Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 29 June 2026 – Friday 3 July 2026,
Monday 6 July 2026 – Friday 10 July 2026 and
Monday 13 July 2026 – Wednesday 15 July 2026

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

Name of Registrant:	**John Omoroje**
NMC PIN:	22B0651E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (Level 1) 4 April 2022
Relevant Location:	Nottingham
Type of case:	Misconduct
Panel members:	James Carr (Chair, lay member) Karen Gardiner (Registrant member) Sophia Clarke (Lay member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Yousrra Hassan
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter Naa-Adjeley Barnor (Tuesday 7 July 2026)
Mr Omoroje:	Present and represented by Alban Brahimi, instructed by the Royal College of Nursing (RCN)
Facts proved:	1(a), 1(b), 1(c),1(d), 1(e), 2, 3, 5, 7(a), 7(b).
Facts not proved:	4, 6.
Fitness to practise:	**Impaired**
Sanction:	**Caution Order (36 months)**

Interim order: **No order**

Details of charge

That you a registered nurse:

Whilst working for [PRIVATE]

1. On 21 October 2022 recorded that you had observed patient A at the following times when you had not:

a. 14.25
b. 14.35
c. 14.50
d. 14.59
e. 15.25

2. Your actions at any or all of charges 1, a - e above, were dishonest in that you sought to create the impression that you had observed patient A when you knew you had not.

3. On 21 October 2022 did not observe patient B between 14.50 and 16.20 which was required.

4. On the 30 December 2022 administered incorrect medication to Patient C.

5. On the 31 December 2022 left a box of diazepam unattended.

Whilst working at [PRIVATE]

6. On 21 May 2024 prepared the wrong dosage of risperidone for patient D.

7. On one or more of the following dates administered an incorrect dose of risperidone to Patient D:

a. 3 June 2024
b. 4 June 2024

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

Background

The charges relate to events that are said to have occurred in 2022 within the Ward within the hospital. The hospital is a low secure rehabilitation and mental health facility. The Ward has a maximum capacity for 15 makes patients who have been deemed to be a risk to others, some of the patients will be transferred from prison and some will have addiction issues.

Charges 6 and 7 relate to alleged events in 2024 within the Home in [PRIVATE].

The Home is a complex care service for service users with learning difficulties and autism; at which service users are known to have a history of violence and aggression.
You qualified as a mental health nurse in April 2022 and were admitted to the NMC register the same month. You commenced work at the hospital in advance of this as a preceptee. The team there supported you through a preceptorship programme which you passed. When you became registered with the NMC you were able to take up duties as a Band 5 nurse. Your duties included being accountable for all patient safety on the ward, fulfilling the role of nurse in charge including managing and organising shifts.

Application to exclude any reference by Mr Whitfield to the hospital CCTV footage

The panel heard an application made by Mr Brahimi on your behalf under Rule 31 to exclude evidence referring to CCTV footage concerning the incidents of 30 and 31 December 2022. He submitted that the original CCTV footage was no longer available to yourself or before the panel. Instead, the NMC sought to rely upon the account of Daniel

Whitfield, who had viewed the footage and subsequently described what he said it showed.

Mr Brahimi submitted that Mr Whitfield's account of the contents of the CCTV constituted hearsay evidence. He drew a distinction between a witness stating that he had watched CCTV footage, which was evidence of an act personally undertaken by the witness, and a witness purporting to give evidence of what the CCTV depicted. He submitted, that this amounted to an indirect account relied upon to prove disputed facts. Mr Whitfield had not personally witnessed the incidents of 30 or 31 December 2022 and his evidence was therefore no more than a recollection and repetition of material that could no longer be independently viewed or tested.

Mr Brahimi further submitted that exhibit DW15 presented an additional hearsay difficulty. The document comprised minutes attributed to Nicole Reynolds, from whom there was no witness statement concerning the meeting or the preparation of the minutes. It was unclear whose description of the CCTV had ultimately been recorded or adopted in the document. Mr Brahimi submitted that the exhibit was arguably double hearsay, as the panel was being asked to rely upon a notetaker's record of what one or more individuals had said about footage they had watched.

Mr Brahimi referred to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *El Karout v NMC* [2019] EWHC 28 (Admin). He submitted that particular caution was required where hearsay evidence was the sole or decisive evidence in support of a serious allegation and was neither demonstrably reliable nor capable of effective testing. He submitted that the NMC had not made a specific hearsay application, had not adequately investigated what had happened to the CCTV and had not established whether the footage had in fact been destroyed or was merely inaccessible. The statement that the hospital, *"no longer have a copy"* of the footage was, he submitted, ambiguous and left unresolved important questions concerning its disappearance and the efforts made to recover it.

Mr Brahimi also drew attention to the apparent inconsistency that CCTV footage relating to an earlier incident on 21 October 2022 remained available, whereas the later footage from 30 and 31 December 2022 could not be produced. Mr Brahimi submitted, it was not for you to fill evidential gaps or prove your innocence by attempting to reconstruct from memory footage that you may previously have seen.

Mr Brahimi submitted that, even if the panel did not categorise the references to the CCTV as hearsay, the evidence should nevertheless be excluded under Rule 31 on grounds of relevance and fairness. He submitted that Mr Whitfield's unverified recollection of the footage should not automatically be treated as reliable or relevant evidence merely because it concerned the subject matter of the charges.

Mr Brahimi submitted that the admission of such evidence would place you at a significant and unfair disadvantage. Although Mr Whitfield could attend and be cross-examined, Mr Brahimi submitted that his evidence could not be meaningfully tested as to the contents of the CCTV because the footage itself was unavailable.

Mr Brahimi submitted that this was precisely the type of case in which the panel should exercise its discretion to prevent the admission of evidence where its use would cause substantial prejudice and procedural unfairness to you. Mr Brahimi further submitted, that the resulting prejudice was particularly acute because Charges 4 and 5 rested upon the CCTV evidence.

Finally, Mr Brahimi relied upon your right to a fair hearing under Article 6 of the Human Rights Act 1998. He submitted that a fair hearing required a genuine opportunity to access and challenge the material relied upon and to defend the allegations effectively. The absence of the CCTV, coupled with the NMC's proposed reliance upon an unverified secondary account of its contents, made it extremely difficult, for you to adequately defend Charges 4 and 5. Mr Brahimi therefore invited the panel to exclude all evidence and references concerning the CCTV footage of 30 and 31 December 2022.

Mr Radley on behalf of the Nursing and Midwifery Council (NMC) opposed the application.

Mr Radley submitted that the application fell to be considered principally under Rule 31 and, in particular, the requirements of relevance and fairness governing the admission of evidence. The panel was required to consider the evidence in the round before reaching its decision and to have regard to the manner and purpose for which the references to the CCTV were relied upon. He submitted that, when the evidence was considered as a whole and in its proper context, the panel could properly conclude that its admission was fair in the circumstances.

Mr Radley submitted that the requirements of relevance and fairness under Rule 31 applied to the proceedings as a whole and affected both the NMC and you. He reminded the panel that the NMC had a statutory duty to investigate the matters before it. In response to the suggestion that insufficient steps had been taken to obtain the CCTV footage, Mr Radley referred to the correspondence of 11 June 2026. He stated that the NMC caseworker had responded to Kate Prior, the RCN lawyer, and explained that the hospital had previously been approached on 15 October 2024 for the footage, but the NMC had been informed that the hospital no longer had access to it. Mr Radley submitted that the NMC had therefore taken steps during its investigation to obtain further CCTV evidence. He observed that evidence may emerge at different stages, in different formats and from different sources. The NMC could not be held responsible for the fact that some CCTV footage had been obtained whereas other footage was no longer available.

Turning to the relevance of the CCTV references to Charges 4 and 5, Mr Radley submitted that the panel should consider your own statement contained within the hearing bundles. In relation to Charge 5, he referred the panel to paragraph 20 of your statement and submitted that you had made an unprompted statement concerning medication having been taken at the relevant time. Against that evidential background, Mr Radley submitted that the references to the CCTV gave rise to little concern in respect of their admission insofar as Charge 5 was concerned.

In respect of Charge 4, Mr Radley referred the panel to paragraph 18 of your statement. He submitted that the material issue was whether Lorazepam had or had not been administered on the relevant occasion. The significance of the CCTV evidence was that Mr Whitfield's viewing of the footage was said to have revealed that medication had been administered in the circumstances under consideration. Mr Radley submitted that the evidence was therefore relevant.

Mr Radley further submitted that the fact that the CCTV footage itself was no longer available did not render evidence concerning its contents automatically inadmissible. A witness who had watched an event depicted on CCTV could be cross-examined about what he had observed and the reliability of his recollection. The assessment of that evidence, including its reliability and the appropriate weight to be attached to it, was ultimately a matter for the panel.

Mr Radley submitted that the existence and significance of the CCTV had been known to you throughout the history of the allegations and that there had been discussions and attempts by the RCN to obtain the footage. He further submitted that you had viewed the footage before the disciplinary hearing. In those circumstances, the panel should consider whether the application realistically demonstrated such unfairness as to justify excluding the evidence altogether.

Mr Radley therefore invited the panel to reject the submission that the CCTV references should be excluded as hearsay. The NMC's position was that the evidence should be placed before the panel as it presently stood. The panel could hear and assess that evidence, consider any challenges made to it through cross-examination and submissions, and thereafter determine the appropriate weight to attach to it. Accordingly, Mr Radley invited the panel to reject the application and admit the evidence referring to the CCTV footage.

The panel accepted the advice of the legal assessor.

Decision and reasons on application to exclude the CCTV footage evidence

The panel considered whether it would be fair to admit Mr Whitfield's account of what he had seen on CCTV.

The panel noted that Mr Whitfield's witness statement was dated 25 November 2024, almost two years after the events in question. It further noted Mr Whitfield's evidence that, upon his return to work in January 2023, he had accessed and viewed the relevant CCTV footage. However, in his subsequent witness statement, Mr Whitfield stated: *"Unfortunately,* [PRIVATE] *no longer have a copy of this CCTV."*

The panel considered that, by the time Mr Whitfield prepared his witness statement in November 2024, the CCTV footage was no longer available to him. Accordingly, he had been unable to review the footage immediately prior to making his statement or otherwise to use it to refresh his memory as to what it depicted. The panel considered this to be a relevant factor when assessing the fairness of admitting his account of the contents of the CCTV footage. Although the panel was provided information as to the unavailability of the CCTV, it was not provided any cogent reason or explanation as to why it why the CCTV was not available other than the hospital no longer had access to it.

The panel also noted that the NMC confirmed via email on 11 June 2026 that the hospital confirmed that they no longer had access to the CCTV.

