Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 6 August 2025 – Monday 18 August 2025,
Friday 19 December 2025,
Tuesday 20 January 2026 (In – Camera) &
Wednesday 1 July 2026 – Monday 6 July 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Santa Mandera**
NMC PIN:	03H0364O
Part(s) of the register:	Registered Nurse - Mental Health (5 August 2003)
Relevant Location:	Wandsworth
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, lay member) Chloe McCandlish-Boyd (Registrant member) David Newsham (Lay member)
Legal Assessor:	Gaon Hart (6 – 18 August 2025 & 1 July 2026 - 6 July 2026) Nigel Pascoe (19 December 2025) Gillian Hawken (20 January 2026)
Hearings Coordinator:	Rebecka Selva (6 August 2025) Khatra Ibrahim (7 August 2025, 12 – 18 August 2025) Ibe Amogbe (8 August 2025) Fabbiha Ahmed (11 August 2025) Clara Federizo (19 December 2025) Shela Begum (20 January 2026) Salima Begum (1 July 2026 - 6 July 2026)
Nursing and Midwifery Council:	Represented by Wafa Shah, Case Presenter (6–18 August 2025 and 19 December 2025) Rosie Welsh, Case Presenter (1 July 2026 -

Ms Mandera:	Present and represented by Priya Khanna, instructed by Royal College of Nursing, (RCN)
Facts proved:	1a, 2a, 2b, 2c, 3a, 3b, and 4
Facts not proved:	1b (not considered by reason of the decision in 1a) and 5
Fitness to practise:	**Impaired**
Sanction:	**Striking off order**
Interim order:	**Suspension order (18 months)**

Decision and reasons on application to not admit CCTV footage

The panel heard an application made by Ms Khanna, on your behalf under Rule 31 of the Nursing and Midwifery Rules 2004 (the Rules). She submitted that the CCTV footage should not be admitted as the threshold for the evidence being relevant and fair is not met.

Ms Khanna outlined that the footage is not dated or timestamped and that the only evidence that relates to the date referred to in the charge, is the assertion made by Witness1 in their written statements that the footage relates to the incident in question. She further submitted that the NMC have not indicated which parts of the CCTV supports the charges against you and that you disputed the CCTV footage in the local investigation.

Ms Khanna submitted that there is a risk of prejudice by admitting this CCTV footage and the panel is being asked to assume that this footage is contemporaneous with the allegations and as such, it is wholly unfair to you.

Ms Shah, on behalf of the Nursing and Midwifery Council (NMC), submitted that under Rule 31 it is both fair and relevant to admit the CCTV footage provided by Witness 1 into evidence. She submitted that this application by Ms Khanna is premature and at the fact-finding stage, Ms Khanna would be welcome to suggest to the panel what weight to attach to this evidence.

Ms Shah submitted that in Witness 1's witness statement they identify the time frame of the footage *'between 21:00 and 22:00'*, she further submitted that both Ms Khanna and the panel will be able to test the evidence by questioning Witness 1 about how they procured the CCTV footage.

Ms Shah submitted that this CCTV footage is admissible and fair for the panel to consider as not only must the panel consider fairness to you, but also to the regulator and the public.

The panel heard and accepted the legal assessor's advice on the issues which it should take into consideration in respect of this application. This included Rule 31 and NMC guidance DMA-6, which provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the application in regard to the admissibility of the CCTV footage. The panel accepted that the CCTV footage was not dated or timestamped and that you disputed this when you were questioned about it at the local level investigation. However, the panel considered that the CCTV footage is relevant to charge 1 and it is not the sole and decisive evidence as there is evidence from the local investigation dated 26 August 2024, Night Shift Allocation sheet dated 18 March 2021 and statements of Witness 1. It also considered that this evidence was capable of being tested through the questioning of Witness 1.

The panel considered that the quality of the footage is clear, and it is able to identify people and faces.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the CCTV footage submitted by Witness 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it. The panel acknowledged your challenges around the weight that should be applied to the CCTV footage.

Decision and reasons on application to redact parts of Exhibit and Witness Bundles

Ms Khanna made an application to redact parts of the exhibit and witness statement bundles. She submitted that the panel are due to hear from two live witnesses, and Witness 1 has provided two witness statements, which included commentary on the quality of the documentary evidence.

Ms Khanna submitted that significant areas of Witness 1's evidence in the two witness statements are matters of opinion, and as such, are not admissible. She submitted that Witness 1 is being presented as a witness of fact, and their opinions should not be permitted. Ms Khanna referred the panel to the various parts of Witness 1's witness statements and their exhibits and had marked significant areas as opinion evidence for redaction. She also referred the panel to Witness 1's commentary around the CCTV footage, and submitted that the following points of the commentary would be unfair to you and your case to admit into evidence:

1. *I discovered that Ms Mandera's initial statement to* [Colleague 2] *on 1 April 2021 contradicted the CCTV footage'*
2. *'CCTV footage confirmed that…left ward and headed…'*
3. *'This contradicts the information relayed by Ms Mandera that* [Colleague 4] *left the Ward at that time in a rush to answer an urgent call…'*

Ms Khanna submitted that in relation to parts 1 and 2 of the excerpts aforementioned, these are clear examples of Witness 1 giving evidence of their opinion. She submitted that in relation to the third point, there are no other witness statements before the panel to support this and so this should also not be admitted.

Ms Khanna submitted that Witness 1 is not an expert witness and so other commentary and interview statements should also not be admitted. She submitted that it is a matter for this panel to determine what the CCTV purports to show, and that it is not for Witness 1 to decide. She further submitted that their comments '*infected*' other areas of the interview and witness statements, and much of it should be redacted.

Ms Khanna submitted that by using terms such as '*highly likely',* Witness 1, whose sole role was to be an objective investigator, provided commentary which made it appear that the allegations were found proved at the time of the local interview. She submitted that the panel would be led by these findings, and as such the NMC is providing unreliable evidence to make a decision on facts.

Ms Khanna submitted that in relation to the DATIX incident, the date of the incident was not reported until 31 July 2021, and that Witness 1 was not the person who reported the incident, and that it was in fact Colleague 1. She submitted that Colleague 1 did not provide any evidence about this incident, and that Witness 1 set out Colleague 1's evidence, when they should not have done so. She submitted that Witness 1 went on to comment on an '*accidental occurrence'*, and submitted that this is not acceptable, as Witness 1 was not present at the time of the incident, and their only role was to analyse any underlying documentation. She submitted that that DATIX report in its entirety should be redacted.

Ms Khanna submitted that the entirety of Witness 1's summary which reflected other people's evidence should not be accepted, as it is opinion evidence that leans towards hearsay. She submitted that Colleague 1 should have appeared to give evidence but has not and Witness 1's conclusions were influenced by their opinions and judgments.

Ms Khanna submitted that there is a significant risk of bias when an investigator is not being objective in an investigation and invited the panel to exclude the entirety of that section of the interview, as it is '*infected'* with commentary throughout.

Ms Shah submitted that there are parts of the redactions as applied for by Ms Khanna that can be redacted, if the panel are also in agreement. She submitted that paragraph 38 of Witness 1's witness statement can be redacted. She also submitted that parts of paragraph 29 up to the word '*ward'* can also be redacted.

In regard to the exhibit bundle, Ms Shah submitted that page 31 should be redacted and agreed with Ms Khanna that page 33 mirrors the redaction and submitted that should also be redacted.

Ms Shah submitted in relation to the DATIX form that relevant parts should not be redacted, as although they appear similar to the aforementioned redactions, there is a distinct difference. The discussions held around the prescribing do not include any conclusions as to whether it was an accident or not, and that it only describes the concerns raised.

Ms Shah submitted that there are a number of redactions applied for by Ms Khanna that are not agreed with. She submitted that the test for admissibility is looking at the relevance and fairness and stated that the evidence provided by Witness 1 is relevant to the issues raised as they investigated the alleged matters and is best placed to explain to the panel what can be seen on the CCTV footage. She submitted that it is for the panel to arrive to its own conclusions in regard to the charges raised against you. She submitted that Witness 1 does not address the charges put to you, and that Witness 1 can answer questions put to them.

Ms Shah submitted that in regard to paragraph 18 of Witness 1's witness statement, the CCTV footage has been provided to assist the panel to confirm what happened at the time, and that their comments on the CCTV footage does not in any way fill the role of the panel in deciding what occurred. She submitted that '*the statement given by* [you] *contradicts the evidence'* is simply a description of what can be seen on the CCTV footage and will be of benefit to the panel when they review the CCTV footage.

Ms Shah submitted that in relation to paragraph 19, Witness 1 can be cross-examined and questioned as to why they stated that the CCTV shows what they indicate is being shown. She submitted that it is expected that when witnesses give evidence that someone carried out a particular action, it is then for the panel and other parties to question as per the normal and fair course of proceedings. She submitted that it would be unfair for the panel to be provided CCTV without any assistance as to what is being viewed.

In relation to the comments and summaries provided by Witness 1, Ms Shah submitted that inferences from words used by Witness 1 such as *'serious'* or *'guilty'* were allegations that they could rightly put to you in the local investigation interviews. She submitted that it would not be right to redact questions asked of you at the interview and to leave your answers unredacted, as it would not be clear to the panel, and it would require clarification of what was asked. She also submitted that the purpose of an interview is to give you an opportunity to explain what you believed occurred, and why something may not be the case. She submitted that the interview is not inadmissible but is in fact contextual evidence which the panel should consider.

Ms Shah submitted that parts of Witness 1's evidence, where it may appear that they are being biased, is them simply describing what occurred at the time, and should be allowed in. She also submitted that you say this is a conclusion, but again, she submitted, the commentary is only a description of the allegations being put to you, and Witness 1 was only providing you with an opportunity to respond to the allegations. She invited the panel to admit the evidence in.

