Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

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

Wednesday 13 August 2025 – Thursday 21 August 2025

Virtual Hearing

Monday, 9 March 2026 – Wednesday, 12 March 2026

Name of Registrant:	Patience Kandenga
NMC PIN:	18A1835E
Part(s) of the register:	Nursing – Sub Part 1 Registered Children Nurse (RNC) – Children (18 March 2018)
Relevant Location:	Bournemouth
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia CBE (Chair, Lay member) Emma Quinn (Registrant member) Kamaljit Sandhu (Lay member)
Legal Assessor:	Nicholas Baldock
Hearings Coordinator:	Antonnea Johnson (13 – 21 August 2025) Abigail Addai (21 August 2025, 9 March – 12 March 2026)
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter (13 – 21 August 2025) Represented by Robert Benzynie (9 March 2026 – 12 March 2026)

Mrs Kandenga:	Present and represented by Mr Jon Trussler, Royal College of Nursing (RCN)
Facts proved:	Charges 1a)v), 1b)i), 1b)ii),1e)i), 1e)ii), 1e)iii), 2a), 2b)
Facts proved (by way of admission):	Charges 1a)i), 1a)ii), 1a)iii), 1a)iv), 1b)iii), 1b)iv), 1b)v), 1b)vi), 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v), 1f), 3a)
Facts not proved:	Charges 1a)vi),1d), 3b)
Fitness to practise:	Impaired
Sanction:	**Suspension order (9 months)**
Interim order:	**Interim Suspension Order (18 months)**

Preliminary matters - Day one

At the outset of the hearing, Mr Brahimi, on behalf of the Nursing and Midwifery Council (NMC), addressed the panel on the cause for the delays to the start of the hearing. He submitted that it was understood that the NMC had circulated the relevant evidence bundles, including seven hours of Closed Circuit Television (CCTV) footage relating to concerns raised about the care given to Patient A, which had been sent to all parties including you and your Royal College of Nursing (RCN) representative in 2023. Both Mr Trussler, your representative and you, advised the panel that you had received the bundles three days before the hearing. However, you had only received the CCTV footage on Tuesday 12 August 2025 at 16:20, and were unable to access and view the footage prior to the commencement of the hearing due to access permissions and device compatibility.

Mr Brahimi submitted that it would be in the interests of justice for you and Mr Trussler to have sight of the CCTV footage.

Mr Brahimi advised the panel of the intended collaboration with you, Mr Trussler and the Hearings Coordinator to troubleshoot the technical issues to allow you access to the CCTV footage. He submitted that some time was needed to assist you and suggested a postponement of the hearing would be appropriate in order to facilitate this.

Mr Brahimi submitted that when access to the CCTV footage was obtained by you and Mr Trussler, it would be fair and just for you to be given the requisite time to review the footage and for Mr Trussler to then take instructions from you.

Mr Brahimi therefore submitted opening the case and dealing with preliminary matters on day two of the hearing.

Decision and reasons on postponement – Day one

In considering this matter, the panel had regard to all the information before it, together with the submissions of counsel.

The panel accepted the advice of the legal assessor.

The panel referred to Rule 32 and had regard to the public interest in the expeditious and proper disposal of these proceedings, the inconvenience to any party and the overall principle of justice and fairness to the registrant.

The panel was of the view that a postponement for the remainder of the day was fair to you and Mr Trussler and would allow you the opportunity to access and review the evidence in its entirety.

The panel noted that the day's postponement may cause potential inconvenience to Witness 1 but was of the view that the aforementioned reasons outweighed this, and that in any event the Hearings Coordinator would keep Witness 1 informed and check on their availability through the days ahead.

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

At the outset of the hearing, Mr Brahimi made a request for this case to be held partly in private on the basis that some of the evidence cannot be adduced without reference to the health of Patient A, and references to/viewing of CCTV footage which gives rise to issues of privacy. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Trussler indicated that he supported the application in respect of Patient A's health, and the CCTV footage.

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

The panel decided it would be appropriate to go into private session in respect of Patient A's health. This decision includes references to viewing of the CCTV footage as and when such issues are raised in order to preserve their dignity and privacy.

