

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

**Substantive Hearing
Tuesday 7 April 2026 – Friday 10 April 2026
Monday 20 April 2026 – Tuesday 21 April 2026**

Virtual Hearing

Name of Registrant: Sara Morrissey

NMC PIN 9714456E

Part(s) of the register: Registered Nurse - Learning Disabilities
(RNLD) 11 September 2000

Relevant Location: Wolverhampton

Type of case: Misconduct

Panel members: Graham Coulston-Herrmann (Chair, Lay Member)
Alison Thomson (Registrant Member)
Robert Marshall (Lay Member)

Legal Assessor: Neil Fielding

Hearings Coordinator: Maya Khan (7-10 April 2026)
Emily Mae Christie (20-21 April 2026)

Nursing and Midwifery Council: Represented by Nicola Kay, Case Presenter

Mrs Morrissey: Not present and not represented

Facts proved: Charges 1, 2, and 3b

Facts proved by admission: Charges 3a, 3c and 3d

Fitness to practise: Impaired

Sanction: **Conditions of practice order (12 months)**

Interim order: **Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Morrissey was not in attendance and not represented. The panel was informed that the Notice of Hearing letter had been sent to Mrs Morrissey's registered email address by secure email on 9 March 2026.

Ms Kay, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the contact email address held by the NMC, which was evidenced by a screenshot in the service bundle. Ms Kay referred the panel to the witness statement in the service bundle, which confirmed that the Notice of Hearing had been sent to Mrs Morrissey's email address on 9 March 2026.

Ms Kay submitted that the Notice of Hearing has been served in good time and the NMC has complied with the requirements of Rules 11 and 34 of 'the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended' (the Rules).

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on application for hearing to be held partly in private

Ms Kay made a request that parts of this case be held in private on the basis that there will be reference to Mrs Morrissey's health in relation to her non-attendance at this hearing. The application was made pursuant to Rule 19 (2).

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

Having heard that there will be reference to Mrs Morrissey's health matters, the panel determined to hold those parts of the hearing in private.

Decision and reasons on proceeding in the absence of Mrs Morrissey

The panel next considered whether it should proceed in the absence of Mrs Morrissey. It had regard to Rule 21 and heard the submissions of Ms Kay, who invited the panel to continue in the absence of Mrs Morrissey.

Ms Kay provided the panel with a '*Proceeding in Absence*' (PIA) bundle, including attempts by the NMC to contact Mrs Morrissey by email regarding her attendance at this hearing. The PIA bundle included the following:

- Emails from Mrs Morrissey dated 28 April 2025 and 30 April 2025 confirming that she would not be attending. Ms Morrissey stated: [PRIVATE]
- On 25 July 2025, Mrs Morrissey responded to her NMC case officer, stating that she does not wish to apply for voluntary removal;
- [PRIVATE]
- Email from Mrs Morrissey dated 2 April 2026 to the Hearings Coordinator stating: '*No I am not joining Virtual Hearing. [PRIVATE]*'; and
- No adjournment has been expressly sought by Mrs Morrissey.

Ms Kay informed the panel that there are two witnesses expected to attend the hearing to give evidence, and not proceeding would inconvenience the witnesses and their employers.

In relation to unfairness to Mrs Morrissey, Ms Kay submitted that there would be minimal, if any, unfairness to Mrs Morrissey because there is no evidence before the panel that she would attend any adjourned hearing and therefore, in the circumstances, it is fair, appropriate and proportionate to proceed in Mrs Morrissey's absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised '*with the utmost care and caution*' as referred to in the case of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5. The panel was also referred to the case of *GMC v Dr. Hayat* [2018] EWCA Civ 2796.

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

The panel noted the following:

- In an email from Mrs Morrissey, dated 1 March 2024, she stated:
'I need to add that I have not practised as a nurse since October 2022
[PRIVATE]';
- The NMC received emails from Mrs Morrissey in April 2025 confirming that she would not be attending the hearing due to her health matters;
- [PRIVATE]
- In an email from the Hearings Coordinator was sent to Mrs Morrissey on 2 April 2026, providing her with the Teams link and asking her to confirm her attendance. Mrs Morrissey replied to this email on 2 April 2026, stating that she would not be attending the hearing [PRIVATE];
- Mrs Morrissey has not applied for an adjournment;

- [PRIVATE] adjourning the proceedings today would not increase the likelihood of her attendance;
- There are two witnesses who are due to give live evidence in this case, and not proceeding may inconvenience the witnesses and their employer(s);
- The charges relate to events that occurred in 2020 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

[PRIVATE]

[PRIVATE]. It seems highly unlikely in these circumstances that an adjournment would be of any benefit in achieving the Mrs Morrissey's attendance. The likely consequences would be to further delay matters causing inconvenience to the witnesses [PRIVATE].

There is some disadvantage to Mrs Morrissey by proceeding in her absence. The evidence upon which the NMC relies has been sent to her. She will not be able to challenge the evidence relied upon by the NMC in person nor will she be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Kay under Rule 31 to allow the following hearsay evidence:

In respect of Ms Kayla Dube, the NMC seeks to rely on the unsigned witness statement, and the local statement dated 13 July 2020. Ms Kay submitted that the NMC have not been successful in obtaining a signed witness statement.

In respect of Patient A's mother, the NMC seeks to rely on the unredacted copies of her local verbal statement and a complaint form. Ms Kay submitted that the NMC have not been successful in obtaining a signed witness statement.

In respect of Robbie Steels, the NMC seeks to rely on his NMC witness statement and supporting exhibits, which include the incident form. Ms Kay submitted that the NMC have not been able to secure his attendance at this hearing and referred to his email response dated 2 April 2026, which stated:

'Im [sic] afraid I cant [sic] attend whilst away as not taking anything with me to ensure an actual break.'

Ms Kay advanced the argument that there was no lack of fairness to Mrs Morrissey in allowing these documents into evidence. She submitted that it is a matter for the panel to give the appropriate weight to the evidence.

The panel heard and 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 was referred to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel gave the three separate applications serious consideration. The panel noted that Mrs Morrissey had been provided these documents beforehand.

The panel was satisfied in each instance that the evidence the NMC seeks to admit is relevant to these events and of probative value.

