Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 7 April 2026 – Tuesday 14 April 2026;
Monday 24 August 2026 – Wednesday 26 August 2026

Virtual Hearing

Name of Registrant:	**Melissa Papandrea**
NMC PIN:	96J1052E
Part(s) of the register:	Nurses Sub Part 1 RNA Adult nurse Level 1 9 October 1999
Relevant Location:	Maidstone
Type of case:	Misconduct
Panel members:	Derek Artis (Chair, lay member) Alison Bielby (Registrant member) Caroline Ross (Lay member)
Legal Assessor:	Andrew Granville-Stafford (7 – 13 April 2026) Nigel Pascoe (14 April 2026) Monica Daley (24 – 26 August 2026)
Hearings Coordinator:	Andrew Ormsby
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter (7 – 14 April 2026); Matthew Kewley, Case Presenter (24 – 26 August 2026)
Melissa Papandrea:	Present and unrepresented (7 – 14 April 2026); Not present and unrepresented (24 – 26 August 2026)
Facts proved:	Charges 1, 2 and 3

Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to admit hearsay evidence

At the outset of the hearing the legal assessor invited the panel to consider, under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules), whether hearsay testimony, including parts of Ms Dorcas Mukuzwazwa's evidence, Mr Neil Salmon's evidence and Ms Keya-Macy Beagle-Wessel's evidence, be admitted into evidence.

The legal assessor stated that it was part of the duties of a legal assessor to raise questions in respect of admissibility of evidence or potential inadmissibility of evidence, whether or not that issue is raised by either of the parties. He stated that it was part of the duties of the legal assessor to ensure that the hearing is conducted fairly and in accordance with the law. He stated that, as part of that duty, he had highlighted passages in the witness statement bundle and in the exhibit bundle in relation to Ms Mukuzwazwa's, Mr Salmon's and Ms Beagle-Wessel's evidence.

The legal assessor stated that he had highlighted passages relating to Ms Mukuzwazwa's written evidence as she had given evidence as to the findings and conclusions which she came to in the local investigation that she carried out.

He stated that it was apparent that Ms Mukuzwazwa was not present when any of the events which give rise to the three charges occurred, and therefore her evidence as to what did or did not happen must be based on what other people had told her.

Further, the legal assessor stated that normally, the findings of fact made at some earlier investigation, by another panel, or another person are not admissible in proceedings before a Fitness to Practise Committee.

Dr Joshi, on behalf of the Nursing and Midwifery Council (NMC) submitted that the simple rule for the panel was that it should not blindly follow any conclusion reached by a different investigation but the panel may take such parts as it deems may be relevant by way of

background, and that really means that a panel can either regard of disregard any conclusion of a different investigatory body.

Dr Joshi stated that the NMC acknowledged that Ms Mukuzwazwa was not present when the incident on 7 November 2022 occurred and that what she states in her evidence has been gleaned in the course of her employment from other sources, and the panel may consider it to be hearsay evidence.

Dr Johsi submitted that it was for the panel to decide what weight it attaches to Ms Mukuzwazwa's evidence and whether the source of the evidence was reliable, and what Ms Mukuzwazwa said could be compared to other evidence. He also stated that Ms Mukuzwazwa statements are not the sole and decisive evidence because of course you have the statements of the paramedics.

You did not oppose this application.

The panel heard and accepted the advice of the legal assessor. 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 noted the following case *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), which outlines principles for the panel to consider when determining whether it is fair to admit the evidence:

1. *"Whether the statement is the sole and decisive evidence in support of the charges;*
2. *The nature and extent of the challenge to the contents of the statement;*
3. *Whether there was any suggestion that the witness had reason to fabricate their allegation;*
4. *The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;*

   […]'

The panel also took account of NMC guidance, namely DMA-6:

> *"Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested."*

The panel determined that the conclusions of the local investigation were inadmissible as they were not relevant.

However, the panel also determined that the hearsay evidence was admissible and that the panel would give what it deemed appropriate weight. The panel determined that the hearsay evidence was not sole and decisive and could be tested.

Details of charge

'That you, a registered nurse, on 7 November 2022:

1) Failed to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death.

2) Failed to follow directions given by the 999 call handler to commence Cardiopulmonary Resuscitation ("CPR") on Resident A.

3) Carried out CPR on Resident A incorrectly, in that you did not apply deep compressions as instructed to do by the first responder~~s~~.

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

Background

The charges arose whilst you were employed as a registered nurse working at the Poplars Care Centre (the Centre) which is part of Forest Healthcare Group.

The allegations relate to the events of 7 November 2022.

There are three units at the Centre, namely Magnolia, Wisteria and Willow.

Events of 7 November 2022

On 7 November 2022 you were working as the nurse in charge (NIC) of the Magnolia and Wisteria units. During your shift you received a call at 05:45 from an emergency call handler asking to speak to the nurse that the handler had just previously been speaking to, regarding Resident A who was not breathing.

Resident A had been admitted to the Centre on 4 November 2022.

You transferred the telephone call to the Willow unit as you had not called the emergency services regarding a resident of the unit you were the NIC of. You did not hear an emergency buzzer because it was out of operation and no one had called you for any assistance, so you continued on your unit medication round before proceeding to the Willow unit to check on what was happening.

When you arrived at Resident A's room, on the Willow unit your colleague, Ms Abolurin, who was speaking to the emergency call handler, no handover was given by Ms Abolurin, and you had no prior knowledge of Resident A.

Your colleague passed you the telephone in order to look for a defibrillator and the emergency call handler asked you to perform CPR on Resident A. It is alleged that you refused to do so on the basis that Resident A had already passed away. You then

returned the telephone to Ms Abolurin and walked back to a Magnolia unit to call your manager. On your way to Magnolia unit you passed the first responder and admitted him into the building.

When you returned to the Willow unit you saw a first responder at the head of Resident A's bed maintaining his airway and your colleague Ms Abolurin was carrying out CPR. Resident A also had defibrillator pads on his body. The defibrillator had been provided by the first responder as the Centre did not have one. The first responder asked you to take over CPR. The first responder was not satisfied with your performance in carrying out CPR on Resident A and took over from you. The first responder asked for a suction machine which was in a different part of the Centre.

Resident A's death was subsequently confirmed. Resident A's death was also subject to a Coroner inquest which concluded on 14 November 2023. The inquest recorded the cause of death as a bowel ischaemia.

The first responder raised a safeguarding referral to Kent Council regarding your alleged conduct on 7 November 2022 and also sent a referral to Kent and Medway Coroners on 8 November 2022.

A local investigation also took place regarding your conduct in relation to the above events.

Decision and reasons on facts

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

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 oral evidence from the following witnesses, who also provided written statements, called on behalf of the NMC:

- Dorcas Mukuzwazwa, Registered Home Manager at the Centre;
- Oluwatoyin Abolurin, Registered Nurse and Nurse in Charge (NIC) at the Willow Unit at the Centre.
- Keya-Macy Beagle-Wessel, Paramedic
- Neil Salmon, Registered Nurse, trained first responder at the time of the events in question and used the GoodSam application on 7 November 2022. The GoodSam application uses GPS technology to alert trained first responder if there is a nearby emergency.