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

In reaching its decision, the panel initially considered the issue of relevance with regard to all the evidence before it. It considered Witness 1's evidence, in that they were the investigator at the time, reviewed the CCTV footage and conducted the interview, and their evidence speaks to all of the charges put to you.

In relation to charge 1, the panel determined that Witness 1 would be able to explain the layout and who is present on the CCTV footage.

In regard to the consideration of records in relation to charge 2, the panel were of the view that Witness 1 considered the documentation themselves, and some of the reports provided to the panel were made directly to them in the first instance and therefore concluded that the records are entirely relevant to the charge.

In regard to the interview notes, the panel considered that Witness 1 was present at the time of the interviews and exhibited the interview notes. It determined that the interview records are relevant to the charges and determined that the charge of dishonesty is a matter for the panel to consider. It therefore concluded that the interview notes are relevant to the underlying maters, but not to the charge itself.

It also determined that the exhibits in relation to charges 4 and 5 are also relevant, as Witness 1 produced the exhibits and documents. In relation to charge 5, it is for the panel to find whether the issue of dishonesty is proved or not proved, but that Witness 1's evidence will assist in reaching that decision. The panel concluded that the evidence is wholly relevant.

Having considered relevance, the panel proceeded to review each and every proposed redaction line by line within the two witness statements provided by Witness 1 with regard to whether it is fair to admit. Not every redaction will be reproduced here, however the below examples are indicative of the decisions made:

- Paragraph 18 of Witness 1's first witness statement where the panel considered the term *'contradicted'*. The panel determined that it is admissible, as it is a factual statement made as a way of conveying relevant facts personally perceived by the maker.
- However, with regard to evidence around what Colleague 2, the original investigator had identified and Witness 1's comments in interview around how the statements from you contradicted that information, the panel determined that Witness 1's statement is the sole and decisive evidence that the CCTV directly contradicts what Colleague 2 identified. Therefore, it was the sole and decisive evidence of what Colleague 2 identified which is not capable of being tested as Colleague 2 is not a witness, and any information around their evidence should be omitted as inadmissible.

The panel did not have sight of any evidence directly from Colleague 2 and determined that Witness 1's evidence is relevant, as it speaks to the charge of dishonesty. However, it determined that Witness 1's statement is the sole and decisive evidence that the CCTV directly contradicts your initial statement, as there is no evidence before this panel of the initial statement made by you to Colleague 2.

The panel decided to accept the redaction up to the end of the sentence including '*I discovered that Ms Mandera's initial statement to* [Colleague 2] *on 1 April 2021 contradicted the CCTV footage.'*[sic]

The panel considered that the descriptions provided by Witness 1 as to what they saw on the CCTV footage are factual, can be challenged, is not the sole and decisive evidence and are wholly relevant. The panel is fully aware that it is for the panel to determine what occurred, and that by reading terms such as *'confirmed'*, the panel consider that it is only confirming what Witness 1's perception of the footage shows and

is what they personally feel they directly see. The panel also had sight of the interview notes and concluded that this is not the sole and decisive evidence.

The panel was conscious of the fact that at this stage it has not had full sight of the CCTV footage, and that Witness 1's commentary around this footage is fair and relevant to admit. However, it was of the view that if Witness 1 strays into interpreting the evidence, this would be inadmissible.

The panel considered each line where Witness 1 strayed into interpretation opinion evidence and included:

- Para 21: '*When Ms Mandera returns to the corridor of patient A's room…smell cigarette smoke…'* as smelling smoke appears to be an interpretation of your behaviours

- Para 25: the word, '*abandoning'* is a word that has some potential semantic linguistic inferences and is implying that the word means there is no '*good reason to leave'*. The panel concluded that the word is quite emotive and on its ordinary meaning implied that someone with no reason was not coming back. They therefore decided to exclude the part, *'…abandoning their 1:1 observation of Patient A by'*, and it should read, *'the first cctv footage captures Ms Mandera going to the nursing station, and the second…'*

- Para 27: the panel contrasted the reference to '*smell smoke'* in paragraph 21 above as in this context, it could be a fact observed on the CCTV footage or could be opinion. Until the panel see the actual CCTV and assesses the evidence, it does not know if it is opinion evidence and therefore will leave that decision until after the CCTV has been seen and will consider again at the facts stage.

- Para 28: 'the first CCTV footage Witness 1 evidence that you '*abandoned your 1:1 observations of patient A for over 20 minutes'*. The panel considered this to be opinion evidence and an interpretation of why you were doing what

can be seen. The panel agreed to the redaction as applied for.

With regard to many of the interview questions that were contentious, such as paragraph 30 of Witness 1's exhibit, the panel considered that these were valid questions and gave you an opportunity to respond. Witness 1 put to you the allegations and gave you an opportunity to respond to them. The panel consider the question is relevant, not the sole evidence and is fair to include. The panel also considered whether any of the questions could be deemed as 'oppressive questioning' but determined that at no stage did the questions become oppressive or have that effect on you as far as could be seen from your responses.

In other areas, such as paragraph 62 '*and discovered that their background information was exactly the same word for word*'. The panel determined that these were a factual assessment of what Witness 1 had seen. It is an evidential question that can be examined and appears at this stage to be within their competence of what they had personally perceived.

The investigation report and issues with specific questions were considered by the panel in detail. Having reviewed the totality of these, the panel were conscious to give some leeway to an investigator putting their case to an individual in a robust fashion which is understandable but were particularly concerned to review if there was any oppression. On the specific issue of admissibility, the panel on reviewing all the comments, were unable to make an assessment at this stage without having seen the evidence in detail, as to whether the specific comments objected to are opinion or fact, relevant, fair or on a balance should be ruled inadmissible. Therefore, the panel concluded that these documents will be ruled admissible currently and be considered after the evidence has been presented to them in full.

With regard to the submissions relating to the exhibit bundle, the panel reviewed each request individually but determined that they were within Witness 1's competence and factual statements personally perceived or accounted for what you actually said in your response. Therefore, the panel determined that this evidence should be admitted.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Shah to amend the wording of charges 2b and 2c:

Details of charge

'That you, while working as a registered nurse [PRIVATE] *Hospital:*

1. While working as nurse in charge on the shift of 18 March 2021, in relation to Patient A who was on 1 to 1 observations:

(a) Failed to undertake adequate observations, in that you left Patient A unsupervised for approximately 20 minutes;

(b) In the alternative to 1(a) failed to ensure adequate observations were undertaken in respect of Patient A.

2. On the nightshift of 27 to 28 July 2021:

(a) administered 7.5mg of Diazepam to [Patient E] *when they were prescribed 3mg;*

(b) ***recorded and/or*** *administered 10mg of Olanzapine to* [Patient F] *at 22.00 when that medication had been discontinued by a doctor;*

(c) Recorded that you had administered a further 10mg Olanzapine to [Patient F] *at 00.00, ~~when that medication had been discontinued by a doctor.~~* ***when you did not in fact administer Olanzapine at that time.***

3. Your action at charge 2(c) was dishonest in that:

a) you knew you did not administer this medication to Patient SV at 00.00 on 28 July 2021;

b) you sought to mislead as to the time when you administered Olanzapine to [Patient F]*.*

4. On 7 August 2021 copied background information in Patient C's admission notes into the admission notes for Patient D.

5. Your actions at charge 4 were dishonest in that you knew that the background information for Patient C did not apply to Patient D.

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

Ms Shah stated that the changes would more accurately reflect the evidence before the panel. Charge 2b was proposed to add '*Recorded and/or administered*' in the charge to distinguish your potential admissions that you made recording errors, but not administration errors.

Charge 2c was proposed to more accurately reflect the evidence and correct an error. The proposal was to add '*when you did not in fact administer Olanzapine at that time*' and remove '*when that medication had been discontinued by a doctor*', to amend the error relating to repeating the Charge 2b phrase.

Another proposed amendment was to correct the name of the hospital. It was submitted by Ms Shah that the proposed amendment would more accurately reflect the evidence, as it was an error.

Ms Khanna did not oppose either proposed amendments on your behalf.

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

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed, as these clarify the charges, enable you to make admissions to the charges and were all agreed

by both parties. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Details of charges (as amended)

That you, while working as a registered nurse on [PRIVATE] Hospital:

1. While working as nurse in charge on the shift of 18 March 2021, in relation to Patient A who was on 1 to 1 observations:
    (a) Failed to undertake adequate observations, in that you left Patient A unsupervised for approximately 20 minutes;
    (b) In the alternative to 1(a) failed to ensure adequate observations were undertaken in respect of Patient A.

2. On the nightshift of 27 to 28 July 2021:
    (a) administered 7.5mg of Diazepam to [Patient E] when they were prescribed 3mg;
    (b) recorded and/or administered 10mg of Olanzapine to [Patient F] at 22.00 when that medication had been discontinued by a doctor;
    (c) Recorded that you had administered a further 10mg Olanzapine to [Patient F] at 00.00, when you did not in fact administer Olanzapine at that time.

3. Your action at charge 2(c) was dishonest in that:
    a) you knew you did not administer this medication to Patient SV at 00.00 on 28 July 2021;
    b) you sought to mislead as to the time when you administered Olanzapine to [Patient F].

4. On 7 August 2021 copied background information in Patient C's admission notes into the admission notes for Patient D.

5. Your actions at charge 4 were dishonest in that you knew that the background information for Patient C did not apply to Patient D.

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

Decision and reasons on application of no case to answer

The panel considered an application from Ms Khanna that there is no case to answer in respect of charges 1, and 2a and 2b, to the extent of administering Olanzapine. This application was made under Rule 24(7) of the Rules.

