Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 17 June 2026 – Tuesday, 23 June 2026

Virtual Hearing

Name of Registrant:	**John Pius Akwasi Peprah**
NMC PIN:	21I0859O
Part(s) of the register:	Registered Nurse, Sub Part 1 Mental health nurse, level 1 (15 September 2021)
Relevant Location:	East Sussex
Type of case:	Misconduct
Panel members:	Michelle Lee (Chair, registrant member) Timothy Kemp (Registrant member) Sally Ann Kitson (Lay member)
Legal Assessor:	Caroline Hartley
Hearings Coordinator:	Clara Federizo
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mr Peprah:	Present and represented by Jerome Burch, instructed by the Royal College of Nursing (RCN)
Facts proved:	All charges proved by admission
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Caution order (12 months)**

Details of charge

That you, a Registered Nurse, in the course of, or in relation to a shift you worked on 25-26 April 2024:

1. In the course of 1:1 observation of Patient F, failed to make 3 of 4 required observation entries in their observation record

2. Between approximately 02:00 and approximately 03:00, failed to carry out:

    a) One or more observations of Patient B within 30 minutes of the previous observation

    b) An observation of Patient D within 1 hour of the previous observation

3. Between approximately 04:00 and approximately 05:00, failed to carry out one or more Head Count observations of a patient.

4. Recorded that you had carried out one or more of the observations at Schedule A when you had not.

5. Your actions at one or more of Charge 4 Schedule A, were dishonest, in that you knew you were representing that you had carried out a patient observation which you had not.

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

Schedule A:

a) In respect of Patient A, one or more entries recorded as having taken place at:
   i) 04:07
   ii) 04:18
   iii) 04:27
   iv) 04:39

b) In respect of Patient B, one or more entries recorded as having taken place at:
   i) 02:20, in that any such observation took place at 02:30
   ii) 02:51

c) In respect of Patient C, one or more entries recorded as having taken place at:
   i) 04:18
   ii) 04:32
   iii) 04:45

d) In respect of Patient D, an entry recorded as having taken place at 02:59 in that any such observation took place at 03:07

e) In respect of Patient E, one or more entries recorded as having taken place at:
   i) 04:11
   ii) 04:20
   iii) 04:31

Background

The charges arose whilst you were employed as a registered nurse by Elysium Healthcare. On 3 June 2024, the Nursing and Midwifery Council (NMC) received a referral from Elysium Healthcare in relation to concerns about your fitness to practise including patient assessment, poor record keeping and dishonesty.

On 25-26 April 2024, you were the nurse in charge of the shift and had allocated yourself to a period of 1:1 observation between 03:00 am and 04:00 am, and then intermittent observations between the hours of 04:00 am and 05:00 am. You allegedly failed to undertake observations as you were reportedly completing paperwork in the nursing office, but then dishonestly completed the observation documentation to conceal that these had been missed. Following this, a local investigation took place and the CCTV was reviewed, which showed that the intermittent observations were missed and that you had falsely completed the observation records.

During the internal disciplinary hearing, you admitted the matters alleged and demonstrated insight and reflection. However, you were dismissed from Elysium Healthcare. You did not submit a response to the NMC in relation to the charges.

Decision and reasons on facts

At the outset of the hearing, Mr Burch informed the panel on your behalf that you made full admissions to all of the charges in terms of fact, but he submitted that you deny any current impairment on your fitness to practise.

The panel finds charges 1 to 5 proved in their entirety, by way of your admissions.

Evidence

In relation to the next stages of misconduct and impairment, the panel heard evidence from you under oath. The panel also heard live evidence from the following witness called on your behalf:

- Ms Jomina Gilles: Registered Care Home Manager at Ashurst Park Care Home, where you are currently employed and practising.

Fitness to practise

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

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

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

Submissions on misconduct

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.'*

Mr Kabasinskas, on behalf of the NMC, invited the panel to take the view that the facts found proved by admission amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified the specific, relevant standards where in his submission your actions amounted to misconduct.

Mr Kabasinskas addressed the individual charges. He submitted that your failings engaged multiple provisions of the Code relating to patient care, patient safety, communication and risk management. He submitted that completing patient observations promptly and accurately is a fundamental nursing responsibility, particularly in relation to vulnerable patients in a mental health clinical setting. Moreover, in relation to the charge of recording observations that you had not actually completed at the time recorded, Mr Kabasinskas submitted this engaged additional concerns about accurate documentation in clinical records. In particular, he submitted that the admitted dishonesty charge was a breach of core professional obligations of honesty and integrity.