The panel also heard oral evidence from you under oath.

The panel also received documentary evidence which included, but was not limited to:

- Recording of incoming telephone call from the Ambulance Service;
- Transcript of the telephone call;
- Resident A's care notes;
- Local Investigation Report;
- The Centre's Basic Life Support (BLS) policy;
- The Centre's End of Life policy;
- Your statement to the Coroner's Court, dated 10 November 2022;
- Your response to the NMC charges; and
- Your statement to the local Trust investigation.

The panel considered the witness and documentary evidence provided by both you and the NMC.

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

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

Charge 1

1) Failed to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death.

This charge is found proved.

In reaching this decision, the panel took your written statement and oral evidence at the hearing into account.

The panel was mindful of the evidence it received from the NMC, in particular the Basic Life Support Policy of the Forest Healthcare Group, notably the following:

> ***'Key Messages from Resuscitation Council (RC) Guidelines 2015***
>
> - *Ensure it is safe to approach the victim.*
> - *Promptly assess the unresponsive victim to determine if they are breathing normally.*
> - *Be suspicious of cardiac arrest in any person presenting with seizures and carefully assess whether the victim is breathing normally;*
> - *For the victim who is unresponsive and not breathing normally:*
>   - *Dial 999 and ask for an ambulance. If possible stay with the victim and*
>   - *get someone else to make the emergency call.*
>   - *Start CPR and send for an AED as soon as possible.*

- *If trained and able, combine chest compressions and rescue breaths,*
- *otherwise provide compression-only CPR.*

[…]

- *Do not stop CPR unless you are certain the victim has recovered and is breathing normally or a health professional tells you to stop*

[…]

Adult Basic Life Support Sequence

***From**: Resuscitation Council (UK) Resuscitation guidelines*:

[…]

Look, listen and feel for normal breathing for no more than 10 seconds

In the first few minutes after cardiac arrest, a victim may be barely breathing, or taking infrequent, slow and noisy gasps. Do not confuse this with normal breathing. If you have any doubt whether breathing is normal, act as if it is they are not breathing normally and prepare to start CPR'

The panel heard from Ms Mukuzwazwa in her oral evidence that staff would carry out Basic Life Support (BLS) training annually and that the Centre BLS policy would be covered in this training.

The panel also noted the Group training statement in relation to Basic Life Support policy:

'Training Statement

Staff will receive mandatory training in basic life support (BLS) and must ensure that knowledge and skills are updated at least every three years.

All staff, during induction are made aware of the organisations policies and procedures, all of which are used for training updates. All policies and procedures are reviewed and amended where necessary and staff are made aware of any changes. Observations are undertaken to check skills and competencies. Various methods of training are used including one to one, on-line, workbook, group meetings, individual supervisions and external courses are sourced as required.

This policy will be reviewed with the Registered Manager and at Board level
[…]
Date: 04.22
Review Date: 04.23'

The panel also noted Forest Healthcare Group's 'End of Life' policy:

'Where the death is unexpected, the nurse has the responsibility to initiate resuscitative measures, as long as they are in the best interests of the individual and unless an agreed statement has been made that resuscitation is not to take place.'

The panel was of the view that there was a duty to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death. Further, it determined that, by your actions, you had accepted this duty.

When considering what constitutes a proper clinical assessment of irreversible signs of death the panel noted the Group BLS, which referenced Resuscitation Council Guidelines 2015. It noted that you should have been aware that a clinical assessment as to whether Resident A had signs of irreversible death would have included an assessment as to

whether Resident A was breathing, and that this would have included looking, listening and feeling for normal breath.

The panel also took account of Ms Abolurin's witness statement, dated 12 November 2024:

> *'I called 999 and reported everything to the emergency call handler. The emergency call handler told me to go back to* [Resident A's] *room and they would call me back because I told them I was calling from the office. When I got back to the room, the healthcare assistants had left and* [Resident A] *was gasping for breath so I pressed the emergency buzzer and started performing cardiopulmonary resuscitation ("CPR"). He started vomiting a little so I turned him on his side so he will not aspirate. While I was waiting for the paramedics, I heard him take his last breath and he stopped breathing. All this while, nobody came in to assist me although I had pressed the buzzer. At the coroner's inquest, I found out that when the buzzer was pressed in Willow Unit, it did not ring in the other units. The buzzer is also not loud.*
>
> *I do not remember the exact time but Melissa later came into the room and spoke to the emergency call handler. I did not hear what the call handler asked Melissa to do but based on her response, it seemed like she was asked to perform CPR. She said "no" to the emergency call handler and said that had stopped breathing.'*

The panel noted that Ms Abolurin had stated that she saw Resident A take his last breath after she had called for an ambulance. It further noted that Ms Abolurin was recorded in the telephone call recording as saying, in the background, that Resident A was *'still warm'*.

The panel took account of your oral evidence at the hearing during which you stated that you did not know Resident A, had not treated him before the events in question, and that

you were not familiar with his medical history. Further, you stated that you had not received a handover.

It also noted your written response to this allegation, in particular:

> *'My clinical assessment, formed in the absence of a handover, was that the resident had died. This assessment was based on the following observed clinical features: unresponsiveness; fixed and dilated pupils; absence of a palpable pulse; pallor with yellow-white discolouration; waxy skin texture; and a tepid to cool body temperature* […] *These findings are consistent with recognised post-mortem changes'*

The panel noted the recording of the telephone call with the emergency operator during which you stated that you were not commencing CPR as the *'patient was dead'.* It also noted the Centre's record of minutes taken from a meeting on 10 November 2022 which records you as stating that '*the call handler said can you start CPR and I said no, this gentleman is deceased'* and '*it was obvious he was deceased. I have done death verification training and he was ticking all the boxes'.* You were also recorded at the Minutes of the investigation meeting as stating *'I checked his pupils with my pen torch, touched him with the back of my hand on his chest as advised by the call handler'.*

The Centre's record of Minutes of the investigation meeting taken on 10 November 2022 recorded you as stating that the emergency call handler had asked you to touch Resident A, as she had been informed that he was still warm to touch. You were recorded as stating that you touched Resident A after being asked to do so by the emergency call handler, and resident A was *'tepid and cool'*. The panel noted that this is the first time that you have touched Resident A and is after you have made the decision that Resident A has signs of irreversible death.

The panel further noted that your arrival, as recorded in the telephone call recording, is audible at 03:32 minutes and, as you stated in your written response to the allegation, no

clinical handover was provided to you before Ms Abolurin passed you the telephone, at 03:53 minutes, whereupon you almost immediately stated that Resident A was deceased and refused to perform CPR. The panel considered that this indicated that your clinical assessment of Resident A was approximately 32 seconds.

