You stated that you caution them to look out for bad practices in order to avoid the consequences you are going through and to adhere to best practices wherever they find themselves.

You told the panel that on two occasions, you were at [PRIVATE] train station when you heard a request for assistance to attend to a medical emergency and responded, albeit on both occasions by the time you had arrived at the scene, others had arrived before you. You stated that you had the urge to prove to the public that you can be caring, responsive, compassionate and selfless.

You reiterated that you have developed genuine insight into what went wrong, and you are committed to ensuring it never happens again. You asked the panel to consider that you have been candid and open in admitting your failings. You stated that you have demonstrated insights, both, into your conduct and any underlying factors that contributed to it, including the organisational culture. You said that you firmly believe the risk of repetition is low. You stated that you remain committed to safe, effective and compassionate practice. You said that you deeply regret your actions and the anxiety they may have caused Patient A's family members and your colleagues.

You stated that you have learnt from this experience, and you are determined to use it to become a safer, stronger and more accountable professional. You asked the panel to allow you to continue to serve in this profession, demonstrating through your future practice the lessons you have learnt and your commitments to those in your care. You

also asked the panel to consider this a serious but remediable lapse rather than dishonesty.

You indicated that you are aware of the NMC code of conduct, and you agree that your conduct fell far below the standards expected of a nurse.

In respect of your failings, you stated that it would have been difficult to do anything differently because there were "*only two nurses assigned on the Ward*" and you all accepted the situation for what it was, however in hindsight, you would escalate the matter to ensure that you were supported.

[PRIVATE]

You informed the panel that in the first two years after the incident, you worked solely in carrying out assessments. This involved triaging referrals from General Practitioners (GPs) and other sources, calling patients and assessing them in person or over the phone, and writing up assessment reports with recommendations to either the GPs or your treatment team. You stated that you then moved back to the community, where you were allocated a caseload of patients and came up with interventions via care plans, and worked with them into recovery, including supporting them with medication management, managing their homes, and ensuring their finances were in order.

You clarified that since the initial interim order hearing in September 2020, you had no contact again from the NMC until March 2020, when another interim order hearing was scheduled, and interim conditions of practice were imposed on your practice.

You agreed that it is your responsibility as a registered nurse to ensure that you are following best practice and the responsibility does not lie solely with your employer.

In relation to the dishonesty that had been found proved, you stated that with hindsight, you could see how your actions could be viewed as dishonest. You said, however, that at

the time when you completed the clinical records, it was not because you were concealing anything, but rather it was just something that you and your colleagues did. You stated that you never considered those actions as dishonest as it was never your intention to hide something from anyone. You stated that nobody who knows you would ever describe you as dishonest because you are very open and honest about your mistakes. You admitted that with hindsight, you could see the risks related to recording something you had not done.

You stated that you have not dealt with any medical emergencies in your capacity as a registered nurse since the incident. You said that if you were to find yourself in a similar situation, you would not let your emotions or panic hinder your ability to carry out your role because of the consequences of the incident and the fact that you do not "*think [it] would ever leave [you] until … [you] take it to [your] grave*".

You provided the panel with training certificates from 2020 and training logs to demonstrate successful completion in various mandatory training courses including basic life support. You also provided images of webpages from training courses in '*The Importance of Good Record Keeping*' (dated 4 March 2025), '*Resuscitation Adult Level 2*' (undated), and '*National Early Warning Score (NEWS) 2*' (undated). You informed the panel that you did not have certificates of completion for any of these courses because they were completed through your agency at the time, and payment was required if you wished to receive them.

You informed the panel that you have been out of work since April 2025 because of the interim conditions of practice that were imposed on your practice in March 2025. You stated that there was an "*erroneous condition*" which was misunderstood by a new manager in your previous job, and this led to other issues. You said that you [PRIVATE] and so asked to step away from the role. [PRIVATE].

You acknowledged that an ordinary member of the public would view your actions at the charges found proved as not doing your job correctly. You accepted that it did not reflect

well on the reputation of the nursing profession and that it would impact on the trust that fellow nurses and the public have on nursing as a profession.