In various documentation supplied to the NMC, Mrs Morrissey broadly accepts many of the key matters relating to each of the contested charges, and some of her admissions corroborate the accounts provided by both Patient A's mother and Ms Dube, namely:

- a) that she (Mrs Morrissey) may not have turned on the ventilator properly
- b) that Patient A appeared cyanotic before she (Mrs Morrissey) turned on the ventilator
- c) that she (Mrs Morrissey) did not seek further medical assistance.

The areas of dispute concern not the fact that the ventilator was off, but how it came either not to be switched on or came to be switched off. The panel noted that in relation to this issue, there is other evidence to consider concerning the ease of using the ventilator in question.

In relation to the sequence of events and the precise timings which are disputed by Mrs Morrissey, the panel notes that the key issue in relation to the charges is whether her intervention was timely. There is other evidence from Mrs Morrissey's own admissions that Patient A appeared cyanotic before the ventilator was turned on. This is consistent with the accounts provided by Patient A's mother and Ms Dube and is relevant to the issue of timings.

Mrs Morrissey contends that she did check Patient A's vital signs, and as these were normal the circumstances did not require her to seek further medical advice. Neither Patient A's mother nor Ms Dube appear to address this issue.

Had Mrs Morrissey been in attendance, it would have been open to her to provide her own account of these events under oath or affirmation. She could also have made submissions regarding any inconsistencies between the accounts provided by each witness along with highlighting any inconsistencies between the accounts of the two witnesses. In relation to the account of Patient A's mother Mrs Morrissey would also have had the opportunity to question Ms Anju Dhadra about the accuracy or otherwise of the account she recorded from Patient A's mother. In Mrs Morrissey's absence, the panel can ask Ms Dhadra relevant questions. The panel can also compare Mrs Morrissey's written accounts of events with the written accounts of these witnesses and

consider whether there are any inconsistencies in the accounts relied upon by the NMC to test their credibility and reliability.

There has been no suggestion, and there is no plausible reason to believe that any of the witnesses has fabricated their accounts.

The panel notes that these are serious allegations that could lead to restrictions on Mrs Morrissey's practice.

In relation to Ms Dube, she was originally cooperating with the NMC, and a witness statement was prepared following discussions with her but never signed. The NMC has made extensive efforts to trace her without success.

In relation to Patient A's mother, she has made it plain from the outset that she was content the Mrs Morrissey was no longer involved in caring for Patient A. She did not wish to assist with the NMC investigation despite several attempts to engage with her. In relation to Mr Robbie Steels, the panel notes that the decision to call him as a live witness was made at short notice and Mr Steels was unavailable to attend.

The panel noted that Mrs Morrissey had been provided with hearsay bundles in respect of each of these applications albeit in the case of Mr Steels relatively recently (1 April 2026). However, in relation to Mr Steels, Mrs Morrissey would have been aware that the NMC was originally seeking to read this evidence without calling Mr Steels to give live evidence. This is because Mr Steels exhibits a number of contemporaneous documents originally received by another witness who has since died. The witness, therefore, has no direct knowledge of the events and would not, therefore, appear to have been a contentious witness. This is underlined by the fact that Mrs Morrissey raised no objection to the original course of action the NMC proposed. The NMC sought to call him as Mr Steels witness statement does not refer to each of his exhibits despite the fact that he has signed, dated and labelled them.

In these circumstances, the panel came to the conclusion that it would be fair and relevant to accept all three hearsay applications into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence

before it. The panel also took into account that Mrs Morrissey had been informed that it was the intention of the NMC to invite the panel to adopt these statements and she did not raise any objections.

Addendum to reasons to admit the hearsay evidence of Ms Dube and Patient A's mother

During the panel's deliberation on the facts, the panel received an On-Table document containing an email from Mrs Morrissey, dated 5 April 2026. In this email, Mrs Morrissey suggests that the accounts of Ms Dube and Patient A's mother may have been '*exaggerated or fabricated*'. This email was not before the panel when it made its decision to admit the hearsay evidence of Ms Dube and Patient A's mother.

Mrs Morrissey has not provided any specific reasons why the witnesses may have either exaggerated or fabricated their accounts. In any event, the panel considered these matters to be peripheral to the main facts in issue and considered all of the other relevant factors with care.

Details of charge

That you, a registered nurse, on 12 July 2020:

1. Failed to switch Patient A's dry circuit ventilator on or in the alternative failed to notice that it had switched off.
2. Failed to identify Patient A's deteriorating condition in a timely manner.
3. In respect of the dry circuit ventilator not being switched on for a period of time:
 - a. Failed to document it in Patient A's notes and/or make a record of it.
 - b. Did not carry out additional checks and/or seek medical advice following the incident.
 - c. Did not provide details of the incident in the handover to Colleague 1.
 - d. Did not report the incident to Secure Healthcare Solutions.

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

Background

Mrs Morrissey first entered the NMC register on 11 September 2000 as a registered adult nurse, and she commenced employment with Secure Healthcare Solutions in 2017. Mrs Morrissey referred herself to the NMC on 29 July 2020 in relation to an incident which occurred on 12 July 2020.

Mrs Morrissey was working at a service user, Patient A's home, at the relevant time, and Secure Healthcare Solutions provided a package of care to Patient A. Patient A required 24-hour care and had a number of clinical needs, including requiring constant ventilation 24 hours a day. Patient A used a ventilated tracheostomy, which is known within the case papers as a '*wet circuit*' whilst in bed. Patient A used a dry circuit or ventilator (which has been described as a '*nippy*' within some of the documentary evidence) whilst sitting in her chair.

On 12 July 2020, at approximately 18:00, Mrs Morrissey and Ms Dube, the support worker, facilitated Patient A getting out of bed and into her chair. This movement required a changeover from the wet circuit ventilator to the dry ventilator circuit. Mrs Morrissey was the nurse responsible for changing over the ventilators for Patient A. Patient A was put in her chair and taken into the lounge by Mrs Morrissey. Ms Dube remained in Patient A's bedroom cleaning up whilst Mrs Morrissey took Patient A to the lounge, and then it became apparent that the dry ventilator circuit was not turned on.