The panel also took into account your oral evidence in that you stated that the resident had a sheet across him and his arms were out of the sheet. He was wearing a white tee-shirt and there was dried vomit on the bed and pillow. You then explained what you did stating '*I came within about a foot of him, I could see that his chest was not rising, skin was pale and one eye was open'*. When asked if you physical touched the patient you responded by saying *'not at this point'*. You explained that you checked Resident A's pupils using your pen torch. Further, when asked if you tried to take a pulse you responded '*no I don't think I did'*.

The panel determined that your oral evidence was inconsistent with your written response to the allegations, and with the Minutes of the 10 November 2022 meeting.

Further, the panel also took account of your statement to the Coroner, dated 10 November 2022:

> *'He was not warm, his eyes were fixed and dilated, his skin colour was that of a person who had not had oxygenated blood for a while (yellow/white), he was not responsive to touch or stimuli and there was no cardiac output'*

The panel determined that your assertion that Resident A had no cardiac output was inconsistent with your other evidence, as you did not claim to have taken his pulse to check cardiac output as part of your clinical assessment of irreversible signs of death in your oral evidence or the Minutes recorded at your Investigation meeting at the Centre on 10 November 2022.

In the circumstances, the panel determined that your evidence relating to the time period from when you arrived at Resident A's room to the time at which you informed the emergency call handler that Resident A was deceased, with irreversible signs of death, was inconsistent and not aligned with the Centre's policy. It bore in mind that the evidence it received from Ms Abolurin indicated that Resident A was still warm to touch and that she had seen him take his last breaths.

You provided the panel with the BMA/RCN/BLS Joint Guidance on Decisions Relating to Cardiopulmonary Resuscitation, in section 8 of this guidance under the heading 'Initial Presumption in Favour of CPR when there is no recorded CPR decision' it states that there are instances where healthcare professionals discover patients with irreversible features of death for example rigor mortis, however Mr Salmon stated that Resident A was still warm to touch when he arrived and there was no rigor mortis present in Resident A's jaw whilst he cleared Resident A's airways and the head tilted back with ease. This also contradicted your assertion that *'the first responder was unable to extend the residents head due to rigor mortis'* as you stated in the Regulatory Concerns Response Form.

The panel concluded that if it was the case that you clinically assessed Resident A as having signs of irreversible death, relatively shortly after he had taken his last breaths, without touching him and without taking his pulse, this would not have constituted a proper clinical assessment and would not be consistent with BLS guidelines, in particular the instruction to 'look, listen and feel'.

In the circumstances, the panel concluded that given the inconsistency in your evidence and the consistency of the evidence presented by the NMC, from a number of witnesses, it was more likely than not that your clinical assessment of irreversible signs of death was inadequate.

Therefore, the panel concluded that it was more likely than not that you failed to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death.

Accordingly, the panel determined that charge 1 was found proved.

Charge 2

2) Failed to follow directions given by the 999 call handler to commence Cardiopulmonary Resuscitation ("CPR") on Resident A.

This charge is found proved.

The panel took account of the recording of your telephone call with the 999 call handler on 7 November 2022.

The panel took also took account of the transcript of the call, in particular the following:

> *'NURSE 1* [You]: *Hello, this is [inaudible] from the other unit. I tried transferring you and I couldn't get through. It's very evident that this gentleman has passed. He's deceased.*
> *AMBULANCE SERVICE: Okay. Please go to the patient.*
> *NURSE 1: I'm a qualified nurse and I can tell you by looking at the resident that he has passed. His heart has stopped. There is no –*
> *AMBULANCE SERVICE: Please go to the patient now.*
> *NURSE 1: I'm with the patient now and there is no heartbeat.*
> *AMBULANCE SERVICE: Okay, can you touch him on the chest? Is there any warmth at all?*
> *NURSE 1: No. He's deceased.*
> *AMBULANCE SERVICE: Is he stone-cold to touch on his chest?*
> *NURSE 1: Yes, he's cold. If I'm able to certify –*
> *NURSE 2* [Ms Abolurin]: *He's warm.*
> *NURSE 1: He's warm but not like he should be. I'm able to certify his death.*
> *AMBULANCE SERVICE: Okay, so if he's still warm, you need to start CPR.*

NURSE 1: No. I'm sorry. That isn't possible because he is deceased. I've had this argument before with the emergency services.
AMBULANCE SERVICE: If he is warm at all, he needs –
NURSE 1: There is no circulation. His eyes are fixed and dilated. He is deceased.
AMBULANCE SERVICE: You need to do CPR.
NURSE 1: No, I'm not doing CPR because he is deceased. Right, just bear with me a second. Was this an expected death?
NURSE 2: No, [inaudible].
AMBULANCE SERVICE: Hello? If the patient is warm to touch and he's not breathing, then I need you to start CPR.
NURSE 1: No. There is no cardiac output. I'm not commencing CPR.
AMBULANCE SERVICE: Well, you called us for a reason and we're here to offer help.
NURSE 1: I know, but I didn't call you. This is my colleague. I've just come down as a senior nurse to check what's going on and I can see that the gentleman is deceased and I can certify his death.
AMBULANCE SERVICE: So if he's not breathing and he is still warm to touch, we do advise that you start CPR immediately.
NURSE 1: I cannot do that because there is nothing. There is no cardiac output. He is deceased. Right, so there's no point – we can't... Just grab that a second. There's nothing we can do. He is deceased. So he's got no DNR.
NURSE 2: No DNR. He came two days ago.
NURSE 1: Right, okay. That's fine. I can certify. You can certify as well, can't you? I had this last time 1 with somebody. There's no point –
NURSE 2: Hello?
AMBULANCE SERVICE: I'm still here. Just bear with me one moment.
NURSE 2: Thank you.
NURSE 1: They can send a paramedic but [inaudible] there's nothing.'

The panel received evidence that the emergency call handler, upon being told that Resident A was still warm and that there was not a DNR (Do Not Resuscitate) in place, instructed you to commence CPR.

The panel noted that the instruction to commence CPR on a patient who was still warm and with no DNR in place was consistent with the Centre's BLS policy.

> ***'Key Messages from Resuscitation Council (RC) Guidelines 2015***
>
> - *For the victim who is unresponsive and not breathing normally:*
>   - […]
>   - *Start CPR and send for an AED as soon as possible.*
>   - *If trained and able, combine chest compressions and rescue breaths*
>   - *otherwise provide compressions only CPR'*

The panel also noted that the emergency caller's instruction was also consistent with the Centre's policy on 'End of Life' Care, of which you should have been familiar:

> *'Where the death is unexpected, the nurse has the responsibility to initiate resuscitative measures, as long as they are in the best interests of the individual and unless an agreed statement has been made that resuscitation is not to take place.'*

The panel considered your written response to this allegation, namely, that you acknowledged that you did not immediately commence CPR when directed to do so, but asserted that this decision was made on the basis of my clinical judgment that resuscitation would be futile.

