Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 June 2026 – Thursday, 18 June 2026

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

Name of Registrant:	**Jay Hobbs**
NMC PIN:	11F0456E
Part(s) of the register:	Nurses part of the register, sub part 1; Registered Nurse – Children; RNC; Level 1
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, lay member) Vickie Glass (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Tyra Andrews
Nursing and Midwifery Council:	Represented by Selena Jones, Case Presenter
Mr Hobbs:	Not present and unrepresented at this hearing
Facts proved:	1a) i), 1a) ii), 1b) i), 1b) ii), 2a), 2b), 3a) i), 3a) ii), 3a) iii), 3c), 3e), 4a), 4b), 4c), 5a), 5b), 5c), 5d), 5e), 5f), 5g) i), 5g) ii), 6a), 6b), 7a), 7b), 8a) ii), 8b), 8c), 8e), 8f) i), 8f) iii), and 8f) iv)
Facts not proved:	3b), 3d), 3f), 3g), 8a) i), 8d) and 8f) ii)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim Suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Hobbs was not in attendance and that the Notice of Hearing letter had been sent to Mr Hobbs' registered email address by secure email on 30 April 2026.

Ms Jones, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr Hobbs's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Further, the panel noted that the Notice of Hearing was also sent to Mr Hobbs' representative at the Royal College of Nursing (RCN) on 30 April.

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

Decision and reasons on proceeding in the absence of Mr Hobbs

The panel next considered whether it should proceed in the absence of Mr Hobbs. It had regard to Rule 21 and heard the submissions of Ms Jones who invited the panel to continue in the absence of Mr Hobbs. She submitted that Mr Hobbs had voluntarily absented himself.

Ms Jones referred the panel to the letter from Mr Hobbs' representative at the RCN, dated 22 May 2026 which stated:

'Our member will not be attending the hearing nor will they be represented. No disrespect is intended by their non-attendance. Our member has received the notice of hearing and is happy for the hearing to proceed in their absence.'

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Mr Hobbs. In reaching this decision, the panel has considered the submissions of Ms Jones, the representations made by the RCN on Mr Hobbs' behalf, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones [2002] UKHL 5* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Hobbs;
- Mr Hobbs has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- 9 Witnesses have been called to give live evidence throughout this hearing,
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the patients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Hobbs in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered

email address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Hobbs' decisions to absent himself from the hearing, waive his rights to attend, and be represented, and to not provide evidence or make submissions on his own behalf.

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

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

At the outset of the hearing, Ms Jones made a request that this case be held partially in private on the basis that proper exploration of Mr Hobbs' case involves reference to sensitive and private matters relating to witnesses who have experienced the loss of their children. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session when Mothers 1, 3 and 4 give evidence to enable them to do so comfortably, and enable them to refer to their children by their names if they so wish in order to maintain confidentiality and protect their right to privacy.

The panel also decided to go into private session if and when any personal or health related matters arose regarding any other witnesses or the registrant himself to protect their right to privacy.

Details of charge

That you, a registered nurse:

1) On 28 March 2022 in relation to Child 4,
   a) Failed to provide appropriate discharge advice, in that you incorrectly advised Child 4's mother:
      i) That Child 4 had most likely suffered a sprain rather than a broken leg.
      ii) To go home, as Child 4's leg didn't look broken.

   b) Incorrectly recorded in Child 4's patient records that:
      i) Child 4's mother wished to take them home.
      ii) That you wanted Child 4 to be seen for an X-ray and/or blood samples.

2) Your actions in charge 1) b) i) & 1) b) ii) above were dishonest in that:
   a) You knew you had advised Mother 4 that she could take Child 4 home;
   b) You intended to mislead anyone reading the patient record into believing that you had advised Mother 4 about the risks associated with leaving the hospital.

3) On 10/11 November 2022:
   a) After being informed that Child 3 scored a '2' on the Child Early Warning Tool, failed to;
      i) Escalate Child 3 to the Band 7 Nurse in Charge.
      ii) Start the sepsis pathway for Child 3.
      iii) Carry out a Nurse in Charge review of Child 3's 'Child Early Warning Score'.
   b) Failed to immediately escalate the failed attempts to cannulate Child
   c) Failed to consider an oral fluid challenge for Child 3.
   d) Failed to ensure that observations were carried out every hour for Child 3.

e) Failed to ensure that Child 3’s blood pressure was monitored.
f) Failed to escalate Child 3 to the Paediatric Registrar for cannulation.
g) Failed to ensure the correct versatile vascular access solution/system was used to cannulate Child 3.

4) On 4 December 2022, following your consultation with Child 2, after Child 2’s parents left Accident & Emergency without seeing a doctor, you failed to:
a) Consult with a doctor to make an assessment of Child 2.
b) Call Child 2’s parents to provide discharge advice.
c) Carry out a social care referral for a welfare check of Child 2.

5) On 7 April 2023:
a) After Colleague A had triggered Child 1 for sepsis and handed them over to you, failed to adequately check Child 1 after hand over.
b) Failed to start a fluid challenge for Child 1, as required.
c) Incorrectly informed Mother 1 that you had seen Child 1’s heart rate, drop below 140bpm.
d) Incorrectly recorded in Child 1’s nursing documentation at that you had seen Child 1’s heart rate, drop below 140bpm.
e) Failed to complete a safe discharge check/plan before discharging Child 1.
f) Discharged Child 1 without consulting a doctor.
g) Failed to document adequate records relating to Child 1’s discharge, in that you:
i) Failed to record adequate information about why Child 1 was being discharged in their patient notes.
ii) Failed to document the advice you provided to Child 1’s parents on discharge.

6) Your actions in charge 5) c) above were dishonest in that you:
a) Knew that Child 1’s heart rate had not dropped below 140bpm.
b) Intended to mislead Mother 1 into believing that Child 1’s heart rate had dropped below 140bpm

7) Your actions in charge 5) d) above were dishonest in that you:

a) Knew that Child 1's heart rate had not dropped below 140bpm.
b) Intended to mislead anyone relying on Child 1's nursing documentation into believing that their heart rate had dropped below 140bpm

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   a) Failed to use the Children's Early Warning Tool for Child 1, in that you:
      i) Did not complete a full set of observations for Child 1.
      ii) Did not complete a plan of care for Child 1.
   b) Failed to put out a cardiac arrest/2222 call for Child 1, in a timely manner.
   c) Failed to move Child 1 to the resuscitation room.
   d) Failed to actively participate in the resuscitation of Child 1.
   e) On one or more occasions left the paediatric ward unattended, without any clinical justification.
   f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:
      i) Did not provide oversight of Child 1;
      ii) Spent most of your time at the nurses' station.
      iii) On one or more occasions declined Colleague Y's request to move Child 1 to the resuscitation area.
      iv) Did not accompany Child 1 to the resuscitation area.

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

Decision and reasons on application to admit the written statement and report of Dr Nelly Ninis (Dr Ninis) as hearsay evidence.

The panel heard an application made by Ms Jones under Rule 31 to adduce the written statement and report of Dr Ninis as hearsay evidence. She submitted that the evidence is relevant, goes towards the charges raised and should be admitted. Ms Jones submitted that the NMC had made sufficient efforts to ensure her presence however, she refused to attend this hearing.

Ms Jones submitted that Dr Ninis' report (dated August 2023) and signed witness statement (dated 29 July 2024) were completed having been employed by the Trust to complete an external investigation. She further submitted that Dr Ninis' evidence was not the sole and decisive evidence and it has probative value to the issues at hand.

In preparation for this hearing, the NMC had indicated to Mr Hobbs in the Case Management Form (CMF), dated 1 September 2025, that it was the NMC's intention for Dr Ninis to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Dr Ninis, Mr Hobbs made the decision not to attend this hearing. On this basis Ms Jones advanced the argument that there was no lack of fairness to Mr Hobbs in adducing Dr Ninis' written statement and report into evidence.

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

The panel gave the application in regard to Dr Ninis' evidence serious consideration. The panel noted that Dr Ninis' statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and is signed by her.

The panel considered whether Mr Hobbs would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Dr Ninis to that of her written evidence.

The panel considered that as Mr Hobbs had been provided with a copy of Dr Ninis' statement and report and, as the panel had already determined that Mr Hobbs had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. He had the opportunity to challenge the contents of this evidence but had not done so. There was also public

interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered that the reason for the non-attendance of Dr Ninis was that she stated she did not wish to give evidence as an expert witness and she stated she could add nothing to the detail already provided in the report. The panel also noted that the NMC were not asking her to appear as an expert witness. The panel was of the view that the NMC had made efforts to secure her attendance. It had regard to the email and telephone correspondence between the NMC and Dr Ninis between August 2025 to May 2026. The panel further noted that Mr Hobbs was served with the evidence to be relied upon prior to the hearing and considered that there were no challenges to this evidence.

The panel acknowledged that Dr Ninis is an independent witness with no connections to the Trust and was of the view that there was no reason for her to fabricate her evidence.

The panel further noted the seriousness of the charges and the potentially career ending consequences for Mr Hobbs should the charges be found proved. The panel considered the evidence to be relevant specifically to the charges in relation to Child 1. The panel determined that this was not the sole and decisive evidence and had regard to the Coroner's Report and associated documents as well as the evidence from the other witnesses including Suzanne Reynolds, Jessica Wagjiani, Teresa Tredoux and Mother 1, provided by the NMC.

The panel determined that there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the written statement and report of Dr Ninis but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit the Coroner's Record of Inquest dated 21 November 2022 as hearsay evidence.

The panel heard an application made by Ms Jones under Rule 31 to allow the Coroner's Record of Inquest and associated documents into evidence. She submitted that the document is a written record and reliable evidence that is relevant to the charges and matters to be considered at this hearing. Ms Jones submitted that the document was completed within the course of business and is a contemporaneous document consisting of a number of healthcare documents. She submitted that there is no prejudice to Mr Hobbs and invited the panel to admit this document as hearsay evidence.

In the preparation of this hearing, the NMC had indicated to Mr Hobbs in the Case Management Form (CMF), dated 1 September 2025, that it was the NMC's intention for this document to be produced at this hearing before the panel. Despite knowledge of the nature of the Coroner's Record of Inquest document to be given before the panel, Mr Hobbs made the decision not to attend this hearing. On this basis Ms Jones advanced the argument that there was no lack of fairness to Mr Hobbs in allowing the document into evidence.

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

The panel gave the application in regard to the Coroner's Record of Inquest and associated documents serious consideration. The panel considered that as Mr Hobbs had been provided with a copy of the documents and, as the panel had already determined that Mr Hobbs had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered the evidence to be relevant to charge 3 in its entirety. The panel determined that the evidence is not sole and decisive in relation to this charge and had regard to the exhibits provided by witness Suzanne Reynolds, Louisa Higgs, Jessica Wagjiani and Mother 3 and noted that these witnesses are all due to be called to give oral evidence at this hearing.

The panel found that there was good reason for the non-attendance of the author of the report and determined that it would not be proportionate or appropriate for the coroner to attend. It considered the document to be an independent business record. The panel was of the view that there is no information to suggest any animosity between parties and considered that there is no reason for the document to be fabricated.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the Coroner's Record of Inquest and associated documents into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Jones, on behalf of the NMC, to amend the wording of charges 5) d) and 8) f) iii).

The proposed amendment was to correct typographical errors and better reflect the evidence in the case. It was submitted by Ms Jones that the proposed amendment does not affect the nature of the charges in this case and would provide clarity.

"That you, a registered nurse:

1) …

5) On 7 April 2023:

    a) …

d) Incorrectly recorded in Child 1's nursing documentation ~~at~~ **in** that you had seen Child 1's heart rate, drop below 140bpm.

6) …

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:

   a) …

   f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:

      i. …

      iii. On one or more occasions declined Colleague ~~Y's~~ **A's** request to move Child 1 to the resuscitation area.

      iv. ...

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Hobbs and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit the written statement and undated letter of complaint from Mother 4 as hearsay evidence.

Prior to the conclusion of the NMC's case, the panel heard an application (in private) made by Ms Jones under Rule 31 to allow the written statement and letter of complaint of Mother 4 into evidence. Ms Jones referred the panel to email correspondence and telephone logs between Mother 4 and the NMC between 13

May 2026 and 5 June 2026 and submitted that Mother 4 had been engaging with the NMC and had every intention of attending the hearing. She specifically referred to email correspondence received dated 4 June 2026 where Mother 4 had informed the Hearings Coordinator that she is currently in hospital and is unavailable to give evidence at this hearing as expected.