Charge 1

Ms Khanna referred the panel to the case of *R v Galbraith* [1981] 1 WLR 1039 (CA) and submitted there is some evidence before the panel in the form of CCTV, however, there is no factual evidence to state that the incidents took place on the dates alleged. She submitted that Witness 1's evidence as to the CCTV date and time is the only evidence that you were the nurse in charge on the shift of 18 March 2021. She submitted that the only other evidence relating to you being the nurse in charge was from the allocation sheet, which was also only dated by Witness 1.

Ms Khanna submitted that in regard to the allocation sheet if Witness 1 had also provided evidence from 17 and 19 March 2021, it could have been inferred that it also covered the period of 18 March 2021, as it was a bound document, that flowed in sequential date order. She submitted that Witness 1 altered the allocation sheet to add the date of 18 March 2021, which Witness 1 accepted in oral evidence, and is therefore weak evidence. She submitted that there is insufficient evidence in order for the NMC to meet its evidential threshold. She submitted that the relevance of the primary document and the CCTV rely solely on Witness 1's evidence, and their admission that Witness 1 had added the date on the form undermined their credibility, to the extent that there was no realistic reliable evidence on the stem of charge 1.

Ms Khanna submitted that for the NMC to prove you failed to complete adequate observations, it would require more evidence than the CCTV footage of you allegedly carrying out observations and needs to demonstrate that you also had a duty to carry out observations. The only evidence of that comes from the disputed and unreliable allocation sheet. She submitted that the CCTV alone is insufficient and does not support a finding of fact.

Charge 2

Ms Khanna submitted that there is no evidence of any tally in the Drugs Liable to Misuse (DLM) document between 27 July and 30 July 2021 in relation to the administration of Diazepam. It is clear who checked the balance on the 31 July 2021, but the panel have not heard from the person who signed the chart. She submitted that there was clear evidence from Witness 1 that there could be other explanations for medication stock errors, including that medications could have been moved between the wards, so it could be there are other explanations for the missing tablets which do not relate to any action by you. Witness 1 also told the panel that daily checks were not carried out as per protocol. She submitted that it may also be that the medications may have been taken without permission, and so there is an ambiguity, and although there may be a discrepancy, this cannot be blamed on you due to so many other factors, and that the evidence is unreliable under the second limb of *R v Galbraith.*

Ms Khanna submitted that Witness 1 told the panel that they could not be sure about the micrograms of drugs being checked on 31 July as, if the panel calculated the tablets that were stated to be administered, the final number left in stock was incorrect, even after the check on 31 July. She submitted that this is not sufficient evidence to relate this to your administration of Diazepam and cannot be linked to you. She submitted that there was a clear gap in time in the entry by you, and when the error was picked up. She submitted that there are a number of possibilities, and there is some evidence, but it is so poor that it would be unsafe to leave it to the panel to consider at the facts stage.

Charge 2b

Ms Khanna submitted that you admit a recording error, but that there is only some evidence which is too inherently weak or vague for any reasonable panel, properly informed, to rely on this evidence to establish whether you administered the medication that you signed for. Witnesses 1 and 2 both told the panel that they could not confirm and if the administration of Diazepam had actually occurred. There is no evidence in the form of patient notes of Patient F to indicate what drugs had been administered to him. She submitted that in regard to the administration and signing, you did sign for it, but that Witness 2 told the panel that the record appeared to look different to when Witness 2 had sight of it. The panel also heard that the entire drug chart had not been provided to the NMC, and therefore the evidence is ambiguous, inconsistent and inherently unreliable. She submitted that it would be a stretch for the panel to decide that the evidence is not inherently weak.

Ms Khanna submitted that the investigation notes were taken by a person who is not a witness in these proceedings and Witness 1 confirmed that you could not clearly see your notes or responses on Zoom and therefore this document was not verified. She submitted that there is an inherent unreliability of notes from 24 and 26 August 2024.

Ms Khanna submitted that the panel's decision requires an assessment of Witness 1's credibility. She submitted that you accepted at the local interview that you were the nurse in charge at the time, and this is confirmed in the interview notes before the panel, but that it was based on a misunderstanding of the evidence being presented to you.

Ms Shah submitted that in relation to the missing dates and charge 1, if the panel accept Witness 1's evidence, the panel could find the facts proved. She accepted that it involves an assessment of Witness 1's credibility. Ms Shah submitted that in relation to the CCTV, it is heard that Colleague 3 tells you to leave the observation, and your actions confirmed that you were in fact taking observations. She submitted that there was a significant departure in failing to complete your observations. She submitted that by you carrying out other duties, you still failed in completing your duties in observations.

In relation to charge 1b, Ms Shah submitted that there is a duty for you to ensure cover is available as the nurse in charge, and that you should have resisted leaving your post, and that this was a legal and Policy obligation. She submitted that there is sufficient evidence to find charge 1b proved.

In regard to charge 2b, Ms Shah accepted that a number of factors may have affected the discrepancies in the DLM, but that it is for the panel to decide whether the events happened as alleged. She submitted that in relation to the records, you were duty bound to ensure the records were sufficiently accurate, and that you should have noted that the balance chart was hard to read and interpret.

Ms Shah referred to the evidence from Witness 1, namely the drugs chart for Patient E, from the time of the allegations, and submitted that the diazepam could have been administered to the patient. She submitted that you also had signed the balance sheet. She submitted that up until you administered Diazepam recorded at 22.10, the balance was correct. She submitted that the error goes on to confuse future administration, to the point where the medication had to be discontinued. She also submitted that the panel can, when properly directed, decide that there is a discrepancy of the medication due to you administering the wrong dose of medications, and that you administered 7mg in totality. She submitted that once the facts have been assessed, it is more likely than not that the allegations took place as charged.

Ms Shah invited the panel to consider the Olanzapine drug chart, and submitted that Witness 2 confirmed in oral evidence that the *'x'* on the drug chart means that no drug was to be administered at that time and your signature below that in an area of the chart that should not be used, indicates that the 'x' was present when you signed the chart. She submitted that the panel could consider all the evidence before it, and that when taken at its highest it can be found proved.

She referred the panel to the case of *R (Dutta v General Medical Council)* [2020] EWHC 1974 (Admin). She submitted that the medication was administered at the times as indicated on the medication chart, and despite the 'x' being there, it is clear that a

signature in the chart meant that the medication had been administered. She submitted that documents were shown to you during your interviews, where you stated:

'*the medication being crossed off was not handed over to me…I monitored him'.*

Ms Khanna submitted that you had enough time to think about the question, but that you stated that the cancellation by Witness 2 was not handed over to you. She submitted that you gave several excuses for the error in the interviews, and initially you said that the patient was fine, then stated that you may have put it in the wrong place.

Ms Shah submitted that there are multiple changes in your accounts, and as such you lack credibility. Your signature on the medication chart is sufficient evidence to indicate that the charges happened as alleged. She submitted that there is sufficient and clear evidence to allow the panel to infer that the allegation happened. She invited the panel to reject the entirety of Ms Khanna's application for no case to answer.

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

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could come to the conclusion that the prosecution evidence, taken at its highest, is such that if properly directed, they could properly find a charge proven upon it.

In reaching its decision on the stem of charge 1, the panel considered all the evidence before it, including the documentary evidence on page 40 of exhibit bundle and the CCTV footage. The panel noted that whilst the date was not there originally, you were named as the nurse in charge of the shift, as noted down in your handwriting. The panel also had sight of CCTV footage provided by Witness 1, which showed that at some stage you sat in the chair opposite the patient's room and appeared to assume the role of completing one to one observations for Patient A.

The panel determined that a panel, taking the evidence at its highest, could consider Witness 1's evidence to be credible and reliable and that a reasonable panel could conclude that their admitted addition of the date and their explanation for why they did that, for example, simply as a note to themselves for the interview phase, did not undermine their evidence. This was a matter that should be left to the facts stage after all the evidence had been heard and that his evidence was not so unreliable or weak at this stage to be inadmissible in accordance with *Galbraith* limb 2. The panel considered that, taken at its highest, a reasonable panel could still find Witness 1 credible, and reliable.

Overall, with regard to evidence for charge 1, the panel was of the view that the CCTV could be seen as demonstrating that you were carrying out one to one observations on Patient A and that your gesticulating and the audio could potentially support this. It also saw on CCTV that Patient A went out of your line of sight in the footage. The panel was satisfied that the evidence, if taken at its highest, could reasonably lead to a conclusion that you had taken responsibility for one to one observations of Patient A. The panel had before it the Supportive Engagement and Observation Policy (the Policy) and determined that there was enough evidence that a panel could reasonably be deemed to support the charge if taken at its highest. For example, in the interview notes, dated 26 August 2021, you stated:

> '[Witness 1]: *You are the nurse in charge…*
> *You: I will learn from it…'*

The panel determined that you could be deemed to be the nurse in charge and heard from Witness 1 in oral evidence that a patient cannot be observed if they are in separate areas to the nurse. It also heard that the corridor was a separate area to the nursing station, even if in line of sight. The panel considered the CCTV footage, where it saw that there were extensive periods of time where Patient A was not in your direct line of sight. The panel was satisfied that a properly directed panel could reasonably find that if the evidence was taken at its highest that you had a duty to carry out observations and left Patient A unobserved for more than 20 minutes.

Charge 1b

The panel considered all the evidence before it, including the Policy, dated July 2022, which states:

> *'The nurse in charge or designated person in charge should ensure that the person allocated to undertake observations is not assigned any other duties during that period.'*

The panel determined that this indicates that if a panel found that you were the nurse in charge then it could reasonably find that you had a duty to designate someone else to undertake one to one observations. The panel therefore found that there is a case to answer in its entirety.

Charge 2a

The panel noted the evidence of Witness 1, who stated that Patient E was the sole patient on the ward who was prescribed Diazepam, and that the discrepancy identified in the DLM logbook relating to the 2mg dosage corresponds to the discrepancy indicated in the DLM logbook in relation to the 5mg dosage. The panel noted that your signature was present next to the disputed entry. There is no dispute on the dates in the charge and whether you were on shift, the panel considered the documentary evidence, including the ward's DLM logbook, the local interviews, and Patient E's medication chart. The panel was satisfied that a properly directed panel could reasonably find that if the evidence was taken at its highest, that the documents could demonstrate administration errors.

