Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 5 January 2026 to Wednesday 14 January 2026

Virtual Hearing

Name of Registrant:	**Anne Marie Magalong**
NMC PIN:	02C1189O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (level 1) – 1 April 2002
Relevant Location:	Kensington and Chelsea
Type of case:	Misconduct
Panel members:	George Duff (Chair, lay member) Hazel Walsh (Registrant member) Shelley Hemsley (Lay member)
Legal Assessor:	Jayne Salt
Hearings Coordinator:	Emma Norbury-Perrott
Nursing and Midwifery Council:	Represented by Lindsey McFarlane, Case Presenter
Miss Magalong:	Not present and not represented
Facts proved:	Charges 1, 2, 3, 4, 5 and 6
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Application to postpone proceedings until Tuesday 6 January 2026

Ms McFarlane, on behalf of the Nursing and Midwifery Council (NMC), directed the panel to an email from Miss Magalong, received by the NMC on 4 January 2026. Ms McFarlane told the panel that based on earlier correspondence with Miss Magalong in December 2025, it was initially understood by the NMC that Miss Magalong was seeking to postpone the hearing to a later date. In the most recent email from Miss Magalong, dated 4 January 2026, she said:

> *'May i request your Good office to move the date for the Substantive hearing please.*
> *…*
> *Any available date is ok for me as long as not the January 5 pls.'*

Ms McFarlane explained to the panel that on 5 January 2026, the NMC asked Miss Magalong to confirm whether she can attend the hearing from 6 January 2026, based on Miss Magalong stating *'Any other date is ok for me as long as not the January 5 pls.'*

Ms McFarlane submitted that in the circumstances, the NMC believes it to be fair to postpone the hearing until Tuesday 6 January 2026 to allow Miss Magalong time to respond to the NMC and indicate whether she can attend from 6 January 2026.

The panel heard and accepted the advice of the legal assessor. She directed the panel to Rule 32 (1) and 32 (2) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons on application to postpone proceedings until Tuesday 6 January 2026

The panel had regard to Rule 32 of the Rules and the public interest in the expeditious disposal of these proceedings. The panel also had regard to the email correspondence between Miss Magalong and the NMC, dated 9 and 26 December 2025 and 4 January 2026.

The panel acknowledged that in Miss Magalong's most recent email to the NMC, dated 4 January 2026, she states: *'Any other date is ok for me as long as not the January 5 pls.'* The panel also acknowledged that Miss Magalong had previously requested a postponement twice on receiving the hearing documentation (9 and 26 December 2025) via email, as documented in the Proceeding in Absence bundle.

The panel noted that postponing proceedings for a day may inconvenience witnesses who are due to attend. However, the panel determined that Miss Magalong has been engaged with the NMC and, in the circumstances, postponing proceedings for one day was in the interest of fairness to allow Miss Magalong the opportunity to engage and to secure her attendance at the hearing.

The panel determined to postpone proceedings until 9:30am on Tuesday 6 January 2026.

Decision and reasons on service of Notice of Hearing

The hearing officially commenced at 9:30am on Tuesday 6 January 2026.

The panel was informed that Miss Magalong was not in attendance and that the Notice of Hearing letter had been sent to Miss Magalong's registered email address on 4 December 2025.

Ms McFarlane, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of 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 hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Magalong'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 Miss Magalong has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Magalong

The panel next considered whether it should proceed in the absence of Miss Magalong. It had regard to Rule 21 and heard the submissions of Ms McFarlane who invited the panel to continue in the absence of Miss Magalong. She submitted that Miss Magalong had voluntarily absented herself due to a holiday.

Ms McFarlane referred the panel to an email sent to the NMC by Miss Magalong, dated 9 December 2025, requesting an adjournment of the hearing and for the dates to be rescheduled. Ms McFarlane referred the panel to Miss Magalong's email, dated 4 January 26, asking for a postponement and stating: *'Any other date is ok for me as long as not the January 5 pls.'* Ms McFarlane told the panel that the NMC had sought clarity from Miss Magalong regarding whether she was requesting a postponement of one day, or for the full dates (5 January 2026 – 15 January 2026).

Ms McFarlane directed the panel to an email sent to the NMC by Equality for Black Nurses (E4BN), dated 6 January 2026. It said:

‘Ms Magalong is currently outside the UK and was in Manila at the time of the substantive hearing listed for 5 January 2026. Her return flight to the UK is scheduled for 9 January 2026, and she is therefore not able to attend the hearing from 6–15 January 2026, either in person or otherwise.’

Ms McFarlane told the panel that in this email, E4BN also state that they are supporting Miss Magalong with proceedings. However, the email does not indicate whether E4BN intend to represent Miss Magalong at the hearing and additionally, they have not disclosed whether they wish to be listed as Miss Magalong’s representative.

Ms McFarlane submitted that based on the information before it, the NMC had concluded that Miss Magalong was indeed asking to postpone the hearing for the full duration of the dates which have been scheduled (5 January 2026 to 15 January 2026).

Ms McFarlane submitted that the NMC opposes Miss Magalong’s request to postpone the hearing for the full dates and she invited the panel to proceed in accordance with Rule 21 of the Rules. She referred the panel to the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

Ms McFarlane submitted that notice had been served in accordance with the Rules and Miss Magalong was made aware of the scheduled hearing dates (5 January 2026 to 15 January 2026) in August 2025. She told the panel that Miss Magalong had not engaged with the NMC between April 2025 and 9 December 2025, and that Miss Magalong had not made the NMC aware of her holiday plans until 9 December 2025. Ms McFarlane submitted that there was no indication that Miss Magalong’s travel plans relate to an emergency matter and it is unclear when her travel plans were made. Ms McFarlane submitted that Miss Magalong has provided insufficient reasons to postpone the hearing at such a late stage.