The panel considered, DMA 6. The panel had been referred by the legal assessor to the case of *R (Bonhoeffer) v GMC* [2011] EWHC 1585 (Admin), which states that particular weight should be given to the seriousness and nature of the allegations and the gravity of the adverse consequences to the accused party in the event of the allegations being found to be true. The more serious the allegation or charge, the more astute the panel should be to ensure that the process is a fair one.

The panel considered Charge 5, in particular, to be a serious allegation. In considering the references to the CCTV footage contained within Mr Whitfield's statement, the panel noted that his statement had been made approximately two years after he had viewed the footage. The panel considered that Mr Whitfield's account represented his recollection and interpretation of what he had observed on the CCTV and, in the absence of the original footage, amounted to secondary evidence of its contents.

The panel concluded that it would be unfair to admit Mr Whitfield's account of the CCTV footage. His evidence represented his own recollection and interpretation of what he had viewed on the footage, as recorded in a witness statement approximately two years later, rather than the direct and objective evidence that the CCTV footage itself would have provided. In the absence of the original footage, Mr Whitfield's account of its contents could not be meaningfully tested or challenged against the primary evidence. The panel considered that your inability to scrutinise and effectively challenge this evidence gave rise to significant unfairness. Accordingly, the relevant parts of Mr Whitfield's witness statement concerning his interpretation of the CCTV footage will not be admitted into evidence. Further, no questions relating to his recollection or interpretation of the contents of the CCTV footage may be put to him during the course of his oral evidence.
The panel further considered the investigation interview exhibited at DW15 and the investigation report exhibited at DW14.

The panel concluded that the contents of these documents were relevant and of significance to its consideration of Charges 4 and 5.

The panel also noted that these documents were produced in January 2023, within approximately one month of the allegations. The investigation report exhibited at DW14 is dated 16 January 2023, while the investigation hearing meeting recorded at DW15 took place on Wednesday 25 January 2023, between 14:30 and 16:45.

The panel noted that Mr Whitfield was recorded as being present at the investigation hearing meeting as the manager who had conducted the investigation referred to in

DW14. The panel further noted that you were also recorded as being present at that meeting.

The panel considered the hospital's disciplinary policy and, in particular, paragraph 5.1, which states that:

> *"...a manager...will promptly investigate any matter that is reasonably suspected to contravene the employer's policies...or may otherwise be a disciplinary matter."*

The panel also considered paragraph 5.12 of that policy. It noted the requirement for an *"appropriate person to record the meeting"* and the provision that the manager conducting the investigation would *"not form part of the panel but may present supporting facts and material to the hearing."*

In this context, the panel noted that Nicola Reynolds, in her capacity as Office Manager, was recorded as being present at the meeting for the purpose of taking and recording the minutes.

The panel acknowledged that you were not represented during the investigation interview. However, it noted that the contemporaneous record indicated that you had been afforded the opportunity to be represented.

The panel concluded that DW15, the minutes from the disciplinary hearing on 25 January 2023, was an official record of a formally constituted disciplinary hearing in accordance with the hospital's disciplinary policy, which Mr Whitfield has exhibited in his statement at DW15.

The panel noted a number of references within DW15 recording that you had been shown the CCTV footage. These included references to you being shown CCTV footage relating to the incident of 30 December 2022 on two occasions. The panel also noted references to you being shown CCTV footage concerning the incident of 31 December 2022,

including records indicating that footage relating to that date was shown to you on three separate occasions. The evidence contained within DW15 relating to CCTV is not an interpretation of what Mr Whitfield had seen but answers to questions put to you after you viewed the CCTV during the meeting.

The panel concluded that there was a material distinction between this evidence and the references to the CCTV footage contained within Mr Whitfield's witness statement. In respect of DW15, the panel considered that the evidence was capable of being meaningfully explored and challenged during cross-examination and through questions from the panel.

The panel further considered the investigation report exhibited at DW14, which contained information gathered by Mr Whitfield during the course of the local investigation and which was subsequently put to you during the investigation meeting recorded at DW15. The panel concluded that the contents of DW14 were similarly capable of being tested and challenged during cross-examination and through questions from the panel.

The panel recognised that DW14 and DW15 contain references to CCTV viewed solely by Mr Whitfield and when you were not present. Although these documents are recorded closer to the date of the incident, these references remain his interpretation and as such are inadmissible in evidence.

Accordingly, the panel determined that it was fair to admit the greater part of Exhibits DW14 and DW15 into evidence. The panel decided to exclude any element within DW14 or DW15 where it relates solely to Mr Whitfield’s interpretation of the CCTV.

Application to exclude part of the evidence of Kyle Kemp

Mr Brahimi submitted that the panel should not admit the evidence of Kyle Kemp insofar as it related to the alleged incident of 21 May 2024 and Charge 6. He submitted that the relevant evidence was hearsay or secondary evidence and that its admission would be

unfair under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. Although he accepted that the evidence was relevant, he submitted that the central issue for the panel was whether it could fairly be admitted.

Mr Brahimi submitted that in Mr Kemp's witness statement it did not derive from matters personally witnessed by Mr Kemp. Rather, Mr Kemp's account originated from information provided by an individual referred to as *"Jonathan*" (Jonathan Wilson, according to the preceding paragraph in Mr Kemp's statement). He submitted that Mr Kemp was therefore repeating another person's account and relying upon it as evidence of the truth of the alleged medication error. In those circumstances, Mr Brahimi submitted that the evidence was plainly hearsay and was not capable of being effectively tested through the cross-examination of Mr Kemp.

Mr Brahimi further submitted that the NMC had not addressed the difficulties arising from its reliance upon this hearsay evidence. In particular, no hearsay application had been made, there was no evidence that *"Jonathan"* had been spoken to as part of the investigation, and there was no explanation as to why he had not been approached or called as a witness. Mr Brahimi submitted that, as Mr Kemp was not the original source of the allegation, the most he could do in oral evidence was repeat what he had been told by another individual.

In relation to exhibit KK2 which is Mr Kemp's statement, Mr Brahimi submitted that this did not provide a separate or independent evidential source capable of supporting Charge 6. He submitted that the questions asked during the interview themselves appeared to derive from the information attributed to "Jonathan". The repetition of the same allegation within an interview record did not, he submitted, transform one hearsay source into two independent sources of evidence.

Mr Brahimi drew the panel's attention to the reference in KK2 to you having:

"…made medication error when being shadowed and was stopped, and then did it twice after".

He submitted that this wording was unclear and did not accord with the account contained at paragraphs 8 and 9 of Mr Kemp's witness statement. The reference did not identify a date and did not expressly link the alleged medication error to 21 May 2024. He submitted that this undermined the suggestion that KK2 provided support for the specific allegation underlying Charge 6.

Mr Brahimi also challenged Mr Kemp's assertion in his witness statement that, when the matter concerning 21 May 2024 was raised, you had responded, "*I accept this"*. He submitted that a careful examination of the interview record disclosed no corresponding admission by you in respect of an incident on 21 May 2024. In his submission, Mr Kemp's later account was therefore not supported by the contemporaneous interview record.

Mr Brahimi further submitted that the substance of KK2 concerned incidents on 3 and 4 June 2024 involving the same medication and dosage of 500 micrograms. He submitted that the NMC sought to rely upon this document as supporting Charge 6 despite there being no clear reference within it to 21 May 2024. The evidence relating to the June incidents could not, without more, establish that the separate alleged medication error on 21 May 2024 had occurred.

Referring to the NMC's hearsay guidance and the authorities of *Thorneycroft v Nursing and Midwifery Council*, *El Karout v NMC* and *Ogbonna*, Mr Brahimi submitted that the panel was required to undertake a careful balancing exercise, with fairness being the central consideration. He emphasised the particular concern arising where hearsay evidence was sole or decisive in respect of a serious and disputed allegation and was neither demonstrably reliable nor capable of being properly tested.

Mr Brahimi submitted that you had no meaningful means of challenging the allegation concerning 21 May 2024. Mr Kemp had no direct knowledge of the alleged incident and

could only repeat the account attributed to "*Jonathan*". You could not cross-examine the original source of the allegation, and the ambiguous reference in KK2 did not provide a clear or independent account of an incident occurring on the date alleged.

Accordingly, Mr Brahimi submitted that it would be unfair to admit the evidence relating to the alleged incident of 21 May 2024. He invited the panel to exclude paragraphs 8 and 9 of Mr Kemp's witness statement, together with the ambiguous reference within KK2 insofar as the NMC sought to rely upon it as evidence in support of Charge 6.

Mr Radley opposed the application and submitted that the evidence of Mr Kemp to be admitted. He submitted, that the evidence should be admitted and placed before the panel for its consideration rather than excluded on the basis that it was hearsay.

Mr Radley submitted that the alleged incident had formed part of an investigation and had been discussed during your probation review. You had been present and aware that the incident was being raised and discussed on that occasion. He submitted that this was relevant to the question of fairness, as the allegation was not a matter of which you had been unaware or had been given no opportunity to address.

Mr Radley referred the panel to the principles in *Thorneycroft* and submitted that, if the panel determined that the evidence was hearsay, it could nevertheless be fairly admitted. He submitted that it was fair for the relevant information to be placed before the panel and that you would have the opportunity to provide your own account and explanation in relation to the alleged incident. Accordingly, Mr Radley invited the panel to admit Mr Kemp's evidence for the panel to consider and assess in the context of the evidence as a whole.

In response to a question from the panel as to whether Jonathan Wilson, the apparent source of the information, had been asked to provide a witness statement for the purposes of the NMC proceedings, Mr Radley was unable to confirm whether he had been

approached. He was also unable to provide an explanation as to why Mr Wilson had not been required to provide evidence in relation to this matter.

The panel accepted the advice from the legal assessor.

Decision and reasons on application to exclude part of the evidence of Kyle Kemp

The panel considered the application under Rule 31 and determined that the evidence identified within the application should not be admitted. The panel concluded that the relevant parts of Mr Kemp's evidence amounted to hearsay and therefore went on to consider the NMC's application to admit that evidence, having regard to the principles set out in Thorneycroft and the relevant factors concerning the fairness of admitting hearsay evidence.

The panel considered that the hearsay evidence was sole and decisive in respect of Charge 6. It concluded that the evidence was not demonstrably reliable and could not be meaningfully challenged through cross-examination. Mr Kemp was not the original source of the allegation, and the panel had not been provided with a witness statement or any other direct evidence from Mr Wilson, from whom the information was said to have originated from. Nor had the panel been provided with good and cogent evidence explaining Mr Wilson’s absence or why he had not been called to give evidence.