Details of charge

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

    a) Created inaccurate records in that you recorded:

        i) That you had administered water at 01.30 and 03.30 when you had not;

        ii) That their oxygen saturations and heart rate were being continuously monitored by way of probe between 02.49 and 05.00 when they were not;

        iii) That they were receiving oxygen at 03.00 and 04.00 when they were not;

        iv) Vital sign observations which had not been taken adequately, or in the alternative, had not been taken at all;

        v) No clinical concerns when they had had one or more seizures;

        vi) Having carried out a medication check and found no issued when their Gabapentin was out of date

b) Provided a poor standard of care in that you:

   i) Failed to deliver them sufficient water;

   ii) Removed their continuous oxygen and heart rate monitor;

   iii) Failed to carry out vital sign observations adequately or, in the alternative, failed to carry them out at all;

   iv) Slept while on waking duty;

   v) Used your personal mobile phone while on duty;

   vi) Failed to carry out instructions in their care plan when they experienced seizures

c) Failed to make accurate and contemporaneous records of:

   i) The times and frequency of the administration of water;

   ii) Oxygen saturations;

   iii) The delivery of oxygen;

   iv) Vital sign observations;

   v) Seizures

d) Administered medication that had expired.

e) Followed poor manual handling practices in that you:

i) Failed to use a hoist in lifting them out of bed;

ii) Failed to follow their care plan for positioning them in bed;

iii) Failed to follow standard procedures in removing their nasal cannula.

f) Failed to wear a mask or gloves when providing care.

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate
b) you intended to mislead others.

3) In relation to Patient B:

a) Between the 30 December 2020 and 25 April 2021, failed to complete a prescribed safety checklist;

b) On the 19 January 2021 failed to report that medication was out of stock.

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

Background

The allegations relate to your employment at Thornbury Community Service as a registered Paediatric nurse based in the community.

You joined the register on 18 March 2018 and commenced employment as a Community Nurse through Thornbury Community Services in September 2020.

Thornbury Community Services is an agency that provides at home care to vulnerable adults and children with complex clinical care needs. It is of note that all services are provided within patients' homes with the intention of bridging acute care monitoring and treatment, otherwise delivered in a hospital setting, with the patient at home.

On 20 May 2021, the NMC received a referral from Relative A about concerns relating to the care of Patient A. On 29 December 2020, you provided care to Patient A for the first time. You started the shift with an additional 30 minutes in order to allow time for you to review Patient A's care plan.

The following regulatory concerns resulted in allegations being made against you in relation to your practice, specifically that during your night shift at Patient A's home between 22– 23 March 2021 you:

- Documented that you had administered water to Patient A hourly, but did not do this;
- Documented that Patient A's saturations were being monitored every hour via an oxygen and heart rate probe, when this was not the case;
- Removed Patient A's saturation probe;
- Documented that Patient A had received oxygen every hour between 22:00 – 05:00, when this was not the case;
- Inappropriately removed Patient A's nasal cannula;
- Documented observations for Patient A when you had not completed the observations adequately or at all;
- Did not document Patient A's seizures; and did not wear gloves or a mask when caring for Patient A;
- Administered out of date medication to Patient A.
- Did not follow Patient A's care plan when moving them;

On 12 May 2021, Witness 1 audited Patient B's package of care documentation. It was at this time that Witness 1 noticed that you had:

- Documented that Patient B's Co-Amoxiclav was out of stock, but did not escalate this; and
- Did not complete shift safety checklists for Patient B on several occasions between 30 December 2020 – 21 March 2021.

Internal investigation meetings were held with you on 6 and 27 May 2021. Following the local investigation, Witness 4 held a breach of contract meeting with you. The outcome of those meetings was that your contract of employment was terminated on 28 June 2021.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Brahimi to amend the wording of charge 1a)vi).

The proposed amendment was to amend a typographical error. It was submitted by Mr Brahimi that the proposed amendment would provide clarity and more accurately reflect the evidence.

That you, being a registered nurse:

1. Between 22 and 23 March 2021, in relation to Patient A:

    a. Created inaccurate records in that you recorded:

        vi) Having carried out a medication check and found no ~~issued~~ **issues,** when their Gabapentin was out of date

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

The panel heard from Mr Trussler who had no objections to the proposed amendment.

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 you 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 improve accuracy.

Details of charges [as amended]

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

a) Created inaccurate records in that you recorded:

i) That you had administered water at 01.30 and 03.30 when you had not;

ii) That their oxygen saturations and heart rate were being continuously monitored by way of probe between 02.49 and 05.00 when they were not;

iii) That they were receiving oxygen at 03.00 and 04.00 when they were not;

iv) Vital sign observations which had not been taken adequately, or in the alternative, had not been taken at all;

v) No clinical concerns when they had had one or more seizures;

vi) Having carried out a medication check and found no issues when their gabapentin was out of date

b) Provided a poor standard of care in that you:

i) Failed to deliver them sufficient water;

ii) Removed their continuous oxygen and heart rate monitor;

iii) Failed to carry out vital sign observations adequately or, in the alternative, failed to carry them out at all;

iv) Slept while on waking duty;

v) Used your personal mobile phone while on duty;

vi) Failed to carry out instructions in their care plan when they experienced seizures

c) Failed to make accurate and contemporaneous records of:

i) The times and frequency of the administration of water;

ii) Oxygen saturations;

iii) The delivery of oxygen;

iv) Vital sign observations;

v) Seizures

d) Administered medication that had expired.

e) Followed poor manual handling practices in that you:

i) Failed to use a hoist in lifting them out of bed;

ii) Failed to follow their care plan for positioning them in bed;

iii) Failed to follow standard procedures in removing their nasal cannula.

f) Failed to wear a mask or gloves when providing care.