Ms McFarlane submitted that five witnesses are due to attend to give live evidence and there is a strong public interest in the expeditious disposal of the case. She referred to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162. Further, she submitted that postponing proceedings would be an inconvenience to the witnesses and that there is no guarantee that they may be available in the future, particularly as the next available hearing dates would be October 2026 due to NMC hearings capacity.

In conclusion, Ms McFarlane invited the panel to refuse Miss Magalong's request to postpone the hearing and proceed in her absence.

The panel heard and 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.*

The panel has decided to proceed in the absence of Miss Magalong. In reaching this decision, the panel has considered the submissions of Ms McFarlane, the emails sent by Miss Magalong to the NMC, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Miss Magalong did not engage with the NMC between April 2025 and 9 December 2025. On 9 December 2025 Miss Magalong requested a postponement. This was two days before she planned to travel abroad and there was no indication of any emergency situation or circumstance. This was described as a holiday;
- Although the panel were provided of evidence of Miss Magalong's flight tickets, there was no evidence of when the flights were booked;

- In correspondence with Miss Magalong, the NMC had informed Miss Magalong of the hearing dates in August 2025, which is supported by documentation;
- E4BN state they are 'supporting' Miss Magalong, but there is no indication that they intend to represent Miss Magalong and attend the hearing;
- Miss Magalong stated she was unable to attend virtually due to limited internet access whilst on holiday. This is documented in her email to E4BN, dated 5 January 2026;
- Five witnesses are due to attend the hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022;
- 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.

There is some disadvantage to Miss Magalong in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, Miss Magalong will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Magalong's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse,

1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-

a) Did not review and/or countersign the observations taken by healthcare assistants at:-

i) 21.30pm on 29 September 2022;

ii) 06.45am on 30 September 2022.

b) Did not take or ensure observations were taken every four hours as required between 23.28 pm and 06.30am.

c) Recorded in Patient A's clinical notes at:-

i) 00.00am that they were "asleep";

ii) 02.00am that they were "asleep";

iii) 04.00 that they had "no complaints"

d) When Patient A's telemetry alarm was repeatedly activated between 21.30pm and 06.45am:-

i) Did not check whether the alarm was working properly;

ii) Did not assess Patient A's condition.

iii) Did not escalate Patient A's high respiratory rate to a doctor during the shift.

e) When Patient A's blood test result became available at 21.48pm:-

i) Did not check their Troponin T level;

ii) Did not escalate the raised Troponin T level to a doctor for review.

2) Your conduct at 1c) i) and/or 1c) ii) and/or 1c) iii) was dishonest in that you knew you had not observed Patient A at the times recorded and by your conduct you intended to create the impression that you had observed them.

3) In a questionnaire completed by you on/around 3 October 2022 when asked if you reviewed the telemetry you incorrectly stated "…went to see pt. in few occasion and patient was asleep".

4) During an investigation interview with Colleague 1 on 12 October 2022 incorrectly stated that you had checked Patient A a "few times throughout the night" (or words to that effect) when their telemetry alarm had been activated.

5) Your statement(s) at charge 3 and/or 4 above was or were dishonest in that you knew that you had not assessed Patient A and your conduct was motivated by an intention to conceal your failure to assess Patient A when their alarm was activated.

6) Did not complete your two yearly mandatory training in respect of the National Early Warning Score ("NEWS") by 19 August 2022.

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

Decision and reasons on application to admit written notes of Nurse 1 into evidence

The panel heard an application made by Ms McFarlane under Rule 31 to allow the interview notes of Nurse 1 into evidence. She told the panel that the notes relate to the local investigation conducted by Witness 2. Ms McFarlane explained to the panel that Nurse 1 was not present at this hearing but Witness 2 would be attending to give evidence and could be questioned about the notes. Ms McFarlane submitted that the evidence is highly relevant and was produced for the purpose of the local investigation.

Ms McFarlane referred the panel to the NMC guidance DMA-6 'Evidence', last updated on 9 June 2025, and the case of *Thorneycroft v. Nursing and Midwifery Council [2014] EWHC 1565 (Admin).* Ms McFarlane submitted that it was relevant and fair to find the notes of Nurse 1 admissible. She also submitted that the notes of Nurse 1 are not sole and decisive in relation to any of the charges.

Ms McFarlane submitted that in the preparation of this hearing, the NMC had indicated to Miss Magalong in the Case Management Form (CMF) that it was the NMC's intention to rely on this document as part of the exhibit bundle. Despite knowledge of this, Miss Magalong made the decision not to attend this hearing. On this basis Ms McFarlane advanced the argument that there was no lack of fairness to Miss Magalong in allowing Nurse 1's interview notes into 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. She referred the panel to the case of *Thorneycroft*.

The panel considered the principles outlined in the case of *Thorneycroft* when making its decision on Ms McFarlane's application to admit Nurse 1's interview notes into evidence. The panel determined that the interview notes of Nurse 1 are not sole and decisive in

relation to any of the charges, but it does provide wider context in relation to the health of Patient A. It is supported by the witness statement and documentary evidence provided by Witness 2, who conducted the interview with Nurse 1, and Witness 2 be attending the hearing to give live evidence.