The panel considered whether steps could be taken to secure evidence from Mr Wilson. However, it noted that the hearing had reached its fourth day and that these matters date back to 2022. The panel considered whether it would be appropriate for it to direct the NMC to seek a statement from Mr Wilson. In the panel’s judgment it would be likely that Mr Wilson, if approached now, four years after the events, would not have a clear recollection. Moreover, if the process of finding Mr Wilson and obtaining a statement from him could not be executed expeditiously this would be likely to result in this 13-day hearing being derailed and adjourned for a considerable period. This would present difficulties to you and the panel. If available, this evidence relates only to Charge 6, which is not as

serious as other charges which the panel will be considering. The panel informed the parties that the panel's decision would not debar the NMC from making further enquiries, and if appropriate, applying to the panel to admit further relevant evidence.

Accordingly, having considered Rule 31 and the relevant *Thorneycroft* factors, the panel determined that it would not be fair to admit the hearsay evidence relating to Charge 6.

Application of no case to answer in relation to Charge 6

The panel considered an application from Mr Brahimi that there is no case to answer in respect of charge 6. This application was made under Rule 24(7).

In relation to this application, Mr Brahimi submitted that there was insufficient evidence upon which the panel could properly find the facts underlying Charge 6 proved. He invited the panel to consider whether, on the evidence remaining before it, that you had a case to answer in respect of that charge.

Mr Brahimi referred the panel to the principle in *R v Galbraith* [1981] 1WLR 1039, he submitted that where there is no evidence that the alleged offence or conduct has been committed by the defendant, the position is straightforward and the case should be stopped. He submitted that the first limb of the Galbraith test was engaged at present.

Mr Brahimi relied upon the panel's earlier ruling excluding paragraphs 8 and 9 of Mr Kemp's witness statement and the relevant parts of exhibit KK2 concerning the alleged incident of 21 May 2024. He submitted that, following the exclusion of that evidence, there was no remaining evidence capable of supporting Charge 6 and no further evidence which the NMC could place before the panel in support of the allegation.

In these circumstances, Mr Brahimi submitted that this charge should not be allowed to remain before the panel.

Mr Radley did not oppose this application. He informed the panel he had indeed spoken to Mr Kemp and explored other areas including the possibility of receiving information from Mr Wilson. In light of the fact it was clear this was not possible the NMC has no opposition to this application as it can provide no further evidence.

The panel took account of the submissions and accepted the advice of the legal assessor.

In reaching its decision, the panel has 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 find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 6 proved. The panel concluded that, following its earlier ruling on the admissibility of the relevant evidence, there was no evidence remaining upon which Charge 6 could properly be found proved. Accordingly, the panel determined that the first limb of the *Galbraith* test was engaged. The panel further noted that the application was not opposed by the NMC. In those circumstances, the panel accepted the application and determined that there was no case to answer in respect of Charge 6.

Application to exclude any reference by Marie Howlett to the hospital CCTV footage specifically relating to Patient B and No Case to Answer submission in relation to Charge 3

Mr Brahimi submitted that any evidence referring to CCTV footage concerning Patient B should not be admitted. He submitted that the application fell under Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004.

Mr Brahimi submitted that Marie Howlett's evidence concerning the CCTV amounted to hearsay or secondary evidence. Ms Howlett had not personally witnessed the events of 21

October 2022 but had viewed CCTV footage and subsequently provided her account of what she believed the footage depicted, including that observations of Patient B had been missed. Mr Brahimi submitted that this was materially indistinguishable from the evidence of Mr Whitfield which the Panel had previously considered: in each instance, the witness sought to describe and interpret CCTV footage which was no longer available to the panel or yourself.

Mr Brahimi further submitted that the same difficulty arose in respect of exhibit MH6 which is the investigation report. He submitted that the report could only have been produced following Ms Howlett's review of the CCTV and contained her description of what she had observed on the footage. It did not constitute a separate or independent evidential source. Rather, it repeated Ms Howlett's interpretation of the CCTV and was therefore subject to the same hearsay and fairness concerns as her witness statement.

Mr Brahimi referred to the NMC hearsay guidance and *Thorneycroft, El Karoute and NMC,* [2019] EWHC 28 (Admin) and *Ogbonna*, Mr Brahimi submitted that fairness was the central consideration, particularly where the evidence was sole or decisive in relation to a serious allegation and was neither demonstrably reliable nor capable of being properly tested. He submitted that the NMC had made no application to admit the evidence as hearsay, had failed to retain or secure the CCTV despite its significance to the case, and had now confirmed that the footage could not be recovered.

Mr Brahimi submitted that you had been placed at a substantial disadvantage. Ms Howlett had been able to view the CCTV and formulate her account of what it showed, whereas you had never been provided with the footage. Without the primary evidence, neither you or the panel could compare Ms Howlett's account against the CCTV to determine whether her interpretation was accurate, incomplete or mistaken.

Mr Brahimi further submitted that Ms Howlett's evidence was sole and decisive in relation to the allegation concerning Patient B. No other witness independently confirmed that the relevant observations had not been undertaken. To the extent that Rhiannon Fitzpatrick

referred to the matter, Mr Brahimi submitted that she merely repeated information contained in Observation record for Patient B and did not provide an independent evidential account. The remaining witnesses did not provide relevant evidence concerning Patient B or the events of 21 October 2022.

Mr Brahimi submitted that admitting Ms Howlett's description of the CCTV would cause significant prejudice to you and undermine your ability to defend the allegation effectively. Accordingly, Mr Brahimi invited the panel to exclude any reference to the Patient B CCTV contained within Ms Howlett's evidence or any other witness statement and to exclude the investigation report, either in its entirety or insofar as it referred to the CCTV footage concerning Patient B.

Mr Brahimi made further submission of no case to answer in respect of Charge 3 pursuant to Rule 24. Referring to the principles established in *Galbraith*, he submitted that a no case to answer application should succeed where there was no evidence capable of proving the alleged conduct or where the remaining evidence was so tenuous, inherently weak or vague that a properly directed panel could not safely find the allegation proved. Mr Brahimi submitted that, if the panel excluded Ms Howlett's references to the CCTV and the related evidence in the investigation report, the only potentially relevant material remaining was the observation record for Patient B. He submitted that Ms Fitzpatrick's evidence did not provide further or independent support for the allegation because she merely referred to and repeated the contents of the Observation record of Patient B. Similarly, the investigation report could not constitute separate supporting evidence because it was itself based upon Ms Howlett's review and interpretation of the unavailable CCTV.

Mr Brahimi submitted that the essential elements of Charge 3 could only be objectively verified by reference to the CCTV footage. In particular, the allegation that you did not observe Patient B and that this occurred between 14:50 and 16:20 depended upon establishing what had, or had not, occurred during that specific period. He submitted that,

without the CCTV, the panel could not safely determine those matters and would be left to speculate as to whether you had observed Patient B.

Accordingly, Mr Brahimi invited the panel to conclude that, following the exclusion of the CCTV-related evidence, there was no sufficient evidential basis upon which Charge 3 could properly be found proved. He submitted that the *Galbraith* test was met and invited the panel to determine that there was no case to answer in respect of Charge 3.

Mr Radley opposed the application.

Mr Radley submitted that there remained sufficient evidence before the panel in respect of Charge 3 and that the application should not succeed. He referred the panel to your statement:

> "*I again refer to exhibit "JO1" attached to this statement. However, between 14:25 to 15:00 I was on call I could see via the glass panel in the office Patient B in the communal lounge walking around within the lounge and waking towards the corridor leading to his bedroom. Patient B was on a 30 minutes eyesight observation level, meaning, no matter where you are, as long as you can see him, patient B is regarded as being observed."*

Mr Radley submitted that your own position was that you were not required to carry out observations of Patient B and, as a consequence, did not do so, although you maintained that you had not seen Patient B in any event.

Mr Radley accepted that the evidence from Ms Howlett concerning what she observed on the CCTV may give rise to issues similar to those already considered by the panel in relation to earlier CCTV evidence. He submitted, however, that the panel should carefully consider each category of evidence before reaching a conclusion. He drew a distinction between Ms Howlett's description of what was or was not seen on CCTV and the wider evidential picture. He submitted that the case did not turn solely on whether you were

visible on the CCTV. Rather, your position was that you were not responsible for carrying out observations in that area at the relevant time and were therefore under no duty to undertake them.

Mr Radley submitted that, even if the panel were to exclude references to Ms Howlett's observations from the CCTV concerning Patient B, there remained surrounding evidence which you could challenge and which the panel could properly consider. He relied in particular upon the planner produced by Ms Howlett, which he submitted underpinned the requirement for observations to be carried out. He acknowledged that the authenticity and weight of that document may be matters for the panel, particularly given Ms Howlett's evidence that she obtained it from hospital management.

Mr Radley submitted that other witnesses also provided admissible evidence relevant to Charge 3. In particular, he referred to the evidence of Lauren Redfern in her statement, where she raised concerns regarding observations for Patient B. He submitted that the weight to be attached to that evidence would be a matter for the panel, but it was capable of being considered.

Mr Radley also referred to the evidence of Ms Fitzpatrick, in her statement. He submitted that she gave evidence raising concerns as to how and why observations had been missed and whether those observations were your responsibility. Mr Radley submitted that this evidence was admissible and could properly be placed before the panel when considering whether there was a case to answer.

In relation to timing, Mr Radley noted that some of the evidence referred to 16:00, whereas Charge 3 alleged a period ending at 16:20. He submitted that, if the panel concluded there was a case to answer, any issue as to the timing of the charge could be

reflected upon or addressed during the course of the proceedings and any relevant applications.

In conclusion, Mr Radley submitted that, even if the panel had concerns about Ms Howlett's evidence describing observations from CCTV, there was still sufficient admissible evidence before the panel at the facts stage. He therefore invited the Panel to reject the no case to answer application and to conclude that there was a case to answer in respect of Charge 3.

The panel accepted the advice of the legal assessor.

Decision and reasons on application to exclude any reference by Marie Howlett to the hospital CCTV footage specifically relating to Patient B and No Case to Answer submission in relation to Charge 3

The panel first considered the admissibility of the evidence relating to the CCTV footage concerning Patient B. It determined that Ms Howlett's description of what she had observed on the CCTV amounted to secondary evidence rather than primary evidence, the primary evidence being the CCTV footage itself. The panel therefore considered the relevance and fairness of admitting any descriptive reference to the CCTV footage in accordance with Rule 31.

The panel considered Ms Howlett's evidence to be relevant to Charge 3. The panel concluded that on inspection of available evidence there was a plethora of other documents and witness testimony upon which the panel could consider at the appropriate stage of this hearing.

The panel considered that those parts of her statement referring to hospital CCTV in relation to Patient B represented her interpretation of what she had observed on the CCTV and were therefore secondary evidence. The original CCTV footage was not available to the panel, and no good or cogent reason had been provided to explain why it had not

been produced. The panel had no evidence before it that you had seen the CCTV during the local investigation process. The panel noted that in Ms Howlett's evidence she was under the impression that the CCTV footage had been made available to the NMC.