Ms Jones submitted that Mother 4's statement and letter of complaint are not the sole and decisive evidence in relation to the relevant charges. She further submitted that Mother 4 had completed a signed witness statement which includes a statement of truth. Ms Jones submitted that Mother 4's evidence has probative value and there is justification for adducing the statement and letter of complaint into evidence.

In the preparation of this hearing, the NMC had indicated to Mr Hobbs that it was the NMC's intention for Mother 4 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Mother 4, Mr Hobbs made the decision not to attend this hearing. On this basis Ms Jones advanced the argument that there was no lack of fairness to Mr Hobbs in allowing Mother 4's written statement and letter of complaint into evidence.

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

The panel gave the application in regard to Mother 4 serious consideration. The panel noted that Mother 4's written statement had been prepared in anticipation of it being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' dated and signed by her on 31 July 2024.

The panel considered whether Mr Hobbs would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Mother 4 to that of a written statement and letter of complaint. The panel considered that as Mr

Hobbs had been provided with a copy of Mother 4's statement and exhibits and, as the panel had already determined that Mr Hobbs had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered Mother 4's evidence to be relevant to the charges. The panel had regard to other supporting evidence provided by Suzanne Reynolds who was due to give evidence at this hearing and did not consider Mother 4's evidence to be the sole and decisive evidence in relation to the relevant charges.

The panel had regard to the correspondence between Mother 4 and the NMC and considered that there was good reason for the non-attendance of this witness due to the unforeseen circumstances and her recent hospitalisation. In consideration of the seriousness of the charges and the potential career ending consequences to Mr Hobbs should any of the charges be found proved, the panel considered that there is also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the written statement and letter of compliant of Mother 4 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Jones, on behalf of the NMC, to amend the date in charge 1 and the wording in charge 3 a) iii).

It was submitted by Ms Jones that the proposed amendment would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse:

1) On ~~28~~ **29** March 2022 in relation to Child 4,

2)…

3) On 10/11 November 2022:

a) After being informed that Child 3 scored a ‘2’ on the Child Early Warning Tool, failed to;

…

iii) Carry out a ~~Nurse in Charge~~ review of Child 3’s ‘Child Early Warning Score’

…

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

In relation to the proposed date amendment to charge 1, the panel was aware that Child 4 was admitted to the Emergency Department (ED) on the night of the 28 March 2022 and the documentation showed that Child 4 was admitted after midnight, hence the date of 29 March 2022 on the medical documentation.

In relation to the proposal to remove the words ‘nurse in charge’ from charge 3 a) iii), the panel was of the view that the original wording was unclear as to whether it was in relation to the nurse in charge of Child 4 or nurse in charge of the department, and that the substance of the charge was the failure to carry out a review of the CEWT score.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Hobbs and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow these amendments, as applied for, to ensure clarity and accuracy.

Details of charge as amended

That you, a registered nurse:

1) On 29 March 2022 in relation to Child 4,
   a) Failed to provide appropriate discharge advice, in that you incorrectly advised Child 4's mother:
      i) That Child 4 had most likely suffered a sprain rather than a broken leg.
      ii) To go home, as Child 4's leg didn't look broken.
   b) Incorrectly recorded in Child 4's patient records that:
      i) Child 4's mother wished to take them home.
      ii) That you wanted Child 4 to be seen for an X-ray and/or blood samples.

2) Your actions in charge 1) b) i) & 1) b) ii) above were dishonest in that:
   a) You knew you had advised Mother 4 that she could take Child 4 home;
   b) You intended to mislead anyone reading the patient record into believing that you had advised Mother 4 about the risks associated with leaving the hospital.

3) On 10/11 November 2022:
   a) After being informed that Child 3 scored a '2' on the Child Early Warning Tool, failed to;
      i) Escalate Child 3 to the Band 7 Nurse in Charge.
      ii) Start the sepsis pathway for Child 3.
      iii) Carry out a review of Child 3's 'Child Early Warning Score'.
   b) Failed to immediately escalate the failed attempts to cannulate Child 3.
   c) Failed to consider an oral fluid challenge for Child 3.
   d) Failed to ensure that observations were carried out every hour for Child 3.
   e) Failed to ensure that Child 3's blood pressure was monitored.
   f) Failed to escalate Child 3 to the Paediatric Registrar for cannulation.

g) Failed to ensure the correct versatile vascular access solution/system was used to cannulate Child 3.

4) On 4 December 2022, following your consultation with Child 2, after Child 2's parents left Accident & Emergency without seeing a doctor, you failed to:
   a) Consult with a doctor to make an assessment of Child 2.
   b) Call Child 2's parents to provide discharge advice.
   c) Carry out a social care referral for a welfare check of Child 2.

5) On 7 April 2023:
   a) After Colleague A had triggered Child 1 for sepsis and handed them over to you, failed to adequately check Child 1 after hand over.
   b) Failed to start a fluid challenge for Child 1, as required.
   c) Incorrectly informed Mother 1 that you had seen Child 1's heart rate, drop below 140bpm.
   d) Incorrectly recorded in Child 1's nursing documentation in that you had seen Child 1's heart rate, drop below 140bpm.
   e) Failed to complete a safe discharge check/plan before discharging Child 1.
   f) Discharged Child 1 without consulting a doctor.
   g) Failed to document adequate records relating to Child 1's discharge, in that you:
      i) Failed to record adequate information about why Child 1 was being discharged in their patient notes.
      ii) Failed to document the advice you provided to Child 1's parents on discharge.

6) Your actions in charge 5) c) above were dishonest in that you:
   a) Knew that Child 1's heart rate had not dropped below 140bpm.
   b) Intended to mislead Mother 1 into believing that Child 1's heart rate had dropped below 140bpm

7) Your actions in charge 5) d) above were dishonest in that you:
   a) Knew that Child 1's heart rate had not dropped below 140bpm.

b) Intended to mislead anyone relying on Child 1's nursing documentation into believing that their heart rate had dropped below 140bpm

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   a) Failed to use the Children's Early Warning Tool for Child 1, in that you:
      i) Did not complete a full set of observations for Child 1.
      ii) Did not complete a plan of care for Child 1.
   b) Failed to put out a cardiac arrest/2222 call for Child 1, in a timely manner.
   c) Failed to move Child 1 to the resuscitation room.
   d) Failed to actively participate in the resuscitation of Child 1.
   e) On one or more occasions left the paediatric ward unattended, without any clinical justification.
   f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:
      i) Did not provide oversight of Child 1;
      ii) Spent most of your time at the nurses' station.
      iii) On one or more occasions declined Colleague A's request to move Child 1 to the resuscitation area.
      iv) Did not accompany Child 1 to the resuscitation area.

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

Background

Mr Hobbs was referred to the Nursing and Midwifery Council (NMC) on 22 February 2024 by Suzanne Reynolds, Associate Director of Nursing for Paediatrics, Mid Essex Hospital Services NHS Trust (the Trust). A further referral was received from the parent of Child 1 on 5 March 2024.

The Trust received a letter of complaint from the mother of Child 4 who stated that she attended A&E on 28/29 March 2022 with Child 4, with a suspected leg injury and

Mr Hobbs advised her to take Child 4 home. She then attended A&E again about eight days later with Child 4 who was then found to have sustained a broken leg which was not identified on the first visit on the 28/29 March 2022.

Child 3 died at the Trust on 11 November 2022 which led to the Trust conducting a Root Cause Analysis Investigation (RCA) where Mr Hobbs was identified as the triage nurse on shift. The Trust identified concerns about the care and treatment of Child 3 which involved aspects of Mr Hobbs' role in their care and treatment.

On 4 December 2022 Mother 2 attended the ED with Child 2. On the same day she sent a written complaint to the Trust about the poor attention and lack of professionalism displayed by Mr Hobbs when she attended the ED with Child 2.

On 7 April 2023 Child 1 was brought to ED by her parents and discharged later that night by Mr Hobbs. Child 1 was re-admitted the following day being acutely unwell and died a few hours later on 9 April 2023. The Trust investigated the circumstances surrounding Child 1's death and identified that Mr Hobbs had failed to comply with the appropriate policies and procedures.

The referrals received by the NMC resulted in an investigation which identified the regulatory concerns set out in the charges.

Decision and reasons on facts

At the outset of the hearing, the panel had regard to Mr Hobbs Agreed Removal Form dated 22 May 2026, where he had admitted to some of the charges. The panel noted that Mr Hobbs is not present nor is he represented at this hearing. It therefore decided to treat all of the charges as contested in order to ensure fairness throughout these proceedings.

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

The panel has drawn no adverse inference from the non-attendance of Mr Hobbs.

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:

- Mother 3: Mother of Child 3;
- Jessica Wagjiani: Band 7 Nurse in the Children's Emergency Department (ED) at Broomfield Hospital;
- Louisa Higgs: Band 3 Healthcare Support Worker (HSW) in the Children's ED at Broomfield Hospital;
- Teresa Tredoux: Associate Director of Nursing employed by Mid Essex Hospital Services NHS Trust;
- Mother 1: Mother of child 1;
- Melanie Edwards: Colleague A: Band 5 Junior Staff Nurse in the Children's ED at Broomfield Hospital;
- Suzanne Reynolds: Associate Director of Nursing: Paediatrics at Broomfield Hospital.

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

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

Charge 1 a) i) and ii)

That you, a registered nurse:

1) On 29 March 2022 in relation to Child 4,
   a. Failed to provide appropriate discharge advice, in that you incorrectly advised Child 4's mother:
      i) That Child 4 had most likely suffered a sprain rather than a broken leg.
      ii) To go home, as Child 4's leg didn't look broken.

These charges are found proved.

In reaching this decision, the panel took into account Child 4's Children Emergency Document dated 29 March 2022, the oral and documentary evidence of Suzanne Reynolds (Ms Reynolds), Mr Hobbs' statement dated 28 March 2022, the written statement of Mother 4, the Job Description for a Band 6 Junior Charge Nurse, RCA Report dated 11 November 2022, the NMC Code of Conduct and the letter of complaint from Mother 4 dated 13 April 2022.

When deliberating the panel referred to the same evidence for charge 1 a) i) and 1 a) ii) and therefore considered these charges separately but expressed its findings together.

The panel first considered whether Mr Hobbs had a duty to provide appropriate discharge advice to Mother 4. The panel had regard to the Band 6 Junior Charge Nurse job description which highlighted that it is within the role to adhere '*to the NMC Code of Professional Conduct and Trust Policies and Procedures*'. The panel also

considered the NMC Code of Professional Conduct, and the requirement to provide accurate advice to people receiving care. This was also supported by Ms Reynolds who in her oral evidence talked to these documents. The panel heard from Ms Reynolds who confirmed that it was Mr Hobbs' responsibility as Nurse in Charge to provide appropriate discharge advice to Mother 4. It had regard to Mr Hobbs' nursing documentation notes where he confirmed that he had discharged Child 4. The panel therefore determined that Mr Hobbs did have a duty to provide appropriate discharge advice to Mother 4.

The panel also had regard to Mr Hobbs' local statement (undated):

> *'My normal process as nurse in charge in relation to children with injuries wishing to self discharge would be to advise parents that without an x—ray we would not be able to rule out any fracture and that need a clinical assessment to decide on the most appropriate X—ray if felt required. If the child has not already had an x-ray I would examine the limb myself and If I am able to request the X-ray I would do.'*

The panel considered 'appropriate discharge advice' to mean providing accurate information and following the correct procedure as highlighted by Mr Hobbs in his statement and following up should there be an ongoing concern. The panel noted that this position was supported by Ms Reynolds in her oral evidence.

The panel had regard to Mother 4's original letter of complaint dated 13 April 2022 which stated:

> *'[Mr Hobbs] then advised me to go home as it doesn't look broken and if in the morning I'm worried or it looks swollen etc to come back up but it's most likely a sprain.'*

It then considered Mother 4's written statement dated 31 July 2024 which stated:

> *'Then, [Mr Hobbs] advised me to go home, saying that [Child 4] leg didn't look broken. The other thing he said to me was that, if, in the morning I was still*

worried or his right leg looked swollen, to come back. [Mr Hobbs] said it was most likely to be a sprain'

The panel found Mother 4's evidence to be consistent between her original written complaint and the witness statement provided 2 years after Child 4 was discharged. The panel further considered the oral evidence of Ms Reynolds who spoke to Mother 4 on the telephone after the complaint was made. Ms Reynolds informed the panel of Mother 4's account provided on the telephone. The panel noted that this was consistent with what was documented in Mother 4's witness statement.