Mrs Morrissey provided several accounts in relation to this incident, including a reflective account, an email to the agency dated 14 July 2020 and a local statement. Mrs Morrissey explained that she noticed Patient A appeared to be a little blue and asked Ms Dube to bring in the blood pressure machine and the SATS machine. It was established that the ventilator was turned off, so Mrs Morrissey switched it on.

However, this account by Mrs Morrissey conflicts with the two NMC witnesses who were present during the incident. Ms Dube states in her local statement that when she

entered the lounge, she heard Patient A's mother say Patient A's stomach was pumping fast and there was no air coming out of the tracheostomy tube.

Patient A's mother stated in her local statement that she asked Mrs Morrissey why Patient A was breathing that way, and it was at that point that Mrs Morrissey told Ms Dube to bring in the blood pressure machine and the SATS machine. Patient A's mother states that she asked Mrs Morrissey if the ventilator was on, and Mrs Morrissey said it was on as the red light was on. Patient A's mother then pointed out that it was the green light that needed to be on and not the red one. At that point, Mrs Morrissey checked the ventilator again, switched it on and soon after, Patient A's breathing started to normalise.

It is accepted by Mrs Morrissey that the dry ventilator was off when it was connected to Patient A. Mrs Morrissey says that the machine was off for a couple minutes. However, it is the NMC's case that the machine was off for about 10-15 minutes. The accident form dated 13 July 2020 states that the machine was off for 10 minutes and Ms Dube's witness statement says it was off for about 10 minutes. No ongoing harm was caused to Patient A because of this incident.

Mrs Morrissey's shift ended at 20:00, and Ms Tracy Whitehouse, the night nurse, took over the care for Patient A.

Mrs Morrissey made admissions and accepted that she did not document or report this incident to Ms Whitehouse. Patient A's mother was the person who informed Ms Whitehouse of the incident.

Ms Dhadra, the day nurse, on the following day, 13 July 2020, who took over from Ms Whitehouse, was informed of the incident. Ms Dhadra reported the incident to Secure Healthcare Solutions on 13 July 2020 during her shift and spoke to the Clinical Lead/Manager at the time.

The Clinical Lead/Manager completed the accident report form, spoke to Patient A's mother and then completed a complaint form containing the complaint from Patient A's mother.

In respect of charges 1, 2 and 3b left to be determined by the panel, Mrs Morrissey has produced a response to these charges. Mrs Morrissey states that the circuit was switched on, but may not have been properly, she did notice it was switched off, and it was not 10 minutes before she had noticed it. Mrs Morrissey explains that she noticed Patient A's lips were cyanosed, and she checked the dry circuit switch, which was off and switched it on.

In respect of charge 3b, Mrs Morrissey says that she checked Patient A's oxygen saturations, pulse and blood pressure, and all were normal. She says there was no need to seek medical advice.

Decision and reasons on facts

Ms Kay referred the panel to Mrs Morrissey's response to the charges form with her signature dated 2 August 2025. In that form, Mrs Morrissey admitted charges 3a, 3c and 3d. Mrs Morrissey signed this form under the declaration, which stated '*I understand the panel will use any admissions I've made in this form when they're making the final decision about the charges against me*'. Ms Kay submitted that the panel should be relying on this response from Mrs Morrissey and invited the panel to find charges 3a, 3c and 3d proved by way of admission.

The panel found charges 3a, 3c and 3d proved by way of Mrs Morrissey's admissions in the signed response form dated 2 August 2025.

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 Kay.

The panel has drawn no adverse inference from the non-attendance of Mrs Morrissey.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact

will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Ms Tracy Whitehouse: Night Nurse at Secure Health Solutions at the time of the events.
- Ms Anju Dhadra: Registered Nurse at Secure Health Solutions at the time of the events.

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

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

Charge 1

‘That you, a registered nurse:

- 1. Failed to switch Patient A’s dry circuit ventilator on or in the alternative failed to notice that it had switched off.’*

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Ms Dube, Patient A’s mother, and Mrs Morrissey.

The panel took account of Ms Dube’s unsigned witness statement, which stated:

'...I didn't see whether the ventilator was switched on or off, however I don't remember seeing Sara [Mrs Morrissey] switch on the ventilator before putting Patient A in the wheelchair which, as the nurse on shift, she was supposed to do. I also don't remember hearing the ventilator beep to indicate that it had been switched on. Once was in the wheelchair, Sara [Mrs Morrissey] wheeled Patient A into the living room.'

It also took into account Ms Dube's incident report, dated 12 July 2020, which stated:

'Approximately around 1700-1800, Patient A's mum asked us to get Patient A out of bed onto her chair. I, Kayla [Ms Dube], was in the room, and the lead nurse was also present in the room along with Patient A's mum. Patient A was changed and placed onto the wheelchair by the nurse behind wheelchair, mum on the side and I Kayla [Ms Dube] in front to balance Patient A, which she was transferred safely. After that, Patient A was wheeled into the living room by the lead nurse.'

I was in Patient A's bedroom changing and cleaning, I was called to bring the nebuliser and the nebuliser machine into the living room where Patient A was with the nurse and mum said "Patient A stomach is pumping fast and there's no air coming out of the tracheotomy tube (black part)" that's when the lead nurse checked if the dry cough assist was turned on and I heard the machine "beep" and the lead nurse said it was on. After the machine "beeped" there was air coming out of the tracheostomy tube. Approximately, Patient A was breathing fast for about 10 minutes estimating.'

The complaint form, completed by Ms Irene Simunyu, dated 13 July 2020, which stated:

'...Patient A's mother stated that her daughter's lips looked cyanosed and she listened to the flow of the ventilator. Patient A stated she informed the nurse (Sara [Mrs Morrissey]) that there was no sound of flow of air and asked if the ventilator was on. Patient A's mother stated

that the nurse went to check the ventilator and informed her that the button was red. Patient A's mother stated that she told Patient A the nurse that the light is supposed to be green and that is when the nurse switched on the ventilator.

Patient A's mother sounded quite distressed and expressed that the nurse did not know how to care for her daughter.'