However, the panel also took account of evidence of the absence of a proper clinical assessment as to whether Resident A had signs of irreversible death, or an obvious sign

such as rigor mortis. Such an assessment might have justified a refusal to follow instructions to commence CPR on Resident A, and might have been in their best interests.

In the circumstances, and as a simple matter of fact, the panel considered that the telephone recordings and transcript provided clear probative evidence of your refusal to follow directions given by the 999 call handler to commence CPR on Resident A.

Accordingly, the panel determined that charge 2 was found proved.

Charge 3

3) Carried out CPR on Resident A incorrectly, in that you did not apply deep compressions as instructed to do by the first responders.

This charge is found proved.

The panel took account of your written response to this allegation:

> *'I deny that any deficiency in CPR technique arose from a lack of competence; rather, any limitation was attributable to the physical environment and positioning constraints.*
>
> *Basic Life Support (BLS) guidance requires that CPR be performed on a firm, flat surface. In this instance, the resident remained on a profile bed which did not have a CPR function, and was positioned at an elevated height with side rails in place.*
>
> *Upon my return to the room, I observed that CPR had been commenced, and, when requested, I took over compressions. Due to the height of the bed, I was required to stand on my tiptoes and lean over the resident, which significantly limited my ability to achieve optimal compression depth'*

The panel also noted the Minutes from the local investigation, dated 10 November 2022, where in response to being asked *'why you did not administer the 5cm compressions'* you stated that the '*bed was too high and he lowered the bed, but it was difficult. But it's difficult as when you compress the body it goes into the mattress'*.

This panel also took account of Mr Salmon's oral evidence at the hearing. It particularly noted that, when asked whether your compressions on Resident A were deep enough, he stated that he could not recall. He did, however, state in his oral evidence that he did not think that you were solely focused on providing resuscitation and that your comments relating to certifying Resident A's death were inappropriate.

However, the panel took account of Mr Salmon's statement, dated 4 February 2026:

> *'I requested assistance from the registrant so I could update the ambulance emergency operations centre and focus on the patient's soiled airway. Upon requesting assistance from the staff, the registrant was unable to provide adequate CPR so I instructed the registrant to step aside as the compressions were inadequate.*
>
> *The registrant stated it's an going battle when calling 999 where they instruct BLS to commenced but she feels it's inappropriate. The registrant was focusing on practicalities to certifying the patients death and not active resuscitation for a witnessed cardiac arrest no advance care planning.'*
>
> .

The panel also noted Ms Abolurin's witness statement, dated 12 November 2024:

> *'The ambulance arrived and the paramedic put a defibrillator on and I started CPR. The paramedic asked Melissa to take over because he saw that I was getting tired and she did. The paramedic asked her to do deeper compressions (5cm deep) but Melissa said she did not want to break his ribs so he took over from her.'*

The panel bore in mind that the responder, Mr Salmon, stated in his oral evidence at the hearing that he could not recall whether your compressions were deep enough. However, it also took account the consistent accounts of Ms Abolurin which included her local statement made at the time of the events in question, her witness statement dated 12 November 2024, and her supplementary witness statement dated 15 January 2026.

The panel also took account of the fact that your written response to the allegation and your answers given at the local investigation on 10 November 2022 do not deny that you did not apply deep compressions as instructed to do by the first responder, but rather give an explanation as to why you did not do so.

The panel considered that although Mr Salmon, during his oral evidence at the hearing, could not recall whether you did not apply deep compressions, but rather emphasised that you were not solely focused on providing resuscitation, this did not undermine the probative value of the near contemporaneous local investigation Minutes, dated 10 November 2022.

Further, the panel was mindful that Ms Abolurin's written statement supported the allegation that you did not apply deep compressions as instructed to do by the first responders.

The panel determined that, on the balance of probabilities, in light of the totality of the evidence, and given your explanation as to why you were not able to administer adequate compressions at the Centre local investigation on 10 November 2022, it was more likely than not that you carried out CPR on Resident A incorrectly, in that you did not apply deep compressions as instructed to do by the first responder.

Accordingly, the panel found that charge 3 was found proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the resumption of the hearing, on 24 August 2026, that Ms Papandrea was not in attendance and that the Notice of Hearing letter had been sent to her registered email address on 6 July 2026.

Mr Kewley, on behalf of the NMC, submitted that it had complied with the requirements of Rule 32 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Ms Papandrea has been served with the Notice of Hearing in accordance with the requirements of Rule 32.

Decision and reasons on proceeding in the absence of Ms Papandrea

The panel next considered whether it should proceed in the absence of Ms Papandrea. It heard the submissions of Mr Kewley who invited the panel to continue in the absence of Ms Papandrea. He submitted that Ms Papandrea had voluntarily absented herself and had told the NMC that she did not want to attend in correspondence dated 20 August 2026. He stated that Ms Papandrea had indicated that she would rather that the panel proceed and consider her material, and reflections, on the papers rather than hear from her directly. He stated that this was a clear case of voluntary absence and that any adjournment was

unlikely to secure Ms Papandrea's attendance, and there was no suggestion that different dates would secure her attendance. Further, Mr Kewley stated that there was a public interest in the expeditious disposal of this case.

The panel accepted the advice of the legal assessor.

The panel decided to proceed in the absence of Ms Papandrea. In reaching this decision, the panel considered the submissions of Mr Kewley, correspondence from Ms Papandrea, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* [2003] 1 AC 1 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 determined that Ms Papandrea had chosen not to attend and had given clear reasons why she would not attend. She stated in her correspondence, dated 20 August 2026:

> *'My decision not to attend is not intended to delay or avoid these proceedings, and I respectfully ask the Panel to consider this written statement in my absence.'*

Further, the panel noted that Ms Papandrea had submitted reflections to be considered by the panel and concluded that there was no unfairness or injustice in proceeding in her absence.

Decision and reasons on Fitness to Practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Papandrea'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, effectively and 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. Firstly, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Papandrea's fitness to practise is currently impaired as a result of that misconduct.

Ms Papandrea did not attend at this stage of the hearing but submitted written evidence which included written submissions, reflective pieces, training certification and testimonials submitted on her behalf.

Submissions on misconduct & impairment

Submissions on behalf of the NMC

Mr Kewley referenced the NMC Code of Conduct (2018) (the Code) and submitted that Ms Papandrea's fitness to practise was impaired by reason of misconduct. In particular he referred to the following paragraphs of the Code:

- Paragraph 1.4 in relation to the need to have administered CPR without delay and referenced paragraph;
- Paragraph 6 in relation to basic life-support policy;
- Paragraph 8.1 in relation respecting the skills of colleagues;
- Paragraph 8.2 with regard to maintaining effective communication with colleagues;
- Paragraph 8.5 in relation to working with colleagues to preserve the safety of those receiving care;

- Paragraph 13.1 in relation to the need to accurately identify, observe and assess signs of worsening health in the person receiving care, and relevant to the panel's finding that there was a failure to properly assess the resident's condition;
- Paragraph 15.2 in relation to arranging wherever possible for emergency care to be accessed and provided promptly, and relevant to Ms Papandrea's failure to follow the emergency call handler's instructions.