Charge 2b

The panel noted that you made admissions that you recorded that you had administered Olanzapine, but you assert that you did not actually administer the drug. The panel considered the evidence before it, including your signature on Patient F's drug chart at 10pm, and the signature under the 'x', which was confusing and could be interpreted, that you administered 10mg Olanzapine at that time.

The panel also noted that you gave differing accounts as to your actions during your local interviews which were inconsistent with each other. There was also evidence of Witness 2 regarding the conversation they had with you after they discovered the error. This included your comment that you administered Olanzapine as the patient was *'agitated'.*

The panel determined that the evidence was not so weak or unreliable or so poor that it was unsafe and it was not prepared to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Background

You were referred to the NMC on 17 January 2022 by the Hospital Director at [PRIVATE] (the Hospital), while working as a Mental Health Nurse. It is alleged that a number of incidents took place between March 2021 to August 2021.

It is alleged that on 18 March 2021, while working as a shift coordinator and responsible for conducting one to one observations with Patient A who was deemed to be high risk, you left Patient A unobserved for approximately 20 minutes.

It is further alleged that during a shift between 27 and 28 July 2021, you administered a total dose of 7.5mg of Diazepam to a patient, instead of the prescribed dose of 3mg. The error was identified following an audit, as 1.5 tablets of Diazepam could not be accounted for. Another alleged incident took place during the same shift, where you allegedly administered 10mg of Olanzapine at 22.00, despite it having been discontinued on the previous day by the doctor on shift. Following escalating the drug error, it was discovered that you had allegedly created a new administration time of 00.00, to reflect that the medication had been injected intramuscularly. It is also alleged that you altered the medication chart in an attempt to make it unclear what had been administered within a 24 hour period.

On 9 August 2021, it is alleged that a concern was raised that the information in Patient C's notes was a duplication of Patient D's notes, both of which were allegedly entered by you. It is alleged that you intended to mislead your employer that you had accurately, and in line with your role as a nurse, completed the patient records, when you had not.

As a result of these allegations, the Hospital opened an investigation, in which you attended two interviews on 24 and 26 August 2021, at which point you denied the allegations put to you. You tendered your resignation on 4 November 2021, and the Hospital's investigation concluded at a disciplinary hearing on 4 January 2022. You are currently not working in a nursing role.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Khanna, who informed the panel that you made full admissions to Charge 2c in its entirety, this submission was subsequently withdrawn. The panel also heard that you made partial admission to charge 2b to the extent that you failed to record 10mg of Olanzapine to Patient F at 22.00 when that medication had been discontinued by a doctor.

You deny all other charges put to you.

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 Shah and Ms Khanna.

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: Head of Nursing and Quality at [PRIVATE]

- Witness 2: Consultant Forensic Psychiatrist at [PRIVATE]

You gave evidence under oath.

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

Ms Khanna made a request that this case be held in private on the basis that proper exploration of your case involves reference to your health and private matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Shah supported the application to the extent that any reference to your health or private matters should be heard in private.

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

Having heard that reference will be made to your health and other private matters, the panel determined to hold part of the hearing in private in order to protect your privacy.

Decisions and reasons to adjourn the hearing

On 19 August 2025, Ms Khanna made an application to adjourn the hearing for the day. She submitted that you have been giving evidence for approximately six hours today, and that this has taken a toll on you. She reminded the panel of its power to adjourn, and submitted that you are tired, and that it would not be fair to begin asking its questions. She invited the panel to adjourn for the remainder of the day.

You told the panel that you wish to resume your evidence the next morning.

Ms Shah did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel, having heard submissions from Ms Khanna and Ms Shah, considered its powers pursuant to Rule 32 of the Rules and decided to adjourn the hearing until 9am on 20 August 2025.

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

Decision and reasons on facts

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

Charge 1a

> **1. While working as nurse in charge on the shift of 18 March 2021, in relation to Patient A who was on 1 to 1 observations:**
>
> > **(a) Failed to undertake adequate observations, in that you left Patient A unsupervised for approximately 20 minutes;**
> > **(b) In the alternative to 1(a) failed to ensure adequate observations were undertaken in respect of Patient A.**

This charge is found proved.

In reaching its decision, the panel took into account the NMC's evidence, and the oral and written statements of the two witnesses, and your own oral evidence. The panel

first considered the stem of the charge as it has been disputed that the CCTV relates to 18 March 2021 and that you were the nurse in charge for that shift.

The panel considered the evidence of Witness 1, who carried out the local investigation and interviewed you at the time of the allegations. It found that Witness 1's explanation of the circumstances that led to his recovery of the CCTV evidence, which during oral evidence he stated related to the dates detailed in the charge, was credible in that he described and explained the process several times and was consistent in his account. The panel also considered that the CCTV evidence was consistent with the allocation sheet in which you recorded yourself as the nurse in charge on the 18 March 2021 and your admissions in interview to being the nurse in charge.

Furthermore, the panel also considered the evidence of Witness 1 in relation to his addition of the date on the allocation sheet and found his reason for doing so to be reasonable. During oral evidence Witness 1 stated that he personally copied the sheets between the 17 and 19 March 2021 which were part of a bound folder, which remained a live in use document. He stated that he added the date of 18 for his own reference. He was able to provide the undated copy of the document. In the circumstances, the panel found this allocation sheet to be a reliable and credible document.

The panel noted that Witness 1 was able to identify the staff on the CCTV which matched those named in the allocation sheet. The panel was of the view that this further corroborated the NMC's case that the CCTV evidence is from 18 March 2021.

The panel considered your submissions that your admission in interview should not be relied upon as they were made without having full knowledge or disclosure of documents and CCTV footage. Furthermore, that the panel should be cautious of the CCTV footage when considering whether the charges are found proved. The panel decided that although the admission made by you in the interview is consistent with the evidence of Witness 1, it did not place much weight on this, as the panel understood that this admission may have been made without having full knowledge or disclosure of the documents.

In conclusion, the panel found the evidence of Witness 1 to be credible, reasonable and reliable and accepted his explanation of the manner in which he had obtained the CCTV footage and the allocation sheet. The panel was satisfied that the CCTV footage was consistent with the allocation sheet and determined that the evidence relied upon by the NMC was corroborative with each other. The panel therefore determined that you were the nurse in charge on 18 March 2021 and therefore went to consider the charge of 1a.

Charge 1a

In regard to charge 1a, in reaching its decision, the panel considered the NMC's evidence, your oral evidence, the Supportive Engagement and Observation Policy (the Policy), and the evidence of Witness 1.

The panel noted that the allocation sheet, which you completed, shows between 21.00 and 22.00, you were the nurse responsible for 1:1 observation with Patient A. You also told the panel that you accept that you were meant to be carrying out the observation.

Having viewed the CCTV evidence, the panel noted that you left your observation point in front of Patient A's room at 1.07 and returned at 1.32. The CCTV shows you present in the nurse's office and waiting area outside the office during this period of time.

The panel was of the view that as a registered nurse, it was your responsibility to ensure adequate observations were being carried out. The panel considered the Policy, where it states:

> *'Colleagues must NEVER leave a patient they are allocated to observe on continuous observations.'*

Whilst the panel accepted that the Policy postdated this incident, it is of the view that a similar responsibility would have existed at the time of the incident, which Witness 1 confirmed.

The panel considered your evidence that you told the panel that you downgraded the level of observations for Patient A because they were calm and relaxed. The panel was of the view that due to the serious implications of a downgrade this would have been a significant action requiring an in-depth discussion with your staff and note that there is no evidence of such a discussion captured on the CCTV footage. This downgrade in observations was never raised in any interviews or evidence after the incidents occurred. The panel therefore found your account to be inherently implausible.

The panel, having viewed CCTV footage and considered the timeframe, was satisfied that you left the patient alone for at least 20 minutes. The panel also heard from Witness 1 that there was considerable distance between the nurse's station, corridor and day room were three separate areas in the ward. It accepted Witness 1's oral evidence that 1:1 observations could only take place efficiently if nurse and patient were in the same area. If you were at the nurse's station, you were not carrying out your observation duties.

Considering all of the evidence before it, the panel determined this charge is found proved.

Charge 1b

1. While working as nurse in charge on the shift of 18 March 2021, in relation to Patient A who was on 1 to 1 observations:

(b) In the alternative to 1(a) failed to ensure adequate observations were undertaken in respect of Patient A.

Having found charge 1a proved, the panel did not go on to consider charge 1b.

Charge 2a

2. On the nightshift of 27 to 28 July 2021:

(a) administered 7.5mg of Diazepam to [Patient E] when they were prescribed 3mg;

This charge has been found proved.

In reaching its decision, the panel considered the evidence before it, including the ward stock sheets (the sheet) for drugs liable for misuse and Patient E's medication chart. The panel noted that the NMC's case is that there was an error in that you administered 1.5 tablets of 5mg (totalling 7.5mg) rather than 1.5 tablets of 2mg (totalling 3mg) of Diazepam to Patient E.

Due to the overt nature of the evidence against you, being based on contemporaneous documentary evidence, the panel determination focuses on alternative possible explanations for the ward stock sheet evidence. At all times, the panel reminded itself that you do not have to prove anything and the burden is on the NMC.

The panel noted that you gave a number of suggestions as to how the balance error recorded on the ward stock sheet could have occurred, including that the tablets were transferred to another ward within the Hospital. The panel determined that it is not plausible for another ward to take half a tablet or even a few tablets of Diazepam, and they would be more likely to take a larger stock of medication, as evidenced in other sections in the ward stock sheets. The alternative explanation you gave was that the medication may have been taken by a staff member or other persons. The panel is of the view that it is implausible that such a small number of tablets were taken.