The panel also considered Ms Dhadra's witness statement, dated 8 November 2023, which she confirmed in oral evidence. It had regard to the following:

'To turn on the dry ventilator, it's necessary to press the on/off button down firmly for a long time. If you press it too gently or not for long enough, it might not switch on. Once it's switched on, it makes a beeping sound for around two to three seconds, all the lights and settings on the machine come on, and it sounds like air is being pushed in and out. The sound of the air is present for the whole time.'

The panel looked at the differing accounts and weighed up the evidence from Patient A's mum and Ms Dube. It saw the peripheral discrepancies between Ms Dube's initial report and her statement. It considered that they did not see a signed statement or hear from either witness. The panel were cognisant that both accounts were hearsay. When assessing the evidence, the panel took into account that both accounts were made the day after the incident, so the matters would have been fresh in their mind. The panel noted that in Mrs Morrissey's email, dated 5 April 2026, she suggested that Ms Dube and Patient A's mother *'have been exaggerated and fabricated.'* The panel noted that there was no evidence to support this statement. Notwithstanding the extraneous discrepancies, the panel was of the view that they independently corroborate each other's accounts. With regard to the following accounts from Mrs Morrissey, the fact that the ventilator was not on is not in dispute.

The panel also took into consideration Mrs Morrissey's accounts, which included her admissions, which stated:

'I need to point [out] that I definitely turned the Nippy machine on before transferring Patient A to it. I did notice [Patient A] was cyanosed and could not understand why until I realised the Nippy was not on and so switched it back on...'

'...I then checked the dry circuit and it was switched off. I switched it back on...I have no idea how the nippy machine became switched off. I estimate it would have only been off for a couple of minutes.'

The panel also took into account Mrs Morrissey's reflective statement, where she said:

'I quickly realised that the dry circuit had not been switched on properly and so I pressed the switch again and it started to ventilate...When I think about it I still feel anxious about it but have no explanation? The only thing that could have happened is that I did not press the switch down properly when switching it on.'

Mrs Morrissey provided a response to charge 1 in the 'Response to charges form', which was signed on 2 August 2025. In respect of charge 1, her form stated:

'The circuit was switched on but maybe not properly of course I noticed it had switched off and it was not ten minutes before I noticed. I noticed A's lips were cyanosed and checked dry circuits switch which was off and switched it on.'

Mrs Morrissey provided a further account in an email, dated 5 April 2026, in which she stated:

'I realised the Nippy was not on and switched it on.

...

I truly have no idea why the Nippy machine was not on and can only summarise [sic] that I had not switched it in properly.'

The panel noted that there are two matters charged in charge 1. It determined that, based on the evidence before it, which included consistent evidence from two witnesses that the ventilator was off, and Mrs Morrissey's admissions, it is more likely than not that Mrs Morrissey had failed to switch Patient A's dry circuit ventilator on.

The panel did not move on to the second limb of the charge, as it follows that, if, as it has done, it found that the machine was not turned on, it could not be the case that she failed to notice it had switched off.

Having regard to the evidence, the panel was satisfied that Mrs Morrissey failed to switch Patient A's dry circuit ventilator on. Accordingly, the panel found charge 1 proved on the balance of probabilities.

Charge 2

'That you, a registered nurse:

2. *Failed to identify Patient A's deteriorating condition in a timely manner.'*

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Ms Dube, Patient A's mother, and the oral evidence of Ms Dhadra. The panel also took into account the written accounts provided by Mrs Morrissey.

The panel noted Ms Dube's unsigned witness statement, which stated:

'I remained in Patient A's bedroom cleaning and tidying. From the bedroom, I heard Patient A's mum move from the kitchen to the living room. I could hear her talking. After around 10 minutes, I heard her say something like "Why is gasping for air?". Sara [Mrs Morrissey] replied saying that she didn't know. At that point, I entered the living room to see what was wrong with as I was worried she was potentially having a

silent seizure. Patient A's skin looked a little reddish and she was struggling to breathe. I could see she was gasping for air and breathing very fast. Patient A's mum seemed distressed.

I was worried about Patient A's condition and so I visually checked to see whether the ventilator was on. I could see it was switched off as no light was on. I quietly told Sara [Mrs Morrissey] to turn on the ventilator, trying not to let Patient A's mum hear. Sara [Mrs Morrissey] then calmly moved to the back of Patient A's wheelchair and switched on the ventilator without saying anything. I could tell she switched it on because it made a beeping sound.

I could also see the air coming out of the tracheostomy tube, like how you can see your breath when it's cold. As soon as Sara [Mrs Morrissey] switched on the ventilator, Patient A started breathing normally straightaway. I believe Patient A was without ventilation for around 10 to 15 minutes as that's approximately how long I was tidying Patient A's bedroom for.

I don't recall there being any discussion about the fact that the ventilator had been switched off. Once Sara [Mrs Morrissey] turned the ventilator on and Patient A's breathing returned to normal, Patient A's mum just walked out of the room without saying anything. There was nothing said about it in my presence for the remainder of the shift.'

The panel took into account the local verbal statement of Patient A's mother, which stated:

'Both Patient A's mother and father rose the below concerns:

- 2. If they had not return [sic] home on time what could have happened to Patient A*
- 3. They could not understand how Sara [Mrs Morrissey] could be sat in front of Patient A and not notice the distress Patient A was going through, that it took a family member to raise alarm.*

4. *They were concerned that nothing was documented by Sara [Mrs Morrissey] and that she did not hand over to the night nurse for continued monitoring during the night.'*

The panel took account of Ms Dhadra's oral evidence. The panel asked Ms Dhadra how long the ventilator would need to be off before a patient shows signs of distress. Ms Dhadra said 10 seconds.

The panel took account of Mrs Morrissey's local statements, which included her response to the incident. It stated:

'I need to point [out] that I definitely turned the Nippy machine on before transferring Patient A to it. I did notice she was cyanosed and could not understand why until I realised the Nippy was not on and so switched it back on. I find the Nippy machine a lot quieter than the wet circuit. No harm would have happened if the Nippy had failed to turn on I would have immediately transferred her to her room and back on wet circuit. The incident was dealt with quickly by me and Patient A suffered no adverse effects. I have no explanation or excuse for not documenting the incident.

...

...Patient A seemed much more happy in her self at this point although she did look a little cyanosed so I called Kayla [Ms Dube] to bring me the Sats monitor, and BP machine...'