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate

b) you intended to mislead others.

3) In relation to Patient B:

a) Between the 30 December 2020 and 25 April 2021, failed to complete a prescribed safety checklist;

b) On the 19 January 2021 failed to report that medication was out of stock.

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

Preamble

Before making any findings on the facts, the panel had regard to your previous experience as a registered nurse working in collaboration with the general Paediatric and Neonatal teams. The panel was made aware that you worked in a ward environment as a newly qualified nurse where you had gained two and a half years' experience, and would have been accustomed to receiving support from colleagues with varied experience and authority, whom you could go to for advice. The panel noted that although a relatively experienced nurse, you had spent a limited amount of time working providing one-to-one care as a nurse in the community where you did not have the same levels of support. It noted that in your reflective statement you had stated, *'…I believe I had not yet acquired enough experience as a nurse for me to fully comprehend the responsibilities that I had taken on and what was expected of me…'.*

You further told the panel that you held a sincere belief that your judgement during the shifts in question were based on providing good care to your patients. The panel also heard you say that you departed from care plans prescribed to you because you felt you knew the patients well and knew how to provide them with personalised care. Finally, you told the panel that you did all of this working alongside the parents with whom you had a close working relationship.

The panel had regard to all the documentary evidence and noted 'Thornbury Community Services Care Plan for Patient A' in addition to the Patient A's 'Suction, Dystonia and Seizure Checklist', 'Risk Assessment document relating to the Moving and Handling of Patient A', 'Meeting Minutes from Investigation meeting with Ms Kandenga on 27 May 2021', 'Patient A's Observation Checklist' and CCTV footage.

Decision and reasons on facts proved by admission

During the course of the hearing, the panel heard from Mr Trussler, who informed the panel that you made admissions to charges 1a)i), 1a)ii), 1a)iii),1a)iv), 1b)iii), 1b)iv), 1b)v),

1b)vi), 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v), 1f) and 3a). The panel therefore finds these charges proved by way of admission.

Decision and reasons on facts - disputed charges

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 Mr Brahimi and by Mr Trussler.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Clinical Nurse Manager at Thornbury Community Services at the time of the incidents
- Relative A/Witness 2: Relative A of Patient A, a service user, at Thornbury Community Services
- Witness 3: Clinical Lead (Paediatrics) for Thornbury Community Services
- Witness 4: Divisional Chief Nurse for Acacium Group, parent company of Thornbury Community Services

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Trussler.

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

Charge 1a)v)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

a) Created inaccurate records in that you recorded:

v) No clinical concerns when they had had one or more seizures;

This charge is found proved.

In reaching this decision, the panel took into account 'Patient A's Observation Checklist', 'Thornbury Community Servies Care Plan', the oral evidence from Witness 1 which was contemporaneous with the documentary and oral evidence from Witness 3. It was of the view that the evidence before it clearly established that all seizures were to be considered a clinical concern and appropriately documented.

The panel also considered your oral evidence in which you stated seizures were *"a normal part of Patient A's condition"*, and that you thought Patient A was presenting *"normally"* during the night of 23 March 2021, and that you did not feel it necessary to document them as a matter of concern.

The panel had regard to 'Thornbury Community Services Care Plan - Seizure Management (Process)' record which states, '*Please monitor me for signs of seizure presentation...'* and *'…Document all observations and actions in record of events and MAR chart ensuring in timely and accurate fashion...'.* The panel determined that you had sufficient time to review Thornbury Community Services' Care Plan at the start of your shift, and that you should have been aware that seizures should always be regarded as a clinical concern, and should have documented them in Patient A's 'Observation Checklist', despite your personal view that seizures were part of Patient A's condition. The panel also noted no entries on the 'Suction, Dystonia and Seizure Checklist' which required a detailed recording of seizures. It also had sight of your handwritten note on 23 March 2021 stating, *'no overnight clinical concerns'*.

The panel therefore found the charge proved.