The panel also had regard to Mr Hobbs' statement, and it found his account to be vague and lacking clarity. The panel was of the view that Mr Hobbs continued to state what he would have done when providing discharge advice to the mother of a child, instead of recalling and explaining specifically what he did do during the discharge of Child 4.

The panel acknowledged that Mother 4's statements are adduced as hearsay evidence however, it determined her evidence was consistent with the other evidence presented by the NMC. It therefore finds this charge proved on the balance of probabilities.

Charge 1 b) i) and 1 b) ii)

1) On 29 March 2022 in relation to Child 4,
    - b) Incorrectly recorded in Child 4's patient records that:
        - i) Child 4's mother wished to take them home.
        - ii) That you wanted Child 4 to be seen for an X-ray and/or blood samples.

These charges are found proved.

In reaching this decision, the panel took into account Child 4's Children's Emergency Document dated 29 March 2022, the letter of complaint from Mother 4 dated 13 April

2022, Mother 4’s witness statement, Ms Reynolds witness statement and oral evidence.

When deliberating the panel referred to the same evidence for charge 1 b) i) and 1 b) ii) and therefore considered these charges separately but expressed its findings together.

The panel had regard to the discharge notes completed by Mr Hobbs in Child 4’s Children Emergency Document dated 29 March 2022. He wrote:

> *‘Mum wishes to take child home as pain free and now walking full ROM. No tenderness…’*

The panel also had regard to Mother 4’s original letter of complaint dated 13 April 2022, and her written statement dated 31 July 2024, and as established in the reasoning provided regarding the previous charge. The panel found Mother 4’s evidence to be consistent and accepted her account that Mr Hobbs had advised her to take Child 4 home due to a wait time of 6 hours and that the injury was most likely a sprain not a broken bone.

The panel noted that Mother 4’s account was supported by Ms Reynolds oral evidence and written statement. The panel further had regard to Ms Reynolds oral evidence where she said that Mr Hobbs’ notes and documentation lacked the sufficient detail required when discharging and caring for paediatric patients. The panel was of the view that Mr Hobbs’ clinical documentation was vague and lacked clarity. Furthermore, it was written some 4 hours after Mother and Child 4 had left the hospital and was not recorded as a retrospective entry.

The panel next considered Mother 4’s written statement which said:

> *‘… I was told on my original first visit with ([Mr Hobbs] … it was likely a sprain and that I could just take [Child 4] home). If I had been told there was even the slightest possibility that [Child 4’s] leg was broken, I would have waited ANY amount of time.’*

The panel found that the evidence provided by Mother 4 and Ms Reynolds contradicts the account provided by Mr Hobbs and determined that it was unlikely, in the circumstances, that Mother 4 would have taken Child 4 home against medical advice, and therefore preferred the evidence of Mother 4 and Ms Reynolds.

It therefore finds both charges 1 b) i) and 1 b) ii) proved on the balance of probabilities.

Charge 2 a)

2) Your actions in charge 1) b) i) & 1) b) ii) above were dishonest in that:
   a) You knew you had advised Mother 4 that she could take Child 4 home;

This charge is found proved.

In reaching this decision, the panel took into account Child 4's Children's Emergency Document dated 29 March 2022, letter of complaint of Mother 4 dated 13 April 2022, Mother 4's witness statement, and Ms Reynolds witness statement and oral evidence.

Having found charge 1 a) ii) proved the panel determined that Mr Hobbs had known that he told Mother 4 to take Child 4 home. As such the panel was of the view that this was his genuinely held belief.

The panel considered the implications of discharging a limping child without proper assessment or treatment and had regard to Ms Reynolds oral evidence. She informed the panel that the discharge of a limping child without proper assessment or treatment could have serious medical implications, she stated that clinical documentation should be recorded immediately at the time of the consultation, due to the associated safeguarding and clinical risk involved.

In consideration of the evidence before it, the panel was of the view that ordinary decent people would find Mr Hobbs' actions to be dishonest in that he inaccurately

recorded in clinical documentation that Mother 4 wished to take Child 4 home when there are consistent accounts that he had advised Mother 4 that she should take Child 4 home. The panel noted that in line with the NMC Code and the Band 6 Charge Nurse Job Description Mr Hobbs had a duty to keep accurate and detailed records. It considered that Mr Hobbs' documentation should have reflected the discussion with Mother 4 and should have included any clinical advice given to her. The panel determined that Mr Hobbs' clinical documentation did not accurately record any of this information and had misrepresented what had in fact been discussed.

It therefore finds this charge proved.

Charge 2 b)

2) Your actions in charge 1) b) i) & 1) b) ii) above were dishonest in that:
    b. You intended to mislead anyone reading the patient record into believing that you had advised Mother 4 about the risks associated with leaving the hospital.

This charge is found proved.

In reaching this decision, the panel took into account Child 4's Children's Emergency Document dated 29 March 2022, the letter of complaint from Mother 4 dated 13 April 2022, Mother 4's witness statement, Ms Reynolds witness statement and oral evidence, Job Description for Band 6 Junior Charge Nurse, RCA Investigation Report dated 11 November 2022 and the NMC Code.

The panel considered the clinical documentation entry made by Mr Hobbs dated 29 March 2022. The panel found the entry made to be vague and lacking detail surrounding the risks involved with Child 4 leaving the hospital. The panel was of the view that the clinical note did not reflect the correct procedure surrounding safeguarding and safe discharge of a paediatric patient, nor does it reflect the conversation Mr Hobbs had with Mother 4. As such Mr Hobbs would have known that the entry would be misleading to anyone reading it.

As highlighted in the panel's reasoning under charge 1 b), the panel considered Mother 4's account to be accurate and reliable in consideration of the evidence before it. The panel further noted that the clinical document did not state whether Mr Hobbs explained or informed Mother 4 of any risks involved with discharging Child 4 without any medical assessment and treatment.

The panel determined that making such a clinical entry would not have been done mistakenly and considered that an incorrect clinical entry would only be done to intentionally mislead colleagues and would therefore amount to dishonesty. The panel further considered that an ordinary decent person would also believe an incorrect clinical entry would be misleading and therefore be dishonest. The panel therefore considered Mr Hobbs' actions to be dishonest, and it finds this charge proved.

Charge 3a) i)

3) On 10/11 November 2022:
   a) After being informed that Child 3 scored a '2' on the Child Early Warning Tool, failed to;
      i) Escalate Child 3 to the Band 7 Nurse in Charge.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Jessica Wagjiani (Ms Wagjiani), Care of the Critically Ill Child Policy Document, the Child and Young Person Observation Policy and the witness statement and oral evidence of Louisa Higgs (Ms Higgs).

The panel noted the chronology of events when making its decision. It understood that Child 3 was triaged by Mr Hobbs at 22:01 under triage category 'URGENT'. At 22:05 Child 3 had a temperature of 40 degrees C with a Children's Early Warning Tool (CEWT) score of 1. At 22:50 observations were completed again by Ms Higgs

and Child 3 had escalated to having a CEWT score of 2, Ms Higgs escalated this to Mr Hobbs.

The panel had regard to the CEWT pathway document stipulating that a score of 1 does not need to be escalated. However, a CEWT score of 2 should be escalated to the nurse in charge. The panel next considered whether Mr Hobbs had a duty to escalate the CEWT score of 2. The panel noted that Mr Hobbs was employed as a Band 6 nurse and had significant experience caring for paediatric patients. Mr Hobbs was the nurse responsible for the care of Child 3 who had a CEWT score of 2. The panel was therefore satisfied that Mr Hobbs had a duty to escalate the CEWT score to Ms Wagjiani (who was the nurse in charge) as per the policy.

The panel considered Ms Wagjiani's statement to HM Coroner for Essex dated 11 October 2023 which stated:

> *'At 23:50 repeat observations were undertaken by Health Care Assistant Louisa Higgs and [Child 3] had a CEWT score of 2 which was escalated to Charge Nurse [Mr Hobbs], action from this escalation at the time was a further dose of ibuprofen given orally by Charge Nurse [Mr Hobbs]. I as the Nurse in Charge was not made aware of her CEWT score as per the CEWT guideline.'*

The panel also had regard to the contemporaneous RCA report dated 23 March 2023 provided by Ms Reynolds which stated:

> *'This [CEWT] score triggers a Nurse in Chare review in accordance with the CEWT policy, however this did not occur, a Band 2 carried out the observations and escalated to the band 6 on duty, the score was not escalated to the Band 7 on duty…'*

The panel noted that Mr Hobbs' position as set out in his statement for HM Senior Coroner dated 29 January 2024, is that he escalated the CEWT score of one to Ms Wagjiani. However, he does not say that he escalated the score of 2 to her. This is therefore consistent with the evidence of Ms Reynolds and Ms Wagjiani which was also supported by the clinical notes and documentation completed at the time. The

panel further had regard to Ms Wagjiani's oral evidence where she stated that she would have escalated the matter further if Mr Hobbs had informed her that Child 3 had a CEWT score of 2 and taken further action such as triggering the sepsis pathway.

In consideration of the evidence before it, the panel determined that on the balance of probabilities it was more likely than not that Mr Hobbs failed to escalate Child 3's CEWT 2 score to the Band 7 nurse as required by the policy. It therefore finds this charge proved.

Charge 3 a) ii)

3) On 10/11 November 2022:
    a. After being informed that Child 3 scored a '2' on the Child Early Warning Tool, failed to;
        ii. Start the sepsis pathway for Child 3.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Ms Wagjiani, Care of the Critically Ill Child Policy Document, the Child and Young Person Observation Policy, the oral and documentary evidence of Ms Higgs and the RCA report.

The panel first considered whether Mr Hobbs had the duty to trigger the sepsis pathway for Child 3. The panel had regard to Ms Wagjiani's oral evidence during which she highlighted that the sepsis pathway should be triggered once a CEWT score of 2 has been escalated. Having found that Mr Hobbs, was aware of Child 3 having a CEWT score of 2 and failing to escalate this to the Band 7 nurse, the panel considered that as a registered Band 6 nurse, responsible for providing care to Child 3, he had the duty to trigger the sepsis pathway. The panel noted that it was Mr Hobbs' duty to follow local and national policy that a CEWT score of 2 or more should trigger a sepsis pathway.

The panel had regard to Ms Wagjiani's statement dated 4 October 2024:

> *'In accordance with that policy [Children's Emergency Department Standard Operating Procedure Policy], [Ms Higgs] escalated this as a sepsis alert to [Mr Hobbs], a fact that I was not aware of at the time and which was NOT escalated to me, either then, or at all…'*

The panel also had sight of the observation chart of Child 3 which confirmed the temperatures recorded and supported the finding of a score of 2 on the CEWT chart. The panel further considered the Early Identification and Management of Severe Sepsis and Septic Shock in Children and Young People Policy, which outlines the recognition of sepsis and the steps that should be taken. In consideration of this evidence, the panel was of the view that the sepsis pathway should have been started.

The panel had regard to the oral evidence of Ms Wagjiani and Ms Reynolds who both stated that there was no evidence to suggest that Mr Hobbs had triggered the sepsis pathway. This was supported by the written statement of Ms Wagjiani:

> *'As I said above, [Mr Hobbs] neither escalated that to me (as his Band 7 Nurse in Charge), nor started the sepsis pathway…'*

And the statement of Ms Reynolds and the RCA Report dated 23 March 2023:

> *'…The sepsis pathway was not commenced…'*

In consideration of the evidence before it, the panel determined that Mr Hobbs did not start the sepsis pathway for Child 3 as required by the CEWT policy. It therefore finds this charge proved.

Charge 3 a) iii)

3) On 10/11 November 2022:

a. After being informed that Child 3 scored a '2' on the Child Early Warning Tool, failed to;
    iii. Carry out a review of Child 3's 'Child Early Warning Score'

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Ms Wagjiani, Care of the Critically ill child policy document, the Child and Young Person Observation Policy dated 10 March 2023, the oral and documentary evidence of Ms Higgs and the RCA Investigation report for Child 3, dated 23 March 2023.

As highlighted in the reasoning for the previous charge, the panel determined that Mr Hobbs had a responsibility to care for Child 3 as the registered Band 6 nurse present at the time Child 3 was admitted to the ED. The panel noted that Mr Hobbs was not the nurse in charge however, considered that the CEWT score of 2 was escalated to him by Ms Higgs having found that as the nurse caring for Child 3 it was his duty to review that CEWT score.

The panel had regard to the statement of Ms Reynolds in the RCA Investigation Report dated 23 March 2023:

> *'No documentation from Band 6 of review of the CEWT score when the HCA escalated a score of 2. Observations are repeated at 2am child had a CEWT score of 1.'*

It also considered the written statement of Ms Wagjiani dated 4 October 2024:

> *'There is nothing to confirm that [Mr Hobbs] reviewed the CEWT score, as advised to him by [Ms Higgs]…'*

The panel also considered Mr Hobbs' statement for the HM Senior Coroner dated 29 January 2024 where he does not confirm that he reviewed Child 3's CEWT score.