Mrs Morrissey also provided a response to the witness statements in an email to her NMC case officer, dated 1 March 2024. She stated:

'As the nurse in charge on that particular day I can honestly say that Patient A was not left without oxygen for 10 minutes. I would like to know where this came from and where the evidence is for this. In my statement I wrote 2 minutes, so this is the accurate length of time. I also dispute that Patient A's eyes were bulging and her lips were blue. She

did show signs of cyanosis but not to that extent. She certainly was not gasping for breath. My observations and swift actions prevented any harm occurring to Patient A. I quickly realised that the dry circuit had not been switched on properly and so I pressed the switch again and it started to ventilate I checked her observations immediately and found them to be normal. I cannot believe why someone stated that could have died if it was not for the intervention of the night nurse. This is absolute rubbish. The incident occurred about 6.30pm. The night nurse did not come in duty until 8pm.'

Mrs Morrissey provided a response to charge 2 in the 'Response to charges form', which was signed on 2 August 2025. In respect of charge 2, her form stated:

'I noticed Patient A's lips were cyanosed and checked dry circuit switch which was off and switched it on'.

Mrs Morrissey provided a further account in an email dated 5 April 2026, in which she stated:

'Patient As Mother stated that Patient A was hitting herself on the chest. At no point did Patient A hit herself on the chest. She showed no signs of agitation at all.

...

I realised this because I could see Patient As lips were tinged with blue. That's when I shouted to the care assistant to bring Sats monitor and BP machine. I had switched the Nippy on before care assistant came into room.

...

No harm occurred [sic]. I did think quickly and managed the situation adequately. If the Nippy had failed to switch on I would have immediately

*taken Patient A back to her bedroom and put her back on the wet circuit.
No harm could possibly have occurred [sic] to her.'*

The panel noted that there was a dispute between the witnesses and Mrs Morrissey's accounts regarding how long the dry circuit machine was turned off for and who noticed this. The panel determined, irrespective of the precise timeframe, there was a significant period of time when Patient A was settled in her chair and then taken from the bedroom to the lounge, and during that time, the dry ventilator was off. The panel was of the view that who noticed the ventilator was off in the lounge was not relevant to the central issue in this charge about how long it took for anyone to notice. The panel also determined that it would expect the nurse in charge of Patient A, Mrs Morrissey, to be attentive to Patient A's needs and quickly identify any signs of deterioration of Patient A. In these circumstances, not noticing the ventilator was switched off until Patient A was very obviously cyanosed, could not be considered to be identification in a timely manner. Particularly as Ms Dhadra's evidence made clear the very short timeframe before Patient A was likely to become distressed.

Having regard to the evidence, the panel was satisfied that Mrs Morrissey failed to identify Patient A's deteriorating condition in a timely manner. Accordingly, the panel found Charge 2 proved on the balance of probabilities.

Charge 3b

'That you, a registered nurse:

*3. In respect of the dry circuit ventilator not being switched on for
a period of time:*

*b. Did not carry out additional checks and/or seek
medical advice following the incident.'*

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Patient A's mother, Ms Dhadra, and Mrs Morrissey.

The panel took into account the local verbal statement of Patient A's mother, which stated:

'Sara (nurse) [Mrs Morrissey] at that point shouted for the carer (Kayla) [Ms Dube] to bring the blood pressure machine, thermometer and SATS machine in order to check vital signs'

The panel took into account Ms Dhadra's witness statement, which was confirmed during her oral evidence, where she stated:

'If I had been the night nurse on duty and Sara [Mrs Morrissey] had told me about the incident, I would have checked that Sara [Mrs Morrissey] had taken all 's vital signs and that these indicated she was well, re-checked them myself and ensured she didn't require any additional oxygen after being deprived of it earlier, considered contacting an out of hours service (111, 999 or a GP review), reassured Patient A's parents and checked they were okay, reported the incident to Secure Healthcare Solutions, and carried out additional checks such as regular oxygen level and blood pressure checks throughout my shift. Because Sara [Mrs Morrissey] didn't hand over the incident to the night nurse, the night nurse didn't know to do any of this.

...

Secure Healthcare Solutions doesn't (and didn't at the time) have any written policies or processes on Patient A's ventilators or carrying out safety checks etc. Her care plan in place at the time would have stipulated that it was necessary to switch on the ventilators and change the tubing. It wouldn't have gone into how to switch on the dry ventilator. For example, it wouldn't have mentioned the need to firmly press the on/off button down for an extended period of time.'

The panel took into consideration Mrs Morrissey's accounts, which included her response to the incident, which stated:

'... Patient A seemed much more happy in her self at this point although she did look a little cyanosed so I called Kayla [Ms Dube] to bring me the Sats monitor, and BP machine...'

Mrs Morrissey provided a response to charge 3b in the 'Response to charges form', which was signed on 2 August 2025. In respect of charge 3b, her form stated:

'I checked oxygen saturations, pulse, and all were normal. No need to seek medical advice?'

Mrs Morrissey also provided a response to the witness statements in an email to her NMC case officer, dated 1 March 2024. She stated:

'As the nurse in charge on that particular day I can honestly say that Patient A was not left without oxygen for 10 minutes. I would like to know where this came from and where the evidence is for this. In my statement I wrote 2 minutes, so this is the accurate length of time. I also dispute that Patient A's eyes were bulging and her lips were blue. She did show signs of cyanosis but not to that extent. She certainly was not gasping for breath. My observations and swift actions prevented any harm occurring to Patient A. I quickly realised that the dry circuit had not been switched on properly and so I pressed the switch again and it started to ventilate I checked her observations immediately and found them to be normal. I cannot believe why someone stated that could have died if it was not for the intervention of the night nurse. This is absolute rubbish. The incident occurred about 6.30pm. The night nurse did not come in duty until 8pm.'

The panel noted that, based on the evidence before it, Mrs Morrissey had taken reasonable steps to carry out the checks on Patient A following the incident. As such, the panel found the first limb of charge 3b not proved.

Whilst Mrs Morrissey did not seek further medical assistance, there is no evidence to contradict Mrs Morrissey's account that Patient A's vital signs were normal. The panel

further noted that Secure Healthcare Solutions does not and did not have any policies or processes for employed registered nurses to follow safety checks. Therefore, there is insufficient evidence to suggest that any further medical advice was necessary.