Charge 1a)vi)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

a) Created inaccurate records in that you recorded:

vi) Having carried out a medication check and found no issues when their Gabapentin was out of date

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Relative A, in addition to reviewing the 'Daily Checklist' and your oral evidence. The panel first had regard to the fact that Gabapentin is a controlled drug, which always requires a second check before being administered. The panel heard evidence from Relative A who said that

they had been advised of the expiry of Gabapentin by Patient A's school. The panel also considered the evidence in the daily checklist from 22 March 2021, which had been ticked and signed for by you, suggesting that the Gabapentin was in date and administered. The panel noted in your oral evidence that you stated, *"…I recall the medication was not expired…"*. On the balance of probabilities, given the conflicting accounts before it, and the absence of the bottle of medication with its labelling, or direct evidence from the school, the panel finds that the NMC has not discharged its burden of proof and therefore finds this charge not proved.

Charge 1b)i)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

b) Provided a poor standard of care in that you:

i) Failed to deliver them sufficient water;

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence from Witness 1 and Witness 3, in conjunction with reviewing 'Patient A's Suction, Dystonia and Seizure Checklist - Fluid Balance Chart' and Patient A's 'Thornbury Community Services Care Plan'. The panel noted that Patient A had been prescribed water enterally to be administered via Patient A's gastrostomy as a bolus of 20mls every hour.

Taken together, this clearly establishes a duty upon you as part of Patient A's care plan. The panel next considered your hand written entry in Patient A's fluid balance chart which noted you had administered 30mls of water as a bolus, on 22 March 2021 at 23:30, on 23 March 2021 at 01:30, 03:30 and 05:30 totalling 120mls every other hour. This fell 20mls

short of the prescribed minimum of 140mls in Patient A's care plan. During the internal investigation you also admitted administering a bolus of 90 mls and 30 mls, which again amounted to 120 mls and fell short of the prescribed minimum.

You made admissions to this in your oral evidence in which you stated, *"…the care plan had been updated and water was to be given to Patient A every other hour"*. You also said in oral evidence *"I never gave him water every hour…I gave 120 that was not sufficient and I admit it was a poor standard of care'*.

In light of the above, the panel found the water you gave to Patient A was not as per the minimum prescribed in the care plan and was therefore insufficient. It therefore found this charge proved.

Charge 1b)ii)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

b) Provided a poor standard of care in that you:

ii) Removed their continuous oxygen and heart rate monitor;

This charge is found proved.

In reaching this decision, the panel took into account Patient A's care plan which states, *'I have a low heart rate 40-60bpm when asleep and above 60bpm when awake. At times of dystonic episodes or seizures my heart rate can escalate to over 200bpm.'* This information clearly identifies the risks to Patient A if they are not continuously monitored whilst asleep. The panel also had regard to Witness 1's oral evidence in which she stated, *"…There was no other way to monitor Patient A's stats"* [sic].

It also viewed the CCTV footage and concluded that there was clear evidence that you had removed the oxygen and heart rate monitor, and that you made no attempts to reattach it during your shift which was in line with your admission during your oral evidence. The panel also referred to the *'*Meeting Minutes from Investigation Meeting with Ms Kandenga on 27 May 2021', where you were asked why you removed the monitor. You stated, *'Because he didn't want it, I felt that he, there is a way of his communication that he doesn't want this that is how I felt at this time?* [sic]*'.* You were then asked during the investigation meeting '*How often does Patient A require his heart rate and oxygen levels monitored by the saturation monitor as per the care plan?'* You replied, *'I think if he is asleep he needs monitoring, but if he is awake it is to his discretion.'*

The panel was concerned about the risks this represented to Patient A and had regard to the care plan, which clearly says, '*I require continuous monitoring visually and need to be monitored via my saturation monitor as I fall asleep and when I am asleep.'* For the panel, this represents another example of where you departed from the care plan and took discretionary action. After viewing the CCTV footage, it accepted that Patient A was without his monitor between 02:46 and 05:00 on 23 March 2021, and appeared to be asleep or attempting to settle to sleep. In light of the above, the panel found the charge proved.

Charge 1d)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

d) Administered medication that had expired.

This charge is found NOT proved.

The panel noted that this sub-charge depends on the same set of facts relating to charge 1a)vi) and therefore considered the relevant evidence relating to them, together before reaching a determination in respect of each sub-charge.

Consistent with its conclusion on charge 1a)vi) found that on the balance of probabilities, given the conflicting accounts in addition to the absence of the bottle in question, the lack of direct evidence from the school and having regard to the records, the NMC has not discharged its burden of proof and therefore the panel finds this charge not proved.

Charge 1e)i)

That you, being a registered nurse:

a) Between 22 and 23 March 2021, in relation to Patient A:

e) Followed poor manual handling practices in that you:

iv) Failed to use a hoist in lifting them out of bed;

This charge is found proved.

In reaching this decision, the panel took into account the CCTV footage, your oral evidence, the evidence from Witnesses 1 and 3 and the documentary evidence before it. The panel bore in mind the care plan which states, *'…Never pick me up please use my hoist and the sliding sheets to do any manual handling…'*. It also noted your attendance and certification for the 'Core Skills Certificate of Attendance…Moving & Handling' on 24 September 2020.