The panel, having heard from both you and Witness 1, determined that there was no direct evidence of administration of Diazepam. However, the panel was satisfied that the surplus recorded in the sheet of 2mg of Diazepam and deficit of 5mg of Diazepam occurred during your shift. The errors in the form make it difficult for the panel to ascertain and assess the reasons for the discrepancies in the sheet other than that you incorrectly administered 1.5 tablets of 5mg Diazepam instead of 1.5 tablets of 2mg of Diazepam. You accepted that entries were of your making, however, stated that they were recording errors only.

You explained that you had sought a colleague to help rectify the recording error and countersign the 2mg of Diazepam, however, the panel noted that on the evidence before it you had signed as having administered Diazepam during the course of your shift to Patient E and there was still a surplus of 2mg Diazepam unaccounted for. This would not be the case unless the administration error had occurred as alleged in the charge. The panel heard from Witness 1 that any errors on the ward stock sheet should be reported to senior staff to allow for further investigation, this was not reported by yourself at any point. The error was only discovered when another staff nurse audited the medication, discovered the missing 5mg Diazepam tablets and raised this to Witness 1.

The panel was satisfied on the balance of probabilities that the NMC have established their case in relation to this charge.

Charge 2b

2. On the nightshift of 27 to 28 July 2021:

> **(b) recorded and/or administered 10mg of Olanzapine to [Patient F] at 22.00 when that medication had been discontinued by a doctor;**

This charge has been found proved.

In reaching its decision, the panel considered the medication chart for Patient F, Witness 1 and 2's evidence and your own evidence. The panel heard from Witness 1 who told the panel that Witness 2 had discontinued the medication. The panel considered the oral evidence of Witnesses 1 and 2, the latter who had discontinued it at the time in question on the night of 27 July 2021. The panel had sight of the chart, where 'x' was noted down by Witness 2. In oral evidence Witness 2 stated that he discontinued the medication as he was concerned about the number of sedating medications that had been administered to Patient F in a 24-hour period. Witness 1 confirmed that registered nurses are used to this 'x' being used in medication charts and it would be understood to mean this medication should not be given at that time.

The panel noted that you accepted that it was your signature underneath the '*x'*. Due to the overt nature of the evidence against you, being based on your signature underneath a clear *'x'*, the panel determination focuses on alternative possible explanations for the presence of your signature there. At all times, the panel reminded itself that you do not have to prove anything and the burden is on the NMC.

The panel considered the conflicting evidence given by you in your written and oral evidence, and noted the following excerpts from your interview:

> *'patient was extremely agitated, so I gave him the meds…'*
>
> *'the doctor had crossed off all the meds off the chart….let me think about it…that chart that you are showing me is not from that night…*
>
> *'it must have been changed afterwards, and that there was no 'x'…'*

In oral evidence, you told the panel that you only saw the '*x'* on the night of the incident and signed it without administering the medication. You told the panel that you administered another drug, Promethazine, instead of the prescribed dose of Olanzapine. You further told the panel that the x must have been signed already when you signed it, and that you were trying to record that you had administered Promethazine and stated this repeatedly in your oral evidence. You were asked again if you had administered Olanzapine, and you stated that you did not administer it at the prescribed time. In cross-examination you told the panel you did not administer Olanzapine at 22.00. The panel found it implausible that as a registered nurse, having admitted that you did not administer the drug at the prescribed time that your signature would have appeared in the signature box. The panel understand that the NMC had not provided the panel with the full medication chart, however, it was satisfied that there was sufficient evidence provided upon which a decision could be made.

In reaching its decision, the panel considered the evidence before it, including the interview notes from 24 and 26 August 2024, where you stated that you called Patient F's family. The panel noted your explanation for calling Patient F's family to inform them

that you administered Olanzapine under restraint via intramuscular injection, and that there could be bruising present. There was no evidence before the panel to suggest that bruising occurred. The panel considered the evidence of Witness 2 who stated that in a conversation with you, you stated that you had contacted the family to advise them of the overdose of the medication.

In light of your previous inconsistent accounts related to this administration, the panel found Witness 2's account more plausible in that you only contacted the family to inform them that a further 10mg dose of Olanzapine had been administered and this could have been an overdose of medication.

The panel were of the view that there is no reason for a registered nurse to sign for medication other than to note that this medication has been administered and find this charge proved.

Charge 2c

2. On the nightshift of 27 to 28 July 2021:

(c) Recorded that you had administered a further 10mg Olanzapine to [Patient F] at 00.00, when you did not in fact administer Olanzapine at that time.

This charge is found proved.

The panel noted your admission to this charge at the outset of the hearing, which was withdrawn after the conclusion of the NMC evidence. The panel considered that at no point during the interview did you suggest that the signature on the chart was not yours.

The panel determined that to the lay-person's eye, the signature on the face of it looks like yours. It was conscious that there was no burden on you to establish your innocence. However, the panel considered that the explanation given by you, that someone else must have completed the chart and forged your signature against this record of administration in the short space of time between Witness 2 reviewing the chart and raising this issue to Witness 1, was inherently implausible. The panel found

on the balance of probabilities that the NMC had discharged its burden of proof in relation to this charge.

The panel therefore found this charge proved.

Charge 3

3. Your action at charge 2(c) was dishonest in that:

a) you knew you did not administer this medication to Patient SV at 00.00 on 28 July 2021;

The panel found this charge proved.

The panel considered all of the evidence before it, including your oral evidence. It also considered that having found charge 2c proved, you were dishonest as you knew that you had not administered the medication to the patient at 00.00 on 28 July 2021 and recorded that you had done so. The panel was of the view that the date recorded is ambiguous particularly in light of the time being recorded as 00.00. It accepted the evidence given by Witness 1 that you attempted to use the time issue to intend to confuse as to which day the medication was administered to the patient. The panel accepted Witness 1's evidence that all nurses are aware that medications are never administered at midnight because of the confusion it can cause in accurately recording the day that administration has taken place.

The panel therefore found this charge proved.

Charge 3b

b) you sought to mislead as to the time when you administered Olanzapine to [Patient F].

This charge is found proved.

For the same reasons for the charge above, the panel found this charge proved.

Charge 4

4. **On 7 August 2021 copied background information in Patient C's admission notes into the admission notes for Patient D.**

This charge is found proved.

In reaching its decision, the panel considered the patient notes of Patients C and D. it accepted the entries for both patients were similar and further noted that both parties accept the entries were copied and pasted, bar a few amendments. The panel heard from Witness 1, who told the panel that your login was used to access the patient notes for Patient D, and that the notes were not accurate.

Due to the overt nature of the evidence against you, being based on the unusual similarity between patient notes, the panel determination focuses on alternative possible explanations for this similarity. At all times, the panel reminded itself that you do not have to prove anything and the burden is on the NMC.

The panel heard during your oral evidence that you left your computer unlocked, and that someone else (unknown) copied and pasted the entries from Patient C's notes onto the record for Patient D. The panel noted your admission in your second interview when you had had the opportunity to review the care notes which contained the pasted entry.

The panel noted the inconsistencies in your evidence. In the first interview you stated that you would sometimes leave your login details for others to use. However, later in the same interview, you contradicted yourself and stated this was not the case. The panel heard that the patient entry was opened and closed in a short space of time. The panel was of the view that if your account was correct, someone else would have had to access your login, and copied and pasted the entries, and that this was done to shed you in a negative light. There was no evidence before the panel to suggest that this was the case.

The panel noted your admission in the second interview to copying and pasting the note from Patient C's record to Patient D's record, which contradicts your comments in the first interview that someone else had made the entry. You explained:

> *"This error has happened and it is a mistake and I apologise for that but it's a common error that everyone does.*
> *[…]*
> *this is a common thing to do copy and paste from one to another and this has been the norm for a long time but in this situation I copied it without reading the content something must have distracted me"*

The panel considered your evidence in cross-examination that you do not recall admitting that you had copied and pasted the notes from Patient C's record to Patient D's record during your second interview. You stated that you believed that the HR representative had recorded the minutes of your comments incorrectly. The panel had no evidence before it to suggest that this was the case and was satisfied that this was an accurate record of the discussion that took place during the interview.

The panel also heard that Witness 1 was present at the time of the interview and determined that Witness 1's recollection of events is credible and reliable.

The panel therefore found this charge proved.

Charge 5

5. **Your actions at charge 4 were dishonest in that you knew that the background information for Patient C did not apply to Patient D.**

This charge is found NOT proved.

Having found charge 4 proved, the panel went onto consider whether you were dishonest at the time. The panel heard from you that you accepted in the interview that you were aware that this was a mistake. The panel noted that after a significant period

of time since the incident, you now state that you did not copy and paste the entry. However, the panel is of the view that you were more accurate in your knowledge at the time and accept your admission that you copied and pasted the patients care notes as you were distracted and failed to check and confirm the details.

The panel concluded that it is more likely that your actions were as a result of an error, as it is improbable that you would have deliberately decided to incorrectly record patient D's care notes with information that did not apply to them. The panel was of the view that this was a careless mistake and noted that you may have been distracted as you were going through [PRIVATE] and looking after your grandchildren.

The panel on balance of probabilities found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Submissions on misconduct

Ms Welsh invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision, in particular paragraphs 4, 10, 12, 14, 16, 17, 18, 19, 20 and 21.

Ms Welsh submitted that the concerns are not isolated matters of poor practice but represent serious failures in fundamental nursing duties, including the supervision of a vulnerable patient, safe administration of medication, accurate record keeping, and maintaining honesty and integrity within professional practice. She stated that the conduct fell significantly below the standards expected of a registered nurse and breached the core themes of the Code, including prioritising people, practising effectively, preserving safety, and promoting professionalism and trust.