The panel determine that there was also public interest in the issues being explored fully which supported Ms McFarlane's application to admit Nurse 1's interview notes into evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the interview notes of Nurse 1, and would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Miss Magalong was referred to the NMC on 30 March 2023 when concerns were raised regarding her practice. Miss Magalong worked as a Registered Nurse in the Cardiac, Medical and Neuro Science Ward ('the Ward') at Cromwell Hospital ('the Hospital') from 25 May 2010 until 16 November 2022. Miss Magalong was suspended on 14 October 2022 when the concerns came to light and was subsequently dismissed as a result of the local investigation.

It is alleged that on 29 September 2022 in respect of Patient A, Miss Magalong failed to carry out mandatory observations, failed to review and escalate an ECG and cardiac blood results, and failed to assess Patient A's condition on multiple occasions. It is also alleged that Miss Magalong falsified Patient A's records.

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 the submissions made by Ms McFarlane on behalf of the NMC. The panel also took into account Miss Magalong's Registrant bundle and email correspondence with the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Magalong.

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:

- Witness 1: Deputy Matron on the Ward at the material time;
- Witness 2: Matron for the Medical Directorate at the material time;
- Witness 3: Deputy Matron for Critical Care at the material time;
- Witness 4: Clinical Nurse Educator at the Hospital; and
- Witness 5: Healthcare Assistant on the Ward at the material time.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The legal assessor referred the panel to the cases of *R Dutta v General Medical Council* [2020] EWHC 1974 (Admin) and of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. It considered the witness and documentary evidence provided by both the NMC and Miss Magalong.

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

Charge 1)a)

> ‘1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-
>
> a) Did not review and/or countersign the observations taken by healthcare assistants at:-
>
> i) 21.30pm on 29 September 2022;
> ii) 06.45am on 30 September 2022.’

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1 and 5, the Bupa Interview Form, the Hospital National Early Warning Score (NEWS) 2 Policy, and Patient A’s NEWS chart.

The panel took account of Patient A’s NEWS chart and observed that it had not been countersigned in respect of the observations taken by healthcare assistants at 21.30pm on 29 September 2022 and 06.45am on 30 September 2022.

Witness 1 told the panel that, as the registered nurse, Miss Magalong was required to check and countersign Patient A’s NEWS observations in line with the Hospital NEWS

Policy. He also told the panel that the NEWS Policy was understood by all staff on the Ward. In his witness statement, Witness 1 said:

> *'Any member of staff can complete the observations, however, it is a nurse's responsibility to counter sign the score. Both of these observations were not reviewed by Miss Magalong; this was evident by the gaps at the bottom of the NEWS chart where a registered nurse is supposed to sign to show they had checked the observations as per NEWS policy*
> *…*
> *Nurses have a duty to ensure observations are done as per the NEWS Policy and Miss Magalong should have completed observations between 23:28 on 29 September 2022 and 06:30 on 30 September 2022. If an accurate nursing assessment was performed initially, Patient A's condition would have been promptly escalated but this did not happen. '*

Witness 5 corroborated Witness 1's evidence by stating that in line with the NEWS Policy, Miss Magalong should have reviewed and countersigned Patient A's NEWS observations, as was her duty as the registered Nurse who was responsible for overseeing Patient A's care at the material time. In her witness statement, Witness 5 said:

> *'I told Miss Magalong that I had taken the observations, and their heart rate or oxygen rate was high, which was why they were scoring as one,*
> *…*
> *Miss Magalong would still needed (sic) to check every NEWS chart, and counter sign the score provided.'*

The panel took account of the Hospital NEWS Policy. It states:

> *'If the observations are performed by a non-registered professional (e.g. healthcare assistant or nursing student), these must be reviewed and initialled by the registered nurse responsible for the patient.'*

The panel took account of the Bupa Interview Form, dated 20 October 2022. When presented with Patient A's NEWS chart at the interview by Witness 1, Miss Magalong confirmed that it was not signed and said:

'Probably I failed on the part that I did not countersign'

The panel determined that based on the evidence before it, Miss Magalong did not review and/or countersign the observations taken by healthcare assistants at 21.30pm on 29 September 2022 or 06.45am on 30 September 2022.

Therefore, the panel find this charge proved.

Charge 1)b)

'1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-

b) Did not take or ensure observations were taken every four hours as required between 23.28 pm and 06.30am.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, 2, and 3, the Bupa Interview Form, the Hospital National Early Warning Score (NEWS) 2 Policy, Patient A's NEWS chart, and CCTV evidence.

The panel took account of the NEWS Policy, in which it outlines that based on the NEWS score of Patient A, their observations should have been completed every 4 hours. Witness 1 and Witness 2 also explained to the panel in oral evidence how often observations

should be completed based on a patients NEWS score, and why this was important for monitoring a patient's health.

In his witness statement, Witness 1 said:

> *'There was a period of nine hours and 15 minutes where NEWS observations were not taken, as per the NEWS chart, as per findings of the Root Cause Analysis ('RCA') commissioned in relation to the incident involving Patient A's care, it was found that Miss Magalong did not enter the patient's room between 23:28 on 29 September 2022 and 06:30 on 30 September 2022, which is a period of seven hours. Miss Magalong had the responsibility to ensure that NEWS scores were taken every four hours, as per Hospital Policy.'*

The panel took account of the CCTV evidence. It observed that during the time frame in question, no one is observed entering or leaving Patient A's room. Witness 2 and Witness 3 independently reviewed the CCTV during the local investigation. Both Witness 2 and Witness 3 confirmed that they did not witness anyone enter, or exit, Patient A's room during the time period in question.