Mr Kabasinskas noted that the panel may assess your conduct collectively where appropriate but cautioned that less serious findings cannot simply be added to already serious conduct to increase its seriousness. Nevertheless, he submitted that your actions and omissions fell significantly below what would be expected of a registered nurse.

Mr Burch submitted on your behalf that having admitted all of the factual allegations, you accepted that the matters were serious including the risks posed to patients and the impact on public confidence and the profession. He emphasised that you have

consistently accepted responsibility throughout the process and had not sought to blame others, which demonstrates genuine insight and your accountability.

Whilst Mr Burch accepted that there was a serious falling short of professional standards, he invited the panel to consider the admitted failings in their proper context. He referred the panel to staffing pressures and the working environment at the time and submitted that these contextual factors help explain the circumstances in which the failures occurred. However, he emphasised that this did not excuse the dishonesty or remove your responsibility.

Mr Burch submitted that your admissions, early acceptance of wrongdoing and focus on patient welfare demonstrated a reflective and patient-centred nurse. He submitted that your actions should be viewed in light of a short period of time, during a single isolated night shift in April 2024, rather than a pattern of behaviour.

Submissions on impairment

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

Mr Kabasinskas outlined that the assessment must look forward while also taking account of past misconduct and any subsequent remediation. He submitted that all four aspects of the test in *Grant* were engaged, as you placed patients at unwarranted risk of harm, had brought the profession into disrepute, had breached fundamental tenets of nursing, and had acted dishonestly.

Mr Kabasinskas accepted that there was no evidence of actual harm but he submitted that there had been a significant risk of harm. He referred the panel to evidence that the patients involved were highly vulnerable and depended on regular observations to manage serious risks, including self-harm. He noted evidence that missed observations could have had serious consequences and he submitted that accurate and timely monitoring was essential in that clinical setting.

Mr Kabasinskas acknowledged the contextual factors raised by you during oral evidence, including staffing shortages, workload pressures and the stressful nature of that particular shift. However, he submitted that these factors did not sufficiently explain the failures as there was information suggesting that you could have delegated tasks more effectively or sought additional support but failed to do so. Additionally, he submitted that these contextual pressures did little to explain or mitigate the dishonesty aspect of the case.

Mr Kabasinskas submitted that the concerns are attitudinal in nature, especially in relation to honesty and integrity. He submitted that the admitted dishonesty charge may indicate deep-seated attitudinal issues which are inherently more difficult to remediate. Although he accepted that you have demonstrated some insight, he submitted that your insight remained incomplete regarding the specific risks created for patients and the implications of recording observations that had not occurred. Mr Kabasinskas also highlighted that the evidence presented of your current safe practice should be treated cautiously. He submitted that although you have undertaken safe practice in a different role, you work in a different environment with different safeguards and levels of responsibility. He submitted that these factors did not eliminate the possibility of repetition and therefore there was an ongoing real risk to patients.

Mr Kabasinskas further submitted that a finding of impairment was also necessary to maintain public confidence in the nursing profession and uphold professional standards. He submitted that dishonesty and inaccurate clinical record keeping strike at the heart of public trust and professional integrity. For those reasons, he invited the panel to find current impairment on public protection and public interest grounds.

Mr Burch submitted that the key question for the panel was whether you currently pose a risk to patients or the public. He submitted that you do not. Given the absence of any evidence of actual patient harm, your insight, remediation, and the passage of time since the incidents, he submitted that the conduct was situational and not indicative of a continuing deficiency in your fitness to practise.

Mr Burch highlighted that you have engaged fully with the regulatory process, provided written and oral reflections and demonstrated genuine remorse. He submitted that you demonstrated you clearly understand the seriousness of your past actions, including the risks associated with inaccurate and false record keeping and failures in patient observation.

Mr Burch also referred the panel to the evidence of strengthened practice since the incidents. He submitted that you have been practising safely and effectively for over two years without concern, had been subject to ongoing monitoring due to the investigation and have received positive feedback from your current employer. He submitted that this demonstrated effective remediation and reduced any likelihood of repetition in future.