Mr Kewley submitted that Ms Papandrea's conduct fell seriously short of what was required in the circumstances. He stated that Ms Papandrea, when confronted with a situation where a resident, Resident A, was unresponsive had failed to carry out a proper clinical assessment as to the resident's condition and decided that he was deceased without having carried out a proper clinical assessment that would allow her to reach that conclusion. He stated that during the telephone call with the emergency call handler, she was clearly instructed to commence Cardiopulmonary Resuscitation (CPR), but instead of working co-operatively, she refused to carry out the request, and, concerningly, stated that she had *'had this argument before'*.

Further, Mr Kewley stated that Ms Papandrea repeatedly refused to carry out CPR and, according to witness evidence from the first responder, appeared not to be focusing on the task in hand.

With regard to the question of impairment, Mr Kewley stated that the NMC's guidance separated public protection considerations from public interest considerations.

In relation to public protection, Mr Kewley accepted that the purely clinical aspects of this case were capable of being addressed, and she has shown '*green shoots'* of insight and invited the panel to have regard to the material Ms Papandrea provided at this stage. He stated that Ms Papandrea appeared to be accepting the panel's findings of fact and clearly accepted that she was not entitled to make a unilateral assumption that Resident A was beyond resuscitation or to withhold treatment on that basis, and further that she should

have followed the appropriate procedures and responded objectively in accordance with the instructions of the call handler.

However, Mr Kewley submitted that the panel should consider that it did not, at this stage, have any up to date evidence showing that Ms Papandrea has used or deployed any this learning in practice in frontline nursing, a resuscitation or even an emergency clinical situation where she is able to take instruction, work with other members of a multidisciplinary team and pull together in the interests of a patient.

Mr Kewley also stated that there was perhaps an attitudinal issue underpinning the events of November 2022. He stated that early on within the telephone call with the emergency call handler Ms Papandrea made it clear that she had had *'this argument before'* and repeatedly refused to follow instructions in an entrenched manner, that nothing was going to shift her from, not even repeated requests. Mr Kewley also referenced a member of the ambulance team being made to feel uneasy with words used in the emergency situation after Ms Papandrea allegedly told the arrived ambulance team that they thought they could resuscitate everyone, and that she seemed more concerned with the practicalities of how Resident A's death should be certified. Mr Kewley asserted that Ms Papandrea's reflections did not make it clear why she took such an entrenched view towards her colleagues, the call handler and the first responders. He stated that, in such circumstances, the panel may not be able to rule out a risk of repetition, and any repetition would place patients at risk of harm.

In relation to the public interest, Mr Kewley submitted that a finding of impairment was required to maintain public confidence in the profession. He stated that this was a case where Ms Papandrea took a view, and could not be shifted from it, and allowed her own subjective view to take priority to the extent that she did not work effectively with her colleagues. He stated that this this type of conduct would cause concern to members of the public, such that a finding of impairment was necessary on public interest grounds.

<u>Ms Papandrea's written submissions</u>

Ms Papandrea did not attend but sent the panel the following signed written submissions, dated 19 August 2026:

> *'I would like to begin by thanking the Panel for taking the time to consider my written submissions and for allowing me the opportunity to provide my reflections in writing.*
>
> *I would like to express my sincere regret for the events of 7 November 2022 and for the findings made by the Panel. I fully recognise the seriousness of this matter and the impact it had on the Resident, their family, the public and the reputation of the Nursing profession.*
>
> *I regret that I am unable to attend my Stage 2 hearing. The Stage 1 NMC FTP hearing had a significant impact* [PRIVATE]. […]
>
> *I have had a long Nursing career and, throughout that time, have sought to uphold the responsibilities and standards expected of a Registered Nurse. I have had no previous fitness-to-practice findings or serious disciplinary issues. My career has included significant clinical experience, as well as leadership and educational responsibilities, including supporting colleagues and contributing to the development of healthcare staff.*
>
> *I recognise that the events of 7 November 2022 were serious and that the Panel had concerns about my actions and clinical decision-making. I have carefully considered the findings and reflected on what I could and should have done differently.*
>
> *I understand the importance of ensuring that clinical assessments in these circumstances are thorough and undertaken in accordance with accepted professional guidance. I also recognise the importance of following the directions of*

emergency call handlers and ensuring that Basic Life Support is provided to the required standard whenever indicated.

I now understand that, where there is uncertainty and no clear and definitive signs of irreversible death, the safest course of action is to commence CPR immediately while following the guidance provided by emergency services. I recognise that these principles are fundamental to patient safety and maintaining public confidence in the Nursing profession.

This experience has caused me to reflect deeply on my clinical decision-making and responsibilities as a Registered Nurse, particularly when working under pressure. It has reinforced the importance of remaining structured, seeking appropriate guidance and adhering to established protocols, regardless of previous experience or confidence.

Since the incident, I have taken meaningful steps to strengthen my knowledge and practice. These include:

- *Undertaking further education and updating my knowledge in Basic Life Support and emergency response.*
- *Delivering training to healthcare staff in Basic Life Support, emergency escalation, end-of-life care and verification of expected death, ensuring that my teaching reflects current guidance, legislation and local policies.*
- *Revisiting relevant clinical guidance and resuscitation protocols to ensure my knowledge remains current.*
- *Reflecting on my decision-making under pressure and the importance of clear communication, appropriate escalation and collaborative working with colleagues and emergency services.*

These steps have strengthened my understanding of how I would approach a similar situation today. I would ensure that my assessment was structured and

consistent with current professional guidance, that any uncertainty was managed in the safest possible way, and that I followed the instructions of emergency services and local protocols without hesitation.

Please could I ask the Panel to consider this incident within the wider context of my professional career. I have worked in Nursing for many years without previous fitness-to-practise findings or serious disciplinary issues. My experience, leadership and educational roles, and otherwise unblemished professional record demonstrate a longstanding commitment to Nursing and to providing safe, compassionate and effective care. I respectfully submit that this was an isolated incident and is not representative of my overall career or professional values.

I remain committed to the Nursing profession and hope to return to a Nursing role in the future. I understand the responsibility that would come with returning to practice and remain committed to maintaining my professional knowledge, skills and adherence to the standards expected of a Registered Nurse.

I genuinely regret the circumstances that have brought me before the Panel. While I cannot change what happened on 7 November 2022, I have sought to learn from it, develop my practice and demonstrate meaningful insight into the concerns identified.

I ask the Panel to take into account my long and otherwise unblemished Nursing career, my years of professional experience, previous leadership and educational responsibilities, the absence of any previous fitness-to-practice findings or serious disciplinary issues, the steps I have taken since the incident, and my genuine remorse and commitment to safe practice.

Finally, I respectfully ask the Panel to consider these matters when determining whether my fitness to practise is currently impaired and, if so, what sanction would be fair, proportionate and sufficient to protect the public while recognising the

significant steps I have taken since this incident.