Accordingly, the panel determined that the descriptive references to the CCTV footage contained in Ms Howlett's witness statement would not be admitted into evidence. Any oral evidence from Ms Howlett concerning her interpretation or description of what she observed on the CCTV footage would not be admitted and would not form part of the panel's future consideration of the facts. The panel also determined that any descriptive references to CCTV footage contained within the investigation report or the minutes of the disciplinary hearing on 25 January 2023 would not be admitted. The panel noted that there was no other evidence before it is providing a descriptive account of what the relevant CCTV footage concerning Patient B showed.

Turning to the application of no case to answer in respect of Charge 3, the panel considered the remaining evidence after excluding the descriptive CCTV evidence at paragraph 16 of Ms Howlett's statement. The panel concluded that Ms Howlett's descriptive account of the CCTV was neither the sole nor decisive evidence in support of Charge 3.

The panel considered the principles in *Galbraith* and asked itself whether there was evidence upon which it could properly find the facts alleged in Charge 3 proved. It did not accept that there was no evidence in support of the charge. The panel therefore concluded that the first limb of the *Galbraith* test was not engaged.

The panel went on to consider the second limb of the *Galbraith* test and whether the remaining evidence, taken at its highest, was so tenuous, inherently weak, vague or contradictory that a properly directed tribunal could not find the charge proved. The panel concluded that there remained evidence available to it upon which the facts alleged were capable of being found proved. The strength, reliability and weight of that evidence were

matters for the panel to determine when considering the evidence as a whole at the facts stage.

The panel therefore concluded that the excluded CCTV evidence was not sole or decisive and that sufficient evidence remained upon which it was possible that Charge 3 could be found proved. Accordingly, the panel rejected the application of no case to answer and determined that there was a case to answer in respect of Charge 3.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Brahimi, who informed the panel that you made full admissions to charges 1(a), 1(b), 1(c), 7(a) and 7(b).

The panel therefore finds charges 1(a), 1(b), 1(c), 7(a) and 7(b) proved, by way of your admissions.

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:

- Catherine Nessfield: Senior staff nurse at the hospital.
- Finbarr Proudfoot: Senior staff nurse at the hospital.
- Daniel Whitfield Ward Manager at the hospital.
- Rhia Fitzpatrick Staff bank at the hospital.

- Marie Howlett — Clinical Manager (Band 8) at the hospital.
- Lauren Redfern — Clinical ward administrator at the hospital.

The panel also heard evidence from you under oath.

After you had given evidence-in-chief, Mr Brahimi sought permission to make an application for no case to answer in relation to charge 4.

The legal assessor advised that it was not open to Mr Brahimi to make such a submission, as the only time it was permissible to do so was at the conclusion of the NMC's case, and before the opening of your case. This followed from Rule 24(7). The panel accepted this advice.

During Mr Brahimi's closing argument, he contended that the panel should not find charges 1(a) - 1(c) proved, even though you had admitted those charges at the outset of the hearing. The legal assessor pointed out that the panel had already found those charges proved following your admissions and that the case had proceeded up to that point on the basis of those charges being found proved, and those charges had not been explored in the evidence. He advised that the panel should not go beyond those findings, but that it was open to Mr Brahimi to argue at the next stage of the proceedings that the admitted charges did not amount to misconduct.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Brahimi, including your evidence, and the submissions made by Mr Radley and Mr Brahimi.

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

Charge 1(d) 1(e)

"That you a registered nurse:

Whilst working for [PRIVATE] hospital

1. On 21 October 2022 recorded that you had observed patient A at the following times when you had not:
d. 14.59
e. 15.25"

These charges are found proved.

In reaching this decision, the panel considered the High level Intermittent Safe and Supportive Observation Record (observation record) for Patient A and the statements of Marie Howlett, Lauren Redfern and Rhiannon Fitzpatrick, inclusive of local investigation statements. It also took into account your oral evidence, your local investigation statement dated 25 October 2022, and a written statement dated 29 June 2026 that you provided in this hearing.

The panel noted as background that Marie Howlett in her written statement recorded that Patient A had a delusional belief that he could not get out of bed:

"Patient A had been placed on these observations because he had a delusional belief that he was unable to leave his bed. Consequently, he required physical health monitoring, repositioning and encouragement to complete his physiotherapy exercises. He was also using a commode, so it was important for us to regularly check for any skin integrity issues. Additionally, we had grown concerned that Patient A was a risk of financial exploitation from his peers which was compounded by his inability to leave his room. We had recently noticed that service users had been

frequently entering his room. Patient A had also expressed thoughts of wanting to end his life in the past and had a diagnoses of paranoid schizophrenia."

The panel also viewed CCTV exhibited by Ms Howlett and noted that you were seen to check Patient A at 14.20 and 14.50.

The panel noted that you signed the records and confirmed that you had completed the entries for 14:59, 15:10, 15:25, 15:35, 15:50 and 15:59, some of which are admitted at charges 1(a) – 1(c). In your oral evidence, you accepted that you had made these entries despite not undertaking the observations following Ms Redfern raising concerns about gaps in the observation record.

The panel considered your oral evidence that, following Ms Redfern's comments, you went to observe Patient A. However, rather than leaving the earlier entries blank, you stated that you completed the observation record by relying upon what you had observed of Patient A previously and your experience of Patient A since their admission in the hospital. The panel determined that this did not amount to you having personally observed Patient A at the specific times recorded at 14:59 and 15:25.

The panel was satisfied that, by signing the observation records for 14:59 and 15:25, you represented that you had observed Patient A and confirmed signs of life at those times. In your own evidence you established that you had not been present and had not undertaken observations of Patient A at those times. The panel considered that the entries were therefore inaccurate and had the potential to mislead colleagues reviewing the observation records into believing that the required observations had been completed contemporaneously.

The panel considered your evidence in relation to the times at 14:59 and 15:25 that even though you accept that you made the entries, it was not your responsibility to carry out those checks on the shift as you were not allocated to observations between 15:00 and

16:00. You produced an allocation tool which showed that you were responsible for two-to-one observations and not general observations.

The panel noted the contrary allocation tool produced by Ms Howlett which showed that you were responsible for general observations at 14:59 and 15:25.

The panel heard evidence from all witnesses that the allocation tool was a live working document that may have many iterations throughout a shift in order to accurately reflect staff responsibilities in a dynamic environment. The panel noted that all staff working in the ward had both access and editing rights to the allocation tool. The panel concluded that it is likely that both documents relate to the day in question. The panel decided that without clarity of the order of those documents it would place little weight on either.

The panel did consider your statement to Ms Howlett dated 25 October 2022 for the local investigation which was four days after the event. In answering questions from the panel, you confirmed that this was your local statement and that it was your signature on the document. You were asked by the panel whether there was anything in the statement with which you disagreed. You said no.

With regard to the member of staff assisting the general manager, the panel noted that in your statement dated 25 October 2022, you stated:

> *"I did not plan for that member of staff to be off ward as of the time of my time planner which resulted on me being left alone on the ward by myself except for those staff on 2:1 observations".*

You also stated in this statement:

> *"… she was initially signed to do observations between 15:00 and 16:00. I took over the observations because Mark Varney needed her to assist him in the interview process."*

During your oral evidence you provided a different recollection and told the panel directly after the morning handover Ms Redfern informed you that she was required to support Mr Varney with an interview between 14:00 – 15:00. In response to this you amended the allocation tool and pointed the panel to your version of the allocation tool which documented upstairs/notes. You explained to the panel *"upstairs"* indicated the management block of the hospital where Mr Varney had his office. The panel explored this further and highlighted Ms Howlett's version demonstrated something different. In response you told the panel that you didn't recognise this planner and it was not the one in use on the shift.

The panel noted your statement was made four days after the incident and therefore your memory was likely to be more accurate and additionally the recorded statement of truth which states, "*I believe the facts stated in this witness statement are true".* The panel gives weight to this document and preferred it over your oral evidence.

The panel therefore conclude that you were responsible for observations between the period 15:00-16:00.

Accordingly, on the evidence before it, including your admissions as to how and why you completed the observation record, the panel was satisfied on the balance of probabilities that you recorded that you had observed Patient A at 14:59 and 15:25 when you had not. The panel therefore found charges 1(d) and 1(e) proved.

Charge 2)

> "2. Your actions at any or all of charges 1, a - e above, were dishonest in that you sought to create the impression that you had observed patient A when you knew you had not.

This charge is found proved in respect of all of charges 1(a)-1(e).

When deciding whether your actions were dishonest, the panel applied the test set out in *Ivey v Genting Casinos (UK) (trading as Crockfords Club)* [2017] UKSC 67 (Ivey). The panel first considered your actual state of mind as to the facts before determining whether, in light of those circumstances, your conduct was dishonest by the standards of ordinary decent people.

The panel had regard to the observation records for Patient A, which constituted an official clinical record, and which required observations to be undertaken at 15-minute intervals. The purpose of this observation was to mitigate against an identified risk to a vulnerable patient.

Patients A's record articulated the risk of material and financial exploitation from peers. The record also required staff to encourage Patient A to get out of bed and move around during the day to lessen the pressure on his back to prevent bed sores.

The panel considers that the observation records' primary purpose was to provide contemporaneous patient status information to other staff members as to the continuing mitigation of the risk to Patient A and reassurance to the multidisciplinary team that these checks have been done.

During your oral evidence the panel explored the responsibilities of the nurse in charge. The panel was satisfied that, as the nurse in charge you were responsible for Patient A's care and that you were aware of the requirement to undertake and accurately record those observations.

The panel noted your evidence both in writing and orally about the two separate phone calls that you took. You stated that staff had been informed that such calls must be answered due to learning from a recent complaint. When asked by the panel whether that policy was in writing, you stated that it was not and that you had been told this during training.

The panel noted that during cross-examination it was put to Ms Howlett by Mr Brahimi on your behalf that the calls were expected to take priority. Ms Howlett stated:

> *"There is no rule in place, but calls are important it's also important to maintain patient safety."*

The panel then considered your evidence concerning your state of mind at the time. You accepted that you knew you had not carried out the relevant checks at the specific times entered on the observation record. You nevertheless completed and signed the record to indicate that you had undertaken observations at those times. During oral evidence you told the panel that when you were supposed to undertake observations for Patient A you were focussing on running the shift and prioritised answering calls because you had been told by management this must take priority.