In her witness statement, Witness 2 said:

> *'From looking at the CCTV, I noted that for about 7 hours no one checked on the patient.'*

The panel took account of the Bupa Interview Form, dated 20 October 2022. It said:

> *'[Miss Magalong] agreed that she did not ensure observations were performed as per protocol'*

The panel determined that based on the evidence before it, Miss Magalong did not take or ensure observations were taken every four hours as required between 23.28 pm and 06.30am.

Therefore, the panel find this charge proved.

Charge 1)c)

> ‘1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-
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> c) Recorded in Patient A’s clinical notes at:-
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> i) 00.00am that they were “asleep”;
> ii) 02.00am that they were “asleep”;
> iii) 04.00 that they had “no complaints”

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, the Bupa Interview Form, and Patient A’s medical notes. It also had regard to its earlier findings at charge 1)b).

The panel took account of Patient A’s medical notes. It noted the handwritten entries of 00.00am *‘asleep’*, 02.00am *‘asleep’*, 04.00 *‘no complaints’* along with an accompanying signature, which was confirmed by Witness 1 to be that of Miss Magalong.

In his witness statement, Witness 1 said:

> *‘Miss Magalong recorded at midnight Patient A was asleep; at 02:00 Patient A was asleep and at 04:00 patient A had no complaints’*

The panel took account of the Bupa Interview Form, dated 20 October 2022. During the interview, Miss Magalong was asked whether she documented the handwritten entries of 00.00am *'asleep'*, 02.00am *'asleep'*, 04.00 *'no complaints'* in Patient A's medical notes. In response, Miss Magalong agreed that it had been documented and *'[Miss Magalong] struggled to explain why the events described on her documentation are false'.*

The panel determined that based on the evidence before it, Miss Magalong completed the entries of 00.00am *'asleep'*, 02.00am *'asleep'*, 04.00 *'no complaints'* in Patient A's medical notes.

Therefore, the panel find this charge proved.

Charge 1)d)

> '1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-
>
> d) When Patient A's telemetry alarm was repeatedly activated between 21.30pm and 06.45am:-
>
> i) Did not check whether the alarm was working properly;
> ii) Did not assess Patient A's condition.
> iii) Did not escalate Patient A's high respiratory rate to a doctor during the shift.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1 and Witness 2, the Bupa Interview Form, the Hospital National Early Warning

Score (NEWS) 2 Policy, Patient A's NEWS chart and Telemetry record, CCTV evidence, and Patient A's Medical Notes.

The panel took account of Patient A's Telemetry Record. This documented the frequency of the Telemetry alarm activating based on Patient A's respiratory rate being elevated beyond normal limits. The panel had regard to Witness 1's written statement:

> *'Miss Magalong silenced the Telemetry alarms multiple times as per telemetry system report, CCTV report and Miss Magalong's statements, but did not enter Patient A's room. The Telemetry monitor at the time was in the reception area. On the CCTV footage, it is noted that Miss Magalong was sitting at the desk, reviewing patient results and notes. Upon hearing the alarm, Miss Magalong should have gone into Patient A's room to ensure the telemetry alarm was working well and assess why the monitor was alarming as the staff nurse assigned to Patient A's care during their shift. As per the Code, they are responsible for that patient assessment and escalation of care needs.*
>
> *…*
>
> *If Miss Magalong had done this, they would have noted Patient A's high respiratory rate, after performing an accurate assessment of Patient A, as the telemetry alarms were alerting to. While I would not have expected Miss Magalong to enter the room 156 times, I would have expected them to check the alarm was working well and assess the patient. The alarm is noticeable on the Ward and for it to ring out 156 times would have been quite annoying for staff as the volume cannot be reduced, Miss Magalong would have been aware that the telemetry alarm would have been ringing and was watched on the CCTV silencing the alarm.*
>
> *…*
>
> *A thorough assessment should have been performed as soon as the alarms started with such an increased respiratory rate, this would have prompted an escalation of care straight away.'*

Witness 2 stated in their witness statement:

> *'Anne recorded that she checked on the patient multiple times throughout the night, and I remember clearly that she told me at interview that she checked on the patient, but there was no sign of this on the CCTV.*
> *…*
> *If the telemetry monitor alarms it usually means the relevant patient is unwell and you should go and check on the relevant patient. If the relevant patient is not checked, they could deteriorate without any action being taken.'*

Witness 1 also stated that during his local investigation, Miss Magalong was presented with the CCTV review findings. Witness 1 states that subsequently, Miss Magalong admitted that she had not assessed Patient A.

The panel considered the CCTV evidence and observed that Miss Magalong was sat at the nurse's station where she was very likely to hear and see the telemetry alarm activating. The panel noted some difference in accounts as to whether the telemetry alarm sounded 156 times, or whether it was generated and reset on some occasions without being manually silenced. However, it was clear to the panel that the large amount of telemetry alarm entries should have reasonably been noted by Miss Magalong as the nurse in charge of Patient A's care. The panel saw that Miss Magalong, nor any other staff, did not enter Patient A's room to respond to any of the alarms documented in the Telemetry record. The panel also noted that Miss Magalong had not completed any documentation of Patient A's condition which would support that she assessed Patient A or escalated his condition to medical staff as per protocol.

The panel determined that based on the evidence before it, Miss Magalong did not check whether the alarm was working properly, did not assess Patient A's condition and did not escalate Patient A's high respiratory rate to a doctor during the shift.

Therefore, the panel find this charge proved.