The panel noted that there is no evidence to suggest that Mr Hobbs reviewed Child 3's CEWT score and in consideration of the evidence before it, the panel finds this charge proved.

Charge 3 b)

3) On 10/11 November 2022:
    b. Failed to immediately escalate the failed attempts to cannulate Child 3.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Ms Wagjiani, Care of the Critically Ill Child Policy document, the Child and Young Person Observation Policy, the oral and documentary evidence of Ms Higgs and the RCA Investigation report.

The panel had regard to Ms Wagjiani's written statement dated 4 October 2024:

> *'When JH did notify me, I told him to escalate to the paediatric Registrar on call that 'there was a failed attempt at cannulation'…'*

The panel considered that Mr Hobbs had a duty to escalate the failed attempts to cannulate Child 3 as per the direction of Ms Wagjiani who was the Band 7 nurse in charge at the time, to ensure she had clinical oversight and could direct appropriate onward care. This was also confirmed in Ms Wagjiani's statement in the report for HM Coroner for Essex document dated 11 October 2023 where she stated that Mr Hobbs informed her that the cannulation attempt was unsuccessful.

The panel was of the view that Mr Hobbs did escalate the failed attempts to cannulate Child 3 and found that there was insufficient evidence to ascertain the timescale as to whether this was escalated immediately. The panel therefore determined that the NMC has not discharged its burden of proof and therefore finds this charge not proved.

Charge 3c)

3) On 10/11 November 2022:

    c. Failed to consider an oral fluid challenge for Child 3.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Ms Reynolds and the RCA Investigation report.

The panel took the context of the charge into account when determining whether Mr Hobbs had a duty to consider an oral fluid challenge for Child 3. It noted that Child 3 was not eating and drinking for a period of couple of days prior to attending the ED and considered that undertaking an oral fluid challenge a fundamental nursing duty particularly when a patient is presenting with the symptoms and history of Child 3.

The panel had regard to Ms Reynolds oral evidence during which she stated that the triage nurse should make an assessment of direct ongoing care and highlighted that it was important that an assessment of hydration was made as dehydration could lead to shock and ultimately cardiac arrest. The panel noted that Mr Hobbs was the triage nurse on shift and therefore found that Mr Hobbs had a duty to consider an oral fluid challenge for Child 3.

The panel next considered Ms Reynolds witness statement dated 4 June 2024:

> *'…there is no evidence of consideration of an oral fluid challenge…'*

The panel also had regard to the RCA Investigation report dated 23 March 2023 which stated:

> *'There was no documentation in relation to an oral fluid challenge the triage notes that the child has a reduced oral intake there is no evidence that a fluid challenge was considered despite this, a fluid chart would have shown that the chid was not drinking enough and prompt a response.'*

The panel further reviewed Mr Hobbs' statement and noted that he makes no mention of a fluid challenge despite stating that Child 3 presented with reduced oral intake.

In relation Child 3, the panel determined that in these specific circumstances Mr Hobbs had the responsibility to consider an oral fluid challenge.

In consideration of the evidence before it, the panel determined that Mr Hobbs failed to consider an oral fluid challenge for Child 3, and therefore finds this charge proved on the balance of probabilities.

Charge 3d)

3) On 10/11 November 2022:
    d. Failed to ensure that observations were carried out every hour for Child 3.

This charge is found NOT proved.

In reaching this decision, the panel took into account the CEWT escalation aid document, Child 3's observation chart and the statement of Roz Blackboro (Ms Blackboro) – Head of Governance for Women and Children Services – to the Senior Coroner dated 26 August 2024.

The policy at the time identified that hourly observations should be carried out with a CEWT score of 3 or above, rather than 2 or above. Ms Blackboro highlighted in her statement to the Senior Coroner that as a result of investigations, the policy had now been reviewed to include hourly observations however, this was not the case at the time.

> *'The observation policy has been reviewed to include hourly observations for children's Early Warning Tool (CEWT) scoring Amber or Red.'*

The panel therefore determined that it was not a requirement at the material time to complete hourly observations of a patient with a CEWT score of 2.

The panel then considered Child 3's observation chart and noted that the observations were carried out in the appropriate intervals to comply with the CEWT escalation aid.

In consideration of the documentation before it, the panel found that the document did not highlight which nurse has the responsibility of carrying out the observations or confirm whether a band 6 triage nurse in Mr Hobbs' position would be responsible for the observations.

The panel therefore determined that the NMC has not discharged its burden of proof and finds this charge not proved.

Charge 3e)

3) On 10/11 November 2022:
    e. Failed to ensure that Child 3's blood pressure was monitored.

This charge is found proved.

In reaching this decision, the panel took into account the Children and Young People Observation Policy dated 10 March 2021, the RCA Investigation Report dated 23 March 2023, Child 3's observation chart and the oral and documentary evidence of Ms Reynolds.

Having established that Mr Hobbs had a duty of care to Child 3 as his position as the Band 6 registered triage nurse on shift, the panel considered the observation chart evidence. The panel noted that the observation chart did not show a blood pressure recording.

The panel also had regard to Ms Reynolds statement in the RCA Investigation Report:

'The Children and young people observation policy states it is essential to do BP [blood pressure] on every child and young person where indicated. With [Child 3's] history a Blood Pressure would have been a helpful diagnostic tool.'

The panel noted that Ms Reynolds also confirmed in oral evidence that no blood pressure recording was undertaken. The panel understood that given the contextual factors a blood pressure reading may have been difficult to perform but it considered that any attempt made should be recorded and in this case it was not.

In consideration of the evidence before it, the panel determined that no blood pressure monitoring had been done or attempted and therefore finds this charge proved.

Charge 3f)

3) On 10/11 November 2022:
    f. Failed to escalate Child 3 to the Paediatric Registrar for cannulation.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of all witnesses.

The panel had regard to the witness statement of Ms Wagjiani where she stated that she had asked Mr Hobbs to escalate Child 3 to the Paediatric Registrar for cannulation as highlighted in the panel's reasoning for charge 3b). The panel therefore established that Mr Hobbs had a duty to escalate Child 3 to the Paediatric Registrar and considered that he had done so in line with its previous reasoning.

The panel was aware that it was custom and practice for suitably trained health care support workers or nurses to cannulate children in the ED. The panel noted that the paediatric registrar confirmed in his written local statement, and statement to the

Coroner, that Mr Hobbs had contacted them to advise that Child 3 needed cannulation. This was consistent with the account of Mr Hobbs.

In consideration of the evidence before it, the panel was of the view that Mr Hobbs escalated Child 3 to the Paediatric Registrar for cannulation as advised and therefore finds this charge not proved.

Charge 3g)

3) On 10/11 November 2022:
    g. Failed to ensure the correct versatile vascular access solution/system was used to cannulate Child 3.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds and Ms Wagjiani.

The panel had regard to the chronology of events and noted that Child 3 was transferred to the Paediatric Assessment Unit (PAU) which was situated on Phoenix ward at 03:00 am. A resuscitation call was made approximately 4 hours later at 07:00 am at which point a clinical decision was made that a versatile vascular access solution/system was needed to cannulate Child 3.

The panel considered that at the time the versatile vascular access solution/system was needed, Child 3 was not under the care of Mr Hobbs because Child 3 had been transferred to another ward. The panel further noted that there is no evidence to suggest that Mr Hobbs was involved in the resuscitation of Child 3.

The panel determined that Mr Hobbs did not have a duty of care to Child 3 once the patient was transferred to the other ward and therefore finds this charge not proved.

Charge 4a)

4) On 4 December 2022, following your consultation with Child 2, after Child 2's parents left Accident & Emergency without seeing a doctor, you failed to
    a. Consult with a doctor to make an assessment of Child 2.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Ms Higgs, Mr Hobbs statement and the Discharge Policy for Children and Young People dated May 2021.

The panel had regard to Ms Reynolds witness statement which confirmed that Mr Hobbs had a duty to follow up with Child 2's parents if a child presents with treatable symptoms but leaves the Accident & Emergency (A&E) department without seeing a doctor or receiving medical advice:

> *'We have a clear process in place to follow up with the parents if a child presents in A&E and leaves without seeing a doctor. The nurse in charge should have a conversation with the doctor to make an assessment of the child and then call the parents to give some advice and recommend that they return if they are majorly concerned.'*

The panel could not find any reference to Mr Hobbs consulting with a doctor to make an assessment of Child 2 in his statement and noted that the account of the incident provided by Ms Reynolds aligns with Ms Higgs' account.

The panel also had regard to the following in Ms Reynolds statement:

> *'There was no documentation that I could find from [Mr Hobbs] following the initial triage assessment as I don't believe that a full clerking proforma was created, this was due to the parents leaving immediately after triage assessment. Therefore, there was no evidence that the policy was considered.'*

The panel noted that Ms Reynolds remained consistent in her oral evidence and considered her to be a credible and reliable witness.

The panel considered the Discharge Policy for Children and Young People dated May 2021, but noted that there is no explicit guidance regarding a scenario where the patient leaves the ED prior to receiving medical assessment.

The panel concluded that there was no evidence of Mr Hobbs consulting with a doctor to make an assessment of Child 2, noting there was no documentation from a doctor or from Mr Hobbs to this effect.

In consideration of the consistency of the evidence before it the panel found that it is more likely than not that Mr Hobbs did not consult with a doctor to make an assessment of Child 2. It therefore finds this charge proved.

Charge 4b)

4) On 4 December 2022, following your consultation with Child 2, after Child 2's parents left Accident & Emergency without seeing a doctor, you failed to

    b. Call Child 2's parents to provide discharge advice.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, the oral evidence of Ms Higgs, the Discharge Policy for Children and Young People dated May 2021, the oral evidence of Ms Wagjiani and Mr Hobbs' local statement.

The panel had regard to Ms Reynold's witness statement which highlighted that Mr Hobbs had a duty to call Child 2's parents to provide discharge advice:

'…The nurse in charge should have a conversation with the doctor to make an assessment of the child and then call the parents to give some advice and recommend that they return if they are majorly concerned….'

The panel also had regard to the Discharge Policy which states:

'The discharging nurse should provide the family with appropriate advice, information and treatment to care for their child at home…'

The panel determined that Mr Hobbs had a duty to contact Child 2's parents to provide discharge advice.

The panel took into account the oral evidence of Ms Higgs (a healthcare assistant) who advised that she had followed the parents when they were leaving the hospital, to try and persuade them to stay for assessment and treatment, and when they refused to do so, she provided safety netting advice to them. The panel had regard to Ms Reynolds oral evidence where she said that despite Ms Higgs providing advice to the parents of Child 2, Mr Hobbs is a band 6 registered nurse and was therefore not absolved of any responsibility of contacting Child 2's parents after the ED visit to provide discharge advice.

The panel considered Mr Hobbs' statement and noted that he did not mention making a follow up call with Child 2's parents to provide follow up clinical advice. In consideration of the evidence before it, the panel determined that Mr Hobbs did not contact Child 2's parents and therefore finds this charge proved.

Charge 4c)

4) On 4 December 2022, following your consultation with Child 2, after Child 2's parents left Accident & Emergency without seeing a doctor, you failed to
    c) Carry out a social care referral for a welfare check of Child 2.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, Responsibilities of the Nurse in Charge of the Paediatric A&E Department document dated November 2022 and the Emergency Department Discharge letter of Child 2.

The panel had sight of the responsibilities of the Nurse in Charge of the Paediatric A&E Department document which stated it was the nurse in charge's responsibility to:

> *'Ensure staff complete Safeguarding processes and procedures correctly…'*

The panel had regard to the oral evidence of Ms Reynolds who confirmed that the circumstances in relation to Child 2 falls under safeguarding considerations, namely that Child 2 was taken from the ED prior to assessment and against medical advice. The panel determined that Mr Hobbs, as the nurse in charge at the time, had the responsibility to carry out a social care referral for a welfare check of Child 2.

The panel also had regard to the ED discharge letter completed by Mr Hobbs and noted that there was no record of any safeguarding referral which would have been critical information to provide to Child 2's General Practitioner (GP).

In consideration of the evidence before it, the panel was satisfied that no social care referral or welfare check was completed, and it therefore finds this charge proved.

Charge 5a)

5) On 7 April 2023:
    a) After Colleague A had triggered Child 1 for sepsis and handed them over to you, failed to adequately check Child 1 after hand over.