Having regard to the evidence, the panel was satisfied that Mrs Morrissey did carry out checks following the incident but did not seek medical assistance (on the basis that it was unnecessary). Accordingly, on the balance of probabilities, the panel found Charge 3b factually proved in relation to the second limb.

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 Mrs Morrissey's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and professionally, without restriction.

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, Mrs Morrissey's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Kay invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) in making its decision. Ms Kay also referred the panel to the cases of *Calhaem v General Medical*

Council [2007] EWHC 2606 (Admin); and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Kay identified the specific, relevant standards under which Mrs Morrissey's actions amounted to misconduct, including breaches of the following provisions of the Code: 1.2; 1.4; 8.2; 8.3; 8.5; 8.6; 10.2; 13.1; 13.2; 14; 20.1; and 20.8.

Ms Kay submitted that Mrs Morrissey's actions could have caused serious harm in that she failed to switch on Patient A's dry circuit ventilator, which was a fundamental aspect of Patient A's care. Further, she submitted that Mrs Morrissey could have caused serious harm by failing to identify Patient A's deteriorating condition in a timely manner.

Ms Kay submitted that Mrs Morrissey's conduct breached the obligations required of a registered nurse in failing to comply with the Code. She submitted that whilst not every breach amounts to professional misconduct, her failure to switch on the ventilator, along with her failure to identify Patient A's deterioration, raises serious questions about her professionalism and the safe and adequate patient care she provides, especially in respect of vulnerable patients. She submitted that Mrs Morrissey's misconduct was particularly serious as the use of a ventilator was a significant aspect of Patient A's clinical care.

Ms Kay also submitted that the record-keeping and safeguarding concerns were serious matters, relating to Mrs Morrissey failing to document the incident, not handing it over to a colleague, or reporting it to her manager.

In all the circumstances, Ms Kay submitted that in respect of the matters proved, Mrs Morrissey's behaviour was a serious departure from the fundamental tenets of the profession and the professional standards and behaviour expected of a registered nurse. Therefore, she invited the panel to find misconduct with respect to all the charges.

Submissions on impairment

Ms Kay moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Kay submitted that the first three limbs, as outlined in the case of *CHRE v NMC and Grant* [2011], were engaged. She submitted that the fourth limb was not as this case does not relate to dishonesty.

In relation to the first limb, Ms Kay submitted that Mrs Morrissey's actions clearly put Patient A at an unwarranted risk of harm, and that the evidence demonstrates that there was a change in Patient A's presentation during the period the ventilator was turned off. In relation to the second limb, Ms Kay submitted that Mrs Morrissey's misconduct was serious in nature and that she had failed to uphold the standards and values set out in the Code and, as such, failed to uphold the reputation of the profession. In relation to the third limb, Ms Kay submitted that Mrs Morrissey's actions had breached fundamental tenets of the profession. She submitted that Patient A was not prioritised, and that Mrs Morrissey's actions failed to promote professionalism and trust and constituted a serious departure from the standards expected of a registered nurse.

Ms Kay then moved on to make submissions on the considerations set out in the case of *Cohen v General Medical Council* [2008]. She submitted that Mrs Morrissey provided a '*Fitness to practise reflective account form*', dated 27 March 2022, in which she made partial admissions. Ms Kay told the panel that in this form, Mrs Morrissey noted that she fully understood the potential seriousness of the incident and the harm that could have occurred. Furthermore, Mrs Morrissey explained that she would double-check the equipment with another person in future and fully document the incident and report appropriately. Mrs Morrissey had also expressed remorse in respect of the incident. Ms Kay submitted that Mrs Morrissey has developing, or partial insight.

In relation to training, Ms Kay submitted that Mrs Morrissey had provided a certificate for Tracheostomy care, dated 19 November 2019. However, Ms Kay submitted that this predated the incidents in this case. Ms Kay informed the panel that Mrs Morrissey had provided a list of training that she completed whilst she was in another role on 26 July 2021; however, that list does not have specific training on tracheostomy care or record keeping, but does include safeguarding training.

Ms Kay submitted that it is not possible to be confident that the concerns have been fully remediated through further training, or that sufficient remediation has occurred. In light of this, Ms Kay submitted that the misconduct is likely to be repeated. Ms Kay referred the panel to an email from Mrs Morrissey, dated 30 April 2025, in which she confirms that she has not worked as a registered nurse since October 2022. Ms Kay invited the panel to find that Mrs Morrissey is currently impaired on the grounds of public protection as there is a risk of repetition.

In relation to whether Mrs Morrissey is impaired on the grounds of public interest, Ms Kay submitted that the panel should consider whether a finding of impairment is needed to uphold proper professional standards and conduct and or to maintain public confidence in the profession. She submitted that the public would also expect the NMC to ensure that those on its register maintain the required levels or standards of professionalism, particularly that they're able to carry out their roles effectively and safely, which was not met in this case. Therefore, Ms Kay invited the panel to find that Mrs Morrissey is impaired on the grounds of public interest in order to declare and uphold proper standards of conduct and behaviour.

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 AC 311; *Nandi v General Medical Council* [2004] EWHC 2317 (Admin); *Cheatle v General Medical Council* [2009] EWHC 645 (Admin); *CHRE v NMC and Grant* [2011]; and *Cohen v General Medical Council* [2008].

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.2 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:

- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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'

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

In relation to charge 3b, the panel was of the view that although it was factually found proved, in that Mrs Morrissey did not seek medical advice following the incident, she did take vital signs and observations, and there was no evidence which indicated that she was expected to seek medical advice outlined in policy or procedure. In light of this, the panel determined that charge 3b does not constitute serious misconduct.