Charge 1)e)

'1) On a nightshift between 29 September 2022 to 30 September 2022 in respect of Patient A:-

e) When Patient A's blood test result became available at 21.48pm:-

i) Did not check their Troponin T level;
ii) Did not escalate the raised Troponin T level to a doctor for review.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, Patient A's Medical notes and Patient A's blood results.

The panel had regard to Patient A's medical notes and observed that an entry had been made for Patient A's Troponin T level to be checked, and other blood results. The panel also had regard to Patient A's blood results which documented that their Troponin T level was elevated beyond normal limits, a result which was available at 21:48 hours on 29 September 2022, and was subsequently not escalated to a doctor for review.

In his witness statement, Witness 1 said:

'There is no notification of when blood results are available, however, it is a nurse's responsibility to follow up on test results. It is the nurse's responsibility to review availability of results and report the consultant or RMO for review either by phone call or text message according with the relevance of the results or agreed with the RMO/consultant. The results

are uploaded to the system Ordercomms which Miss Magalong was proficient user, and typically would be printed by the Nurse in Charge and handed to the nurse caring for the patient as soon as results available.

The second blood test results showed the cardiac marker, Troponin, was more than double (30) the first blood test result (12) which is a cause for concern and a reason for urgent escalation to the RMO. At this point Miss Magalong should have called the RMO on duty to assess the results and escalate care accordingly.'

The panel was told by Witness 1 that not checking Patient A's Troponin T levels, and subsequently not escalating the raised Troponin T levels to the medical team, presented a huge risk to Patient A. He told the panel that Miss Magalong would have known that the blood results were available from an early stage in her shift. The panel noted that there was no documentary evidence to support that Miss Magalong had reviewed the blood results for Patient A. The panel also noted that there was no documentary evidence to support that Miss Magalong had escalated Patient A's elevated Troponin T level to medical staff in line with escalation protocol.

The panel determined that based on the evidence before it, Miss Magalong did not check Patient A's Troponin T level and did not escalate the raised Troponin T level to a doctor for review.

Therefore, the panel find this charge proved.

Charge 2

'2) Your conduct at 1c) i) and/or 1c) ii) and/or 1c) iii) was dishonest in that you knew you had not observed Patient A at the times recorded and by your conduct you intended to create the impression that you had observed them.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, 2, and 3, the Bupa Interview Form, and CCTV evidence. The panel also had regard to its earlier findings at charge 1c).

The panel had regard to Witness 2's evidence. In her witness statement, Witness 2 said:

> *'I found that there was some discrepancy in what Anne told me at interview compared to what she recorded and what we saw on the CCTV. Anne recorded that she checked on the patient multiple times throughout the night, and I remember clearly that she told me at interview that she checked on the patient, but there was no sign of this on the CCTV.'*

The panel also considered Miss Magalong's responses in the Bupa Interview when she admitted that she failed to complete the records accurately, agreed that she did not assess the patient and struggled to explain why the events documented were false.

The panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 which sets out the test for dishonesty.

The panel determined that Miss Magalong acted in a deliberate way in order to mislead professional colleagues. It was of the view that Miss Magalong knew that she had not observed Patient A at the times recorded by her in Patient A's medical notes, and by this conduct, she intended to create the impression that she had observed Patient A at the material times. Miss Magalong did so by creating false patient observation records when she had not observed Patient A. These events could not have occurred in error.

The panel also determined that, from an objective point of view, Miss Magalong's conduct was dishonest by the professional standards set out within the NMC code, and by the standard of ordinary, decent people.

Therefore, the panel found this charge proved.

Charges 3 and 4

> '3) In a questionnaire completed by you on/around 3 October 2022 when asked if you reviewed the telemetry you incorrectly stated "…went to see pt. in few occasion and patient was asleep".
>
> '4) During an investigation interview with Colleague 1 on 12 October 2022 incorrectly stated that you had checked Patient A a "few times through out the night" (or words to that effect) when their telemetry alarm had been activated.'

Charges 3 and 4 are found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, 2, and 3, the Incident Questionnaire form, the Local Interview notes, and CCTV evidence.

The panel had regard to the Incident Questionnaire which Miss Magalong completed at the material time. It noted that Miss Magalong reported that she went to see Patient A throughout the night on a few occasions: *"…went to see pt. in few occasion and patient was asleep".*

The panel also had regard to the local interview notes in which Miss Magalong stated that she had checked on Patient A when their telemetry alarm activated a few times through the night. However, at the Bupa Interview when being presented with CCTV evidence,

Miss Magalong made admissions to not observing Patient A due to him having 'capacity' and not being called by the patient.

The panel had regard to the CCTV which demonstrated that Miss Magalong did not attend Patient A's room. This was also corroborated by Witness 2 and Witness 3.

The panel determined that based on the evidence before it, Miss Magalong incorrectly stated in the Incident Questionnaire *'…went to see pt. in few occasion and patient was asleep'*, and during the Investigation Interview with Colleague 1, Miss Magalong incorrectly stated that she had checked on Patient A throughout the night when their telemetry alarm had been activated.

Therefore, the panel find Charges 3 and 4 proved.

Charge 5

> '5) Your statement(s) at charge 3 and/or 4 above was or were dishonest in that you knew that you had not assessed Patient A and your conduct was motivated by an intention to conceal your failure to assess Patient A when their alarm was activated.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witnesses 1, 2, and 3, the Bupa Interview Form, CCTV evidence, and its earlier findings at charges 3 and 4.

The panel had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 which sets out the test for dishonesty.