Thank you again for taking the time to consider my written submissions.'

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

In approaching the decision, the panel was mindful of the two-stage process to be adopted in relation to a finding of impairment based on misconduct: first, whether the facts as found proved amounted to misconduct, which in this context amounted to a serious departure from generally accepted professional standards, and then whether the finding of that misconduct could lead to a finding of current impairment of fitness to practise.

The panel must determine whether Ms Papandrea's fitness to practise is impaired today, taking into account her conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and whether there is any likelihood of repetition. The panel is also required to have regard to the wider public interest and to consider whether a finding of impairment is necessary in order to promote and maintain public confidence in the nursing profession and to promote and maintain proper professional standards and conduct for members of that profession.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel considered that the following sections of the Code were pertinent to the charges:

'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay'

'6 Always practise in line with the best available evidence'

‘8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate’

‘8.2 maintain effective communication with colleagues’

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

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

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

Charge 1

The panel reminded itself of the proven facts. It noted that it had found that Ms Papandrea had failed to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death.

The panel concluded that assessing Resident A, who did not have Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place, as having signs of irreversible death, relatively shortly after he had taken his last breaths, without touching him and without taking his pulse, did not constitute a proper clinical assessment and was not consistent with BLS guidelines, in particular the instruction to ‘look, listen and feel’, and the BMA/RCN/BLS ‘Joint Guidance on Decisions Relating to Cardiopulmonary Resuscitation’, was clearly unacceptable.

The panel further noted that Ms Papandrea’s conduct was inconsistent with the Centre’s policy on ‘End of Life’ Care, of which you should have been familiar:

‘Where the death is unexpected, the nurse has the responsibility to initiate

resuscitative measures, as long as they are in the best interests of the individual and unless an agreed statement has been made that resuscitation is not to take place.'

The panel was particularly concerned that Ms Papandrea's had decided that Resident A had irreversible signs of death was based on her subjective opinion without following guidelines. Further, she could not have known whether or not there might have been a different outcome had CPR been commenced.

The panel noted that Ms Papandrea in her recent reflections submitted to the panel now accepted that her conduct was based on an assumption:

'On the morning of 7 November 2022, I made a serious error in clinical judgement that I deeply regret. When I discovered the resident, I formed a subjective belief that they were deceased and that resuscitation would not be successful. I recognise now that this was an assumption rather than a clinical conclusion that I was appropriately qualified or authorised to make. As a result of that assumption, I did not initiate Basic Life Support (BLS) when I should have done so.'

The panel considered that Ms Papandrea's conduct in failing to carry out a proper clinical assessment as to whether Resident A had signs of irreversible death, was a serious as departure from the requirements of the Code as set out in the paragraphs quoted above. It determined that Ms Papandrea's conduct fell far below an appropriate professional standard and clearly amounted to serious misconduct.

Further, the panel determined that the requirement to undertake a proper clinical assessment as to whether Resident A had signs of irreversible death was a fundamental tenet of the nursing profession, and fellow professionals would consider a failure to follow guidelines in such circumstances to be appalling.

Charge 2

The panel reminded itself of the proven facts. It noted that it had found that Ms Papandrea had failed to follow directions given by the 999 call handler to commence CPR on Resident A.

The panel considered that the telephone recordings and transcript provided clear probative evidence of Ms Papandrea's refusal to follow directions given by the 999 call handler to commence CPR on Resident A and Ms Papandrea's demonstrated entrenched and unprofessional attitudes on the night in question.

The panel considered that Ms Papandrea should have worked co-operatively with the call handler and noted that the call handler's directions to commence CPR were in line with guidance with which she should have been familiar. If further took account of Ms Papandrea not knowing the medical history of Resident A and seemingly being dismissive of the emergency call handler's instructions.

The panel determined that Ms Papandrea's repeated failure to follow the call handler's instructions to perform CPR, despite Resident A still being warm, and not having a DNACPR decision in place, was a breach of the guidelines.

In the circumstances the panel determined that Ms Papandrea's conduct in failing to follow directions given by the 999 call handler to commence CPR was a departure from the Code and breached a fundamental tenet of the profession and clearly amounted to serious misconduct.

Charge 3

The panel considered that Ms Papandrea's conduct in carrying out CPR on Resident A incorrectly, in that she did not apply deep compressions as instructed to do by the first responders, was a serious departure from the standards expected of a registered nurse. The panel bore in mind that effective resuscitation is a fundamental aspect of nursing and

noted that, as a registered nurse, Ms Papandrea would have been trained to carry out CPR correctly.

The panel took account of Ms Papandrea's evidence which indicated that she had not been able to carry out compressions correctly due to the height of Resident A's bed.

Nevertheless, the panel considered that effective CPR is a fundamental aspect of nursing and noted other witnesses had stated that she was unfocused and preoccupied at a time when she should have been administering what was potentially life saving treatment in an emergency situation.

In the circumstances, the panel determined that Ms Papandrea's conduct in carrying out CPR on Resident A incorrectly was, as a registered nurse, a significant departure from expected standards and amounted to serious misconduct.

Charge 1, 2, and 3 together

The panel considered that Ms Papandrea's conduct, in relation to the totality of charge 1, 2 and 3 was clearly unacceptable and amounted to a breach of fundamental tenets of the profession.

The panel considered that Ms Papandrea's conduct on 7 November 2022 had been unprofessional and unco-operative.

The panel was particularly concerned that Ms Papandrea did not know the medical history of Resident A, who did not have a DNACPR decision in place, and had not followed guidelines but had rather based her initial decision not to carry out CPR on Resident A on her own subjective judgement and had been unco-operative and unprofessional when working with colleagues in an emergency situation.

The panel concluded that fellow professionals would consider Ms Papandrea's conduct on 7 November 2022 to be appalling.

Therefore, the panel found that Ms Papandrea's conduct, in relation to the totality of charges 1, 2 and 3, taken together, cumulatively constituted serious misconduct.

Decision and reasons on impairment

Having found that the facts found proved amounted to misconduct, the panel went on to consider whether, as a result of that misconduct, Ms Papandrea's fitness to practise was currently impaired.

The panel bore in mind that its task was to consider Ms Papandrea's current fitness to practise. This involved necessarily looking at her past misconduct and also considering what, if anything Ms Papandrea had done to remediate the misconduct and any insight gained.

The panel reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the panel's judgement alone, and was mindful of NMC guidance DMA-1 (2016).

Whilst there is no statutory definition of impairment, the panel had regard to the case of *CHRE v NMC and Grant* [2011] EWHC 927 where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested that questions of impairment could be considered in the light of the following considerations:

> *'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 also noted paragraph 76 of *Grant* in which Dame Janet Smith stated the following:

'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.'

The panel had regard to the case of *Cohen v GMC* [2008] EWHC 581 (Admin), and took into account the requirement that '*conduct which led to the charge is easily remediable; that, second, it has been remedied; and, third, that it is highly unlikely to be repeated*'.