Submissions on misconduct

Ms Ghotra referred the panel to the NMC guidance on '*misconduct*' (reference: FTP-2a) and submitted that your conduct in all the charges found proved constituted serious misconduct. She highlighted that your failures related to basic and critical aspects of nursing practice, which should have been undertaken effectively and appropriately. Ms Ghotra submitted that your conduct fell far below the standards expected of a registered nurse and led Patient A to lose a significant chance of survival. She also reminded the panel of its finding that you had acted dishonestly in completing the entries in Patient A's clinical records. Ms Ghotra submitted that your conduct would be viewed as deplorable by fellow practitioners and the public. She referred to *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code), and submitted that you had breached parts 1.2, 1.4, 8.2, 8.6, 10.1, 10.3, 20.1, 20.2 and 20.8.

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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Ghotra referred to the case of *CHRE v NMC and Grant*, which endorsed Dame Janet Smith's "*test*", and submitted that all four limbs were engaged. She submitted that you had in the past acted and are liable in the future to act so as to put a patient or patients at unwarranted risk of harm. Ms Ghotra highlighted the panel's finding that your conduct led

Patient A to lose a significant chance of survival, as well as your evidence that you have not worked in a ward environment since the incident, [PRIVATE].

Ms Ghotra submitted that you have brought the nursing profession into disrepute and your actions fell significantly short of the standards expected of a registered nurse. In addition, your actions directly conflicted with the key responsibilities and qualities that the public expect of a registered nurse, such as being able to respond to medical emergencies properly, carry out increased observations or any observations as required on a patient, and complete documents accurately and honestly. Ms Ghotra submitted that your conduct is likely to erode the trust and confidence the public places in the nursing profession.

Ms Ghotra submitted that nurses are required to promote professionalism and trust. She submitted that your actions were egregious and breached the fundamental tenets of the nursing profession as set out in the Code. She referred to the panel's finding of dishonesty and submitted that you had demonstrated a lack of sufficient and proper insight into the dishonesty element of your misconduct, and you are liable to act dishonestly in the future.

Ms Ghotra asked the panel to consider the NMC guidance titled '*insight and strengthened practice*' (reference: FTP-15), '*can the concern be addressed?*' (reference: FTP-15a), '*has the concern been addressed?*' (reference: FTP-15b) and '*Is it highly unlikely that the conduct will be repeated?*' (reference: FTP-15c).

Ms Ghotra submitted that it could be said that you have some emerging insight into your misconduct, particularly in failing to carry out the observations and some of the misconduct at charge 5. However, in her submission, there had been a focus, particularly in your oral evidence and written reflections, on the shortcomings and organisational failings of the Hospital, the ward culture, your colleagues and Patient A.

In conclusion, Ms Ghotra submitted that the concerns cannot be said to have been fully addressed, and therefore there remains a risk of repetition. She submitted that a finding of impairment is also required to uphold proper professional standards, and if a finding of

impairment were not made, this would undermine public confidence in the profession and the NMC as a regulator.

Ms Ghotra therefore asked the panel to find you currently impaired on both public protection and public interest grounds.

You highlighted the opportunity you have had in the last five years to redeem yourself in the areas of concern. You asked the panel to not only look at what happened on the night of the incident, but to also consider the efforts you have made to become highly effective in the areas that you have worked.

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 and *CHRE v NMC and Grant*. The panel also had regard to the NMC guidance on '*misconduct*' (reference: FTP-2a) and '*impairment*' (reference: DMA-1).

Decision and reasons 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.'*

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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.

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues.

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:

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly.

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...

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to.'

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

Charges 1 and 2

The panel considered your conduct at charges 1 and 2, which you made admissions to. In the panel's view, your failure to undertake Patient A's 15-minute observations as required constituted a failure and omission in a basic and fundamental area of nursing practice. By failing to undertake the observations, you did not follow Hospital policy and as a result, a vulnerable patient on a mental health ward was not observed for some three hours and 15 minutes, and this led to him losing a significant chance of survival. The panel considered that had those checks been carried out, you would have been aware of Patient A's deterioration and responded quicker to the medical emergency.

The panel determined that you had failed to uphold the proper standards expected of you as a registered nurse and it found that your actions would be regarded as deplorable by fellow practitioners. The panel therefore found that your actions at charges 1 and 2 fell seriously short of the conduct and standards expected of a registered nurse, and therefore amounted to misconduct.

Charges 3 and 4

In considering your actions in recording observations within Patient A's clinical records that he was asleep, when you had not undertaken the observations, the panel determined that your conduct was a serious deviation from the standards expected of you. It considered the effect of inaccurately documenting something you had not done; particularly as other practitioners would have relied on the clinical notes.