Taken alongside your oral evidence in which you agreed that lifting Patient A was a departure from the prescribed care plan, the panel came to the conclusion that this was another example of where you say you acted in Patient A's best interest, but departed from your duty under the care plan which the panel considers to be clear and specific. You went on to say that you may have relied on your maternal instincts*, 'I used my intuition, it's not evidenced based…I felt he needed to feel a physical touch', and '…putting him in the hoist upsets him and I have to calm him before he settles'.* You further stated that Patient A was 21 kilograms at the time, and that you had lifted him before and therefore, you felt confident in handling him in this way without causing him or you any harm. Despite your assertions, the panel concluded that you had a clear understanding of the risk to both you and Patient A as you had stated during oral evidence, *"I could have dropped him, I could have hurt myself and I could harm him".*

It concluded that the CCTV footage, along with the accounts from Witnesses 1 and 3 and your admission to lifting Patient A were contemporaneous. In light of the above the panel found that you were in fact following poor manual handling practises and therefore finds this charge proved.

Charge 1e)ii)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

e) Followed poor manual handling practices in that you:

ii) Failed to follow their care plan for positioning them in bed;

This charge is found proved.

In reaching this decision, the panel took into account Thornbury Community Services' digital Risk Assessment form completed on 27 February 2020, which notes a sliding sheet as the appropriate equipment to use when moving Patient A. The panel also had regard to Patient A's care plan which states, *'…I will be trialling sliding sheets, they are not yet in the home but when they are please can they be used…'* and noted contradictions between it and the risk assessment. However, the panel also had regard to 'Thornbury Community Services' Care Plan for Patient A - Manual Handling' which states as a goal *'to be safely and effectively supported by manual handling'*. The panel therefore found there to be a duty to use safe, standard manual handling techniques when positioning Patient A. For the avoidance of doubt, the panel found no difference between positioning and repositioning.

The panel found, having viewed the CCTV footage, you had demonstrated poor manual handling practises by using Patient A's sleeping bag to move them. In oral evidence, you accepted that there were risks to Patient A in that way.

In its consideration, the panel concluded that there was a duty for you to adhere to safe manual handling practises which you did not do. In light of the above, the panel finds this charge proved.

Charge 1e)iii)

That you, being a registered nurse:

1) Between 22 and 23 March 2021, in relation to Patient A:

e) Followed poor manual handling practices in that you:

iii) Failed to follow standard procedures in removing their nasal cannula.

This charge is found proved.

In reaching this decision, the panel took into account the CCTV footage and the written and oral evidence from Witness 3. The panel considered the account of Witness 3's review of the CCTV footage and noted she did not say you had caused any harm to Patient A. The panel bore in mind that Witness 3 had identified and documented in her CCTV review, that Patient A's head was rebounding onto the pillow as you removed the cannula from his head, suggesting the cannula was still attached to Patient A's head. The panel also considered your oral evidence in which you stated, *'…it was half off and he wanted it off…'* and *I do not see myself hurting him…'.* The panel also gave consideration to your oral evidence in which you agreed that basic care required you to be gentle and lift Patient A's head to remove the nasal cannula.

Having had regard to all the evidence before it, including our own careful review of the CCTV footage, the panel concluded that the removal of the cannula required a degree of delicacy which you did not demonstrate. It also regarded your actions as reflecting a poor standard of nursing in that there was a risk of harm. In light of the above, the panel found this charge proved.

Charge 2a)

That you, being a registered nurse:

2) Your actions at 1) a) were dishonest in that:

a) you knew the record you had created was inaccurate

This charge is found proved.

When considering the issue of dishonesty, the panel applied the test set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67:

'*The Panel must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his/her belief is a matter of evidence going to whether he/she held the belief, it is not an additional requirement that his/her belief must be reasonable; the question is whether it is genuinely held;*

Once his/her actual state of mind as to knowledge or belief as to facts is established, the question whether his/her conduct was honest or dishonest is to be determined by the Panel by applying the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what he/she has done is, by those standards, dishonest.'

The panel noted that the allegations related to all elements of charge 1a) as either admitted or found proved. However, it accepted the advice of the Legal Assessor that although a finding of dishonesty in relation to one or more of those elements was enough, it would be appropriate to indicate which element was found proved as dishonest and which not. Mr Brahimi and Mr Trussler agreed with that advice.