Ms Welsh informed the panel that misconduct requires consideration of whether the conduct falls far below the standards expected of a registered professional. In this regard, she referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311. Ms Welsh submitted that the conduct in this case goes beyond a simple breach of the Code and amounts to serious professional misconduct due to the nature of the concerns and the risk to patients.

In relation to the one-to-one observations, Ms Welsh submitted that this was a serious failure in patient safety. You were responsible for ensuring continuous observation of a vulnerable patient, she said that the panel found that Patient A was left unsupervised for a period of time. One-to-one observations are a fundamental safeguarding measure and not an administrative task. The failure to carry out those observations placed the patient at unnecessary risk and demonstrated a failure to maintain safe and effective care.

In relation to medication, Ms Welsh submitted that the administration of medication contrary to the prescription, including the Diazepam and Olanzapine concerns, represented serious failures in medication safety. Medication administration is a core nursing responsibility and requires appropriate checking, accuracy and professional accountability. She reminded the panel that it found that medication was administered incorrectly and that medication records did not accurately reflect what had occurred.

This created a risk to patient safety and undermined the reliability of clinical records relied upon by other professionals.

Ms Welsh submitted that the concerns regarding the medication record were particularly serious because accurate records are essential to safe care. She said that a misleading clinical record can affect decision-making, continuity of care and patient safety. Honesty and integrity are fundamental requirements of nursing practice, and any dishonesty connected to clinical documentation represents a significant breach of professional standards.

Ms Welsh submitted that the copying of Patient C's background information into Patient D's admission record also amounted to misconduct. Admission records must be accurate, patient-specific and reliable. The creation of inaccurate records risked inappropriate assessment and care planning and demonstrated a failure to maintain the standard expected of a registered nurse.

Ms Welsh further submitted that, when considered cumulatively, the concerns demonstrate a pattern of failures across different areas of practice over a period of time. The issues involve patient safety, medication management, record keeping and honesty. These are fundamental aspects of nursing practice, and the overall conduct crosses the threshold for serious professional misconduct. Ms Welsh invited the panel to find that the facts proved amount to serious misconduct.

Ms Khanna informed the panel that you would not be giving evidence during this stage of the proceedings. Furthermore, she informed the panel that you accepted that the facts found proved amounted to misconduct.

Ms Khanna submitted that she agreed with much of the NMC's submissions but highlighted that the personal circumstances you were experiencing at the time formed an important part of the background to the events and assisted the panel in understanding your conduct. Ms Khanna submitted that, had those personal circumstances been different or had been resolved, you may have responded differently. She accepted that context does not remove the seriousness of the concerns

or eliminate risk but submitted that it was relevant when considering how your conduct arose and how it should be viewed.

Ms Khanna referred the panel to your bundle and submitted that you had undertaken relevant training following the events. She submitted that the training focused on teamwork, raising concerns appropriately, professional accountability and taking responsibility for your actions. She submitted that this demonstrated that learning had taken place and that you recognised aspects of your conduct which had fallen below the standards expected of a registered nurse.

Ms Khanna submitted that you accepted that the way you responded to the allegations in this forum did not sufficiently acknowledge the concerns and patient safety. She submitted that you recognised that your focus at the time had been on your perception of your employer and the difficulties you were experiencing personally, rather than on your own professional responsibilities. She invited the panel to take into account that this demonstrated the root of insight into your conduct which was not advanced to the stage where you were fit to go into full practise.

Submissions on impairment

Ms Welsh addressed the panel on impairment and the need to have regard to protecting the public and the wider public interest. She said that there is a 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 Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin).

Ms Welsh submitted that your fitness to practise is currently impaired on public protection and public interest grounds. She further submitted that the public protection concerns remain because your conduct involved repeated failures affecting patient care. The concerns are not limited to one area of practice. They include failures in supervision, medication administration, medication documentation and patient records.

The breadth of the concerns demonstrates that the risk cannot be viewed as a single isolated incident.

Ms Welsh submitted that there is limited evidence of insight, remediation or acceptance of responsibility. She said insight requires more than engaging with the process; it requires an understanding of what went wrong, why it was serious, the impact on patients and what steps have been taken to prevent repetition. Ms Welsh submitted that the absence of meaningful reflection, targeted remediation and evidence of strengthened practice means that repetition is highly likely.

Ms Welsh submitted that the dishonesty finding is particularly significant because it relates directly to clinical practice. Nurses are trusted to maintain accurate records, be open when things go wrong and act with honesty and integrity. Where dishonesty is linked to medication documentation, it undermines trust between patients, colleagues, employers and the NMC as its regulator. Ms Welsh said that even if the panel considered there was limited ongoing clinical risk, a finding of impairment is still required on public interest grounds. The public would expect appropriate regulatory action where a nurse has failed to maintain safe care, accurate records and honesty within professional practice. A finding of impairment is necessary to maintain public confidence in the profession and uphold professional standards. For those reasons, Ms Welsh invited the panel to find that your fitness to practise is currently impaired on both public protection and public interest grounds.

Ms Khanna submitted that you accepted that your fitness to practise is currently impaired. She submitted that the context in which the events occurred remained relevant. Whilst accepting that context does not remove the seriousness of the misconduct or negate any risk identified by the panel, she submitted that it assisted in explaining your behaviour at the time and should be considered when assessing your current fitness to practise. She submitted that, had your personal circumstances been different or resolved, you may have responded differently. The context was therefore relevant to understanding and managing your conduct, rather than diminishing your acceptance of current impairment.

Ms Khanna referred the panel to your bundle and submitted that you had undertaken training designed to strengthen your professional practice. She submitted that the training focused on teamwork, raising concerns appropriately, professional accountability, record-keeping and taking responsibility for your actions. She invited the panel to conclude that these were positive steps towards strengthening your practice and demonstrated that learning had taken place.

Ms Khanna submitted that there were roots of insight beginning to emerge. She submitted that you accepted that the panel had been particularly concerned by the ambiguity surrounding the medication record, including the entry recorded as 00.00, and acknowledged that you had relied upon that ambiguity when explaining what had occurred. Ms Khanna said that on reflection, you accepted that your response at the time did not adequately recognise the concerns created by the record or the potential impact upon patient safety, professional accountability and public confidence.

Ms Khanna further submitted that you now recognised that, even where documentation appears unclear, it is your professional responsibility to address those concerns openly, carefully and transparently rather than relying upon uncertainty within the records. You also accepted that the explanation suggesting another individual had completed and signed the medication chart was unsupported by the evidence and understood why the panel regarded that explanation as implausible. She submitted that you recognised this had affected the panel's assessment of your insight.

Ms Khanna submitted that you accepted your approach to the panel should have been different. Rather than focusing upon your perception of your employer and the difficulties you were experiencing at the time, you now recognised that you should have concentrated on establishing an accurate factual account, addressing the uncertainty within the documentation, and accepting responsibility for your professional record-keeping and the explanations you provided.

Ms Khanna submitted that, through reflection of the panel’s decision at stage one, you had developed a greater understanding of the importance of accurate medication records and appreciated that ambiguity, inconsistency and inadequate explanations

could have significant implications for patient safety, professional accountability and public confidence. She submitted that you recognised the concerns extended beyond the documentation itself to the way you responded when those concerns were raised.

Ms Khanna submitted that you remained committed to continuing your remediation and strengthening your practice. She submitted that you recognised rebuilding trust and confidence required sustained insight demonstrated through your actions and that you intended to ensure your future practice would be safe, transparent and professionally accountable.

Ms Khanna invited the panel to take into account your personal circumstances, including [PRIVATE] information contained within your bundle. She submitted that you have experienced [PRIVATE] and have not worked since September 2025. She submitted that these matters formed part of the wider context of the case and should be considered alongside your acceptance of misconduct and impairment, the developing insight demonstrated, and the training undertaken when assessing your current fitness to practise.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.2** make sure you deliver the fundamentals of care effectively* (relevant to all charges found proved)

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* (Charge 3c)

***10.3** complete all records accurately and without any falsification…* (Charge 3c & Charge 4)

***10.4** attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed…*(Charge 3c & Charge 4)

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

***19.1** take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place* (Charge 1, 2c and 4)

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* (relevant to all charges found proved)

***20.2** act with honesty and integrity at all times…* (Charge 3a and Charge 3b)

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'* (Charge 1)

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered the NMC Guidance *'Misconduct'* (Reference: FTP-2a Last Updated: 20/05/2026) and recognised that serious professional misconduct is more likely to arise where concerns occur within professional practice and when conduct falls far below the standards expected of a registered professional.

The panel was of the view that the conduct in this case involved fundamental breaches of the Code. Across the charges found proved, the panel identified failures engaging the core requirements of nursing practice, including prioritising people, preserving safety, maintaining accurate records, acting with honesty and integrity, and upholding professional standards.

The panel considered that the concerns were wide-ranging and involved different areas of nursing practice, including failures to undertake appropriate observations, failures in medication administration, failures in record keeping, inaccurate documentation, and a failure to demonstrate openness and honesty when concerns arose. The panel found that these were not isolated errors but a pattern of conduct affecting more than one patient over a five month period.

In relation to the observation concerns, the panel considered that your role and responsibilities on the shift were significant. You were the nurse in charge and had responsibility for ensuring that appropriate arrangements were in place for the patient requiring one-to-one observations. The patient was particularly vulnerable and required a high level of supervision due to risks including potential harm to themselves and risks arising from previous behaviour involving attempts to smoke, which created a potential risk of fire and harm to the patient, other patients and staff. The panel considered the evidence of Witness 1 who highlighted the risk due to a recent experience at the hospital where smoking caused a fire. The panel considered that leaving the patient

without appropriate observation exposed that patient and others to an unwarranted risk of harm.