This charge is found proved.

In reaching this decision, the panel took into account the Trust Report dated 14 September 2023 regarding the incident, the oral and documentary evidence of Ms Wagjiani, Ms Reynolds and Melanie Edwards (Ms Edwards), the Children's Emergency Department Standard Operating Procedure (SOP) dated 23 December 2022, Mr Hobbs' local investigation statement dated 18 July 2023 and the oral evidence of Mother 1.

The panel understood that Child 1 came to the ED and was triaged by Ms Edwards who flagged Child 1 for sepsis and handed them over to Mr Hobbs who came on to the night shift as the nurse in charge. The panel had regard to the written statement of Ms Reynolds dated 4 June 2024 which stated:

> *'[Child 1] attended the A&E department on the 7th April and triggered for sepsis by the day team nurse and this was escalated to the Band 7 nurse on shift, Jessica Wagjiani. This was near handover time and [Mr Hobbs] came on shift as the nurse in charge of the night shift. Jessica handed over that [Child 1] had triggered sepsis to [Mr Hobbs], which [Mr Hobbs] confirmed.*

The panel determined that as the nurse in charge Mr Hobbs had the responsibility to oversee the patients in his care including Child 1 who was triggered for sepsis. The panel had regard to Mr Hobbs' local investigation statement where he said:

> *'I remember being told that she was prioritized as a query sepsis…'*

The panel was satisfied that Mr Hobbs had a duty to check Child 1 as a priority as the nurse in charge.

The panel considered 'adequate' to include seeing and meeting the patient and ensuring the fundamentals of nursing care were being followed in line with the policy and procedure. The panel considered Mother 1's oral evidence where she stated that Mr Hobbs first introduced himself to her and Child 1 when he came into the room to tell Child 1's parents that he had observed that Child 1's heart rate had dropped. The panel therefore determined that this was the first time that Mr Hobbs

had attended to Child 1 and this would have been over an hour after he had assumed responsibility as the nurse in charge.

The panel had sight of the Trust Report dated 14 September 2023 which stated:

> *'It is clear from his interview that despite the child being handed over as what [Mr Hobbs] would consider a priority patient and being the Nurse in Charge he did not check the patient after handover.'*

The panel also had regard to the clinical notes completed by Mr Hobbs and noted that this interaction was recorded at 21:11 which was over an hour after Child 1 was handed over to him. The panel also had regard to Mr Hobbs' local interview record dated 18 July 2023 where he advised: *'it was only in passing'* that he completed the observations. The panel determined that this did not represent an adequate check of Child 1.

In consideration of the evidence before it, the panel was satisfied that Mr Hobbs failed to adequately check Child 1 after hand over. It therefore finds this charge proved.

Charge 5b)

5) On 7 April 2023:

   b) Failed to start a fluid challenge for Child 1, as required.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Teresa Tredoux (Ms Tredoux), the oral and documentary evidence of Ms Edwards, the Trust Report dated 14 September 2023 regarding the incident, Mr Hobbs' local investigation statement dated 18 July 2023 and the oral and documentary evidence of Ms Reynolds.

The panel found that Mr Hobbs had the responsibility of starting the fluid challenge for Child 1 when he came on shift and took over from Ms Edwards. The panel note that Ms Edwards could have also started the fluid challenge, the panel was of the view that Mr Hobbs should have identified that the fluid challenge had not been started and started one at that point. The also panel had regard to the Trust Report dated 14 September 2023 which stated:

> *'[Child 1] displayed a number of symptoms that would have meant that she was at immediate risk of clinical dehydration…'*

The panel heard oral evidence from Ms Tredoux who advised that a fluid challenge could be an IV challenge prescribed by a doctor. The panel also heard oral evidence from Ms Reynolds who advised that a fluid challenge could also be oral which would entail encouraging the child to drink and monitoring oral intake. In her oral evidence Ms Reynolds confirmed that it was Mr Hobbs' responsibility at this point to ensure that Child 1 had adequate fluid intake and urine output, and she had found no documentary evidence to show that this was considered.

The panel considered Mr Hobbs' local interview in which he stated:

> *'..anyone could start a fluid challenge and consider it, so whether it's doctor, Nurse, HCA, we all kind of involved in that.'*

Mr Hobbs further stated that:

> *'It can be a very quick document. It's very easy to do, but it's also very easy to forget, so it wouldn't be complete.'*

In consideration of the evidence before it, the panel was of the view that whilst it was not Mr Hobbs' sole duty to start the fluid challenge for Child 1, as nurse in charge he had a duty to ensure it was started by someone. The panel determined from the evidence that Child 1 presented as dehydrated and there was a clear clinical need for a fluid challenge and one was not started. It therefore finds this charge proved on the balance of probabilities.

Charge 5 c)

5) On 7 April 2023:

c) Incorrectly informed Mother 1 that you had seen Child 1's heart rate, drop below 140bpm.

This charge is found proved.

In reaching this decision, the panel took into account Mr Hobbs' local investigation statement dated 18 July 2023, the oral and documentary evidence of Mother 1 and the oral and documentary evidence of Ms Reynolds.

The panel heard oral evidence from Mother 1 who stated that Mr Hobbs had told her that Child 1's heart rate had dropped below 140bpm. Mother 1 informed the panel that she was lying on the hospital bed with Child 1 and could see the heart rate monitor at all times in the reflection of the metal door panel, she stated that she did not see Child 1's heart rate drop.

The panel considered Mr Hobbs' local investigation statement which said:

'I informed mum that I had seen the heart rate below 140 and was currently at 130 and therefore safe for discharge as per the doctors plan. Mum was happy to take child home if the team was and I reassured mum that I had noticed the heart rate had reduced when I passed and while in the room the heart rate Was at a steady 130.'

The panel also considered the witness statement of Ms Reynolds:

'[Child 1] was moved to a side room and was monitored. She had three sets of abnormal observations from other nurses and then [Mr Hobbs] recorded a normal set of observations where her heart rate had decreased.

The panel further considered the oral evidence of Ms Reynolds who remained consistent in this statement and stated she was concerned that the observations had dramatically changed when Mr Hobbs observed Child 1.

The panel had regard to the contextual factors regarding Child 1, namely the lack of fluid challenge, and further to Ms Reynolds' oral evidence accepted that it would be surprising for Child 1's heart rate to drop in these circumstances. The panel further considered that Mother 1 would be vigilant and focused on monitoring Child 1's heart rate in order to assess whether her heart rate had dropped and it would be safe to take Child 1 home. The panel found Mother 1 to be a credible and reliable witness and noted that Mother 1 would naturally be sensitive to the wellbeing of her child. The panel preferred the evidence of Mother 1 to that of Mr Hobbs on the basis that she remained consistent in her account.

Furthermore, the panel noted that in Mr Hobbs' account he informed Mother 1 that the heart rate had dropped and remained at 130bpm whilst Child 1's parents were in the hospital room. The panel considered this to be implausible, as the panel was of the view that given the significance of Child 1's heart rate falling, had it reduced, Mr Hobbs would have directed Child 1's parents to look at the monitor showing a reduced heart rate before advising it was safe to take Child 1 home. He did not do so.

In consideration of the evidence before it, the panel therefore finds this charge proved on the balance of probabilities.

Charge 5 d)

5) On 7 April 2023:

    d. Incorrectly recorded in Child 1's nursing documentation in that you had seen Child 1's heart rate, drop below 140bpm.

This charge is found proved.

In reaching this decision, the panel took into account Mr Hobbs' local investigation statement dated 18 July 2023, the oral and documentary evidence of Mother 1, Child 1's Hospital Notes dated 7 – 9 April 2023 and the oral and documentary evidence of Ms Reynolds.

The panel reviewed Child 1's hospital notes which recorded a heart rate of 130bpm. The panel was satisfied that Mr Hobbs made this entry, and that it was incorrect as set out in charge 5c) and therefore finds this charge proved.

Charge 5 e)

5) On 7 April 2023:

    e) Failed to complete a safe discharge check/plan before discharging Child 1.

This charge is found proved.

In reaching this decision, the panel took into account Mr Hobbs' local investigation statement dated 18 July 2023, the oral and documentary evidence of Ms Reynolds and Ms Tredoux, the Trust Report dated 14 September 2023 regarding the incident, the witness statement of Mother 1 dated 28 August 2024, Reflective Learning Statement from Mr Hobbs and the Children's Emergency Department SOP dated 23 December 2022.

The panel had regard to Mr Hobbs' local investigation statement where he confirmed he had a duty as the charge nurse to safely discharge Child 1, and follow the correct procedure, and complete the relevant discharge documentation. This was also confirmed by Ms Reynolds in both her oral and documentary evidence. The panel considered Mr Hobbs' reflective learning statement (undated) where he outlined the safe check/plan in line with the discharge policy:

> *'At this stage I could have gone back to the doctor who had assessed they child informing them of the observations to confirm they was still happy with discharge and jointly completed the safe discharge boxes.'*

The panel also had regard to the Children's Emergency Department SOP document which stated:

> 'All care treatment and discussions with the child and family should be *documented in line with the clinical record keeping policy'*

The panel considered the process outlined by Mr Hobbs to reflect a safe discharge check/care plan. The panel was therefore satisfied that Mr Hobbs had a duty to complete a safe discharge check/plan before discharging Child 1.

The panel next considered the oral evidence of Ms Tredoux where she stated that:

> *'the fact that Child 1 wasn't eating or drinking should have formed part of the decision as to whether Child 1 could be discharged and it would be unsafe to discharge Child 1 as they were dehydrated.'*

The panel also had regard to Mother 1's witness statement, in particular:

> *'We later found out that the registrant did not follow the correct discharge protocol. He was meant to sign her discharge paperwork and also get a doctor to sign but he failed to do this.'*

Ms Reynolds also supported this position in her witness statement dated 4 June 2024.

The panel considered the evidence to be consistent between several witnesses and confirmed by Mr Hobbs himself in his statements. The panel therefore finds this charge proved.

Charge 5 f)

5) On 7 April 2023:
    f. Discharged Child 1 without consulting a doctor.

This charge is found proved.

In reaching this decision, the panel took into account Mr Hobbs' local investigation statement dated 18 July 2023, the oral and documentary evidence of Ms Reynolds and Ms Tredoux, the Trust Report dated 14 September 2023 regarding the incident, the witness statement of Mother 1 dated 28 August 2024, Reflective Learning Statement from Mr Hobbs and the Children's Emergency Department SOP dated 23 December 2022.

The panel considered the written statement of Ms Reynolds dated 4 June 2024:

> *'[Mr Hobbs] did not confirm this with a doctor that he could send her home.'*

Having found that one aspect of failing to complete a safe discharge plan is failing to consult with a doctor, the evidence in charge 5d) also supports this finding. The panel determined that Mr Hobbs did not consult with a doctor before discharging Child 1. The panel therefore finds this charge proved.

Charge 5 g) i)

5) On 7 April 2023:
    - g. Failed to document adequate records relating to Child 1's discharge, in that you:
        - i. Failed to record adequate information about why Child 1 was being discharged in their patient notes.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, Child 1's hospital notes dated 7 -9 April 2023 and Mr Hobbs' local investigation statement dated 18 July 2023.

As set out in charge 5 e), the panel determined that Mr Hobbs had a duty to record adequate information regarding Child 1’s discharge from hospital as required by the policy.

The panel reviewed the clinical notes written by Mr Hobbs and was of the view that the clinical rationale for discharging Child 1 was not specific or sufficiently detailed. The panel considered the oral evidence of Ms Reynolds where she highlighted that it would be appropriate to record adequate information about Child 1’s discharge from hospital because:

> *‘Child 1 had a complex background which would make you more cautious in your approach and ensure that there was some record in place’*

In the context of a child with a complex medical background presenting with medical sepsis, the panel was of the view that more specific documentation surrounding the discharge of Child 1 should have been completed. This view was supported by the oral and documentary evidence of Ms Reynolds who explained what clinical information should be documented in discharge notes. For example, the consideration of lack of fluid intake in the context of the other presenting symptoms of the child and more thorough documentation regarding what Child 1’s parents have been advised to look out for with regard to any deterioration and the potential need to return to the hospital.

The panel had regard to the clinical notes and information regarding the complexity of Child 1’s presentation at the hospital. The panel found that the documentation completed by Mr Hobbs contained no justification for the decision made and instead focused on the conversation with Child 1’s parents rather than clinical assessment and evaluation.

Upon review of the evidence before it, the panel determined that the clinical notes contained insufficient evidence of appropriate clinical discharge documentation and therefore determined that this charge is found proved.