In general, the panel carefully considered your evidence that at the time of the allegations, you used a jotter, as an informal way to note events which you would later transcribe into Patient A's records. It also found that during your oral evidence, you demonstrated an understanding of the necessity to make accurate entries of Patient A's overnight care and condition. The panel further had regard to your acknowledgment, in the 'Meeting minutes from investigation meeting with Ms Kandenga on 27 May 2021', in which you stated, *'I jot sometimes, probably I do try and rely on my memory, which is something I can now tell I cannot do that [sic]. It is not something I should rely on. Now I think we can see in the documentation, that relying on your memory can lead to incorrect documentation'.*

Having had regard to the evidence before it, the panel determined that it was more likely than not that you knew you had created inaccurate entries (which the panel has found

they were) on Patient A's record by using the jotter and partially relying on your memory. The panel noted that this action was likely a repercussion of you rushing to complete Patient A's records at the end of your shift.

Having considered the facts generally, the panel went on to consider dishonesty in charge 2a) specifically in relation to charges 1a)i) to 1a)v) individually. The panel noted that these sub-charges arise from the same set of facts, and therefore, could consider them together before reaching a determination in respect of each sub-charge.

In relation to charges 1a)i) to 1a)iv), the panel found that the test of dishonesty was met. Having found that you knew the entries were inaccurate the panel has determined that a reasonable person would consider them dishonest in all the circumstances. Those circumstances include the duty on you to keep accurate records as part of Patient A's care plan.

The panel went on to consider the charge of dishonesty in relation to charge 1a)v). It considered Patient A's care plan has a clearly set out action plan and noted that by you omitting an entry into Patient A's record, you had not told the whole truth about Patient A's overnight condition, and in particular, seizures which the panel is satisfied did take place.

The panel was of the view that you had intentionally omitted making the entry in Patient A's record. However, the panel has decided that you had a genuine belief there was no clinical concern that required recording, as you considered seizures as part of Patient A's 'normal' condition and a regular occurrence.

The panel therefore accepts that on the balance of probabilities, you were not acting dishonestly and therefore finds this charge not proved.

The panel did not need to consider the charge of dishonesty in relation to charge 1a)vi), given that it was found not proved.

Charge 2b)

That you, being a registered nurse:

2) Your actions at 1) a) were dishonest in that:

b) you intended to mislead others.

This charge is found proved.

The panel adopted the same procedural approach to this charge as it did to that on 2a) and repeats and adopts the findings made in relation to it.

The panel was of the view that you knowingly gave a false impression to the reader of the relevant records that the important duties that you were supposed to have completed had been, when you knew they had not. After careful consideration, the panel found the only explanation to be that you intended to create a false impression to the reader, and therefore found that you dishonestly intended to mislead. As a result, the panel was of the view that the charge of dishonesty (applying the test as advised above) as it relates to charges 1a) to 1a)iv) are found proved.

For the same reasons as set out above in relation to 1a)v) dishonest misleading is not proved.

Charge 3b)

That you, being a registered nurse:

3) In relation to Patient B:

b) On the 19 January 2021 failed to report that medication was out of stock.

This charge is found NOT proved.

In reaching its decision the panel took into account the evidence before it, which included Patient B's Medicine Administration Chart (MAR Chart) and your oral evidence. The panel gave careful consideration to your account that Patient B had been prescribed 14 days of Co-Amoxiclav, however only seven days of this had been dispensed. You said, once the first seven days of tablets had run out, the GP decided not to continue with the remaining seven days, but instead to resume with the patient's normal prescription of Azithromycin. The panel also had regard to your account during your oral evidence, in which you stated that Azithromycin was Patient B's regular and continuous antibiotic and could not be given to the patient whilst they were taking Co-Amoxiclav. The panel found your evidence to have aligned with the dates of the medication being prescribed, contemporaneous with the MAR chart.

The highest that the NMC put its case was that there was an implied duty to report the lack of stock to the Regional Clinical Lead (RCL). The panel did not accept that submission, therefore found this charge not proved.

Submissions on interim order

The panel took account of the submissions made by Mr Brahimi. He submitted that the NMC is asking for an interim conditions of practice order for a period of 18 months. Mr Brahimi submitted that this will cover the appeal period should an appeal be lodged. He submitted that an interim conditions of practice order is important, given the panel have found the dishonesty and misleading charges proved. He invited the panel to make the interim conditions of practice order on the grounds of public protection and in the wider public interest because of the risk of harm identified, your record keeping and the way you manoeuvred Patient A.

Mr Trussler did not oppose the application.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The panel took into account the submissions from both parties and its finding on fact. It noted that you were in charge of a vulnerable child who was non-verbal and had mobility issues. Taking all the charges together, the panel determined that this raises concerns about whether you understood the gravity of the regulatory concerns and the charges found proved, which go to basic nursing practice.

The panel next took into account the dishonesty charges which was also found proved. It noted that the charges relates to you exercising your own discretion, and not following the duties and responsibilities in the care plan, and going on to make dishonest records in that regard. In light of this, the panel concluded that you had departed from the fundamental tenets of the nursing profession.