The panel also considered the medication concerns to be serious. Medication administration is a fundamental nursing responsibility. The administration of medication contrary to the prescribed instructions created a risk of patient harm and overmedication.

The panel considered the record-keeping concerns to be particularly serious. Accurate records are essential to safe patient care. Where records are inaccurate or misleading, there is a risk that other healthcare professionals may make decisions based upon incorrect information, potentially placing patients at risk and unknowingly undermining their professional practice.

The panel was of the view that there are a number of serious elements to this case, and your dishonesty adds to that. A registered nurse is expected to act with honesty, integrity and candour. The panel found that conduct involving falsification of medication records and an attempt to mislead colleagues represents a serious departure from the standards expected of a nurse. The panel was of the view that the amendments you made as found proved in charge 2b, followed a complaint by the responsible doctor. Additionally, you intentionally tried to hide your error as proved in charge 2c. Your dishonesty led to ambiguity as to the amount, time and strength of medication administered, which appeared to demonstrate a disregard for the importance of such records and the potential impact on patient safety, care and the work of colleagues. The panel also took into account the concern relating to the copying of patient information into another patient's record. It acknowledged that this appeared to be a genuine mistake rather than deliberate dishonesty. However, that carelessness resulted in a serious failure in maintaining accurate, patient-specific records and could have resulted in inappropriate care planning.

The panel considered that the cumulative effect of your conduct demonstrated a disregard for fundamental nursing responsibilities which was a consistent theme. The concerns created risks to patient safety, undermined confidence in the accuracy of

clinical information being relied upon for patient care and impacted the practise of other healthcare professionals.

The panel took into account that you accepted that your conduct amounted to misconduct. The panel acknowledged this admission and considered it was to your credit. However, having considered all of the evidence, the panel determined that the seriousness of the conduct went beyond poor practice and amounted to a serious falling short of the standards expected of a registered nurse.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 a number of judgments including the judgement 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 considered that all four limbs of the *Grant* test were engaged. In relation to patient safety, the panel found that your misconduct placed patients at risk of harm. The failures in observations created a risk to a vulnerable patient who required continuous

supervision and potentially others. The medication failures created a risk of incorrect treatment being provided. The inaccurate records and dishonesty created a further risk because colleagues may have relied upon those records when making decisions regarding patient care.

The panel found that your misconduct breached fundamental tenets of the nursing profession. Nurses are expected to provide safe care, maintain accurate records, act with honesty, take responsibility for their actions and be open when things go wrong. The panel considered that the range of conduct demonstrated a failure to adhere to these fundamental requirements.

The panel was of the view that the conduct also had the potential to bring the profession into disrepute. An informed member of the public would expect nurses to maintain high standards of honesty, medication safety and patient care. The panel was satisfied that public confidence in the profession would be undermined if conduct involving patient safety failures, inaccurate records and dishonesty was not recognised as impairing fitness to practise.

Regarding insight, the panel considered that there was limited evidence of insight into the failings that led to the charges. Throughout these proceedings, the panel had not been provided with any reflective evidence demonstrating an understanding of what went wrong, the risks posed to patients, colleagues and the wider profession, or how similar concerns would be prevented in the future.

The panel acknowledged the submissions made by Ms Khanna that there were roots of insight beginning to emerge. The panel took into account Ms Khanna's acceptance that your conduct amounted to misconduct and that your fitness to practise is currently impaired. Ms Khanna submitted to the panel that you were embarrassed at having brought the profession into disrepute, and accepted responsibility for the ambiguity in your evidence to the panel. Whilst the panel accepted that the submissions made by Ms Khanna appear to demonstrate the beginnings of your insight, in the absence of any reflective evidence from you, the panel was only able to attach limited weight to those submissions and determined that your insight is insufficient at present.

The panel noted that the clinical failings, such as the record-keeping error involving copied information, may be capable of being addressed through training and strengthened practice. However, the panel considered that failing to observe a vulnerable patient and dishonesty were more difficult to remediate.

The panel determined that both of these aspects together with your poor medication practice demonstrated deep seated attitudinal concerns relating to a disregard to patient safety. Your actions demonstrated that you did not have proper regard to the rules, processes and policies which are fundamental to delivering safe and effective nursing practice. Together your actions demonstrated a lack of focus on patient care and wellbeing. You failed to consider the impact of your actions on colleagues, potentially undermining their own practice.

The panel considered that your position as nurse in charge was significant. Given your experience as a registered nurse, you should have understood the importance of ensuring patient safety, maintaining appropriate observations and following professional requirements. The failure to ensure alternative cover for a vulnerable patient requiring one-to-one observations demonstrated a serious disregard for fundamental nursing responsibilities.

The panel considered the NMC Guidance '*Insight and strengthened practice'* (Reference: FTP-16 Last Updated 14/04/2021). The guidance recognises that where behaviour suggests deep-seated attitudinal concerns that could place patients at risk, it is less likely that the concerns can be addressed through training alone. The panel considered that this was relevant in this case because the issue was not simply the occurrence of errors, but your actions and implausible explanations minimised the concerns and you attempted to attribute responsibility elsewhere avoiding accountability.

The panel carefully considered the evidence provided regarding personal circumstances. The panel acknowledged the information provided regarding personal difficulties. However, the evidence provided did not specifically relate to the period in

which the concerns occurred and therefore the panel attached limited weight to this information.

In relation to remediation and strengthening of practice, the panel had sight of training records and certificates. However, there was limited evidence demonstrating the content of the training, how it addressed the concerns identified, or how it had been applied in practice. The panel had not been provided with any reflection or testimonials demonstrating strengthened practice. Having considered the lack of developed insight, limited remediation, lack of reflection and absence of evidence demonstrating that the concerns had been addressed, the panel considered there remained a high risk of repetition.

It determined that due to all the reasons above, particularly the deep seated attitudinal concerns identified, a finding of impairment is necessary on the grounds of public protection.

The panel then considered the public interest element. It bore in mind the overarching objectives of the NMC to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest. This includes maintaining public confidence in the nursing profession and upholding proper professional standards.

The panel determined that a finding of impairment on public interest grounds is required because the case involves serious concerns relating to patient safety, failures in professional accountability, inaccurate clinical records and dishonesty within professional practice. The public would expect the regulator to take action where a nurse has deep seated attitudinal issues and failed to meet fundamental standards of safe and honest practice. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment were not made in this case.

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

Sanction

The panel has considered this case and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

Ms Welsh acknowledged the matters advanced in mitigation, including the training you had undertaken and your personal circumstances. However, she invited the panel to attach limited weight to these factors. She submitted that there was limited evidence of meaningful reflection or developed insight, and no evidence of strengthened practice. In relation to your personal circumstances, Ms Welsh submitted that the medical information before the panel did not establish that [PRIVATE] was present or relevant at the time the misconduct occurred. She further submitted that the family circumstances relied upon related to December 2021, whereas the misconduct occurred between March and August 2021, limiting the weight that could properly be attached to those matters.

Ms Welsh submitted that there were significant aggravating features. Firstly, your conduct exposed patients to an unwarranted risk of harm through failures in patient observations, medication administration and inaccurate clinical records. Secondly, she submitted that the dishonesty found proved was at the serious end of the spectrum. She referred the panel to the NMC Sanctions Guidance (SAN-4), submitting that the dishonesty involved a deliberate attempt to mislead by creating an inaccurate clinical record following a medication error. She submitted that the dishonesty occurred at a time when openness, candour and professional accountability were required and this represented a deliberate breach of the Code and created a direct risk to patient safety

because healthcare professionals rely upon accurate medication records when making clinical decisions.

Ms Welsh further submitted that the misconduct demonstrated a pattern of behaviour rather than an isolated incident. The concerns involved multiple patients, different areas of nursing practice and extended over a period between March and August 2021. She submitted that the panel had also found only limited insight, together with deep-seated attitudinal concerns linked to dishonesty and patient safety. Ms Welsh told the panel that these concerns had not been adequately addressed, that there was little evidence of meaningful remediation, and that the risk of repetition remained high.

In considering the most appropriate sanction, Ms Welsh submitted that taking no further action would not be appropriate in a case of this seriousness and would fail to maintain public confidence in the profession. She said that a caution order would also be inappropriate given the seriousness of the misconduct, the continuing risk of repetition and the findings of impairment.

Ms Welsh submitted that a conditions of practice order would neither be appropriate nor workable. The concerns arose from attitudinal issues, including dishonesty, a failure to accept responsibility and attempts to attribute responsibility to others. These were not concerns capable of being adequately addressed through retraining, supervision or conditions of practice.

Ms Welsh submitted that a suspension order would also be insufficient. Whilst acknowledging that suspension provides an opportunity for further insight and remediation, she submitted that there was currently insufficient evidence before the panel to conclude that a period of suspension would realistically address the deep-seated attitudinal concerns identified. In particular, there remained limited insight, limited remediation, no evidence of strengthened practice and a continuing high risk of repetition.

Ms Welsh submitted that a striking-off order was the only appropriate and proportionate sanction. She referred the panel to the case of *Bolton v Law Society* [1994] 1 WLR 512.

She acknowledged that a striking-off order would inevitably have a significant impact upon you, however those personal consequences were outweighed by the need to protect the public, maintain confidence in the nursing profession and mark conduct involving serious dishonesty and risks to patient safety as fundamentally incompatible with continued registration. Accordingly, Ms Welsh invited the panel to impose a striking-off order.

Ms Khanna accepted the seriousness of the findings and acknowledged that the misconduct involved dishonest medication recording, inaccurate records and conduct which exposed patients to a risk of harm. She submitted that this was, at the very least, a case in which a suspension order was the appropriate and proportionate sanction

Ms Khanna submitted that this was not a case requiring permanent removal from the register and your personal context remained relevant. Whilst accepting that it did not excuse the misconduct, she submitted that your personal issues did not arise suddenly or in isolation. Rather, there had been a build-up to the personal difficulties experienced by you, and that context assisted the panel in understanding the circumstances in which the misconduct occurred.