In relation to dishonesty, Mr Burch accepted that this was a serious concern but submitted it was not evidence of a deep-seated attitudinal problem. Instead, he characterised it as an isolated incident linked to a specific stressful situation in April 2024, which you have since learned from and addressed through training and reflection. He further submitted that your current practice environment is supportive and structured, which further reduces any risk of repetition. Additionally, Mr Burch referred the panel to the positive character references and testimonials from your colleagues and a manager, including the NMC's main witness, who described you as a competent and valued nurse.

In terms of public interest, Mr Burch submitted that a fully informed member of the public would not conclude that a finding of current impairment was necessary given your demonstrable remediation, insight and period of safe practice since the incident. He

submitted that you are now able to practise safely and effectively without restriction, and therefore, a finding of current impairment was not required to protect the public or maintain public confidence.

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 (No 2)* [2000] 1 AC 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Cheadle v General Medical Council* [2005] EWHC 2415 (Admin), *Calhaem v General Medical Council* [2007] EWHC 2006 (Admin), *General Medical Council v Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

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. The panel considered each of the admitted charges individually, and then collectively, in relation to misconduct and it found the following:

Charge 1

The panel found Charge 1 amounted to misconduct. It considered that failing to complete 3 of 4 required observation entries fell significantly below expected nursing standards. It was of the view that accurate and contemporaneous observation records are essential for patient safety, particularly where patients in a mental health setting, detained under the Mental Health Act (1983), are under regular observation due to vulnerability and risk. The panel found your admission to failing to undertake the required observations, placed vulnerable patients at risk and therefore met the threshold for serious professional misconduct.

Charges 2a and 2b

The panel found that Charge 2 in its entirety did not amount to misconduct.

The panel noted your employer's Observation and Engagement (Safe and Supportive) policy, which was in effect at the time of the events. Point 7.7 highlights the importance of varying the times of the *"checks"* to reduce risk as *"they [the patients] can predict when the next observations will take place and this may result in harming themselves"*. The panel therefore considered that the observations not taken at the exact intervals prescribed was in fact in keeping with this policy. The panel considered your evidence in that you state you had recorded the observations at the intervals expected and not at the precise time taken. Moreover, the panel recognised that the evidence before it indicates that these patient observations were still completed, but inaccurately recorded, as opposed to the observations not being undertaken at all.

The panel took into consideration your employer's policy, your evidence and the documentary evidence, and concluded that although in this instance the inaccurate record keeping was not good practice, the failings were not sufficiently serious to cross the threshold of serious professional misconduct.

Charge 3

The panel found Charge 3 amounted to misconduct. It noted that "head count observations" involved grouped patient checks carried out as part of a coordinated safety process within the Home. The panel concluded that failing to complete this type of observation represented a serious failing in patient monitoring duties, particularly for multiple vulnerable patients, and created a serious risk to patient safety. As such, the panel found that your actions fell seriously below the professional standards expected of you as the nurse in charge and amounted to misconduct.

Charge 4

The panel found Charge 4 amounted to misconduct. In these instances, the panel was concerned that you recorded observations as having taken place when they had not, which was dishonest. The panel considered this a clear breach of record-keeping standards under the NMC Code, particularly the requirement for accurate, clear and truthful documentation. The panel was equally concerned about the potential serious impact on patient safety. It regarded this conduct as a serious departure from the standards expected of you as a registered nurse.

Charge 5

The panel found Charge 5 amounted to misconduct. It concluded that you admitted having knowingly recorded observations that had not been carried out, and that this constituted dishonest conduct. The panel determined that dishonesty in clinical record-keeping was

inherently serious because it undermines public trust, compromises patient safety and strikes at the heart of professional integrity expected of nurses.

Taken together, the panel found that your actions overall did fall seriously short of the conduct and standards expected of a nurse. The panel concluded that the charges, except for Charges 2a and 2b, amounted to serious professional misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the*

public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

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

The panel determined that all four limbs set out above were engaged in the past, but not liable in the future. It determined that your failings in relation to missed observations, failure to complete required monitoring and inaccurate record keeping did place vulnerable patients at risk of harm, although it accepted there was no evidence that actual harm occurred.

The panel further found that such failings breached fundamental tenets of the nursing profession, particularly those relating to safe care, accurate record keeping and patient monitoring, and therefore brought the profession into disrepute.

In addition, the panel concluded that your admitted dishonesty in relation to recording completed patient observations when they had not been carried out, was a breach of professional integrity that is central to public trust in the nursing profession. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find a charge relating to dishonesty extremely serious.