In relation to charge 4, the panel considered that you had a duty as a registered nurse to be open and honest, and act with integrity, but you did not do so. It was of the view that your dishonesty in respect of charge 3 brought your integrity into question and was a significant departure from the conduct and standards expected of a registered nurse. The panel was therefore satisfied that your dishonesty was so serious as to amount to misconduct.

The panel therefore determined that your actions at charges 3 and 4 fell seriously short of the conduct and standards expected of a registered nurse and therefore amounted to misconduct.

Charge 5a

The panel considered your reason for choosing to call other wards by telephone, instead of using the radios and/or alarms to alert colleagues to the medical emergency involving Patient A. It was satisfied that you had decided to use an alternative means of communicating as you felt it would bring people to your assistance as quickly as possible, given the difficulties you described when requesting help using the radios and alarms. The panel was also reminded of its finding that your failure at this charge did not lead Patient A to lose a significant chance of survival. It therefore determined that your actions at charge 5a were not so serious as to amount to misconduct.

Charges 5b, 5c, 5d (and 6 in relation to these charges)

The panel considered the series of failures at charges 5b, 5c and 5d, in that you failed to communicate to colleagues adequately that Patient A was suffering from cardiac arrest and/or a medical emergency; you failed to commence and/or instruct others to commence CPR on discovering Patient A; and you failed to use the defibrillator on Patient A. It determined that each of these failures related to fundamental areas of nursing practice that a reasonable and competent nurse would have been expected to do. In addition, your failures in these areas led Patient A to lose a significant chance of survival. The panel

therefore determined that your actions at charges 5b, 5c, 5d and 6 in relation to these charges fell seriously short of the conduct and standards expected of a nurse and therefore amounted to misconduct.

Charge 5e

The panel decided that failing to ensure and/or communicate Patient A's medical history to the ambulance personnel in a timely manner was unprofessional. It considered, however, that this delay did not cause Patient A to lose a significant chance of survival. The panel was not satisfied that your failure at charge 5e was so serious as to amount to misconduct.

Charge 7

The panel considered that by permitting Colleague A to have an extended break, at least implicitly, patients were put at significant risk of harm because you were the only member of staff on the Ward between 23:45 and 03:00. It determined that the longer the period of Colleague A's break beyond the standard two hours, the increased chance of issues occurring on the Ward while you were alone. The panel therefore concluded that your actions at charge 7 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, 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. 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 determined that limbs a), b), c) and d) are engaged in this case. The panel found that patients were put at risk of harm, and in relation to your actions at charges 1, 5b, 5c and 5d, Patient A lost a significant chance of survival as a result of your misconduct.

The panel determined that your misconduct had breached the fundamental tenets of the nursing profession, which included making sure that any treatment, assistance or care for which you were responsible was delivered without undue delay. It considered that by failing to act as expected in a medical emergency involving Patient A, you brought the reputation of the nursing profession into disrepute.

The panel also found that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

In its consideration of the future, the panel had regard to the factors set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin):

- whether the conduct is capable of being addressed;

- whether it has been addressed; and
- whether it is highly unlikely to be repeated.

The panel was satisfied that the misconduct in respect of your clinical failings is capable of being addressed through relevant training and support. It determined that whilst your dishonesty at charge 4 was serious, it was not on the higher end of the scale of seriousness, nor at a level at which it could not be addressed by you.

In relation to whether your misconduct has been addressed, the panel first considered your insight. It had regard to your oral evidence and written reflections. The panel took into account that you had made admissions to some of the charges from the outset and demonstrated an understanding of how your actions put patients and Patient A in particular at a risk of harm, and why what you did was wrong and how this impacted negatively on Patient A, his family, your colleagues and the reputation of the nursing profession. You also demonstrated remorse for your misconduct.

The panel found, however, that you have not yet developed full insight into your misconduct as you had not sufficiently demonstrated how you would handle the situation differently in the future. It considered that at some points during your oral evidence, you appeared to make excuses for your misconduct by blaming the systemic failings of the Hospital and the Ward culture. However, there was nothing before the panel to suggest that on that night in question, there was anything that would have prevented you from responding to Resident A's condition in an appropriate manner, had you carried out the tasks expected of you. In addition, the panel was concerned that you did not appear to accept that recording observations within Patient A's clinical records when you had not undertaken those observations was dishonest, even if it was not your "*intention*" to be dishonest.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. Whilst the panel did not receive up to date certificates of completion for relevant training courses, it had regard to your training logs

which listed the titles and dates of completion of various mandatory training courses. The panel had also been provided with images from training course webpages for '*The Importance of Good Record Keeping*' (dated 4 March 2025, and in which you appeared to achieve a grade of 80%), '*Resuscitation Adult Level 2*' (undated), and '*National Early Warning Score (NEWS) 2*' (undated). The panel also had regard to the testimonials from your line manager and their manager from your previous employment.