Charge 5 g) ii)

5) On 7 April 2023:

    g. Failed to document adequate records relating to Child 1’s discharge, in that you:

        ii. Failed to document the advice you provided to Child 1’s parents on discharge.

This charge is found proved.

In reaching this decision, the panel took into account Child 1’s hospital notes dated 7 -9 April 2023, the Trust Report dated 14 September 2023 regarding the incident, Mr Hobbs’ Local Investigation statement dated 18 July 2023, and the Children’s Emergency Department SOP dated 23 December 2022.

The panel established that Mr Hobbs had a duty to document the advice provided to Child 1’s parents for the same reasons as set out in charges 5 e) and 5 g) i).

The panel had regard to the Child 1’s hospital notes completed by Mr Hobbs which states that Child 1 was ‘discharged with a safety net’. The panel noted that Mr Hobbs did not explain what the safety net advice was or provide any further detail regarding this.

The panel also had regard to the Trust Report regarding the incident which stated:

> *‘In preparation for discharge [Mr Hobbs] recalled during his interview that he advised [Child 1’s] mother to give Nurofen or Calpol, but there was no evidence of this advice in the Emergency Department paperwork – he explained in interview that he would usually call this safety net advise; [Mr Hobbs] was unable to recall whether he had documented this.’*

The panel further considered the interview notes between Mr Hobbs and Ms Tredoux where she stated:

'…it just seems a little bit unusual that their child's been there for three hours and there's no mention of eating, drinking, any drugs that she's had, or any specific advice given…'

In consideration of the evidence before it, the panel determined that Mr Hobbs failed to adequately document the advice provided to Child 1's parents on discharge, and therefore finds this charge proved.

Charge 6a) and 6b)

6) Your actions in charge 5) c) above were dishonest in that you:
   a) Knew that Child 1's heart rate had not dropped below 140bpm.
   b) Intended to mislead Mother 1 into believing that Child 1's heart rate had dropped below 140bpm.

These charges are found proved.

In reaching this decision, the panel took into account Child 1's hospital notes dated 7 - 9 April 2023, the Trust Report dated 14 September 2023 regarding the incident, Mr Hobbs' Local Investigation Statement dated 18 July 2023, and the witness statement of Mother 1 dated 28 August 2024.

Having found charge 5 c) proved the panel considered whether Mr Hobbs was dishonest in his actions. The panel had regard to the context surrounding the incident and noted that Mr Hobbs was an experienced nurse who was familiar with monitoring observations and working in a paediatric environment. The panel were therefore of the view that it would be unlikely that Mr Hobbs would mistakenly state that Child 1's heart rate had dropped. The panel had regard to Mr Hobbs' local investigation statement where he said that Child 1's heart rate had dropped twice and remained at 130bpm whilst speaking with Mother 1 in the hospital room.

Having determined that Mr Hobbs knew Child 1's heart rate had not dropped below 140bpm, the panel noted that he also informed Mother 1 that she could take Child 1

home as Child 1’s heart rate had dropped below 140bpm. This was supported by Mr Hobbs’ own clinical entry:

> *‘repeat observations. HR130 and family (mum) happy to take child home if team happy the HR has reduced. Reassured mum on two occasions, seen below 140 but can continue to monitor if mum would like. Mum happy to take child home. Mum happily discharged with safety net.’*

The panel was satisfied that Mr Hobbs’ actual state of mind as to knowledge or belief as to facts was that Child 1’s heartrate had not dropped below 140bpm. However, Mr Hobbs intended to mislead Mother 1 into believing it had so that he could inform her that it was safe to take Child 1 home. The panel was satisfied that Mr Hobbs so intended to mislead Mother 1 despite knowing that it would not be safe for Child 1 to be discharged when their heart rate had not in fact dropped below 140bpm.

In light of the above, the panel was satisfied that Mr Hobbs’ conduct, as set out in charges 6 a) and b) was dishonest by the standards of ordinary and decent people. The panel noted that the impact of this was that Mother 1 had been given false assurance that Child 1 was improving when in fact they were not.

In consideration of the evidence before it, the panel therefore finds charges 6 a) and b) proved.

Charge 7a) and 7 b)

7) Your actions in charge 5) d) above were dishonest in that you:
    a) Knew that Child 1’s heart rate had not dropped below 140bpm.
    b) Intended to mislead anyone relying on Child 1’s nursing documentation into believing that their heart rate had dropped below 140bpm

These charges are found proved.

In reaching this decision, the panel took into account Mr Hobbs’ local investigation statement dated 18 July 2023, the oral and documentary evidence of Mother 1, Child

1’s hospital notes dated 7 -9 April 2023 and the oral and documentary evidence of Ms Reynolds.

Having found charge 5 d) proved in that Mr Hobbs incorrectly recorded in the nursing documentation that Child 1’s heart rate had dropped below 130 bpm, the panel was of the view that Mr Hobbs had completed an intentional act to document what he knew was an incorrect recording. The panel had regard to Child 1’s hospital notes and considered this to be false documentation and a false entry. It determined that Mr Hobbs knew he was being dishonest in making an incorrect entry and that the only reason for him to do this would be to mislead anyone reading the documentation.

The panel found that Mr Hobbs had intentionally incorrectly recorded that Child 1’s heart rate had dropped below 140bpm on the clinical records. The panel was of the view that ordinary and decent people would consider Mr Hobbs heart rate recording to be false documentation and misleading to colleagues. The panel noted that the dishonesty resulted in an unwell child presenting with a complex medical background being inappropriately and prematurely discharged from hospital.

The panel finds Mr Hobbs’ actions in charge 5 d) to be dishonest and it therefore finds charge 7 a) and b) proved.

Charge 8 a) i)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
    a) Failed to use the Children’s Early Warning Tool for Child 1, in that you:
        i) Did not complete a full set of observations for Child 1.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Children’s Emergency Department SOP dated 23 December 2022, the CEWT escalation aid and Child 1’s Hospital notes dated 7 -9 April 2023.

The panel had regard to the CEWT observation aid and whilst the aid was clear in stating that observations should have been completed in line with the CEWT score, which should have been hourly at a minimum, the panel had insufficient evidence before it to be satisfied that it was specifically Mr Hobbs' duty to complete the observations albeit it was his duty to ensure that they were completed in line with the CEWT guidance.

The panel reviewed Child 1's hospital notes and observation chart and noted that observations were completed at every 15–30 minute intervals by other staff which is in line with the requirement of the CEWT escalation tool.

On this basis, while satisfied that Mr Hobbs did not complete a set of observations, the panel finds this charge not proved because there was no information to suggest that it was specifically Mr Hobbs' responsibility to complete the observations. The panel was aware that Mr Hobbs was the nurse in charge and as such his duty was to ensure that the observations were completed by someone, which indeed they were. The panel therefore finds this charge not proved.

Charge 8 a) ii)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   a) Failed to use the Children's Early Warning Tool for Child 1, in that you:
      ii) Did not complete a plan of care for Child 1.

This charge is found proved.

In reaching this decision, the panel took into account the CEWT escalation aid, the Trust Report dated 14 September 2023 regarding the incident, Child 1's Hospital Notes dated 7-9 April 2023, the oral and documentary evidence of Ms Reynolds and Ms Tredoux.

The panel had regard to the CEWT escalation aid which highlights that a child presenting with a CEWT score of 2 must be escalated to a nurse in charge or doctor for review. The panel had regard to the oral evidence from Ms Tredoux and Ms Reynolds advising that Mr Hobbs should have provided oversight of nursing care, given his level of experience and advanced training. The panel therefore determined that Mr Hobbs had a duty to review, complete and document a care plan following the review of Child 1.

The panel also had regard to the Trust Report dated 14 September 2023 which stated:

> *'[Mr Hobbs] was not involved in making a plan for the care of [Child 1] as he confirmed during his interview that he trusted [Ms Edwards] and the team working with [Child 1] to care for them.'*

The panel further noted that the clinical documentation completed by Mr Hobbs did not show any record of a plan of care.

In light of all the evidence before it, the panel therefore found this charge proved.

Charge 8b)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   b) Failed to put out a cardiac arrest/2222 call for Child 1, in a timely manner.

This charge is found proved.

In reaching this decision, the panel took into account the CEWT escalation tool, the oral and documentary evidence of Ms Reynolds, Mr Hobbs' local investigation statement dated 18 July 2023.

The panel referred to the CEWT escalation tool where it states that once the score is 5 to:

‘call 2222 immediately and if the team is not immediately available, increase frequency of observation to ½ hourly’.

The panel was therefore satisfied that in the circumstances Mr Hobbs had a duty to put out a cardiac arrest/2222 call for Child 1 immediately following the first CEWT score of 5.

The panel further noted that Mr Hobbs was the nurse in charge and was Emergency Paediatric Life Support (EPLS) trained and considered that he would recognise the importance of making the 2222 call or putting out a cardiac arrest for Child 1.

The panel had regard to the interview noted between Ms Tredoux and Mr Hobbs:

‘[Ms Tredoux] – “So effectively, [Child 1] did have three CEWT scores of five. Appreciate that was half an hour's worth without an arrest call being put out. First one at 9:45, one at 5 past 10 and one at 20 past 10, I think, and then I believe that the arrest call went out at 22:22.

[Mr Hobbs] – “I believe so. Yeah. I don't know.’

The panel also had regard to the witness statement of Ms Reynolds dated 4 June 2024 which states:

‘if [Mr Hobbs] placed the 2222 call then additional staff would have attended and that is the emergency procedures we have in place.’

The panel noted Mr Hobbs’ local interview in which he stated that the doctor had advised him to fast bleep for additional support rather than putting out a 2222 call. However, the panel was of the view that as a senior EPLS trained nurse he should have made his own assessment of the situation based on the CEWT score of 5 and followed the correct procedure.

The panel was satisfied that Mr Hobbs had not put out a cardiac arrest/2222 call for Child 1 in a timely manner and therefore finds this charge proved.

Charge 8 c)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:

    c) Failed to move Child 1 to the resuscitation room.

This charge is found proved.

In reaching this decision, the panel took into account the Trust Report dated 14 September 2023 regarding the incident, the oral and documentary evidence of Ms Reynolds and Mr Hobbs' Local Investigation Statement dated 18 July 2023.

The panel had regard to the Trust Report dated 14 September 2023 which stated:

> *'The Children's ED SOP section states 12.1 Table 1 KPIs states that children whose CEWT score or clinical impression suggests need to immediate intervention should be moved to resus; 100% compliance is expected with this. By not moving [Child 1] to the resuscitation room [Mr Hobbs'] actions were in contradiction to the SOP.'*

The panel noted that this position was supported by Ms Reynolds in her oral and documentary evidence. The panel understood that the reason for moving Child 1 to ensure that the appropriate equipment needed for resuscitation was immediately available.

The panel had regard to Mr Hobbs' local investigation statement where he confirms he did not move Child 1:

> *'So I didn't wanna [sic.] delay the right people in the child at that time and then if they need to be in Resus, we go to Resus, if we don't need to go to Resus,*

we can stay here. So we were still in the middle ground, I felt, and yeah, I didn't want people and delay in that review.'

The panel heard oral evidence from Ms Reynolds that Mr Hobbs decision was not sound clinical decision making and the failure to move Child 1 was against the guidance. The panel noted that Child 1 was eventually moved to the resuscitation room under the instruction of other clinical staff.

The panel therefore finds this charge proved.

Charge 8 d)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
    d) Failed to actively participate in the resuscitation of Child 1.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Trust Report dated 14 September 2023 regarding the incident.

The panel had regard to the following statement within the Trust Report:

'In relation to [Mr Hobbs] participating in resuscitation, once [Child 1] was moved to the resuscitation room, with nursing support in place from Phoenix Ward, there was not specific clinical need for [Mr Hobbs] to provide hands on care.'

The panel considered that Mr Hobbs was suitably qualified to assist with the care of Child 1 as the nurse in charge and advanced EPLS training. The panel noted that at the point resuscitation was commenced, another nurse who was equally qualified took over the care of Child 1 from Mr Hobbs.

Whilst the panel was of the view that Mr Hobbs did not actively participate in the resuscitation in the presence of other staff, the panel determined that Mr Hobbs did not have a duty to do so. It therefore finds this charge not proved.

Charge 8 e)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   e. On one or more occasions left the paediatric ward unattended, without any clinical justification.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Ms Reynolds, the Trust Report dated 14 September 2023 regarding the incident and the oral and documentary evidence of Ms Tredoux.

The panel considered Mr Hobbs' local interview dated 18 July 2023 with Ms Tredoux where he confirmed that he left the paediatric word unattended with unqualified staff on one or more occasions.