In respect of proportionality, the panel began with the least restrictive sanction, namely an interim conditions of practice order. It determined that it could find workable, appropriate and proportionate conditions which would adequately protect the public and address the public interest concerns.

The panel determined that the following conditions would be workable and proportionate whilst covering the risk it identified:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer’s contact details.

2. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

4. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.

b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

5. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

6. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from your line manager.

7. You must ensure that you are supervised by a Band 5 nurse at any time you are working. Your supervision must consist of:

   - Working at all times while being directly observed by a registered nurse of a Band 5 or above.

8. You must keep a personal development log on a monthly basis, including written reflections from a Registrant who has supervised you. The log must include actions you have undertaken to address learning and practice related to:
   - Duty of Candour
   - The Manoeuvring and Handling of Patients
   - Record Keeping

9. You must keep a personal reflective practice profile recording written reflections on a monthly basis. The profile must include actions you have undertaken to address learning and practice

related to:

- Duty of candour
- The Manoeuvring and Handling of Patients
- Record Keeping

The panel decided to make this order for a period of 12 months.

Fitness to practise

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

At the outset of the hearing, it was confirmed by Mr Trussler that in relation to charges 1a)iv) and 1b)iii), your admissions were to having failed to adequately record and observe vital signs, rather than failed to record and observe them at all. The panel proceeded on that basis.

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 Benzynie, on behalf of the Nursing and Midwifery Council (NMC), invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015' (the Code) in making its decision.

Mr Benzynie identified the specific, relevant standards where your actions amounted to misconduct, including 1.2, 10.3, 13.4, 17.1, 20.1, 20.2, 20.5.

Mr Benzynie submitted that your actions fell significantly short of the standards expected and amounted to misconduct. He further submitted that the standard of care would be considered deplorable and fell significantly short of the standards expected of a nurse.

You gave evidence under affirmation.

You told the panel that you drafted your reflective piece around a week ago for these proceedings, and the evidence contained within it is the truth.

With regards to the professional ethics and workplace integrity course for which you provided a record of attendance, you told the panel that it was an online course which had about four sections and five questions after every section. You said it took you about two hours. You said you have read over the findings of the panel and accept your failings.

In response to panel questions, you told the panel that the course was one hour long but it took you two hours. You explained that when you are doing the course, it gives you a credit for one hour and it does not account for how long it took you to complete the course.

You said that after the incident, you beat yourself up about it and took time out of nursing and became a Healthcare Assistant. You said you have worked with other colleagues who can see how you work. You also told the panel that you redid your manual handling, health and safety and infection control training to meet the requirements expected of you as a nurse. You also said that you were unable to obtain details of the training because your employer did not provide access to this.

With regards to your dishonesty, you said you are now more careful and double check entries and record shift details in a jotter. You said you record things as they happen, have backup, run it by someone and speak to senior nurses. You said there is no room for dishonesty and aim to be a nurse who abides by the NMC Code.

You told the panel that it is your wish to practise as a Band 5 nurse.

[PRIVATE].

You said you are not the same person as you were at the time of these incidents and have sought help and have measures in place to know when to ask for help. For example, in your workplace there is [PRIVATE].

With regards to manual handling, you said you have gone over it multiple times and learnt a technique where you slide a sheet instead of sliding the actual patient. You understand the negative side of manual handling through your work with adults. You told the panel that your work with adult care has given you transferrable skills in children's nursing.

Mr Trussler submitted that there is a broad area of agreement with Mr Benzynie regarding misconduct. He submitted that misconduct is a matter for the panel and he could not reasonably submit that the findings and the admitted allegations do not amount to misconduct.

Submissions on impairment

Mr Benzynie 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. He referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and of *R (on application of Cohen) v General Medical Council [2008]* EWHC 581 (Admin).

He asked the panel to consider the following:

- Whether the concern is easily remediable
- Whether it has in fact been remedied and;
- Whether it is highly unlikely to be repeated

Mr Benzynie submitted all four limbs of *Grant* are engaged in this case. He submitted in considering those issues, the panel may have regard to the nature and extent of the misconduct and also consider whether there is evidence of insight and remorse.

Mr Trussler submitted that you have provided a detailed, honest and at times painful reflection in light of the panel's findings. He submitted that in your initial registrant's bundle, there are a number of testimonials and courses undertaken. However, the detail in which you answered the panel's questions was the best evidence of your insight.

Mr Trussler, submitted on your behalf, that the seriousness of the allegations is inescapable. However, some time has now elapsed since the dates of the allegations. He submitted that things have moved on and you have shown an honest and open reflection into what you accept was a substantial failing below the standards required of a nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments including *Sawati v General Medical Council* [2022] EWHC 370, which Mr Trussler had referred to in his submissions.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to all the relevant circumstances and 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 breaches 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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

13.4 take account of your own personal safety as well as the safety of people in your care

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In considering whether the charges amounted to misconduct, the panel considered them individually. However, such were the nature of the charges that the panel's conclusions can be dealt with in the following groups.