The panel determined that Miss Magalong acted in a deliberate way in order to mislead professional colleagues. It was of the view that Miss Magalong knew that she had not assessed Patient A, and by this conduct, she intended to create the impression that she had assessed Patient A in response to their telemetry alarm sounding. Miss Magalong's conduct was motivated by an intention to conceal her failure to assess Patient A when their telemetry alarm was activated. These events could not have occurred in error and Miss Magalong's conduct was calculated to mislead colleagues.

The panel also determined that, from an objective point of view, Miss Magalong's conduct was dishonest by the professional standards set out within the NMC code, and by the standard of ordinary, decent people.

Therefore, the panel found this charge proved.

Charge 6

> '6) Did not complete your two yearly mandatory training in respect of the National Early Warning Score ("NEWS") by 19 August 2022.'

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Witness 1 and Witness 4.

Witness 4 told the panel that he sent two emails to Miss Magalong reminding her that she needed to complete the NEWS training in line with the Hospital policy. He told the panel that Miss Magalong did not respond to either of his emails and did not complete the training as requested.

The panel noted that Miss Magalong did not respond to Witness 4 to explain why she had not completed the training as requested. It also noted that there was no evidence to support when she had previously completed the training.

The panel determined that based on the evidence before it, Miss Magalong did not complete her two yearly mandatory training in respect of NEWS by 19 August 2022.

Therefore, the panel find this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms McFarlane invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The NMC code of professional conduct: standards for conduct, performance and ethics (2004)' (the Code) in making its decision. She referred the panel to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Calhaem v GMC* [2007] EWHC 2606 (Admin), and *Roylance.*

Ms McFarlane identified the specific, relevant standards where Miss Magalong's actions amounted to misconduct, namely: 1.2, 1.3, 1.4, 2.1, 3.1, 8.1, 8.2, 8.3, 8.5, 8.6, 10.2, 10.3, 11.2, 11.3, 13.1, 13.3, 13.4, 14.1, 14.2, 14.3, 19.1, 19.4, 20.1, 20.2, 20.3, and 20.5.

Ms McFarlane submitted that Miss Magalong's misconduct is serious and her fitness to practise is impaired by reason of her misconduct. She submitted that Miss Magalong's misconduct is a serious departure from the expected standards of the Code and represents a risk of harm to the public and brings the nursing profession into disrepute. Ms McFarlane told the panel that nurses occupy a position of privilege and trust in society and are expected at all times to be professional and uphold the professional duty of candour when things go wrong.

Ms McFarlane outlined Miss Magalong's failures and conduct, including that of sustained dishonesty. She submitted that Miss Magalong's conduct is a serious departure from the professional standards and behaviour expected of registered nurse and Miss Magalong's actions clearly amount to serious misconduct.

Submissions on impairment

Ms McFarlane 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)*, Cohen v General Medical Council* [2008] EWHC 581 (Admin). She also referred the panel to Article 22 of the Nursing and Midwifery Order 2001 ('the Order') and the NMC guidance DMA-1 *'Impairment'.*

Ms McFarlane submitted that the NMC invites the panel to find Miss Magalong's fitness to practise impaired as a result of her misconduct. Ms McFarlane referred the panel to the case of *Grant*. She submitted that all four limbs of the test within *Grant* are engaged in this case.

Ms McFarlane outlined Miss Magalong's failings and how her conduct placed Patient A at significant risk of harm, and likely caused harm to Patient A. She submitted that Miss Magalong has brought the nursing profession into disrepute by virtue of her misconduct as a result of multiple failings in patient care and dishonesty. Ms McFarlane told the panel that registered nurses have a professional duty of candour, breaches of which are the most serious category of concerns. She directed the panel to the NMC guidance DMA-8 *'Making decisions on dishonesty charges and the professional duty of candour'.* She submitted that Miss Magalong's actions were not just clinical in nature, but attitudinal.

Ms McFarlane submitted that Miss Magalong's actions have breached fundamental tenets of the nursing profession, namely prioritising people practising effectively, preserving safety and promoting professionalism and trust, as detailed in the code. She referred the panel to the NMC Guidance DMA-1 *'Impairment'*. Ms McFarlane submitted that in addition to the clinical failings, the multiple and sustained instances of dishonesty in this case demonstrate that Miss Magalong failed to act honestly and with integrity and the NMC

submits that her actions are a serious departure from the standards of the Code. She submitted that attitudinal issues are more difficult to remediate.

Ms McFarlane submitted that Mss Magalong has not demonstrated insight or reflection in regard to her conduct and she has not demonstrated strengthening of practice. She submitted that there is a real risk of repetition in this case and therefore a finding of impairment is necessary on the ground of public protection.

Ms McFarlane submitted that a finding of impairment is otherwise in the public interest to declare and uphold the proper standards of conduct and behaviour as the public expect registered nurses to act with the utmost honesty, integrity and professionalism in line with the Code.

The panel accepted the advice of the legal assessor which included reference to Article 22 of the Order, NMC Guidance and a number of relevant judgments including *Roylance,* Cheatle v General Medical Council [2009] EWHC 645 (Admin)*, R (on the application of Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), *Nandi*, *Grant,* and *Calhaem.*

Decision and reasons on misconduct

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

The panel was of the view that Miss Magalong's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Magalong'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

1.3 avoid making assumptions and recognise diversity and individual choice

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

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

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

8 Work co-operatively
To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

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

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

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times
***To achieve this, you must**:*

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

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

The panel considered whether each of the charges found proved amounted to misconduct.