You told the panel you were worried that you would get in trouble if you did not answer the call or the relative might complain in answer to Mr Radley's suggestion that there were alternative options available to you. You said that you believed you were *"going to get in trouble either way"*. You added that you felt really bad after the call and were not settled in your mind or thinking properly and were off balance. You described the situation where it was brought to your attention there were missing patient observations and at the conclusion of the telephone call you immediately went to review Patient A. At this time, you noted that there were multiple gaps in the observation records and wanted to fill those gaps. The panel noted that in evidence you had suggested that in your mind you were just recording a late entry and were content that as you had seen Patient A at 14:20 and 14:50 you were not being dishonest, because of your knowledge of the patient.

In the panel's view, this demonstrated that you understood that the required observations had not been completed and appreciated the significance of the omissions when you subsequently made the entries.

The panel had regard to Ms Redfern's witness statement, in which she recorded that you had suggested that you may have undertaken the observations but forgotten to document them on the records. The panel also considered the local statement of Ms Fitzpatrick, made five days after the incident, which recorded your suggestion that you might have checked Patient A during the relevant period without recording the observations.

The panel has concluded that you made a false record that you had observed signs of life at 14:25, 14:35, 14:50, 14:59, 15:25, 15:35 and 15:50 and that you had seen him in bed and settled and awake.

You knew that you had not made those checks. The panel concluded that it was not just the timings that were false, but the detail contained within. You could not know what Patient A was doing at these times, in particular you could not know whether he had been exploited or whether he had been approached by others, and you were not able to encourage Patient A to move about.

The panel considered the particular responsibilities of a Band 5 Registered Nurse for the health, safety and wellbeing of patients. By recording that the observations had been completed, you created the impression not only that you had observed Patient A at the relevant times, but that Patient A's identified risks had been appropriately monitored.

Having established your knowledge and belief as to the facts, the panel considered his conduct by the objective standards of ordinary decent people. The panel concluded that an ordinary decent person, knowing that you were a registered Band 5 nurse with a professional duty to undertake 15-minute observations of a vulnerable patient, and knowing that you had recorded specific observations as completed when you knew that you had not undertaken them, would regard this conduct as dishonest.

The panel therefore concluded that you made the entries for the purpose of creating the impression that you had observed Patient A at the particular times recorded when you

knew that you had not. Applying the test in *Ivey*, the panel found your conduct dishonest and accordingly found Charge 2 proved.

Charge 3)

> "3. On 21 October 2022 did not observe patient B between 14.50 and 16.20 which was required."

This charge is found proved.

The panel notes the absence of CCTV footage.

In considering Charge 3, the panel had regard to the observation records for Patient B. The records stipulated that Patient B was subject to observations at a minimum frequency of twice per hour, namely at 30-minute intervals. The panel noted that staff undertaking observations were required to observe the patient for signs of life, which could include movement, breathing, talking or another indication that the patient was alive, and to confirm completion of the observation by recording *"yes"* in the relevant signs of life column. The panel also took account of the identified risks relating to Patient B, [PRIVATE]

The panel considered your oral evidence that, between 14:00 and 15:00, you had undertaken what was required of you in respect of Patient B. However, the panel noted the evidence in Ms Howlett's witness statement concerning her meeting with you on 25 October 2022, four days after the incident. Ms Howlett recorded that you had told her that, between 15:00 and 16:00 on 21 October 2022, you had received a telephone call from the mother of another patient who was upset regarding a reduction in the patient's Department for Work and Pensions payment. You had explained that you prioritised that telephone call over undertaking the patient observations. You further stated that there was no other member of staff to whom you could allocate the observations because Ms Redfern had been taken away from the ward to assist with a last-minute interview.

The panel also had regard to the two staff allocation documents, one produced by you and one produced by Ms Howlett.

The allocation tool produced by you showed that between 15:00 and 16:00 you were on two-to-one observations and not general observations.

The panel noted the allocation tool produced by Ms Howlett which recorded that you were on observations.

The panel concluded that the allocation tool was a live document which would change as the day progressed with different issues. The panel concluded that it is likely that both documents relate to the day in question. The panel decided that without clarity of the order of those documents it would place little weight on either.

The panel did not accept the NMC's assertion that you had created the staff allocation document subsequent to the day in question to produce as part of your defence.

The panel considered your local investigation statement made on 25 Oct 2022 four days after the incident. You confirmed that this was your local statement and that it was your signature on the document. The panel noted the statement of truth.

You were asked by the panel whether there was anything in the statement with which you disagreed. You said *“No”.*

The panel noted that in this statement you said, with regard to Ms Redfern assisting the general manager:

> *“I did not plan for that member of staff to be away from the ward as of my time on my planner which left me alone on the ward except for those staff on 2:1 observations”.*

You also said in this statement that you took over observations at 15:00-16:00 because Mr Varney needed Ms Redfern to assist him in the interview process.

The panel concluded that by taking over the observations at that time, you assumed the duty to ensure that checks of Patient B were undertaken in accordance with Patient B's observation requirements. The panel concluded that you did not complete these observations. The panel concluded that you were not responsible for the period between 16:00 and 16:20, but between 14:50 and 16:00 you missed two observations that were required. The panel had considered Mr Brahimi's submission that due to the absence of CCTV, it could not be concluded that you had not undertaken the observations. However, this was not the position, which you had taken in your evidence, which was that you were not responsible for these checks.

Having considered all of the evidence, the panel concluded on the balance of probabilities that you did not carry out the required observations of Patient B during the relevant period. Accordingly, the panel found Charge 3 proved.

Charge 4)

> "4. On the 30 December 2022 administered incorrect medication to Patient C."

This charge is found NOT proved.

In considering Charge 4, the panel had regard to the record of Drugs Liable for Misuse for the hospital. In particular, the panel considered the entry concerning Lorazepam 1 mg, which recorded that the medication was administered on 30 December 2022 at 20:40 to a patient identified by the initials *"JH".*

The panel compared this entry with the entries contained within the same medication record, including the record relating to Diazepam 2 mg. From those records, the panel

established that Patient C was identified by the initials "*KD*". The panel was therefore satisfied that the patient recorded as having received Lorazepam 1 mg at 20:40 on 30 December 2022 was not Patient C as identified in the charge.

The panel considered whether it would be appropriate to canvass with the parties an amendment to Charge 4 to reflect the evidence contained within the medication records. However, it determined that such an amendment would be unfair. The identity of the patient was a material aspect of the charge and was necessary to establishing precisely what had occurred and the circumstances surrounding the alleged medication error. An amendment would therefore require the factual basis of the allegation to be reconsidered and probably necessitate the calling of further evidence.

The panel also took into account the nature and relative seriousness of Charge 4. It concluded that it would not be proportionate to reopen the evidential enquiry and potentially require further evidence to be called in order to pursue a materially amended allegation concerning a different patient.

The panel determined that the evidence before it did not establish that you administered incorrect medication to Patient C on 30 December 2022. Accordingly, the panel found Charge 4 not proved.

Charge 5)

> "5. On the 31 December 2022 left a box of Diazepam unattended.

This charge is found proved.

In considering Charge 5, the panel first considered the ordinary meaning of the word *"unattended".* The panel had regard to the Oxford Dictionary definition, namely, "*without the owner present; not being watched or cared for*." The panel also considered the Cambridge Dictionary definition, "*not being watched or taken care of*."

The panel considered that the meaning of *"unattended"* had to be assessed in the particular context of the incident and the clinical environment in which it occurred. The panel determined that the management of controlled drugs and drugs liable to misuse required the nurse responsible for those medications to ensure that there was no opportunity for them to be accessed without authorisation. The panel considered that the risks associated with such medication were heightened in a ward environment where service users were known to have addiction issues. This, in the panel's view, placed an increased responsibility upon those handling and administering such medication.

The panel had regard to the Controlled Drugs Procedure Policy Drugs Liable to Misuse (DLMs). At paragraph 2.65, the policy provided:

> *"There are certain medications that are liable to misuse for example: Clonazepam tablets; Codeine Phosphate 30mg tablets; co-codamol 30/500 tablets, Co-dydramol tablets; Lorazepam tablets; Diazepam (all strengths), Midazolam (buccal), Zopiclone tablets. This list is not exhaustive and there may be further drugs that, at a local level, are considered to be a risk of being misused, in which case an additional local list should be developed. A list of all DLMS held in medication cupboards should be maintained within the clinical room, clear records of stocks and uses should be maintained at all times. Ward managers/ heads of care are responsible for ensuring all DLMS are closely monitored."*

The panel further noted paragraph 2.66 of the policy:

> *"Drugs liable for misuse MUST be treated in the same way as CDs."*

Paragraph 2.67:

> *"Drugs liable for misuse must be recorded separately from the CD register to an DLM register."*

The panel was therefore satisfied that diazepam was expressly identified as a drug liable to misuse and was required to be managed with the safeguards applicable to controlled drugs.

The panel also had regard to paragraph 2.34 of the controlled drugs procedure document:

> *"Two authorised persons are to be involved in the administration of schedule 2 controlled drugs. "*

Paragraph 2.35:

> *"Both members of staff should be present to witness:*
> - *The preparation of the controlled drug to be administered.*
> - *The controlled drug being administered to the individual.*
> - *The destruction of any surplus drug."*

In light of the policy and the particular ward environment, the panel determined that *"unattended"*, in the circumstances of this charge, concerned whether the security of the diazepam was continuously maintained during the period in which the medication was in use on the ward. The panel considered that the presence of a nurse within the clinic room was not, of itself, sufficient to establish that the medication was attended. Rather, the relevant question was whether the Diazepam was being watched or otherwise adequately secured so that there was no opportunity for a service user to gain access to it.

The panel considered your oral evidence regarding the manner in which controlled drugs and drugs liable to misuse were stored at the hospital. You described the medication as being contained within a locked metal drug trolley, within a separate container used for drugs liable to misuse, which did not have a lid nor was this lockable. When asked if these were usually stored in a locked cupboard, you informed the panel there was no such cupboard. The panel understood your evidence to be that the various medications were

kept within the trolley and that, during the incident, you turned your back and were momentarily occupied with other matters.

During oral evidence you were able to demonstrate to the panel the layout of the room and highlight particular precautions you undertook in order to maintain the security of the drugs. You explained to the panel that at all times the drug trolley was attached to the wall by a chain and you pulled it towards you in order to prevent the drugs being within arm's reach of service users. You told the panel the way the drugs were administered was consistent with what you had observed other nurses' practice was and you had adopted such practice.

The panel had regard to your statement dated 16 January 2023, in which you stated:

> *"…you did not see the diazepam being taken."*

In answer to the question "*how do you think the incident was able to happen?"*

> *"John said he was not sure if it was planned or not by the patient but feels it must have been just after John turned his back and the patient grabbed it at this opportunity. John said he feels the position of the trolley was in reach of the patient."*

The panel accepted that you remained physically present within the clinic room throughout the incident and that you had taken some precautions in relation to the medication. However, it considered those precautions to have been insufficient in the circumstances. The patient was thereby able to take the opportunity to access and remove the medication without your knowledge.