The panel considered that Ms Papandrea had engaged in conduct which would be regarded as appalling by fellow practitioners and members of the public.

The panel considered that Ms Papandrea had taken steps to remediate her practice, and took account of her reflective statements and positive testimonials. It bore in mind that Ms

Papandrea's reflective statement was detailed and focused and applicable to the relevant parts of the Code.

The panel further noted that Ms Papandrea has been working in a clinical teaching role for the last three years, had undertaken continuous professional development (CPD), and had engaged with the regulatory process.

The panel noted that Ms Papandrea now accepted that her actions fell seriously below standards expected:

> *'Attending my Stage 1 NMC Fitness to Practise hearing was a significant moment of professional reflection for me. Hearing the evidence, including the witness testimony, and listening to the Panel's analysis gave me the opportunity to look back at my actions objectively rather than through the perspective I had at the time. It was difficult to hear, but it was necessary. I was able to understand more clearly why my decision was unsafe and why the Panel considered that my actions fell seriously below the standards expected of a Registered Nurse.'*

The panel also took account of Ms Papandrea's expressions of remorse:

> *'I now fully accept that I was not entitled to make a unilateral assumption that the resident was beyond resuscitation or to withhold emergency treatment on that basis. I should have followed the appropriate emergency procedures, responded to the situation objectively, and acted in accordance with the instructions of the emergency call handlers. My initial decision was therefore not simply an error of judgement; it was a failure to recognise the limits of my role and to place the appropriate emergency response above my own subjective assessment.*
>
> *This realisation has had a profound impact on me professionally. I feel genuine remorse for my actions and for the consequences of my decision. I understand that behind the clinical incident was a person, a family, and people who trusted that*

appropriate Nursing care would be provided in an emergency. I deeply regret that my actions did not meet the standard that the resident, their family, the public, and the nursing profession had the right to expect from me.'

When considering whether Ms Papandrea's fitness to practice was impaired on the grounds of public protection the panel was cognisant of the remediation she has undertaken. It particularly noted her reflections regarding reducing the potential for harm:

'My extensive reflection, three years of clinical teaching and continued engagement with the NMC process demonstrate how seriously I have taken the need to reduce the risk of harm. I have worked to transform a deeply regrettable clinical error into meaningful learning and sustained professional development. My commitment now is not simply to avoid repeating the same mistake, but to actively promote safe decision-making, timely intervention, effective communication and patient-centred care in my own practice and through the education I provide to others.'

The panel bore in mind that Ms Papandrea had a previously unblemished career and had received no evidence of similar conduct either before, of after, the events of 7 November 2022.

The panel acknowledged that Ms Papandrea had taken steps to try and remediate any potential risk of repetition.

However, the panel concluded that Ms Papandrea, on 7 November 2022, had demonstrated an entrenched and unprofessional attitude.

The panel considered that, given the extent of Ms Papandrea's unprofessional attitude on 7 November 2022, it had some concerns that there was a risk of repetition. In particular, whilst it noted that Ms Papandrea now accepted that her conduct had been unacceptable, it still had concerns regarding her understanding of the inappropriateness of her

entrenched attitude regarding resuscitation, which was compounded by the fact that she did not know the medical history of Resident A.

The panel also considered that the misconduct found was serious and involved fundamental nursing responsibilities in an emergency situation, including assessment of life, commencement of CPR, and delivery of effective chest compressions. While Ms Papandrea has expressed remorse and demonstrated developing insight, there is no evidence before the panel of remediation being tested in clinical practice or of sustained safe practice in a comparable clinical setting since the incident.

Although Ms Papandrea's misconduct had occurred on one occasion, it determined that there was evidence of an attitudinal issue (although it had not received evidence of other incidents) which might indicate that there might be deep-seated issues.

The panel therefore concluded that it could not exclude the possibility of a residual risk of repetition and, therefore, a risk to patient safety. Accordingly, a finding of impairment is required on public protection grounds.

Further, the panel considered that Ms Papandrea's misconduct on 7 November 2022 was such a serious departure from the standards expected of a professional nurse that a finding of impairment is necessary to mark the gravity of her actions and was in the public interest. It considered that as Ms Papandrea's conduct fell far below the standard expected of a nursing practitioner, public confidence in the nursing profession would be undermined, and there would be a failure to uphold professional standards, if a finding of impairment were not made.

The panel therefore determined that Ms Papandrea's fitness to practise is currently impaired by reason of misconduct.

Decision and reasons on sanction

Having found Ms Papandrea's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the NMC's Sanctions Guidance (2016) (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel has taken into account the background to the case and the evidence received during the earlier stages of the hearing. It also accepted the advice of the legal assessor. All this information is relevant to reaching a decision on what action, if any, it should take with regard to Ms Papandrea's registration.

Submissions on sanction

Submissions on behalf of the NMC

Mr Kewley submitted that the appropriate and proportionate sanction in this case was a suspension order with a review.

Mr Kewley referred to failings which he stated were related to fundamental areas of nursing, firstly he referred to the failure to carry out a proper assessment on a resident and then provide basic life support to that patient.

Mr Kewley referred to the facts of the case and emphasised that there was no evidence to suggest that the ultimate outcome would have been different for Resident A, but, as a matter of common sense, it must follow that if one does not carry out CPR when instructed to do so, that at least must result in a risk of harm.

Mr Kewley stated that the failure to work collaboratively with colleagues was a serious failure. In particular, he stated that Ms Papandrea failed to work collaboratively with an

emergency call handler and a first responder, who were working in their areas of expertise in relation to an unresponsive patient. He asserted that this situation was their *'bread and butter'* and it was all the more important that Ms Papandrea should have worked with these two individuals collaboratively.

Mr Kewley also highlighted the absence of complete insight and the absence of complete strengthening of practice, and evidence of attitudinal type concerns.

Mr Kewley submitted that Ms Papandrea had clearly put effort into her reflections in gathering material for the panel and she was engaged with the regulatory process. Further, he stated that Ms Papandrea had started to try to strengthen her practice and had shown some insight, and clearly her view had shifted from stage 1 in April to the present resumed hearing and was now in almost full acceptance of the panel's factual findings.

Mr Kewley submitted that although the facts were very serious, Ms Papandrea's misconduct took place over a single shift in what was previously an unblemished career, and that this pointed away from a striking off order.

Mr Kewley submitted that the NMC position was that a suspension may well be appropriate in the present circumstances and would allow Ms Papandrea to address the outstanding issues that have been raised, namely the attitudinal issue and the lack of evidence of learning having been put into a practical effect.

Mr Kewley submitted that a 12-month suspension with a review might be appropriate considering the seriousness of Ms Papandrea's misconduct, and a review would be needed before the registrant could be considered fit to return to unrestricted practice.

Mr Kewley concluded by submitting that if one fails to carry out a fundamental nursing task, such as providing life basic life support, and making an important assessment of a patient, comes with a risk of harm, and again emphasised that there was no suggestion that Ms Papandrea was wilfully deciding to turn a *'blind eye'* to Resident A, but ultimately

she had reached a conclusion that she was not entitled to reach because she had not carried out a proper assessment.