In determining whether you are liable to repeat the conduct in future, the panel considered your insight and the steps you had taken since to remediate the concerns.

Regarding insight, the panel considered that you had made full admissions to the facts at the earliest stage, and you have consistently accepted full responsibility for your actions since the initial local investigations. The panel was of the view that you demonstrated a clear understanding of the seriousness of your failings and the potential risks posed to vulnerable patients, particularly in relation to missed observations and inadequate monitoring. Moreover, having read your written reflections and heard your oral evidence, the panel determined that you had fully reflected on your actions, shown genuine remorse and explained how you would act differently in future, particularly in relation to escalation, documentation and patient safety. The panel was impressed by your undertaking of comprehensive and tailored training with support of your employer. Overall, the panel found that your level of insight was developed, and you particularly demonstrated that in your oral evidence, which was strong and robust.

The panel was satisfied that the misconduct in this case is capable of being remediated. The panel carefully considered the evidence before it in determining whether you had taken steps to strengthen your practice. It took into account your engagement with relevant training, as well as your detailed reflections into how you would apply these in practice, and the evidence before it of sustained safe practice over a period of more than

two years, including positive testimonials from your current employer and colleagues. It noted that whilst you do work in a different clinical environment the people in your care are also very vulnerable requiring regular observations.

The panel also noted that you are receiving appropriate supervision, training and support for your current role. This includes preparation for moving into a more senior deputy management position.

The panel heard evidence under oath from your current line manager, who has directly supervised you for over two years. The panel noted that you made her fully aware of the charges prior to the commencement of your employment. She spoke at length about not only your high standard of professional practice but your readiness to use your learning and reflection borne out of these matters to bolster your practice and that of your colleagues.

The panel concluded that there is minimal risk of repetition in relation to patient safety matters, given the passage of time, your demonstrated remediation and your strengthened practice. The panel also rejected the suggestion that your conduct arose from a deep-seated attitudinal issue. It accepted your explanations that the incidents occurred in the context of a highly pressured and poorly supported environment during one shift. The panel was satisfied that the risk of repetition is very low and determined that a finding of impairment is not necessary on the ground of public protection.

Further, the panel noted that it was only through its questioning during the hearing that the full extent of the staffing pressures and workplace culture at your organisation became apparent. The panel considered that these factors formed an important contextual background and were a significant contributing factor to the circumstances that led to your failings. The panel also recognised that, throughout the proceedings, you did not seek to attribute blame to others and instead accepted personal responsibility for your actions, demonstrating full insight, genuine remorse and a determination to learn.

Whilst the panel determined that a finding of impairment is not necessary on the ground 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 had regard to the NMC guidance on *'Impairment'* (Reference: DMA-1, updated 28 January 2026), which recognises that in some cases a professional's fitness to practise may be impaired even where there is no ongoing risk to patient safety:

> *"…This means that in some cases, a professional's fitness to practise may be impaired even though there is no ongoing risk to the safety of people receiving care from that individual. This is because the proven concerns about their conduct or professional practice by and of themselves, were so serious that a finding of impairment is necessary to maintain the public's confidence in the profession generally and to declare and maintain professional standards."*

The panel determined that a finding of impairment is required on public interest grounds. It concluded that although there was no ongoing risk to patients, the nature of the misconduct in this case, particularly the failures in patient observation, record keeping, and the admitted dishonesty, was sufficiently serious that it required a regulatory response to uphold professional standards and maintain public confidence in the nursing profession. The panel emphasised that accurate and honest clinical documentation, alongside reliable patient observations, are fundamental tenets of nursing practice.

Further, the panel concluded that a fully informed member of the public would expect the regulator to make a finding of impairment to mark the seriousness of the failings, even in circumstances where remediation and insight had been demonstrated, to uphold confidence in the profession. The panel considered that not making a finding of

impairment would undermine public confidence in the nursing profession and fail to properly declare and uphold professional standards.

The panel therefore concluded that, notwithstanding the absence of any current public protection concerns, public confidence in the profession and the need to uphold and maintain proper professional standards would be undermined if a finding of current impairment were not made. Accordingly, the panel determined that your fitness to practise is currently impaired on public interest grounds alone.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

Mr Kabasinskas referred the panel to the NMC Guidance on *'The purpose of and approach to sanctions'* (Reference: SAN-1), emphasising that in considering aggravating and mitigating factors, these should not simply be counted and balanced numerically. He submitted that the panel should instead weigh the significance and effect of each factor in the particular circumstances of the case and assess where the overall balance lies.