The panel took into account that you are not currently working as a nurse, and as such, you are not currently in a position to demonstrate strengthened practice. [PRIVATE].

In light of your limited but developing insight and your limited evidence of strengthened practice, the panel could not conclude that it is highly unlikely that your misconduct would be repeated in the future. It therefore found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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 a finding of impairment on public interest grounds is required to mark the unacceptability of your misconduct and to uphold proper professional standards. The panel considered that an ordinary and informed member of the public and fellow practitioners would be concerned, and confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore also found your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was not satisfied that you can practise kindly, safely and professionally. It therefore determined that your fitness to practise is currently impaired.

Sanction

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

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

Your evidence on sanction

You gave evidence under oath.

You reiterated that you acknowledge the seriousness of the concerns in this case and deeply regret the things that occurred. You reminded the panel of your extensive reflections and stated that you have now recognised that your panic during the incident was rooted in knowing that you had not fully completed the tasks expected of you. You stated, however, that you have since made a personal and professional commitment to always carry out exactly what is required of you, such that you would never again allow yourself to be in a position where uncertainty or omissions lead you to panic or make errors.

You informed the panel that nursing remains one of the most noble and meaningful achievements of your life, and [PRIVATE].

You asked the panel to consider the less severe sanctions available, rather than a striking-off order. You stated that you believe you have demonstrated your development of genuine insight and safe and accountable practice over the past five years [PRIVATE].

You clarified that the "*erroneous*" interim conditions of practice that was imposed in March 2025 was removed in a subsequent hearing in July 2025, but your decision to not work since you left your previous job was through choice.

[PRIVATE], you have consistently contributed positively to patient care, service delivery and leading transformations. You asked the panel to allow you to retain your registration so that you can continue to practise safely, compassionately and kindly with the accountability and humility that you have worked hard to develop; [PRIVATE].

Submissions on sanction

In the Notice of Hearing, dated 31 July 2025, the NMC had advised you that it would seek the imposition of a striking-off order if the panel found your fitness to practise currently impaired.

Ms Ghotra submitted that such an order would be appropriate and proportionate.

Ms Ghotra submitted that the following aggravating factors were present in this case:

- Your conduct put people receiving care at risk of suffering harm;
- You have demonstrated a lack of sufficient insight; and
- There is limited evidence of strengthened practice.

Ms Ghotra accepted that, in terms of a mitigating factor:

- You have undertaken some training, although this was mandatory training and there are still some areas such as communication which have not been addressed

through training or any other steps in practice.

Ms Ghotra directed the panel to the NMC guidance on '*Sanctions for particularly serious cases*' (reference: SAN-2), which in her submission applies to this case:

'*Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- ...
- *direct risk to people receiving care*'.

Ms Ghotra then referred the panel to the SG and addressed it on why the lesser sanctions would not be sufficient to protect the public and meet the public interest.

Ms Ghotra submitted that whilst there was a single incident, there were multiple failures including dishonesty and a lesser sanction was not sufficient. She submitted that there was evidence of attitudinal problems relating to your dishonest conduct. Ms Ghotra submitted that there had been no formal finding of repeated behaviour, although you have not worked on a similar ward and therefore have not been tested in a similar situation. She submitted that there was therefore nothing to support the suggestion that you would not act in the same manner if faced with a similar situation. Further, she submitted that the panel could not be satisfied that you had demonstrated sufficient insight and do not pose a significant risk of repeating behaviour.

Ms Ghotra submitted that your actions were a significant departure from the standards expected of a registered nurse, and there had been a serious breach of the fundamental

tenets of the profession, such as commencing CPR, using the defibrillator, undertaking the observations as required. She submitted that, taken together, your actions are fundamentally incompatible with you remaining on the register.