Panel decision

The decision as to the appropriate sanction to impose, if any, is a matter for this panel exercising its own judgement. There is no burden or standard of proof at this stage. It recognises that every case will necessarily turn on its own facts.

The panel has borne in mind that in deciding what sanction to impose, it should consider all the sanctions available, starting with the least restrictive.

Throughout its deliberations, the panel has been proportionate, balancing Ms Papandrea's interests with the public interest.

The panel has taken into account its earlier determinations on the facts and on impairment, the SG and the NMC Code, the submissions of Mr Kewley on behalf of the NMC, and Ms Papandrea's written submissions at stage 2 and her reflections.

Aggravating and Mitigating Factors

The panel first considered the aggravating factors:

- The matters that the panel found proved demonstrated a real risk of harm to patients;
- Ms Papandrea failed to work collaboratively with colleagues, the 999 call handler and first responder;
- Ms Papandrea had demonstrated resistance to listen to and appropriately take account of the views of others, and this demonstrated some possible attitudinal concerns.

The panel then considered the mitigating factors in relation to Ms Papandrea's case:

- The panel took account of the fact that Ms Papandrea's misconduct related to a single occasion, on a single shift, in an otherwise long and unblemished career;
- Ms Papandrea continued to engage appropriately with the regulatory process;
- Ms Papandrea had apologised for her misconduct and had expressed remorse;
- Ms Papandrea had taken some steps to remediate in order to prevent a repetition of her misconduct;
- The panel considered that Ms Papandrea had demonstrated growing insight, albeit at a later stage of the fitness to practise hearing;
- Ms Papandrea had provided a detailed reflective account to the panel and had undertaken CPD and provided positive testimonials.

The panel considered each sanction in ascending order of seriousness starting with the least restrictive.

No Further Action

The panel first considered whether to conclude the case by taking no action. It noted that taking no further action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

The panel determined that there were no exceptional circumstances in this case which would justify taking no action.

The panel determined that to take no action would be inappropriate due to the seriousness of the misconduct. It considered that it would not be sufficient to protect the public, proportionate, or in the public interest to conclude the case by taking no further action.

Caution Order

The panel then considered whether a caution order would be appropriate in the circumstances.

The panel had regard to the SG, in particular SAN-2b:

> *'A caution order is only appropriate if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse, midwife or nursing associate's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again.*
>
> *Because a caution order doesn't affect a nurse, midwife or nursing associate's right to practise, the Committee will always need to ask itself if its decision about the nurse, midwife or nursing associate's fitness to practise indicated any risk to patient safety.'*

The panel considered that Ms Papandrea'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 Ms Papandrea'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.

Conditions of Practice Order

The panel considered whether it would be appropriate to impose conditions on Ms Papandrea's registration. It bore in mind that any conditions imposed should be relevant, proportionate, workable and measurable.

The panel had regard to the SG, in particular SAN-2c:

> *'If there are no appropriate and workable conditions, the Committee should then consider whether suspension would be more appropriate'*

The panel determined that no workable or measurable conditions could be formulated which would address the seriousness of Ms Papandrea's misconduct. The panel found that there were no areas of her practice which were in need of further remediation which would benefit from a conditions or practice order.

Further, the panel considered that the imposition of conditions would not mark the seriousness of Ms Papandrea's misconduct and would be insufficient to maintain public confidence in the profession or to promote and maintain standards for members of the profession.

Suspension Order

The panel then went on to consider whether imposing a period of suspension on Ms Papandrea's registration would be appropriate and proportionate.

The panel acknowledged that suspension has a deterrent effect and can be used as a signal to the registrant, the profession, and to the public about what is regarded as unacceptable conduct.

The panel took account of the following paragraphs of the SG, in particular SAN-2d, which indicate circumstances in which it may be appropriate to impose a sanction of suspension:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the SAN-2d to weigh up before imposing a suspension, and the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation.'*

The panel was satisfied that in this case, whilst Ms Papandrea's misconduct was serious, it was not so serious to be fundamentally incompatible with her remaining on the register.

The panel was of the view that the need to protect the public and uphold public confidence in the profession could be met by the imposition of a period of suspension.

Striking off order

Before determining whether suspension was the appropriate and proportionate sanction in this case, the panel considered whether this case could be met with the imposition of a striking off order.

The panel had regard to the SG, in particular the SAN-3 regarding cases relating to striking-off:

> *'This sanction is likely to be appropriate if the professional's actions are fundamentally incompatible with being a registered professional. Before imposing this sanction, the Committee should consider:*
> […]

- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?'*

The panel noted that Ms Papandrea, during the course of the hearing, in particular following the panel's finding of facts, had demonstrated growing insight, and remorse and that she had taken some steps to strengthen her practice. It further noted that Ms Papandrea had engaged appropriately with the regulatory process from an early stage.

The panel considered that in such circumstances there was a realistic prospect that Ms Papandrea could gain sufficient insight and further strengthen her practice so that risk would be reduced, public confidence in the profession would be maintained, and professional standards upheld.

The panel concluded that Ms Papandrea's actions, although very serious, were not fundamentally incompatible with continued registration, and were capable of being remediated.

The panel therefore determined that a striking-off order, at this stage, would be a disproportionate response to the circumstances of this case.

Accordingly, the panel was therefore satisfied that a period of suspension was the appropriate and proportionate sanction in this case.

The panel considered a 12-month suspension, with a review, to be appropriate and proportionate given the seriousness of the concerns. In addition, such a period would provide sufficient time for Ms Papandrea to undertake the further reflection, remediation and strengthening of practice required.

The suspension order would provide immediate public protection, adequately mark the seriousness of the misconduct and maintain public confidence in the nursing profession, whilst giving Ms Papandrea a defined opportunity to demonstrate that she is capable of returning safely to registered nursing practice.

The panel considered that this order was necessary to protect the public, to maintain public confidence in the profession, and to send a message to the public and the profession in order to uphold standards.

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:

- Ms Papandrea's further reflections on her misconduct, focusing on her underlying attitude that led to the misconduct; and
- Any other evidence capable of demonstrating that her insight has further developed, her practice has strengthened and the risk of repetition has reduced.

This will be confirmed to Ms Papandrea in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kewley. He submitted that in light of the panel's findings, an interim suspension order is necessary on the grounds of public protection and is otherwise in the public interest to cover any period of appeal. He invited the panel to impose an interim order for a period of 18 months.

He stated that if an appeal is lodged during the 28-day appeal period, there could potentially be a period of unrestricted practice until the High Court resolves the appeal if no interim order were made.

He concluded by stating that the panel may consider that it would be inconsistent to its decision to hand down a substantive suspension order on public protection grounds and then allow a period of unrestricted practice.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

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 in order to allow for any appeal process to be concluded on the grounds of public protection and in the wider public interest.

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

That concludes this determination.