In relation to aggravating factors, Mr Kabasinskas submitted that your misconduct involved conduct that deliberately or recklessly placed people receiving care at risk of harm, although he suggested that your conduct was more appropriately characterised as

reckless rather than deliberate. He also identified the vulnerability of the patients involved as an aggravating feature.

Turning to mitigation, Mr Kabasinskas included your early admissions, the fact that the incidents occurred during a single shift, evidence of subsequent safe practice and completion of relevant training. He also submitted that you had demonstrated meaningful insight, reflection and remediation.

Mr Kabasinskas then addressed the available sanctions in ascending order. He submitted that taking no further action would be inappropriate given the seriousness of your misconduct. He submitted that a caution order was also unsuitable because the misconduct was not at the lower end of the spectrum. In relation to a conditions of practice order, he submitted that such an order would neither satisfy the public interest nor be workable in light of the panel's findings on impairment.

Mr Kabasinskas submitted that, particularly because the case involved dishonesty, the panel should consider the NMC guidance on *'Sanctions for the highest risk cases'* (Reference: SAN-4). He referred to the guidance stating that *"honesty is of central importance to professional practice because of the trust placed in professionals"*, and that dishonesty may often place a professional at risk of strike-off. However, he emphasised that not all dishonesty is equally serious and that the guidance distinguishes between more serious forms of dishonesty, particularly those involving direct risk to patients, and less serious conduct such as isolated or spontaneous incidents. He also highlighted that the guidance recognises the importance of remorse, insight and evidence that the conduct will not be repeated and he submitted that you had demonstrated those qualities.

Referring the panel to *Professional Standards Authority v NMC and Joao* [2023] EWHC 3331 (Admin), Mr Kabasinskas submitted that before considering suspension the panel should ask whether this was a case of *"fundamental incompatibility"* with continued registration. He submitted that, although your misconduct was serious and raised significant concerns about professionalism, it did not reach that threshold. In his

submission, public confidence and professional standards could still be maintained without permanently removing you from the register because you had developed insight, strengthened your practice and demonstrated a period of safe practice of two years.

Additionally, Mr Kabasinskas referred the panel to *GMC v Khetyar* [2018] EWHC 813 (Admin) to emphasise that regulatory guidance represents an authoritative statement of how proportionality should be applied. He submitted that where a tribunal departs from the guidance, it must provide clear and case-specific reasons.

To conclude, Mr Kabasinskas invited the panel to consider that a suspension order for six months was the most appropriate and proportionate sanction for this case. He submitted that such an order would adequately protect the public, maintain confidence in the profession and uphold professional standards, while recognising that there is a realistic prospect of your returning safely to unrestricted practice in the future. He submitted that as the misconduct falls around the middle of the spectrum of seriousness, six months would properly mark the seriousness of the conduct while recognising your remediation and insight. He noted that any decision as to whether a review should take place at the end of the suspension period was ultimately a matter for the panel.

Mr Burch submitted that both a striking-off order and a suspension order would be disproportionate outcomes in this case. He reminded the panel that the purpose of sanction, under the NMC Guidance on *'The purpose of and approach to sanctions'* (Reference: SAN-1), is not to punish a professional but to protect the public and maintain confidence in the profession. Although sanctions may have a punitive effect, he submitted that punishment is not their purpose.

Mr Burch submitted that the regulatory process itself had already had a significant impact on you. He submitted that the proceedings had effectively operated as a punishment in practical terms, as you had had to take time away from work and had lived with the prospect of losing your livelihood. Further, he submitted that this experience had focused

your attention on improving your practice and that the evidence demonstrated your practice had strengthened since the events of 26 April 2024.

Referring to the panel's findings on misconduct and impairment, Mr Burch emphasised that you had made full admissions at the earliest opportunity, including during the local investigation process. He submitted that the panel had already recognised your understanding of the seriousness of your failings and your appreciation of the risks posed to vulnerable patients. He further relied upon the panel's findings that you had demonstrated developed insight through written and oral evidence, received comprehensive and tailored support and training from your employer, and shown meaningful remediation through strengthened practice.