In relation to the remaining charges, the panel was of the view that these demonstrated a pattern of behaviour arising from a single incident related to the fundamentals of care, which constituted multiple breaches of the Code. It was of the view that amongst the most serious charges were Mrs Morrissey's failure to document the incident in Patient A's notes, and her failure to provide details of the incident in her handover. The panel found that these failures were essential to Patient A's care, and that the consequences of Mrs Morrissey's failures could have been severe. It noted that Patient A is highly vulnerable with profound learning difficulties and was unable to verbalise their distress; and depended on their registered nurse to ensure their ventilation was adequately monitored. Mrs Morrissey had sole responsibility for managing Patient A's ventilator at the time, and the potential outcomes could have been severe. Had Patient A's presentation deteriorated later on, due to Mrs Morrissey's failure to document the incident or hand it over to the nurse who took over from her, that nurse would have lacked knowledge of this incident and would not have had the opportunity to adapt Patient A's care plan, including any additional monitoring, as appropriate.

In light of this, the panel found that Mrs Morrissey's actions 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 identified misconduct, Mrs Morrissey's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on 'Impairment' (DMA-1, last updated on 28 January 2026) in which the following is stated:

'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'

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. 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* [2011] 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) ...'

The panel found that the first three limbs of the test set out above had been met. It determined that Patient A, who was a vulnerable patient with profound learning disabilities, was put at an unwarranted risk of physical harm as a result of Mrs Morrissey's misconduct. The panel also found that Mrs Morrissey's misconduct had breached a number of the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

In considering whether Mrs Morrissey is liable in the future to act so as to put a patient at unwarranted risk of harm, bring the profession into disrepute, or to breach the fundamental tenets of the profession, the panel considered the factors set out in *Cohen v GMC* [2008].

The panel first considered whether Mrs Morrissey's misconduct was remediable. The panel determined that it was remediable and that identified training courses could be completed by Mrs Morrissey, and that further remediation could be achieved through developed insight and strengthened practice.

In considering whether Mrs Morrissey's misconduct has been remedied, the panel took into account Mrs Morrissey's accounts and reflection. The panel noted that Mrs Morrissey has demonstrated that she understood the potential seriousness of the incident and the harm that could have occurred. Mrs Morrissey has also reflected on

what she would do differently in the future, explaining that she would double-check the equipment with another person, fully document the incident, and report it appropriately. The panel also noted that Mrs Morrissey admitted to several charges and expressed remorse for her actions. However, the panel noted that Mrs Morrissey's responses are limited, as she seeks to minimise her role in these events and the distress caused to Patient A, Patient A's mother, and Ms Dube. The panel was therefore of the view that more work is needed to ensure Mrs Morrissey's insight is developed, and her practice is strengthened sufficiently to reduce the risks of a similar occurrence in the future. In light of this, the panel determined that Mrs Morrissey has developing insight.

The panel then considered whether Mrs Morrissey has strengthened her practice. It took into account Mrs Morrissey's training certificate for '*Tracheostomy Care*', dated 19 November 2019. The panel noted that this predated the charges. It also took into account the 19 training courses Mrs Morrissey completed in 2021 during her most recent employment. The panel noted that although these included safeguarding training, she has not completed any up-to-date training in relation to record keeping or tracheostomy care. The panel was of the view that one of the most relevant matters regarding strengthened practice is that Mrs Morrissey has not worked as a registered nurse since October 2022. In the absence of any further evidence that she has taken steps to strengthen her practice and given that Mrs Morrissey has not worked as a registered nurse since October 2022, the panel determined that she has not, at this stage, strengthened her practice sufficiently in relation to the issues in this case.

The panel then considered whether it is highly unlikely that the conduct will be repeated. The panel was of the view that, although this was an isolated incident and Mrs Morrissey's misconduct is remediable, it has not yet been remediated, as she has only demonstrated developing insight and has not yet taken the steps required to strengthen her practice. Therefore, the panel determined that there is a risk of repetition.

In going back to the test as set out by Dame Janet Smith, the panel determined that Mrs Morrissey is liable in the future to put patients at an unwarranted risk of harm. Furthermore, the panel accepts the submissions of NMC that Mrs Morrissey failed to prioritise patient care, given the serious failing in relation to Patient A's ventilator, both

in ensuring that it was switched on and in monitoring Patient A's presentation. Ms Morrissey also failed to promote professionalism and trust in the profession by failing to document a serious incident, hand it over, or report it appropriately. Until Mrs Morrissey has sufficiently strengthened her practice to ensure that patient safety is not compromised in the future and fully appreciates the importance of ensuring that safety critical incidents are fully documented, handed over and reported, there remains a risk that she will repeat that behaviour breach the fundamental tenets of the nursing profession as set out above and in doing so would seriously damage the reputation of profession.

In all these circumstances, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel then considered whether a finding of impairment on the ground of public interest was required. It bore in mind the NMC's overarching objectives: to protect, promote, and maintain the health, safety, and well-being of the public and patients; and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel was of the view that until Mrs Morrissey's practice is sufficiently strengthened, her misconduct in relation to the failures pertaining to fundamental aspects of Patient A's care was, by and of itself, so serious that a finding of impairment is necessary to maintain the public's confidence and trust in the professions and to uphold professional standards. Therefore, the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that

Mrs Morrissey's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Ms Kay invited the panel to make a 12-month conditions of practice order, with a review. She submitted that this would be the most appropriate and proportionate sanction in this case.

In relation to the aggravating features, Ms Kay submitted that these include that Mrs Morrissey abused a position of trust whilst caring for an extremely vulnerable patient in their home, and that there was a real potential for harm, and Mrs Morrissey currently lacks full insight. In relation to the mitigating features, Ms Kay submitted that these include that Mrs Morrissey made partial admissions to the facts, and has shown remorse.

Ms Kay submitted that there are no exceptional features in this case that would warrant taking no further action. She submitted that, given the serious nature of the concerns, taking no action would not be sufficient to protect the public, maintain standards or maintain confidence in the NMC as a regulator. Therefore, she submitted that taking no action would be wholly insufficient.

In terms of a caution order, Ms Kay submitted that there is no evidence that Mrs Morrissey has sufficiently remediated the concerns, and there is a risk to the protection of the public. Furthermore, she submitted that a caution order would not reflect the seriousness of the misconduct. In light of this and given that there remains a risk to patient safety, Ms Kay submitted that a caution order would not be sufficient to protect the public or satisfy the public interest considerations.