In relation to the panel's finding of deep-seated attitudinal concerns, Ms Khanna submitted that this should be viewed alongside your consistent engagement with the regulatory process. She submitted that you had engaged throughout these proceedings despite the significant period of time between the facts stage and the determination on impairment. She submitted that someone with genuinely entrenched attitudinal issues may have disengaged from the proceedings, whereas you had continued to participate throughout. Ms Khanna invited the panel to conclude that your continued engagement, together with the developing insight, demonstrated the potential for positive change.

Ms Khanna reminded the panel that, prior to these events, you had practised as a registered nurse since 2003 without any previous fitness to practise findings or concerns regarding your honesty or integrity. She submitted that there had been one finding of dishonesty arising from these proceedings and that, whilst serious, it occurred

within a lengthy professional career which had otherwise been free from regulatory concern.

Ms Khanna referred the panel to the NMC's Sanctions Guidance on suspension and striking-off orders (SAN-3), Ms Khanna submitted that there were beginnings of seeds of insight, together with your continued engagement, which demonstrated a genuine willingness to change and improve. Whilst acknowledging [PRIVATE], she submitted that there had been no challenge by the NMC to [PRIVATE] which had [PRIVATE] and impacted your ability to demonstrate strengthened practice in recent years.

Ms Khanna accepted that there was currently limited evidence demonstrating how your learning had been applied in practice. However, she submitted that this was because you had not been working, having been absent [PRIVATE] since August 2025. She submitted that a suspension order, with a review, would provide you with the opportunity to continue developing your insight, produce reflective evidence, and demonstrate how your learning could be applied before returning to unrestricted practice.

Ms Khanna submitted that, whilst remediation may be difficult in cases relating to dishonesty and deep seated attitudinal concerns, it was not impossible. She said that the seriousness of the findings would be properly marked by a lengthy suspension order, which would also protect the public and maintain confidence in the profession.

Ms Khanna invited the panel to consider the personal consequences of a striking off order. She submitted that [PRIVATE] removal from the register would be career ending, as it would be unlikely that you could return to nursing following the statutory five year period. She also referred the panel to your financial circumstances, noting that you had been absent from work since August 2025, [PRIVATE] was coming to an end, your savings were extremely limited, and you remained the principal financial provider for your family. She acknowledged that these matters could not outweigh the panel's duty to protect the public but submitted that they were relevant to the proportionality of sanction.

For those reasons, Ms Khanna invited the panel to find that striking off would be disproportionate, given the realistic prospect of further remediation, and invited the panel to impose a suspension order. She submitted that this would allow you to continue developing your insight, strengthen your practice and demonstrate your ability to return to safe practice at a future review.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Failing to undertake one-to-one observations of a vulnerable patient, administering medication incorrectly, falsifying medication records and maintaining inaccurate clinical records, you deliberately or recklessly placed patients at risk of harm.
- Deliberate breaches of the Code, including failures to act with honesty, integrity, candour and professionalism.
- A pattern of misconduct over a period of five months, between March and August 2021, involving different patients and different areas of nursing practice.
- Dishonesty during the proceedings, including advancing implausible explanations, seeking to attribute responsibility to others, and changing your account, including suggesting that another colleague was the nurse in charge at the relevant time.
- The vulnerability of the patients receiving care, particularly the patient requiring continuous one-to-one observations, together with the wider vulnerability of patients on the psychiatric intensive care ward.

- Premeditated conduct in deliberately falsifying medication records following a medication administration error.

The panel also took into account the following mitigating features:

- Training undertaken since the events, including general training relating to probity and professional accountability.
- The personal circumstances advanced on your behalf. Whilst there was no [PRIVATE] before the panel, it accepted that there were [PRIVATE].
- Your acceptance, at the impairment stage, that your conduct amounted to misconduct and that your fitness to practise is currently impaired.

The panel gave no mitigating weight to any purported early admissions of the facts, as those admissions were subsequently withdrawn during the hearing.

Having identified the aggravating and mitigating factors, the panel gave particular weight to the seriousness and range of the misconduct which appeared to demonstrate a disregard for patient safety. It considered the failure to undertake one-to-one observations of a vulnerable patient, the medication administration errors, the falsification of medication records, the inaccurate record keeping, the findings of dishonesty, and the deep-seated attitudinal concerns previously identified by the panel. These factors were central to the panel's assessment of the appropriate and proportionate sanction.

The panel first considered whether to take no further action but concluded that this would be inappropriate given the seriousness of the misconduct, the continuing risk of repetition and the need to protect the public. The panel determined that taking no further action would be neither proportionate nor in the public interest.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be*

restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel determined that your misconduct was not at the lower end of the spectrum. It involved serious patient safety concerns, dishonesty and repeated failures over a period of time. Given the seriousness of the misconduct and the panel's finding of a continuing risk of repetition, it concluded that a caution order would not adequately mark the seriousness of the case, protect the public or maintain public confidence in the profession. The panel therefore determined that a caution order would be neither proportionate nor appropriate.

The panel next considered whether to place a conditions of practice on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026).

It was of the view that the more serious concerns identified were not fundamentally clinical competency issues capable of being addressed through retraining, supervision or monitoring. Rather, they arose from deep-seated attitudinal concerns, including dishonesty, a disregard for patient safety and poor professional judgement. The panel was therefore unable to formulate any relevant, workable, measurable or proportionate conditions that would adequately address the concerns, protect the public or uphold confidence in the profession. Accordingly, the panel concluded that a conditions of practice order would not be appropriate.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'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 NMC Guidance to weigh up before imposing a suspension. It noted 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*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel carefully considered whether the risk identified could be managed through a period of temporary removal from practice and whether there remained a realistic prospect of you returning to unrestricted practice in the future. It recognised that not every case involving dishonesty requires a striking-off order and accepted that some aspects of your misconduct, particularly the inaccurate record keeping as found proved in charges 2a, 2b and 4, could potentially be addressed through training and strengthened practice.

However, the panel concluded that the misconduct in this case was not the result of a lack of training or clinical knowledge. Rather, it reflected a disregard for patient safety,

professional accountability and the fundamental responsibilities of a registered nurse. The panel considered that the dishonesty was particularly serious as it involved an attempt to conceal a medication error through falsification of clinical records and was compounded by the findings that you continued to advance implausible explanations during the proceedings.

The panel further noted that a significant period of time had elapsed since the events occurred and noted from evidence provided by you that you had been working as a registered nurse up until August 2025. Despite this, there was very limited evidence of insight. The panel had no evidence of reflection, remorse, strengthening of practice or remediation. Whilst the panel acknowledged the training certificates provided, there was no evidence demonstrating how that learning had been applied in practice or how it addressed the concerns identified by the panel. It considered that a suspension order is most appropriate where there is a realistic prospect that a registrant is likely to develop insight, strengthen their practice and remediate concerns during a period of suspension. In this case, the panel had been provided with no evidence demonstrating such potential. The panel considered that a member of the public would regard the continuing lack of insight, lack of remediation and ongoing attitudinal concerns as significant barriers to safe return to practice.

In all the circumstances, the panel concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction to address the seriousness of the misconduct, adequately maintain public confidence in the profession and would not uphold proper professional standards.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-3 and SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *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 also considered the NMC guidance in SAN-4 as to the types of dishonesty that are most likely to require consideration of striking off:

- *Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care.*

It recognised the significant impact such an order would have upon you, including the effect upon your career, financial circumstances and future employment prospects. The panel took those matters fully into account. The panel found that the misconduct demonstrated deep-seated attitudinal concerns relating to patient safety, professional accountability and honesty.

The panel particularly noted the lack of insight demonstrated, the absence of remediation, remorse or strengthened practice, and the lack of reflective evidence which led to the continuing risk of repetition. The panel considered that the dishonesty identified was particularly serious because it involved clinical records upon which colleagues relied when making decisions about patient care. It was of the view that your actions represented significant departures from the standards expected of a registered nurse and were fundamentally incompatible with continued registration. The panel concluded that no lesser sanction would adequately address the seriousness of the misconduct, maintain public confidence in the profession or uphold proper professional standards.

Having balanced all of the circumstances of this case, the panel was satisfied that a striking-off order is necessary to protect the public, maintain public confidence in the nursing profession and uphold proper professional standards.

This will be confirmed to you in writing.

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 or is otherwise in the public interest 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 Welsh. She submitted that as the striking off order cannot take effect until the expiry of the 28-day appeal period and any appeal, she invited the panel to impose an interim suspension order for a period of 18 months. She reminded the panel that such an order may be made where it is necessary for the protection of the public, is otherwise in the public interest, or is in your own interest. Ms Welsh submitted that the panel has already determined that a striking off order is required, in respect of both public protection and the wider public interest.

She further submitted that such an order is necessary to protect the public and to maintain confidence in the profession, covering any appeal period and any subsequent appeal proceedings. Ms Welsh submitted that to impose an interim suspension order would be consistent with the panel's substantive decision. She also reminded the panel that, in the event no appeal is lodged, the interim suspension order would be replaced by the substantive order 28 days after notification of the decision has been sent to you.

Ms Khanna did not oppose the application.

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

Decision and reasons on interim order

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

The panel was of the view that it was necessary to protect the public and maintain public confidence, given the seriousness of the findings which led to your strike off from the register. It determined that it would be inappropriate to allow you to practise during the 28 day appeal window given the risks identified. The panel noted that if you do not appeal, the interim order will fall away once the substantive striking off order takes effect after 28 days. If you do appeal, the interim order will remain in place to ensure ongoing public protection.

The panel therefore imposed an interim suspension order for a period of 18 months as this was a realistic time to allow for any possible appeal to be concluded.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after you have received the decision of this hearing.

That concludes this determination.