Mr Burch placed particular weight on the panel's finding that your conduct did not arise from any deep-seated attitudinal or personality issue. He submitted that this was especially significant in a case involving dishonesty. He emphasised that the panel had accepted your explanation that the incidents occurred in the context of a highly pressured and poorly supported working environment during a single shift, and over a relatively brief period of approximately one to two hours. However, you had not sought to blame others and had accepted full responsibility throughout, which Mr Burch submitted demonstrated genuine remorse, full insight and a determination to learn. He submitted that your consistent acknowledgement of wrongdoing throughout the proceedings should be treated as a factor in your favour.

Mr Burch outlined that the panel should ask itself whether your conduct was fundamentally incompatible with continued registration. He submitted that this threshold had not been met. He submitted that your misconduct had been shown to be remediable, that you had already demonstrated improvement in practice through training and sustained a period of safe practice over the previous two years, and that there was a realistic prospect of your continuing safely in the nursing profession. He submitted that strike-off would therefore be disproportionate and inappropriate for conduct arising during a *"discrete and employer-specific"* period.

Mr Burch also submitted that suspension would be disproportionate. He submitted that such an order would deprive you of your ability to support your family and maintain your livelihood and would *"prioritise punishment over public interest".* He submitted that the public interest would instead be better served by allowing you to continue practising, particularly given the evidence that you had practised safely and to a high standard throughout the past two years.

Mr Burch emphasised that although there had been a risk of harm, no actual patient harm had occurred. He submitted that your dishonesty, while serious, was limited to a brief and isolated period, involved no personal or financial gain, and was not premeditated. He submitted that the conduct arose from the circumstances in which you found yourself rather than from *"deliberate premeditation".* He also relied on your reflective statements and oral evidence, together with positive testimonials and evidence from your current line manager supporting your professionalism and development.

Mr Burch highlighted that taking no further action remained available to the panel. He referred it to guidance indicating that such an outcome may be appropriate where impairment is found solely on public interest grounds, and where remediation and insight are exceptional. However, recognising the seriousness of the admitted dishonesty, he submitted that the panel may find that the more appropriate sanction was a caution order.

Mr Burch submitted that the relevant factors in the guidance for imposing a caution order were present in your case. He submitted that you have undertaken relevant retraining and significant reflections, have shown substantial insight making repetition highly unlikely, and have demonstrable evidence that you were able to practise safely. He submitted that a caution order would appropriately mark the seriousness of the misconduct, uphold public confidence and professional standards, while avoiding a more restrictive and disproportionate sanction.

Further, if the panel concluded that a caution order was insufficient, Mr Burch submitted that a conditions of practice order should be considered as the alternative. He submitted that conditions could be workable because you had demonstrated willingness to engage fully with the NMC process and have the support of your current employer. Mr Burch suggested conditions could include indirect supervision, reporting arrangements and a personal development plan addressing honesty, candour, integrity, record keeping and care of vulnerable patients.

Finally, Mr Burch submitted that if the panel were nevertheless minded to impose suspension, any period should be kept to the minimum necessary. He submitted that the purpose should be limited reflection and continued professional development rather than punishment. However, he reiterated that his overall submission was that a caution order was the most proportionate and appropriate sanction, reflecting the seriousness of the misconduct while recognising your insight, remediation and ongoing safe practice.

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

Decision and reasons on sanction

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

The panel considered the following aggravating features:

- conduct which put people receiving care at risk of suffering harm; and
- the vulnerability of the people receiving care.

The panel also considered the following mitigating features:

- your early admissions of the facts from the earliest stage, including at a local level;
- your unequivocal acceptance of personal responsibility and acknowledgment that your conduct was dishonest and serious;
- genuine remorse and developed insight demonstrated throughout these proceedings;
- comprehensive reflective work and developed reflective accounts evidenced through both your written and oral evidence;
- extensive efforts to prevent recurrence and strengthen your practice;
- evidence that you have worked safely and professionally in a similar role since the events giving rise to concern;
- undertaken relevant training and evidence of ongoing learning and maintaining professional competence;
- positive testimonials and evidence from your current employer/line manager regarding your safe, caring and professional practice; and
- the isolated nature of the misconduct, occurring during one shift over a relatively short period.

The panel also attached weight to the contextual circumstances in which the misconduct occurred. Whilst the panel was clear that workplace pressures and operational challenges cannot excuse dishonest conduct or diminish the importance of accurate and honest record keeping, it accepted that the incidents arose within the context of challenging and insufficiently supported working environment and were not indicative of a broader pattern of unsafe or dishonest practice. The panel also did not identify deliberate or premeditated conduct, deep-seated attitudinal concerns or any direct personal gain.