The panel considered that this was precisely the type of risk which the requirement for close monitoring and the presence of two authorised persons were intended to guard against. The panel determined that, although the period was momentary, the Diazepam was not being watched or adequately secured during that period. Having regard to the

nature of the medication, the physical environment of the clinic room and the known risks associated with the patient group on the ward, the panel was satisfied that the box of Diazepam had been left unattended within the ordinary dictionary meaning of that term and within the context of the applicable medication policy.

The panel also considered the investigation report, and the minutes of the disciplinary hearing dated 15 January 2023. It took account of Mr Brahimi's submissions that little weight should be attached to those documents on the basis that they related to events approximately four years ago, had not been seen or signed by you and were disputed by you as inaccurate. The panel further noted that it had heard no evidence from the authors or any other witness capable of establishing the provenance and accuracy of those exhibits. Accordingly, the panel placed little weight upon those documents.

Nevertheless, the panel was satisfied on the basis of your own oral and written evidence, the circumstances in which the patient was able to access the Diazepam, and the requirements of the Controlled Drugs Procedure Policy, that the medication was left without adequate observation or supervision.

Accordingly, the panel concluded, on the balance of probabilities, that you left a box of Diazepam unattended on 31 December 2022 and therefore found Charge 5 proved.

Discrimination

Before reaching its conclusions on the facts, the panel considered Mr Brahimi’s submissions on whether you had faced discrimination within the workplace on the grounds of race.

The panel took this suggestion seriously.

At this stage of the process, the test for the panel was whether there was anything before it to conclude that the evidence on which it had to base its decision on facts, was tainted.

The panel considered the "*Landmark new NMC anti-racism principles to tackle bias"* and guidance at *FTP 2a.*

The panel has concluded from the evidence you provided, that you held an honest belief that there were elements of discrimination within the workplace which you believed were attributable to race. The panel noted that you stated in evidence that at the time of these issues you did not hold that view, but as this process has progressed and looking back, you have developed this view.

In your evidence you referenced the extension of probation/preceptorship, lack of notification that this had been extended for six weeks and comments in Ms Howlett's statement around you struggling with English language.

The panel noted that the issue of discrimination in any form was not put to any witnesses during cross-examination bar one, and that consequently no opportunity was provided for most of the NMC witnesses to challenge the suggestion. The panel was not provided with any documentation regarding your preceptorship/probation, or reasons why it was extended. The panel noted that you successfully completed both the preceptorship process and your probation.

The panel concluded that there it had no evidence before it that race discrimination or any discrimination has influenced the evidence it has considered at this facts stage. However, the panel has concluded that there is some evidence of a negative culture/practices within the hospital. The panel will give further consideration to this aspect of the case in the light of any submissions relating to it at the next stage.

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 must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Radley 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: Standards of conduct, performance and ethics for nurses and midwives 2008' (the Code) in making its decision.

Mr Radley identified the specific, relevant standards where your actions amounted to misconduct.

Mr Radley submitted that the panel's findings establish conduct which plainly amounts to serious professional misconduct. Per *Roylance v General Medical Council* [1999] UKPC 16, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin); and *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), Mr Radley reminded the panel that misconduct involves conduct falling significantly below the standards expected of a registered professional and must represent a serious departure from those standards. He submitted that your proven conduct crossed that threshold, demonstrating behaviour that would properly be regarded as deplorable by fellow practitioners and indicative of impaired professional standards.

Mr Radley submitted that the proven facts engaged fundamental principles of nursing practice. The misconduct related directly to patient care, medication management and professional honesty, including findings of dishonesty and failures of candour. He submitted that these were not technical breaches of local policy but serious failures striking at the heart of professional nursing responsibilities, particularly where patient safety, accurate documentation and the administration of medicines were concerned.

Mr Radley relied upon The Code: Professional standards of practice and behaviour for nurses and Midwives (2015) (The Code), Mr Radley submitted whether or not the code has been breached is a matter for the panel, however Mr Radley submitted that the following provisions of the code maybe engaged: 1, 1.1, 1.2, 1.3, 1.4, 1.5,2, 2.1, 3, 3.1, 8, 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 9, 9.1, 9.3, 10, 10.1, 10.2, 10.3, 10.4, 11, 11.1, 11.2, 13, 13.1, 14, 14.1, 14.2, 14.3, 16, 16.2, 16.3, 16.5, 17, 17.1, 18, 18.1, 18.2, 18.4, 19, 19,1, 20, 20.1, 20.2, 20.3, 20.8, 21, 21.3, 25 and 25.1.

Mr Radley submitted that it is a Registered Nurse's duty to provide safe and effective care, maintain accurate records, administer medicines safely, communicate effectively with colleagues, work collaboratively, preserve patient safety and, critically, uphold the professional duty of candour. He submitted that honesty and openness are fundamental attributes of Registered Nurses and that the proven dishonesty represented one of the most serious categories of professional concern recognised by the NMC.

Mr Radley further submitted that the misconduct demonstrated attitudinal concerns extending beyond individual clinical errors. He submitted that you showed a lack of insight into medication risks, failed to respond appropriately to concerns raised by colleagues, and displayed an unwillingness to accept responsibility for your actions. Instead, you sought to attribute blame to others and suggested that concerns raised by colleagues formed part of a scheme against you. In Mr Radley's submissions, these features indicated deeper attitudinal issues which are more difficult to remediate and therefore increased the seriousness of the misconduct.

Addressing the wider public interest, Mr Radley submitted that the misconduct undermined confidence in both the nursing profession and the regulatory process. The public is entitled to expect that Registered Nurses will administer medicines safely, maintain accurate records, respond appropriately to colleagues' concerns and act honestly whenever patient safety is at risk. He submitted that your failures were capable of compromising patient safety, adversely affecting working relationships within the clinical team and diminishing public confidence in the profession.

Mr Radley also invited the panel to consider the context in which the misconduct occurred. He submitted that there were few, if any, mitigating contextual factors, noting the evidence that staffing levels and workload were manageable. He emphasised that the misconduct occurred over a period of time rather than as a single isolated incident and involved repeated concerns relating to medication management, observation of patients, missing medication, interactions with colleagues and dishonesty. These cumulative features, he argued, reinforced the seriousness of your conduct.

Accordingly, Mr Radley submitted that the proven findings amounted to serious professional misconduct. He contended that your conduct represented significant departures from the standards expected of a Registered Nurse, engaged fundamental principles of patient safety, integrity and professionalism.

Mr Brahimi submitted that the question of misconduct was ultimately a matter for the panel's professional judgment. He referred to the cases of *Roylance, Calhaem* and *Nandi*. Mr Brahimi submitted that not every proven failing necessarily amounts to misconduct

Mr Brahimi accepted that the panel may conclude that Charge 2 amounted to misconduct. However, he invited the panel to consider the remaining proven charges individually and on their own merits, rather than allowing the seriousness of one finding to influence its assessment of the others. He submitted that, when viewed in their proper context, the remaining matters did not represent conduct sufficiently serious to satisfy the high threshold required for a finding of professional misconduct.

In relation to Charges 1 and 3, Mr Brahimi submitted that you had been responding to a telephone call in circumstances where you believed was required to do so as part of your professional duties. Whilst accepting that observations had not been completed in full, Mr Brahimi submitted that you had carried out some observations and that any shortcomings amounted, at most, to errors of judgment or technical breaches rather than conduct falling seriously below the standards expected of a registered nurse.

Turning to Charge 5, Mr Brahimi described the incident as an unfortunate and exceptional situation in which the actions of the patient were a significant contributory factor. He submitted that you had followed the procedures you had routinely adopted and that the unforeseen theft by the patient was the principal cause of the incident. In those circumstances, he submitted that it would be unfair to characterise your conduct as serious professional misconduct.

With regard to Charge 7, Mr Brahimi submitted that the medication error involved the administration of an underdose rather than an overdose. Whilst acknowledging that it was a mistake, he submitted that the error did not reach the high threshold of seriousness required for misconduct and could not reasonably be described as conduct that fellow practitioners would regard as deplorable.

In addressing the wider context, Mr Brahimi relied upon your written reflective statement and subsequent professional development. He submitted that you had accepted the panel's findings, expressed genuine remorse, apologised for your conduct and demonstrated insight into your failings, particularly in relation to patient observations, record keeping, medication administration and the duty of candour. You acknowledged that patient safety must always take priority and stated that, with hindsight, you should not have completed observation records for observations that had not been undertaken.

Mr Brahimi also submitted that you had taken meaningful steps to remediate your practice by undertaking additional training in integrity and honesty, clinical observations, duty of

candour, medication administration, record keeping and the safe storage of medicines. Mr Brahimi submitted that this learning had enhanced your clinical practice and reduced the likelihood of any repetition.

Finally, Mr Brahimi invited the panel to take account of your subsequent employment history. He submitted that, since leaving your former employer, you had practised successfully with a number of healthcare providers, including your current role within an acute inpatient mental health hospital, without any further concerns being raised regarding your practice. He submitted that this sustained period of safe and unrestricted practice, together with your reflection, training and developing experience since qualifying, demonstrated that the concerns were remediable and that, even if misconduct were found, the panel should conclude that your fitness to practise is no longer impaired.

Submissions on impairment

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

Mr Radley emphasised that dishonesty lay at the heart of the case. He submitted that the panel had found that you had falsely entered comments into a patient's clinical records, creating entries that purported to be contemporaneous when they were not. Given your role as the nurse in charge, you had a clear professional duty to ensure the accuracy and integrity of patient records. Mr Radley submitted that the fabrication of timings and detailed clinical observations undermined the reliability of the patient's record, failed to protect the patient's health, safety and wellbeing, and represented a serious departure from the standards expected of a registered nurse.

Mr Radley submitted that the panel should consider whether the misconduct involved breaches of the NMC Code, noting that the misconduct findings reflected breaches of fundamental professional tenets. He submitted that such breaches were capable, in themselves, of justifying a finding of current impairment, relying on the principle recognised in *Yeong v GMC* [2009] EWHC 1923 (Admin*)* that a finding of impairment may be required to mark the unacceptability of serious misconduct, uphold professional standards and maintain public confidence in the profession.

Mr Radley further submitted that the factual context aggravated the seriousness of the concerns. He invited the panel to consider that the misconduct occurred whilst you were practising as the nurse in charge on a specialist mental health unit caring for particularly vulnerable patients. Mr Radley also submitted that the panel should also take account on the impact of your actions on colleagues, the working environment in which the misconduct occurred, and your attitude when errors arose. Mr Radley submitted that these matters demonstrated that the misconduct substantially and adversely affected your ability to practise professionally and you were not able to practise kindly, safely and professionally.