In respect of Charges 1 – 5, the panel determined that Miss Magalong's conduct resulted in risk of harm, and likely direct harm, to Patient A. The panel determined that failing to check and countersign patient NEWS observations, falsifying patient records, failing to complete observations, failing to respond to telemetry alarms, and failing to escalate a deteriorating patient, represents a serious risk of harm to patients. Further, Miss Magalong's actions amounted to dishonesty. True and accurate patient assessments, medical records and documentation help to ensure a transparent and accurate clinical picture and are therefore fundamental to patient care and safety. The panel determined that dishonesty falls seriously short of the standards expected of a registered nurse.

In respect of Charge 6, the panel determined that mandatory training is very important in terms of making sure nurses are equipped with relevant and up to date knowledge relevant to their job role. However, it did not find that Miss Magalong's actions at Charge 6 amounted to serious misconduct.

The panel found that Miss Magalong's actions in respect of Charges 1, 2, 3, 4 and 5 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. It determined that Miss Magalong's actions amounted to serious misconduct, undermined public confidence in the profession, and put patients at risk of serious harm.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

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

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel concluded that all four limbs of *Grant* apply in this case.

The panel finds that Patient A was put at risk and was caused physical harm as a result of Miss Magalong's misconduct. Miss Magalong's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel determined that Miss Magalong has not demonstrated an understanding of how her actions put patients at a risk of harm, nor why her conduct was inappropriate, unprofessional and impacts negatively on the reputation of the profession. The panel noted that Miss Magalong has attempted to excuse and shift blame to those around her for her failings. She did not express any meaningful remorse or make apologies to the patient and was more concerned with how the incident had affected her. It also noted that during the local investigation, Miss Magalong initially concealed the truth of her conduct and continued to engage in attempting to conceal the truth of the matters for a prolonged period. Miss Magalong was presented with CCTV review evidence by Witness 2 two weeks into the local investigation, and it was only at this point that Miss Magalong made admissions, and excuses, to her conduct.

The panel determined that Miss Magalong's conduct demonstrates a significant lack of accountability, insight or real intention to remedy her misconduct. Indeed, as a result, the panel determined that this indicates deep seated attitudinal issues which, it noted, can be difficult to remediate.

The panel considered Miss Magalong's Registrant bundle. It noted that the testimonials provided are dated 2023 and appear to be written in respect of a job application. There was no indication that the individuals who provided the testimonials were fully appraised of the ongoing NMC proceedings and the concerns regarding Miss Magalong's conduct. The panel also noted various training certificates. However, these training certificates do not specifically address the concerns of this case. The panel saw no evidence before it to determine whether or not Miss Magalong has been working within a healthcare setting and has taken meaningful steps to strengthen her practice and develop her insight.

As a consequence, the panel has concluded that there is a serious risk of repetition of misconduct of this nature.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

Having regard to all of the above, the panel was satisfied that Miss Magalong's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Magalong off the register. The effect of this order is that the NMC register will show that Miss Magalong has been struck-off the register.

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

Submissions on sanction

Ms McFarlane informed the panel that in the Notice of Hearing, the NMC had advised Miss Magalong that it would seek the imposition of a striking-off order if it found Miss Magalong's fitness to practise currently impaired.

Ms McFarlane referred the panel to the NMC sanction guidance and outlined the aggravating features of this case:

- Conduct which placed Patient A at serious risk of harm, and appropriate care being delayed due to Miss Magalong's conduct
- Breached duty of candour
- Sustained and repeated dishonesty
- Lack of insight

Ms McFarlane submitted that there are no mitigating features identified in this case.

Ms McFarlane took the panel through each of the available sanctions in detail, and the corresponding NMC Sanction Guidance. In summary, she submitted that the only appropriate and proportionate sanction in this case is that of a striking-off order due to the seriousness of Miss Magalong's conduct and sustained dishonesty. She submitted that Miss Magalong's conduct is fundamentally incompatible with her remaining on the register and invited the panel to impose a striking-off order.

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

Decision and reasons on sanction

Having found Miss Magalong's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful

regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which put Patient A at serious risk of harm
- Breach of duty of candour
- Sustained and repeated dishonesty
- Lack of insight into failings

The panel noted Miss Magalong's assertions during the local investigations relating to her workload at the material time stating that it was a 'busy shift'. The panel considered the CCTV evidence in which, Miss Magalong was observed very clearly sitting at the nurses station using a mobile phone for periods of time throughout the shift. The panel noted that she looked relaxed and there appeared to be no indication that Miss Magalong's workload was high. The panel determined that this contradicted Miss Magalong's account. The panel saw no evidence to support Miss Magalong's assertions regarding mitigation. The panel determined that there are no mitigating features identified in this case.

The panel took account of the NMC Guidance SAN-2 *'Sanctions for particularly serious cases – cases involving dishonesty'.*

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Magalong's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the*

spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Miss Magalong's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Magalong's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct and sustained dishonesty identified in this case; failing to conduct observations, making incorrect entries on three separate occasions on Patient A's records, and later being untruthful during the investigation, was not something that can be addressed through retraining. The panel therefore determined that given the serious and sustained dishonesty, the nature of the misconduct, the attitudinal concerns, and Miss Magalong's lack of demonstrable insight and remorse into the severity and impact of her actions, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, which poses a risk of harm to patient safety and the reputation of the profession. Consequently, the panel determined that a conditions of practice order would not protect the public, would not reflect the seriousness of Miss Magalong's misconduct, or be in the public interest.