> *'[Ms Tredoux] – "That moves us on to sort of the 7th allegation. You left a few times the department to, as you say, to check on [Ms Higgs] or to check on [Child 1]. Is that something that's OK to do? How should it run because I'm presuming another [Child 1] could come through the doors of the paediatric ED at any point."*
> *[Mr Hobbs] – "Yeah."'*

In consideration of the evidence before it, the panel was satisfied that Mr Hobbs left the paediatric ward unattended on at least one occasion. With regards to any clinical justification, the panel considered the Trust Investigation report:

> *'… there was not specific clinical need for [Mr Hobbs] to provide hands on care [to Child 1]'*

Further, the report stated:

'[Jo Hennessy] stated during her interview that she remembers [Mr Hobbs] coming to Theatre to bring something up earlier in the night. [Ms Higgs] also explained in her interview it was her understanding than an adult nurse was watching the department. This was supported by [Jo Hennessy] who stated she asked who was watching the Department, [Mr Hobbs] confirmed that he had asked 'minors' to cover. For information, minors is a part of the main emergency Department.'

Mr Hobbs in his local interview confirmed that he had left the department stating:

'Luckily, no child did come in that time…'

The panel was satisfied that Mr Hobbs had left the paediatric ward unattended and without clinical justification as Child 1 was in the care of the resuscitation team. The panel therefore finds this charge proved.

Charge 8 f) i)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
    f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:
        i) Did not provide oversight of Child 1;

This charge is found proved.

In reaching this decision, the panel took into account the Responsibilities of the Nurse in Charge document dated November 2022, the Trust Report dated 14 September 2023 regarding the incidents, the written statement of Ms Edwards dated 8 August 2024, the documentary and the oral evidence of Ms Reynolds.

The panel had regard to the Responsibilities of the Nurse in Charge document dated November 2022 which stated:

> *'The Nurse in Charge should have knowledge of any Sick child or a child with a complex need including Sepsis, Safeguarding, Emotional Health and Wellbeing, yellow card holders, pts requiring Resuscitation, Trauma or other.'*

In consideration of this document, the panel determined that Mr Hobbs had a duty to provide oversight of Child 1 as the Nurse in Charge at the time.

When making its decision, the panel considered 'oversight' to include 'clinical leadership'. It determined that clinical leadership is supporting staff, ensuring policy and procedure is followed, making sound clinical decisions, assessing skill mix of staff, ensuring that the correct staff are looking after the correct patients, in particular ensuring that the Sick Child policy is followed in the case of a critically ill child.

The panel also had regard to Ms Edwards written statement dated 4 August 2024:

> *'I do not feel the Nurse in Charge [Mr Hobbs] provided clear clinical leadership, because he didn't seem to have clear oversite [sic.] of [Child 1] who was the sickest child in the department at the time...'*

The panel determined that having found charges 8a) ii), 8b), 8 c) and 8 e), that amounted to failure to provide clear leadership as the nurse in charge and therefore did not provide oversight of Child 1. The panel also had regard to Ms Reynolds oral evidence where she stated that '*the most experienced staff should be looking after the sickest child'*, who was in this case Mr Hobbs. Ms Reynolds also stated that Mr Hobbs failed to follow procedure and his *'non action is what causes harm'*.

In consideration of the evidence before it and having found the previous charges proved in relation to charge 8, the panel determined that Mr Hobbs failed to provide clinical leadership during Child 1's stay in the ED by not having sufficient oversight of them. The panel therefore finds this charge proved.

Charge 8 f) ii)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:

   a) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:

      ii. Spent most of your time at the nurses' station.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement of Ms Edwards dated 8 August 2024, the oral evidence of Ms Reynolds and the Trust Report dated 14 September 2023regarding the incidents.

The panel noted that Mr Hobbs was the nurse in charge at the time of the incident.

The panel had regard to Ms Reynolds' oral evidence where she stated that Mr Hobbs should be caring for the sickest child as the nurse in charge. The panel also considered the written statement of Ms Edwards:

> *'…he was at the nursing station most of the time.'*

The panel further considered the Trust Report regarding Child 1, which stated that:

> *'There was insufficient [evidence] to suggest that [Mr Hobbs] remained at the nursing station'*

The panel was clear that whilst Child 1 was in the ED Mr Hobbs should have been more directly involved in their care, and he was not. However, there was no evidence before it to suggest where Mr Hobbs was in the department at any given time, whether he had spent most of his time at the nurses' station. The panel therefore found that the NMC had not discharged its burden of proof and finds this charge not proved on the balance of probabilities.

Charge 8 f) iii)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:

    f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:

        iii. On one or more occasions declined Colleague A's request to move Child 1 to the resuscitation area.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written statement of Ms Edwards dated 8 August 2024, the Trust report dated 14 September 2023 regarding the incidents and the written statement of Ms Reynolds dated 4 June 2024.

The panel found that Mr Hobbs had a duty to move Child 1 to the resuscitation area as per its reasoning in charge 8 c).

The panel had regard to Ms Edwards' evidence where she said the following in her written statement dated 8 August 2024:

> *'Then I asked [Mr Hobbs] to bleep anaesthetics - when anaesthetics arrived, I said I think we need to go to resus.'*
>
> …
>
> *'I was concerned about [Child 1] and asked [Mr Hobbs] twice to have [Child 1] moved to resus, but he refused to do this. We eventually did go around to the resus. I'm not too sure how long after it took, but the consultants said we were going – and we went;'*

The panel also had regard to Ms Edwards statement provided in the Trust Report which stated:

> *'[Ms Edwards] explained that [Mr Hobbs] decided that they should stay in the department as there were only 2 trained nurses – [Ms Edwards] accepted this decision – [Ms Edwards] had worked in ED for less than 2 months and said that [Mr Hobbs] had worked there for a long time and that she trusted his judgement.'*

The panel also considered the written statement of Ms Reynolds dated 4 June 2024 who supported Ms Edwards' position:

> *'Additionally, [Ms Edwards] asked if [Child 1] could be moved to the resus area. The value of this is that the team then focusses directly on that child and you have all the emergency equipment available'*

The panel found Ms Edwards to be a credible and reliable witness who remained consistent in her written and oral evidence. The panel noted that her account was also supported by Ms Reynolds statement. The panel also had regard to Mr Hobbs' internal interview conducted by the Trust. The panel found that Mr Hobbs confirmed that he declined the request to move Child 1 and stated that his rationale for doing this was because he did not want to delay the paediatric nurse getting to Child 1. The panel noted the oral evidence of Ms Reynolds who said that this was an unsafe clinical decision and prevented other appropriate clinicians from arriving in a timely manner.

The panel determined that effective clinical leadership in this scenario would have been to agree to the appropriate request from Ms Edwards, which was in line with policy and procedure and would have facilitated optimal clinical care for Child 1.

In consideration of the evidence before it, the panel found that Mr Hobbs had declined Ms Edwards' request to move Child 1 to the resuscitation area. It therefore finds this charge proved.

Charge 8 f) iv)

8) On 8 April 2023 after Child 1 had returned to the hospital presenting in a poor state:
   f) Failed to provide clear clinical leadership as the Nurse in Charge, in that you:
      iv. Did not accompany Child 1 to the resuscitation area.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Reynolds, Mr Hobbs' local statement dated 18 July 2023.

The panel determined that Mr Hobbs had a duty as the nurse in charge to provide clinical leadership to the department, in this context appropriate clinical leadership would be to remain with a sick patient under his care until safely transferred to the resuscitation area. The panel reviewed the local interview and Mr Hobbs' statement where he stated that at the time Child 1 was transferred, he was on the phone with the ward in order to get extra support for Child 1.

The panel noted that Mr Hobbs described people rushing past him to go to the resuscitation room. The panel found that Mr Hobbs described in detail what he was doing and who was going past him.

In consideration of the evidence before it, the panel was of the view that it was more likely than not that Mr Hobbs did not accompany Child 1 to the resuscitation area and as such failed to provide clear clinical leadership. It therefore finds this charge proved on the balance of probabilities.

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 Mr Hobbs' 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, Mr Hobbs' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Jones invited the panel to take the view that the facts found proved amount to misconduct. She invited the panel to consider the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision, namely Codes 20.1 and 20.8.

Ms Jones submitted that Mr Hobbs' actions in the charges found proved fell significantly short of the standards expected of a registered nurse and amounted to misconduct. Ms Jones submitted that Mr Hobbs had repeatedly demonstrated that his practice does not adhere to the fundamental standards of nursing and she therefore invited the panel to consider that his actions amounted to misconduct.

Submissions on impairment

Ms Jones 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.

Ms Jones stated that nurses occupy a position of trust and noted that the charges in relation to dishonesty have been found proved. Ms Jones submitted that the dishonesty found proved is on the higher scale and has taken a number of different forms including making inaccurate records, with the intention to mislead individuals reading the records into believing it as the truth and proven instances of misleading patients and colleagues.

Ms Jones submitted that Mr Hobbs has not taken accountability for his actions in the charges found proved or demonstrated any meaningful insight into his failings. She drew the panel's attention to the reflective piece (dated 2023), testimonials (dated 2024) and training certificates (dated 2025) provided by the RCN on Mr Hobbs' behalf. Ms Jones submitted that the documentation provided by Mr Hobbs is outdated and does not suggest what his current state of mind is.

Ms Jones further submitted that there is nothing before the panel to evidence whether Mr Hobbs has a change of mindset, undertaken any recent relevant training courses or developed insight since the charges were raised. She submitted that there remains a real risk that Mr Hobbs would repeat the conduct of that found proved and invited the panel to consider that a finding of impairment is necessary on the grounds of public protection and is within the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*. *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin), *Cohen v General Medical Council* [2007] EWHC 581 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

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

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 Mr Hobbs' actions did fall significantly short of the standards expected of a registered nurse, and that Mr Hobbs' actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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

To achieve this, you must:

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

8 Work co-operatively

To achieve this, you must:

8.1 only act in an emergency within the limits of your knowledge and competence.'

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

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

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. When making its decision, the panel grouped the charges according to 4 overarching themes and considered each theme separately.

The panel first considered the charges relating to providing inaccurate or inadequate information or advice, namely charges 1 a) i), 1 a) ii), 4 b) and 5 c). The panel determined that Mr Hobbs' conduct in these charges fell significantly short of the conduct expected of a registered nurse and therefore amounted to misconduct. The panel noted that Mr Hobbs' actions in charges 1a)i) and 1a)ii) led to Child 4 going home and potentially worsening their injury. The panel further noted the psychological harm Mr Hobbs' actions had caused namely in that Mother 4 stated that she was reluctant to seek help in the future. The panel found this to be extremely serious and therefore amounted to misconduct.

In relation to charge 4b) the panel noted the clinical risk associated with Child 2's parents not being adequately advised of any aftercare. The panel was of the view that Mr Hobbs had disregarded the parental concerns and minimised the clinical risks associated with failing to provide discharge advice to them. The panel considered this to cross the threshold of seriousness and therefore found Mr Hobbs' actions amounted to misconduct.

In relation to charge 5c), the panel considered Mr Hobbs' false assurance to Mother 1 relating to Child 1's heart rate dropping below 140bpm to amount to misconduct. The panel considered Child 1's heart rate to be a critical observation to ensure that

Child 1 was medically stable and safe to go home. This false reassurance delayed Mother 1 returning to ED the following day when Child 1's condition did not improve. The panel found that Mr Hobbs' actions associated with these charges would be considered deplorable by other nurses and fell far below the standard expected of a registered nurse.

The panel next considered the charges relating to recording incorrect, misleading or insufficient information in clinical documentation, namely charges 1 b)i), 1 b)ii), 5 d), 5 g)i) and 5 g)ii). The panel considered all of the charges within this theme amounted to serious misconduct. The panel considered falsification of records is a direct contravention of the NMC Code and would potentially have a significant impact on the onward care received by patients and the standards expected of the nursing profession. The panel found Mr Hobbs' actions to be dishonest in that he intentionally recorded misleading and incomplete information in patients' clinical documentation which other individuals involved in the onward care of the patient would be reliant on.

The panel noted the negative effect Mr Hobbs' actions had on Child 4 and their parents due to safeguarding protocols being triggered on their subsequent visit after Mr Hobbs' incorrect and misleading documentation. This included unnecessary additional clinical examinations for Child 4 and the psychological and emotional harm caused to both Child 4 and their parents. In consideration of the information before it, the panel considered Mr Hobbs' conduct found proved in relation to recording incorrect, misleading or insufficient information in clinical documentation amounted to misconduct.