Addressing insight and remediation, Mr Radley acknowledged that you had engaged with the proceedings by providing reflective material, references and oral evidence. However, he submitted that it remained a matter for the panel to decide whether those reflections evidenced genuine recognition of the seriousness of his misconduct and whether they were consistent with his evidence before the panel. He invited the panel to consider you had demonstrated meaningful learning, whether any identified risks had been adequately addressed, and whether you had demonstrated openness consistent with the professional duty of candour. Mr Radley submitted, that based on the available evidence did not sufficiently demonstrate that the underlying concerns had been fully remediated.

Finally, Mr Radley reminded the panel that the statutory question was one of current impairment rather than past misconduct alone. Nevertheless, he submitted that the seriousness of the misconduct, particularly the dishonest falsification of clinical records,

the resulting damage to colleagues' trust, the failure to uphold proper professional standards, and the impact on public confidence meant that a finding of current impairment remained necessary. He contended that such a finding was required both to protect the public and to uphold confidence in the nursing profession and its regulatory standards.

Mr Brahimi submitted that the evidence before the panel demonstrates that you are capable of practising kindly, safely and professionally, and accordingly he submitted that your fitness to practise is not currently impaired.

Mr Brahimi submitted that in relation to public protection, no actual harm was caused to any patient as a result of the matters before the panel. He submitted that at no stage since the allegations have your employers had any disciplinary concerns arising from your work. He further submitted that you have successfully completed all mandatory training requirements during your employment at the hospital.

Mr Brahimi further submitted that there is no ongoing risk of repetition. He submits that you have demonstrated meaningful insight into the incidents and have taken proactive steps to strengthen your practice through relevant education and professional development. Significantly, you have undertaken further training directly addressing the areas of concern, including Safe Handling and Administration of Medication, Documentation and Record Keeping, Induction to Clinical Observations, Duty of Candour, and Integrity and Honesty. Mr Brahimi submitted that much of this training has been completed relatively recently, demonstrating your continued commitment to maintaining high professional standards and addressing the concerns identified in these proceedings.

Turning to public interest, Mr Brahimi submitted that a fully informed member of the public would recognise the context in which these incidents occurred. The majority of the concerns arose during a relatively short period in 2022, shortly after you had completed your preceptorship and whilst you were still developing confidence and experience as a newly qualified nurse. Importantly, you have made full admissions in respect of Charge 7, demonstrating candour, accountability and genuine insight into your practice.

Mr Brahimi submitted that a reasonable and well-informed member of the public is not a person who reaches conclusions based solely on the existence of allegations. Rather, such a person would consider you conduct as a whole, including the evidence of remediation, your subsequent professional record, and the views of those who have worked alongside you. In this regard, the panel has been provided with numerous testimonials from healthcare professionals and colleagues who have observed your practice first-hand. Those testimonials consistently describe you as an exemplary nurse who demonstrates accountability, responsibility and a holistic therapeutic approach to patient care. You are recognised as representing your employer professionally, working collaboratively within multidisciplinary teams, treating colleagues and patients with kindness and respect, and carrying out your duties efficiently, competently and diligently. Importantly, there have been no reports of any wrongdoing during your current employment, and senior colleagues have expressed the clear view that you remain fit to practise as a hardworking, honest and respectful Registered Nurse.

Mr Brahimi submitted that the concerns before the panel relate to isolated incidents rather than an ongoing deficiency in your professional practice.

[PRIVATE]

Accordingly, Mr Brahimi invited the panel to conclude that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor.

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

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

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

8 Work co-operatively

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

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.

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

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

13 Recognise and work within the limits of your competence

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.4 take all steps to keep medicines stored securely

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

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

20 Uphold the reputation of your profession at all times

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

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

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

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'

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

The panel carefully considered the contextual factors in accordance with the NMC's guidance, FTP-12i: Context, recognising that context is relevant to understanding the circumstances in which the concerns arose, but does not excuse or justify conduct that places patients at risk.

The panel considered the following contextual factors identified in FTP 12i were relevant in this case:

- Factors affecting attention - Distractions in the work environment or personal lives may mean people are unable to focus on what they are doing properly.
- Protected characteristics - Discrimination, harassment or victimisation can affect people's behaviour or be a factor in their referral.
- Contributory factors - Sometimes a nurse, midwife or nursing associate may have to make a difficult decision or prioritise tasks or people in their care. They may feel that their actions were the only thing they could have done under the circumstances.
- Emotions/Mood – [PRIVATE]
- Workload - Workload or work pressures can sometimes get in the way of people providing the ideal level of care or stop them from doing the right thing.
- Relationships - Were there poor relationships between professional groups and what impact did this have on how people acted

- Custom and practice - Was there a poor team culture or were poor practices or widespread workarounds part of the working environment.

The panel accepted that, at the relevant time, you were a newly qualified nurse and therefore had limited clinical experience. It also accepted that you were on probation and in a preceptorship period or had just completed them. It also accepted that you were working in a busy clinical environment and had been distracted by two stressful telephone calls which you found difficult to manage. It accepted that you had formed an opinion that these calls were to be prioritised. The panel considered these to be factors that could be reasonably assessed to be affecting your attention and judgement.

[PRIVATE]

In considering protected characteristics and workplace culture, the panel noted your evidence that you felt victimised within the workplace and believed you had been treated unfairly, including concerns relating to the removal of your mentor and the extension of your preceptorship and probation without explanation. Although the panel found no evidence that these concerns were attributable to discrimination or racism, it accepted that you genuinely believed you were being treated unfairly. The panel also noted evidence demonstrating strained workplace relationships, including oral evidence from Ms Redfern that she did not like you and evidence that negative perceptions of you had developed amongst colleagues through discussions in which you were not involved in. The panel was struck by the statement of Ms Howlett:

> *"He struggled with the English language both in a written and verbal context. This presented concerns regarding his sharing of salient information with colleagues..."*

The panel noted that in oral evidence Ms Howlett stated that she had very little contact with you and developed this view from others. The panel concluded that taken on its own this did not explain or justify the clinical failings found proved, but that it added to the contextual issues in this case.

The panel further considered the working environment. It was satisfied that staffing levels and workload were not excessive. However, it accepted that, as a newly qualified nurse, you found it challenging to balance competing demands, which created significant work pressure. The panel also accepted that there was evidence of an established local practice concerning the management of drugs liable to misuse which departed from the employer's written policy. The panel found that this unsafe custom had become accepted practice within the clinical area and formed part of the context in which some of the medication concerns arose. Nevertheless, the existence of an unsafe local practice did not relieve you of your individual professional responsibility to practise in accordance with accepted standards. However, in relation to charge 5, it is clear that the processes you employed were what you had witnessed others doing and as a relatively new nurse you had followed cultural bad practice.

Having considered all of these contextual factors cumulatively, the panel concluded that they provided important background and mitigation. The panel does not conclude that in isolation the contextual issues identified excuse the conduct found proved, but that it does provide some understanding of a hostile workplace and challenging personal circumstances at the time that these issues occurred.

The panel then went on to consider whether the facts found proved amounted to misconduct by applying the principles set out in FTP-2a, namely whether the conduct represented a serious departure from the standards expected of a registered nurse.

In respect of Charges 1 and 3, the panel concluded that the conduct amounted to misconduct. The panel considered that these charges concerned fundamental aspects of patient safety involving particularly vulnerable patients detained in a mental health setting. The failure to carry out and accurately record patient observations, together with the failure to complete the required checks, represented serious acts and omissions. The panel found that recording incorrect observation times and failing to undertake or document required checks undermined the purpose of safeguarding patients from harm

and neglect, which lies at the heart of a nurse's professional responsibilities under the Code. The panel considered that fellow members of the profession would regard such conduct as deplorable and that it had the potential to undermine public confidence in the nursing profession.

In relation to Charge 2, the panel determined that the conduct also amounted to misconduct because it involved dishonesty and a breach of the professional duty of candour. The panel considered that honesty is a fundamental tenet of nursing practice and essential to maintaining public trust in the profession. It found that you knowingly recorded inaccurate observation times and entered false information into patient records, thereby creating a false impression of the patients' status, risking patient safety. Furthermore, having recognised that you had failed to undertake the observations as required, you did not acknowledge or document the error, nor did you take the appropriate steps required by the professional duty of candour. The panel considered the factors identified in DMA-8, including the need to be open and honest when things go wrong, to inform those affected, to apologise where appropriate, and to accurately record and report incidents. The panel concluded that this represented a serious breach of the standards expected of a Registered Nurse and amounted to misconduct.

In relation to Charge 5, the panel found that you administered drugs liable to misuse without the required second practitioner present and failed to ensure that the medicines remained adequately safeguarded. It noted that the drugs subsequently went missing during the drug round and concluded that the precautions taken were insufficient to prevent their unauthorised removal by a patient. The panel deliberated that you knew you were working in an environment where patients were vulnerable to misusing medication and therefore bore a heightened responsibility to follow the established safety procedures. By failing to comply with them, you exposed patients to avoidable risk and breached a fundamental professional obligation. The panel therefore concluded that Charge 5 amounted to misconduct.

In respect of Charge 7, the panel accepted that a medication error had occurred but found that it was recognised immediately and appropriate action was taken to address it. In the circumstances, the panel was satisfied that this represented an isolated clinical mistake rather than a serious departure from the standards expected of a Registered Nurse. It therefore concluded that, although the charge was proved, it did not amount to misconduct.

The panel found that your actions in relation to charges 1,2,3 and 5 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel determined that your actions represented serious departures from the standards expected of a Registered Nurse. Your failures in relation to patient care and medicines management had the potential to expose patients to a real risk of harm and undermined the fundamental professional obligations to preserve safety, practise effectively and maintain public confidence in the profession.

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.

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. At 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.'*

At 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 she:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel concluded that all four limbs of the *test* were engaged in the past.

The panel considered that the misconduct was capable of remediation but concluded that the dishonesty element would be more difficult.

The panel considered the reflective document produced by you for the hearing on 14 July 2026.

The panel noted that you have remained in employment since the events giving rise to these concerns. The panel also noted that you have continued to work in a similar setting to that where this misconduct was identified, without any restriction. The panel had no evidence before it from the NMC of any concern regarding your practice since the allegations came to light.

The panel also took into account the character references and witness statements provided on your behalf, which were contained within the documentary evidence.