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

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

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

The panel determined that the charges did not reflect a single incident of misconduct, and it was not persuaded that Miss Magalong had sufficiently demonstrated insight in order to convince the panel that she did not pose a significant risk of repeating her past conduct. It noted in an email response to the allegations on 21 October 2022, Miss Magalong said:

> *'Patient's A (sic) safety wasn't impacted or compromise (sic), no delay as patient's treatment took place 72 hours after the transfer to Hammersmith Hospital, the surgery is not classified as urgent or threatening as surgery was not done the day of transfer'*

The panel considered that this demonstrated a lack of insight, remorse, or care for Patient A. The panel also determined that Miss Magalong's repeated and sustained dishonesty, extending from the night shift duty on 29 to 30 September 2022 through to the Root Cause Analysis (RCA) and subsequent investigation, was attitudinal in nature and therefore difficult to remedy.

Miss Magalong's misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Magalong's actions is fundamentally incompatible with Miss Magalong remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Miss Magalong's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The departures being; her failure to conduct or direct observations on Patient A, failure to identify signs of his deterioration by failing to review and act upon blood results, not investigating or acting upon telemetry alarms, completing false patient records which had the potential to mislead colleagues caring for the patient, and later being dishonest by misleading those investigating the circumstances leading to Patient A's deterioration. The panel was of the view that the findings in this particular case demonstrate that Miss Magalong's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Further, members of the public would be concerned if she were allowed to continue to practise as a registered nurse.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Magalong's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

Interim order

As the striking-off 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 Miss Magalong's own interests until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms McFarlane. She submitted that given the panel's decision on sanction, a suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for any appeal to be resolved. It determined that not imposing an interim suspension order would be inconsistent with the panel's earlier decision.

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

This will be confirmed to Miss Magalong in writing.

Post Hearing request

After making its decision on an interim order, and as it was about to hand down its decision, the panel was made aware of an email that had been received by the NMC Case Officer on Wednesday 14 January 2026 at 1:06pm from E4BN. It said:

> *'We write further in relation to the ongoing substantive hearing concerning Ms Anne Marie Magalong, and further to our earlier correspondence requesting disclosure of materials relied upon by the NMC.*
>
> *We formally request:*
>
> *1. Official transcripts and/or audio recordings of all hearing sessions conducted to date, including opening submissions, evidence given, and any procedural or substantive rulings made by the Panel.*
>
> *2. Confirmation of the availability, format, and timescale for provision of those transcripts or recordings.*
>
> *3. Confirmation that no further evidence or witness material will be relied upon without prior disclosure to Ms Magalong and her representatives.*
>
> *This request is made to ensure transparency and to enable meaningful participation before the NMC closes its case.*

Given that proceedings have commenced in Ms Magalong's absence, and in light of the continuing concerns regarding the refusal of the adjournment request, Equality 4 Black Nurses formally requests the opportunity to make representations on Ms Magalong's behalf.

We respectfully ask that the Panel permit us to make formal written and/or oral representations at the earliest opportunity, ideally tomorrow (Thursday) or Friday, before the conclusion of the NMC's case.

This would allow Ms Magalong's position to be properly articulated and would assist the Panel in ensuring that the proceedings remain fair, balanced, and procedurally sound.

For completeness, we reiterate that Ms Magalong maintains her position that proceeding in her absence, despite documented overseas travel, financial impracticability of altering flights, and repeated attempts to engage, raises issues of procedural fairness. Her position on this is expressly reserved.

We would be grateful if you could confirm as a matter of urgency:

- *when transcripts/recordings will be made available, and*
- *whether the Panel will permit formal representations to be made tomorrow or Friday.*

Yours sincerely,

Equality 4 Black Nurses (E4BN)'

Ms McFarlane submitted that all substantive matters in this case have already been decided by the panel and E4BN communications are too late for any substantial submissions to be made on matters. Ms McFarlane submitted that E4BN could attend tomorrow to make representations, but that would be limited to their position on imposing an interim order, as all the other matters have been determined in this case.

Ms McFarlane submitted that there is nothing to say that Miss Magalong has any new evidence that was not considered by the panel and there is the opportunity to appeal the decision in this case. She submitted that it is a matter for the panel if it wishes to hear from Miss Magalong's representative tomorrow, but the NMC is of the opinion that all substantive matters in this case, other than the interim order being handed down, are complete.

The panel heard and accepted the advice of the legal assessor. She reminded the panel that all stages had been completed and that the interim order decision had been made, but not yet communicated, when the email came to light. She directed the panel to the legal principles of reopening cases and the relevant case law.

The panel considered the email from E4BN dated 14 January 2026, received on day 8 of the hearing. It also considered the email from E4BN received on 6 January 2026, day 2 of the hearing, which did not indicate that E4BN intended to represent Miss Magalong in written submissions, or in person, at the hearing. The panel noted that the email from E4BN does not indicate that Miss Magalong has any new evidence that she wishes to share with the panel which would influence proceedings. The panel noted that the hearing is public and that observers have been present through parts of the hearing, an opportunity open to Miss Magalong's representatives and Miss Magalong. It also noted that Miss Magalong was due to return to the UK on 9 January 2026 prior to the timetabled end of the hearing with an earlier opportunity to attend and/or address the panel prior to all decisions having been made and handed down.

Therefore, the panel determined that as it has made its decision on all of the matters, it is too late at this stage in proceedings to invite submissions from E4BN on Miss Magalong's behalf.

The panel acknowledges Miss Magalong's right to appeal the substantive decision if she so wishes.

That concludes this determination.