In addressing the relevant factors set out in the guidance for a striking-off order, Ms Ghotra submitted that the regulatory concerns about you raise fundamental questions about your professionalism; that public confidence in nurses cannot be maintained if you are not struck-off from the register; and that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public and maintain professional standards. She submitted that patient observations, completing clinical records honestly and acting appropriately to a medical emergency are basic and fundamental requirements of nursing care which you failed to do, and Patient A lost a significant chance of survival as a result of some of your failures.

Ms Ghotra submitted that your actions fell far below the standards expected of a reasonable and competent nurse, and in all the circumstances, a striking-off order is the only sanction which would be sufficient to protect the public and maintain professional standards.

The panel also took account of your submissions that had this hearing taken place in 2020 or shortly after the incident, then you would have agreed that a striking-off order is the appropriate order. You submitted, however, that the delay in bringing this matter to a hearing has been in your favour because you have been provided the opportunity to prove that a striking-off order is not the appropriate order in this case. You asked the panel to consider, [PRIVATE], the work you have done in the last five years and the testimonials presented in respect of that.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your conduct put people receiving care at a risk of harm.
- There is limited evidence of strengthened practice.
- There remains a risk of repetition.

The panel also took into account the following mitigating features:

- You have demonstrated developing insight into your failings.
- You have apologised and demonstrated remorse for your failings.
- You have kept up to date with your mandatory training.
- There is no evidence of repetition of the misconduct.

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

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate 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 your 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *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 considered that there were no attitudinal problems in this case. It was satisfied that there were identifiable areas of your practice in need of retraining, namely in respect of patient observations, accurate record keeping and responding appropriately to medical emergencies, and that conditions of practice could be put in place to manage those areas of your practice. Further, there was no evidence of general incompetence in your practice, and you had demonstrated a willingness to comply with conditions of practice and respond positively to training. The panel determined that practical and workable conditions could be formulated to protect patients during the period they are in force, and they could be monitored and assessed.

The panel took into account the evidence it had heard from you at each stage of these proceedings. It considered that you understood what you did wrong, and you have demonstrated genuine remorse for this. The panel was reminded of its finding that whilst

serious, your dishonesty was not at the higher end of the scale of seriousness. It considered the difficulty you appeared to have in recognising that recording observations you had not undertaken was dishonest regardless of your intentions at the time. However, the panel found that there is potential for this to be addressed through further reflection and insight.

The panel, in considering the nature and seriousness of the case, your developing insight particularly in relation to the dishonesty, and the wider public interest concerns, was not satisfied that the placing of conditions on your practice would be appropriate or proportionate at this stage.

The panel therefore 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 considered that this was a single instance of misconduct where a lesser sanction would not be sufficient. There was no evidence before the panel of any attitudinal problem or repetition of the behaviour since the incident. The panel was of the view that your misconduct is capable of being addressed and your practice is capable of being strengthened. It considered that your insight is still developing and so at this stage, you pose a risk of repeating the behaviour.

The panel was satisfied that whilst your misconduct was not fundamentally incompatible with remaining on the register, this was a serious case that warranted your temporary

suspension from nursing practice to protect patients and meet the wider public interest. The panel considered that a suspension order would give you time to undertake training to address the areas of concern, and to reflect on your misconduct and develop further insight, particularly in respect of your dishonesty.

The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse after developing your insight and strengthening your practice through training.

The panel also carefully considered the submissions of Ms Ghotra in relation to the striking-off order that the NMC was seeking in this case. However, taking account of all the information before it, [PRIVATE], the panel concluded that such an order would be disproportionate. Whilst the panel acknowledged that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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 six months was appropriate in this case to mark the seriousness of the misconduct. In addition, the panel concluded

that such a period would be adequate to provide you with the opportunity to demonstrate developed insight and provide evidence of strengthened practice through training.

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:

- Your engagement and attendance at the substantive order review hearing.
- A detailed written reflective account which demonstrates your insight into your misconduct, particularly in recognising that your conduct in relation to the clinical records was dishonest, despite your intentions.
- Evidence of strengthened practice by way of training in the specific areas of concern, in particular communication skills, and your continued professional development.
- Further references and testimonials from paid and unpaid work.

This will be confirmed to you 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 your own interests until the substantive suspension order takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Ghotra. She submitted that an interim order was required on public protection and public interest grounds for the same reasons given for the substantive suspension order. Ms Ghotra invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

You did not oppose the application for an interim order.

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 to ensure that you cannot practise without restriction before the substantive suspension order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.