Nevertheless, the panel remained mindful of the seriousness of any dishonest conduct and the potentially grave consequences that could have arisen for the particularly vulnerable mental health patients in your care. The panel considered that the conduct

represented a significant departure from the standards expected of a registered nurse and therefore required a formal regulatory response.

The panel also considered the submissions made by Mr Kabasinskas in relation to *GMC v Khetyar* [2018] EWHC 813 (Admin). However, the panel did not find that authority helpful in determining sanction in this case. The panel noted that the case concerned materially different facts involving serious sexual misconduct and established principles regarding conduct fundamentally incompatible with continued registration. The panel concluded that those circumstances were not analogous to the present case and therefore gave the authority no weight when considering the appropriate and proportionate sanction.

The panel first considered whether to take no action. The panel recognised that this option remained available to it because impairment had been found solely on public interest grounds rather than on public protection grounds. The panel gave careful consideration to whether your remediation and insight were sufficiently exceptional such that no sanction was required. It acknowledged that there was persuasive evidence that you had done everything reasonably available to address the concerns identified. It also recognised that you had made full admissions at the earliest opportunity, accepted full responsibility without attempting to shift blame, demonstrated insight and reflection, undertaken substantial remediation and continued to practise safely. The panel also took into account the evidence that your employer had confidence in your current practice.

However, after careful consideration, the panel concluded that taking no further action would not be sufficient in the particular circumstances of this case. The panel considered that the seriousness of the misconduct, which involved dishonest record keeping and posed a real risk of harm to vulnerable patients, required a formal regulatory response beyond a finding of impairment alone. The panel concluded that taking no further action would not adequately uphold professional standards or maintain public confidence in the profession.

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

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

The panel was satisfied that there is no current risk to public protection requiring restrictions on your practice. The panel noted it had already found impairment solely on public interest grounds and had accepted that repetition was highly unlikely. The panel recognised that you had shown substantial insight into your conduct. It considered your early admissions, your acceptance that your actions were dishonest and serious, your expressions of genuine remorse, and the evidence that you had reflected meaningfully on what occurred. The panel also noted that your remediation had been demonstrated through undertaking significant and continued relevant training and two years of safe practice, supervision and professional development.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel concluded that no useful purpose would be served by a conditions of practice order. The panel found it was not necessary to protect the public and would be disproportionate to assist your return to practice because you had remained in unrestricted practice throughout and already demonstrated safe practice. The panel also considered there were no identifiable conditions which would address concerns that had not already been addressed through your remediation, reflective work, training and supportive employment arrangements.

In making this decision, the panel also carefully considered the submissions of Mr Kabasinskas in relation to the six-month suspension order that the NMC was seeking in

this case. However, the panel determined that a period of suspension would be wholly disproportionate where no current public protection concerns had been identified, and it concluded that public confidence and professional standards could be adequately maintained by a less restrictive sanction.

In considering proportionality, the panel was mindful not only of maintaining public confidence and upholding professional standards, but also of ensuring that any sanction imposed remained fair and proportionate to the circumstances of this case. The panel concluded that imposing a sanction more restrictive than a caution order would fail to give appropriate weight to the persuasive evidence of insight, remediation, reflection and sustained safe practice you demonstrated since the incidents. The panel considered that the public would be deprived of the services of a highly capable, caring and committed nurse who has demonstrated meaningful learning, strengthened practice and continued safe care if a sanction more restrictive than a caution order were imposed.

Accordingly, the panel decided that a caution order would adequately uphold the wider public interest identified. For the next year, your employer and any prospective employer will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction.

Having considered the general principles above and looking at the totality of the findings on the evidence, the panel determined that to impose a caution order for a period of one year would be the appropriate and proportionate response. The panel considered the length of the caution order. In reaching its decision, it balanced the seriousness of your actions against your full acceptance of responsibility, genuine remorse, well-developed reflections, and your continued personal development. This is also in keeping with the principles of Right-touch regulation in that *“remedy should be appropriate to the risk posed”*, and in this case the panel have already determined that there is no risk to public safety. The panel determined this sanction maintains public confidence in the profession, and sends a clear message about the standards of honesty, integrity and record keeping expected of a registered nurse.

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

This decision will be confirmed to you in writing.

That concludes this determination.