The panel was impressed with those documents and in particular the positive comment regarding your practice. It noted that in a statement of Katie Ashcroft, a senior recruitment consultant for service care solutions, dated 11 April 2023 she said:

"I have nothing but glowing feedback for John and his nursing ability"

The panel also noted the statement from George Linje, dated 20 April 2026, your current line manager. He states that:

"*Since end of February 2025, I have been John's line manager and responsible for his regular supervision and end of year appraisal. I have no concerns regarding his performance and attitude towards patient care",*

and

Ellijah Gumise who was the Deputy hospital Manager of the House for between November 2023 to March 2025, and is also a registered mental health nurse, stated that you are:

"… a team player who treats his patients and colleagues with utmost kindness and respect. It is true to say that John is liked across Magna House".

Finally, the panel reviewed the comments of Dr Godknows Ngeribo, MBBS, MPH, Speciality Doctor:

"During the period we worked together, I found him to be consistently supportive, compassionate, and attentive in his care of patients. He demonstrated a strong commitment to patient-centred care and worked collaboratively with colleagues across the multidisciplinary team.

To the best of my knowledge, there were no concerns regarding his standard of care. He conducted himself professionally at all times and maintained respectful and appropriate relationships with both patients and colleagues."

The panel concluded on the evidence of the documents you have produced it appears that your practice meets the standards expected of you and that this is evidenced by your current line managers and previous employers.

The panel also considered NMC guidance at FTP 16b.

The panel further noted that in making a decision on impairment it was important that it recognised that the guidance required it to do:

> *"…more than simply look at whether a nurse, midwife or nursing associate has shown 'any' insight or not. They need to assess the quality and nature of the insight. midwife or nursing associate's right to practise, even if they have shown 'some' insight into what happened".*

The panel had to consider whether it had before it evidence of insight from you.

The panel has concluded that you have shown some reflection during these proceedings. Taken on its own, that reflection was not of such quality as to satisfy the panel that there was an insignificant risk that you would repeat the misconduct. However, the panel has to take into consideration that you have continued to practice without restriction, and with no evidence before it that your practice has been found lacking. It also has to take into account the context that existed when the misconduct in this case occurred. The panel concluded that any shortcomings in the written reflection were outweighed by the lengthy period of safe practice without restriction, so positively commented on in the testimonials presented to the panel.

The panel considered that it is more difficult to remediate dishonesty.

However, the panel does consider that your episode of dishonesty is remediable. You have stated that you realise that what you did in falsely annotating records was wrong and that you would not repeat this in the future. The panel noted that in all the testimonials you had informed the authors of the NMC proceedings. This evidences your personal integrity and provides the panel some reassurance on the issue of dishonesty. The panel refers again to your unrestricted practice over three years with no concerns raised. Your current manager provided evidence that you owned up to mistakes. The panel considered Mr Radley's submission that there was evidence of deep-seated attitudinal issue at play; it concluded that this was not the case.

The panel in considering impairment is aware that impairment must be considered as of today. The panel has concluded that given those factors it would be difficult for it to conclude that you currently present a risk to the public when you have been allowed to practice unrestricted for the period since the misconduct found in this case, and as such from that evidence it has concluded you are highly unlikely to breach the fundamental tenants or be dishonest and that the misconduct is unlikely to occur in the future.

The panel therefore concluded that you are not currently impaired on public protection grounds.

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

The panel determined that a finding of impairment on public interest grounds is however required because public confidence in the nursing profession and the regulatory process would be undermined if a finding of impairment were not made, particularly where a finding of dishonesty has been made. The panel considered that members of the public would be seriously concerned that a Registered Nurse caring for vulnerable mental health patients had falsified clinical observation records, thereby misrepresenting patients' clinical status, and had been found to have acted dishonestly. In the panel's judgment, a finding of impairment is therefore necessary to uphold proper professional standards and maintain public confidence in the profession.

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

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of 3 years. The effect of this order is that your name on the NMC register will show that you are subject to a caution order and anyone who enquires about your registration will be informed of this order.

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).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley informed the panel that he submitted that a suspension order should be imposed.

Mr Radley identified several aggravating features. He submits that your misconduct represents a serious breach of the trust placed in a Registered Nurses, particularly as it involved dishonesty and failures relating to patient safety. He submits that there remains insufficient insight into the importance of adhering to policies governing drug management and patient observations, that the misconduct exposed a patient to an unwarranted risk of harm, and that it undermined public confidence in the profession.

Mr Radley nevertheless acknowledged a number of mitigating factors. These included your admissions to certain allegations, your continued employment and professional experience, [PRIVATE] He submits, however, that these matters do not outweigh the gravity of the misconduct or remove the need for a substantive sanction.

Turning to the available sanctions, Mr Radley submitted that taking no action or imposing a caution order would fail to reflect the seriousness of the case. He also submits that a

conditions of practice order would be inappropriate because the concerns centre on dishonesty and integrity rather than remediable clinical deficiencies, and because the misconduct involved allegations that cast suspicion on other members of staff.

Mr Radley submitted that a suspension order is the appropriate and proportionate outcome. He submitted that suspension would adequately protect the public and maintain confidence in the profession, whereas a striking-off order would be disproportionate despite the findings of dishonesty. He therefore invited the panel to impose a suspension order.

The panel also bore in mind Mr Brahimi's submissions. He submitted that a suspension order would be a disproportionate response to the findings in this case and that the panel should instead consider whether a lesser sanction, particularly a caution order or a conditions of practice order, would adequately satisfy the public interest.

Mr Brahimi submitted as mitigating factors, your admissions to some of the charges, your completion of relevant training, your positive character testimonials before the panel, the passage of time which is almost four years since the incidents, your remorse, and the fact that the dishonesty was an isolated incident rather than a pattern of behaviour. He further submits that you have no previous fitness to practise history and have never been subject to an interim order.

Mr Brahimi submits that the panel has found impairment solely on public interest grounds, rather than because of any continuing risk of repetition, and that this is a significant consideration when determining sanction. In his submission, the panel's findings that the dishonesty is remediable, together with you demonstrating insight, remorse and remediation, mean that the objectives of sanction can be achieved without removing you from practice.

Mr Brahimi submits that if the panel considers a caution order insufficient, a conditions of practice order would provide a proportionate alternative to suspension. He submits that

the concerns identified by the panel are capable of being addressed through workable and measurable conditions. In particular, he submits that issues relating to patient observations could be managed through supervision and employer reporting; that the dishonesty concerns have already been addressed through training, reflective work and evidence of insight, with further monitoring available if required; and that the medication storage concerns arose from the particular circumstances of the ward environment and could readily be addressed through additional training and appropriate safeguards. He submits that there is no evidence of deep-seated attitudinal or personality problems which would render conditions unworkable.

Mr Brahimi submitted that a suspension order is intended for more serious cases, particularly where the risk to the public can only be managed by temporarily removing you from practice or where the misconduct calls into question your suitability to continue practising. He submitted that those circumstances are absent here. He further submitted that the remaining misconduct arose when you were newly qualified, inexperienced and working under considerable pressure, and that the panel has already accepted that the dishonesty is remediable and unlikely to be repeated.

Accordingly, Mr Brahimi submitted that suspension would be an unnecessarily punitive and disproportionate response, as the objectives of public protection and public confidence can be achieved through a less restrictive sanction.

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:

- Deliberate breaches of the Code (14.1,14.2,14.3, 20.1 and 20.2).
- Dishonesty in relation to falsifying records.
- Developing insight.
- Vulnerability of the person receiving care in this case, arising from: [PRIVATE]
- Risk of harm to Patient A and Patient B.
- Lack of candour.
- Risk to the reputation of the profession.
- Risk of members of the public not seeking assistance in light of the dishonesty.

The panel also took into account the following mitigating features:

- Early admission of some facts.
- Apologies and remorse.
- Some relevant training courses undertaken.
- Working competently and with integrity.
- Significant evidence of you working safely and effectively without restriction.

Personal mitigating features, surrounding contextual issues:

- Level of experience at the time.
- Level of support (in what the panel has concluded to be a hostile environment).
- [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate as it would not mark the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel had regard to the NMC Guidance on ‘Caution order’ (Reference: SAN-2b) Last Updated: 28/01/2026) in which the following is set out:

‘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 concluded that you have shown developing insight into your conduct. The panel noted that you made admissions and apologised to the panel for your misconduct, showing evidence of genuine remorse. You have engaged with the NMC since referral.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel noted that you have continued to practise for approximately three and a half years without any restrictions, demonstrating that you have been able to work safely and effectively in practice.

The panel further concluded that any conditions it might formulate would be neither practical nor workable. It considered that conditions designed to monitor or supervise your practice would impose an unreasonable burden on employers and colleagues, with the potential to detract from patient care rather than enhance it. The panel was therefore not persuaded that conditions could be implemented in a way that was relevant, proportionate, workable or measurable.

The panel concluded that dishonesty is not a matter that can be appropriately remedied or managed through conditions of practice. It therefore determined that a condition of practice order would neither adequately address the seriousness of the misconduct nor meet the wider public interest.

The panel considered Mr Radley’s submission that a suspension order would be an appropriate sanction. The panel concluded whilst it recognises the seriousness of the misconduct in this case a sanction of suspension would be wholly disproportionate and

punitive. It considered that temporarily removing you from practice would serve no useful regulatory purpose. The panel attached significant weight to the fact that you have been practising safely, effectively and without restriction for approximately three and a half years since the events in question, during which time no further concerns had arisen. It was therefore satisfied that you posed no ongoing risk to the public and that the circumstances envisaged by the NMC's Sanctions Guidance (SAN-2d), where suspension is necessary to manage a risk to the public through temporary removal from the Register, were not present.

The panel concluded that removing an experienced and competent mental health nurse from practice would be counterproductive, depriving patients and the local community of a practitioner who had demonstrated safe and effective practice over a sustained period. The panel considered that suspension would place an unnecessary burden on healthcare services without advancing the objectives of public protection. Accordingly, notwithstanding the seriousness of the misconduct, the panel determined that a suspension order would be neither appropriate nor proportionate.

The panel has decided that a caution order would adequately mark the seriousness of the misconduct. For the next three years, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of three years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession but also send the public and the profession a clear message about the standards required of a registered nurse.

The panel would like to make it clear that although the sanction is lower than what the NMC have recommended, this does not mean that the panel takes dishonesty lightly. Honesty is a fundamental tenet of any therapeutic relationship. It is vital for every nurse to uphold this value in their practice. In your case, the panel accepted that your dishonesty

arose during a momentary lapse of judgement, in a matter of minutes while you were under significant stress. The panel is satisfied that this dishonesty and the proceedings which have followed it have had a significant impact on you. You regret your dishonesty, you have not repeated it, and in the panel's judgement it is highly unlikely to recur.

The panel rejected the NMC's sanction bid and determined that a caution order was the least restrictive sanction capable of marking the seriousness of the misconduct, upholding public confidence in the profession, and maintaining proper professional standards.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.