The panel next considered the charges found proved in relation to dishonesty, namely, charges 2a), 2b), 6a), 6b), 7a) and 7b). The panel determined that honesty is a fundamental tenet of the nursing profession and considered that Mr Hobbs had not acted honestly in relation to these proven charges. The panel noted that Mr Hobbs had misled vulnerable sick children, their parents and his colleagues which had significant clinical implications. The panel found this conduct compromised the safety and wellbeing of the children.

The panel determined that Mr Hobbs' conduct would be considered deplorable by other practitioners, was a far departure from the NMC Code and fell significantly short of the standards expected of a registered nurse. The panel therefore determined that Mr Hobbs' actions amounted to serious misconduct.

The panel then considered the charges found proved in relation to failure to provide proper clinical assessment, appropriate care or clinical leadership. Namely, charges 3a)i) 3a)ii), 3a)iii), 3c), 3e), 4a), 4c), 5a), 5b), 5e), 5f), 8a)ii), 8d), 8c), 8e), 8f)i), 8f)iii) and 8f)iv).

The panel considered that a fundamental aspect of nursing care is to make accurate and timely assessments to enable comprehensive and safe holistic care of patients. It determined that Mr Hobbs' failure to make appropriate and timely assessment, provide care or to provide adequate clinical leadership in these charges fell significantly short of the expectations of a registered nurse, and resulted in unnecessary clinical risk to the children he was responsible for.

The panel noted that Mr Hobbs was a band 6 nurse and was also the nurse in charge at the time of some of the incidents highlighted in the charges found proved. Given his experience, senior position and advanced training, the panel determined that Mr Hobbs failed to adequately care for his unwell and vulnerable patients, and had a disregard for the policies and procedures in place which are designed to keep patients safe and maintain high professional standards. The panel found that Mr Hobbs' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Hobbs' 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. 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 and empathy. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel determined that Mr Hobbs' misconduct satisfied the first limb of the *Grant* test. The panel considered that the charges found proved relate to multiple occasions and included multiple children where Mr Hobbs' misconduct had placed vulnerable patients at an unwarranted risk of harm. The panel noted the psychological and emotional harm caused to some of the children and parents under Mr Hobbs' care at the time of the incidents as well as the physical risk of harm to children caused by Mr Hobbs' failure to appropriately assess, escalate and act upon clinical presentation of those children. The panel was therefore satisfied that Mr Hobbs' actions had placed patients at unwarranted risk of harm.

The panel further determined that Mr Hobbs' misconduct has brought the nursing profession into disrepute. The panel considered Mr Hobbs' actions and inactions to have fallen far below the standard expected of a nurse and had particular regard to the charges in relation to dishonesty. The panel noted that nurses occupy a position of trust and considered Mr Hobbs' misconduct to be deplorable namely in that his actions in several charges were misleading and dishonest to the parents of the children he was responsible for. Furthermore, this extended to colleagues who were also involved in the care of the children. The panel was of the view that Mr Hobbs' actions in providing inadequate clinical care and his dishonesty would bring the profession into disrepute, and therefore determined that his misconduct engaged the second limb of the *Grant* test.

The panel further considered that there are multiple examples of Mr Hobbs' misconduct breaching the fundamental tenets of the profession and found 24

breaches across multiple areas of the NMC Code. The panel further found that Mr Hobbs failed to provide basic nursing care which impacted his ability to practice safely and effectively. The panel therefore determined that Mr Hobbs' misconduct breached the fundamental tenets of the profession and concluded that the third limb of the *Grant* test was engaged.

Having found 6 charges proved in relation to dishonesty, the panel also determined that the fourth limb of the *Grant* test was engaged. The panel noted the depth and breadth of the dishonesty which had direct consequences on the outcomes of patient care.

The panel next considered whether the misconduct found is remediable. The panel considered that the misconduct in relation to clinical failings is capable of being addressed. However, the panel was of the view that the charges in relation to dishonesty are more difficult to address and remediate due to being attitudinal in nature. The panel considered the dishonesty charges to be on the higher end of the spectrum and were indicative of deep-seated attitudinal concerns because of the several different forms of dishonesty which occurred with two different children's care over a period of time.

The panel then considered the evidence before it in determining whether or not Mr Hobbs has taken steps to remediate. The panel took into account the training certificates, the 5 positive testimonials, a reflective piece concerning Child 1's care and the Agreed Removal Form completed by Mr Hobbs.

The panel noted that Mr Hobbs' acknowledged that the charges raised are serious in his application for agreed removal, however, didn't go any further than this. The panel had sight of an undated reflective piece concerning only one child's care (Child 1) Mr Hobbs completed during the Trust investigation into Child 1's death, and was of the view that his reflection did not demonstrate any insight, remorse or empathy and he had not taken any accountability or shown any understanding of the impact of his failings on the children, their parents, his colleagues or the wider nursing profession.

The panel noted that Mr Hobbs has not provided a comprehensive reflective account relating to the full scope of the charges found proved and his misconduct. Therefore, the panel cannot be satisfied that Mr Hobbs can demonstrate full insight and understanding into the scope and seriousness of his misconduct and the implications for patients, the wider public and the reputation of the profession.

The panel had regard to Ms Tredoux's statement dated 28 August 2024:

> *'[Mr Hobbs'] response to my questions were surprisingly vague given the tragic nature of the incident. He didn't express any responsibility; he just answered my questions. ...'*

The panel also noted Ms Reynolds' witness statement which said:

> *'[Mr Hobbs'] responses to the incidents and every conversation I had with him about them lacked empathy or feeling. He does not consider the impact on the child, or the family and he is very aware of his own life and what's going on with him. He has taken no accountability or responsibility for his actions.'*

When considering whether Mr Hobbs had taken the appropriate steps to remediate his failings the panel had regard to the training certificates provided. The panel noted that the courses completed were all relevant to some of the charges raised but also noted that they were all completed on the same day. The panel further noted that a reflection piece following completion of the training courses was not provided. Consequently, Mr Hobbs had not outlined what he had learned from the training, nor demonstrated how it would strengthen his practice going forward.

Having carefully considered Mr Hobbs' investigation interviews and local statements, the panel was of the view that Mr Hobbs had minimised his behaviour and not taken accountability for his actions or omissions. The panel determined that Mr Hobbs did not show any empathy or insight into the implications of his actions or inactions.

The panel recognised that Mother 1 told the panel that Mr Hobbs had apologised to her at Child 1's inquest for his failure to follow policy and procedure. She expressed

that she was grateful for this apology. However, the panel noted that Mr Hobbs had not demonstrated any other remorse beyond this for his misconduct or the impact of it.

In light of the lack of remediation, insight and remorse along with the deep-seated attitudinal concerns identified, the panel concluded that Mr Hobbs has not demonstrated that he could practice safely and effectively in the future. The panel is therefore of the view that there is a high risk of repetition of the misconduct identified. The panel found that Mr Hobbs had not provided any evidence to suggest that his attitude or practice has since changed or that he would behave differently in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is necessary because public confidence in the profession would be undermined should the panel not find Mr Hobbs' Fitness to Practise impaired.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case given the seriousness of the charges found proved and in particular the level of dishonesty. The panel therefore also finds Mr Hobbs' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Hobbs' fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Sanction Guidance (Reference: SAN-2, SAN-3, and SAN-4 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Jones submitted that the NMC are seeking the imposition of a striking off order. She submitted that a significant period of time has passed since the incidents had taken place prior to this hearing and this is more than sufficient time for Mr Hobbs to demonstrate remediation, but he has not done so. Ms Jones submitted that there is a need to maintain public confidence and satisfy the public interest and a striking off order would be appropriate in the circumstances of this case.

Ms Jones outlined the aggravating features, namely that Mr Hobbs was in a senior position of trust as a band 6 nurse and caused multiple vulnerable patients a significant risk of harm due to his misconduct. She submitted that there is a pattern of misconduct across a significant period of time which involve numerous clinical failures across fundamental areas of paediatric nursing. Ms Jones submitted that there was an element of pre-meditation in Mr Hobbs’ actions and he failed to show remorse or remediation for his failings.

Ms Jones noted that Mr Hobbs’ has no previous findings against him with the NMC however, she submitted that his actions were attitudinal in nature making it more difficult to remediate and raise fundamental questions regarding his professionalism. She submitted that there remains a real risk that Mr Hobbs would act this way in the future and invited the panel to consider that a striking off order is the appropriate sanction.

Decision and reasons on sanction

Having found Mr Hobbs' 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:

- Mr Hobbs' behaviour, some of which was deliberate, recklessly putting children in his care at risk of harm.
- Abuse of a position of trust – The panel noted that Mr Hobbs was a senior nurse and was the nurse in charge of the shift for many of the charges found proved.
- A pattern of misconduct over a period of time – The panel noted that the misconduct identified occurred over a period of 13 months.
- Absence of insight – The panel found that Mr Hobbs had not demonstrated insight into how his misconduct impacted the children under his care, their parents, and his colleagues or the wider nursing profession.
- Vulnerability of the person receiving care - The panel considered that Mr Hobbs' conduct involved children who were vulnerable due to their age and some even more so due to being acutely unwell.

The panel carefully considered whether there were any mitigating features in the case. It noted that Mr Hobbs had offered an apology to Mother 1 at her child's inquest and also that he had completed some relevant training, albeit completed on a single day without any evidence of reflection about how it will strengthen his practice. The panel determined that these mitigating factors carry little weight and do not go any way towards outweighing the aggravating factors in the case.

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

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

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

The panel considered that Mr Hobbs' misconduct was not at the lower end of the spectrum, and it found that there is a high risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Mr Hobbs' practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Mr Hobbs' registration. In considering whether a conditions of practice order was appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). The panel noted that some of the issues concerning Mr Hobbs' clinical practice could potentially be addressed through a conditions of practice order. However, having found that some of Mr Hobbs' misconduct is indicative of deep-seated attitudinal issues and related to dishonesty, the panel was of the view that conditions could not be formulated to address the misconduct identified and would not be appropriate.

The panel also noted that Mr Hobbs has indicated that he wishes to leave the nursing profession. Mr Hobbs has not shown any potential or willingness to respond positively to re-training and therefore the panel considered that there is no evidence before it to indicate that Mr Hobbs would comply with any conditions if imposed. The

panel also had regard to the nature and seriousness of Mr Hobbs' conduct, the panel determined that a conditions of practice order would not be proportionate or sufficient in the circumstances to protect patients and to uphold professional standards.

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

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

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel also considered NMC guidance SAN-3:

> *‘Consider the professional’s insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.’*

Whilst the panel acknowledged that the risks identified could be managed by Mr Hobbs being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. The panel found the proved charges to be at the more serious end of the spectrum and involve multiple charges involving multiple children who were exposed to significant risk of harm as a result of Mr Hobbs’ actions or inactions.

Given Mr Hobbs’ lack of insight and remorse, together with no evidence of sufficient and meaningful remediation, the panel considered that there is no realistic possibility that he would address the concerns to such a level where he could return to practise safely and effectively.

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

In considering a striking-off order, the panel had regard to the NMC Guidance on *‘Sanctions for the highest risk cases’* (Reference SAN-4 Last Updated: 28/01/2026).

The panel determined that this case falls within the definition of being a ‘*highest risk case’* due to the dishonesty found in 6 charges, and the level of risk associated with Mr Hobbs’ practice.

The panel noted the following statement in NMC guidance SAN -4:

'…allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy; because of this a professional who has acted dishonestly will always be at risk of strike-off…'

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

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel considered that the dishonesty identified was exceptionally serious in this case because it created a direct risk to the children under Mr Hobbs' care, took several different forms and occurred over a long period of time. The panel found that Mr Hobbs used his status and influence as a band 6 nurse to facilitate the unsafe discharge of children and had misled their parents. The panel found that Mr Hobbs having deliberately misled Child 1's parents was particularly serious, as they trusted him as a professional. Mr Hobbs abused that trust and falsified clinical observations so that they would believe it was safe to take their unwell child home. The panel found that Mr Hobbs has not provided any evidence to demonstrate any recognition that any of his actions in the charges found proved were dishonest nor has he expressed any remorse for the consequences of his dishonesty.

The panel determined that Mr Hobbs' actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this

particular case demonstrate that Mr Hobbs' misconduct was so serious that allowing him to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Hobbs' own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Jones. She invited the panel to consider that an interim suspension order for a period of 18 months is appropriate. She submitted that a period of 18 months is sufficient to cover the interim appeal period and is necessary to protect the public and maintain the wider public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover the statutory appeal period of 28 days in which an appeal can be made.

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

That concludes this determination.