In relation to a conditions of practice order, Ms Kay submitted that the identified misconduct does not demonstrate attitudinal concerns and is remediable. She submitted that Mrs Morrissey has indicated that she could not see herself returning to nursing; however, she later expressed a desire to continue nursing. Ms Kay submitted

that conditions could be formulated that would be relevant, workable and measurable and would be appropriate and proportionate in the circumstances, should Mrs Morrissey wish to return to practice. Ms Kay submitted that a conditions of practice order would be sufficient to protect patients and would meet the public interest, and a review would ensure that Mrs Morrissey is only able to return to unrestricted practice should a future panel find that she is no longer impaired.

Ms Kay submitted that a suspension order would not be appropriate in this case, as it was an isolated incident; Mrs Morrissey has not demonstrated deep-seated attitudinal issues; and the panel has found that the misconduct is remediable. Ms Kay submitted that a suspension order would be disproportionate in this case, and that public confidence in the profession and professional standards would be maintained if the conditions of practise order were imposed.

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

Decision and reasons on sanction

Having found Mrs Morrissey's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgment.

In reaching this decision, the panel has had regard to all the evidence adduced in this case and to the NMC Guidance on '*The sanctions available*' (SAN-2, last updated on 28 January 2026).

The panel took into account the following aggravating features:

- Mrs Morrissey's limited insight;
- The vulnerability of Patient A; and
- The potential for serious harm.

The panel also took into account the following mitigating features:

- Mrs Morrissey made partial admissions to the facts; and
- Has demonstrated remorse.

The panel first considered taking no action but concluded that this would be inappropriate given 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 next considered a caution order and had regard to the NMC Guidance on ‘*Caution order*’ (SAN-2b, last updated on 28 January 2026) in which the following is stated:

‘A caution is only appropriate if the Committee has decided there’s no risk to the public or to people using services that requires the professional’s practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.’

The panel considered that Mrs Morrissey’s actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mrs Morrissey’s practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Morrissey’s registration would be appropriate. The panel had regard to the NMC Guidance on ‘*Conditions of practice order*’ (SAN-2c, last updated on 28 January 2026) and had regard to the following factors:

- *‘no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional’s practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*

- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel had regard to the fact that this was an isolated incident that occurred in 2020. It found that the concerns are remediable and that there is no evidence of deep-seated personality or attitudinal problems. The panel noted that there are specific and identifiable areas of Mrs Morrissey's practice that require addressing and was of the view that people using services will not be put at risk, either directly or indirectly, if conditions are imposed on Mrs Morrissey's practice. The panel noted that in a number of emails from Mrs Morrissey to her NMC case officer, dated 25 July 2025 and 1 August 2025, Mrs Morrissey has indicated that she would be willing to undertake retraining. Therefore, the panel was satisfied that Mrs Morrissey would be willing to comply with conditions of practice. In all the circumstances, the panel determined that with appropriate safeguards, it was in the public interest that Mrs Morrissey should be able to return to practise as a nurse.

The panel determined that it would be possible to formulate relevant, proportionate, workable, and measurable conditions that would address and satisfy the public safety and public interest concerns identified in this case. Balancing all these factors, the panel determined that the most appropriate and proportionate sanction is a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate. It found that this would not be a reasonable response in the circumstances of Mrs Morrissey's case because the concerns relate to an isolated incident, there are no concerns regarding dishonesty or deep-seated attitudinal issues, and conditions can be formulated to address the identified public safety and public interest concerns.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

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

1. You must not carry out any work which requires you to provide care for ventilated patients and/or tracheostomy care to individual patients, either directly or indirectly, until you have undertaken retraining in tracheostomy care and/or working with ventilated patients.
2. You must send your NMC case officer evidence that you have successfully completed retraining for tracheostomy care and/or working with ventilated patients within seven days of completion.
3. Once you have completed the retraining, as specified in condition 1, you must ensure you are directly supervised at any time you are working with ventilated patients and/or patients who require tracheostomy care until you are assessed as competent and signed off by your line manager/mentor/supervisor, who must be a registered nurse.
4. You must send your NMC case officer evidence that you have been signed off as competent in providing care for ventilated

patients and/or tracheostomy care within seven days of being signed off by your line manager/mentor/supervisor.

5. You must undertake training in relation to best practice in record-keeping and documentation.
6. You must send your NMC case officer evidence that you have successfully completed training for record keeping within seven days of completion.
7. You must create and keep a personal development plan (PDP). A PDP is a structured document that outlines your goals, learning needs, actions and timelines to help you grow professionally. It should demonstrate thoughtful reflection, clear links between learning and practice.

Your PDP must include evidence of any training you have undertaken, learning from any adverse clinical incidents you have been involved with or witnessed, and testimonials from colleagues you have worked with. Your PDP must address the concerns raised about:

- Standards of record keeping;
- Handing over key information to colleagues; and
- Identifying incidents that require escalation to managers.

You must send your NMC case officer a copy of your PDP seven days before any NMC review hearing.

8. You must keep the NMC informed about anywhere you are working by:
 - a) Telling your case officer within seven days of accepting or leaving any employment.
 - b) Giving your case officer your employer's contact details.

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

10. You must immediately give a copy of these conditions to:
 - a) Any organisation or person you work for.
 - b) Any agency you apply to or are registered with for work.
 - c) Any employers you apply to for work (at the time of application).
 - d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

12. You must allow your case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:
 - a) Any current or future employer.
 - b) Any educational establishment.
 - c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Morrissey has complied with the order. At the review hearing, the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A copy of Mrs Morrissey's personal development plan;
- Records of the specific training Mrs Morrissey has undertaken since this order was imposed;
- Testimonials from any employer Mrs Morrissey works for whilst this order is in place; and
- An up-to-date reflective piece.

This will be confirmed to Mrs Morrissey in writing.

Interim order

As the conditions of practice 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 Mrs Morrissey's own interests until the conditions of practice sanction takes effect.

Submissions on interim order

The panel took into account the submissions made by Ms Kay.

Ms Kay submitted that an interim order is required in the same terms as the substantive conditions of practice order on the basis that it's necessary for the protection of the public and otherwise in the public interest. She submitted that the purpose of seeking an interim order is to cover the potential appeal period of 28 days before the substantive order comes into effect.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months in order to protect the public and the wider public interest during the 28-day period before the substantive order comes into effect

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Morrissey is sent the decision of this hearing in writing.

That concludes this determination.