Charges 1a)i), 1a)ii), 1a)iii), 1a)iv) and 1a)v)

These all expressly relate to the creation of inaccurate records.

The panel took into account that the charges relate to Patient A, who was a vulnerable child in your care at the patient's home. Having had adequate time before the start of the shift to prepare, you will have been aware from Patient A's care plan that there were specific instructions about Patient A's treatment and care; namely that his seizures should

have been recorded to ensure that other interventions could be in place with respect to his care. However, the panel found that there were a series of inaccurate and absent records which could have put Patient A at risk of harm. It also noted that given the inaccurate records, you would have not been able to correctly hand over to colleagues taking over from you. This presented a real risk of harm to Patient A which would not have been identified. As such, other healthcare professionals would not be able to carry out their duties safely due to your inadequate record keeping.

In the previous hearing on facts, your only explanation seemed to be that you chose to exercise your own discretion on matters clearly outlined in the care plan. You also had ample opportunity to review Patient A's care plan prior to your shift starting.

At these proceedings and in response to panel questions regarding how you now maintain accurate records, you said you now *'record as soon as possible, always have a witness and have senior nurses that I turn to'.* This provided some assurance to the panel in respect of steps you would take to avoid similar failings in the future.

However, the panel was of the view that taking contemporaneous notes is essential to nursing practice because nurses taking over the shift would need accurate records to ensure accuracy, safe and effective care. It also determined that there are significant breaches of the code, including 10.1, 10.2, 17.1 and 20.1. Therefore your record keeping has fallen significantly short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Charges 1b)i), 1b)ii), 1b)iii), 1b)iv), 1b)v), 1b)vi), 1f)

These all expressly relate to the provision of a poor standard of care.

The panel found that sections 1.2 and 17.1 of the Code are specifically engaged in respect of these charges. The panel took into account the evidence before it, including Patient A's care plan, Patient A's Suction, Dystonia and Seizure Checklist and the oral evidence from

Witness 1 and Witness 3. It determined that it was clear therefore you had a duty to give Patient A sufficient water and to continuously monitor him whilst he was asleep. It also took into account that you had incorrectly administered the required amount of water via Patient A's gastrostomy, as evidenced by your hand written notes on 22-23 March 2021 including, 30mls of water as a bolus, on 22 March 2021 at 23:30, on 23 March 2021 at 01:30, 03:30 and 05:30, totalling 120mls every other hour. This fell 20mls short of the prescribed minimum of 140mls in Patient A's care plan. You subsequently admitted in the internal investigation, that you administered a bolus of 90ml and 30ml, which fell short of the prescribed minimum of water required for Patient A's care. These were determined by the panel to be fundamental departures from the standard of practice expected of you as a registered nurse.

The panel also took into account the CCTV evidence, which depicts you removing Patient A's oxygen and heart rate monitor and shows that you made no attempts to reattach it. You maintain that you did so because *'he did not want it'* and *'I think if he is asleep he needs monitoring, but if he is awake it is to his discretion.'* The panel determined that the instructions in Patient A's care plan were explicit in stating that Patient A required continuous oxygen and a heart rate monitor while sleeping.

Accordingly, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charges 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v)

In relation to these charges, these likewise refer to a failure of record keeping in relation to Patient A, which were matters of high importance. For the same reasons given above in respect of record keeping failures, the panel determined that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charges 1e)i), 1e)ii), 1e)iii)

These charges all expressly relate to poor manual handling practice.

The panel determined that sections 1.2, 13.4 and 17.1 of the Code are engaged with regards to charges 1e)i and 1e)ii.

With regards to charge 1e)iii), the panel determined that sections 1.1, 1.2, 13.4 and 17.1 of the Code are engaged. It concluded that you failed to uphold Patient A's dignity because Witness 3's CCTV review stated that Patient A's head was rebounding onto the pillow when you attempted to remove the nasal cannula from his head. You said in oral evidence in relation to the nasal cannula that '*it was half off and he wanted it off…'* and I *do not see myself hurting him'.* You also told the panel that you agreed that you were required to be gentle and lift Patient A's head to remove the nasal cannula.

The panel noted that in the previous hearing on facts, you stated that Patient A weighed 21 kilograms and that you had lifted him before without the aid of any equipment. Therefore, you felt confident in handling him in this way without any harm being caused to either of you. However, at this hearing, you gave the panel a different perspective. You had reflected on your more recent experience of working with adults, and now recognised the harm that could have been caused to Patient A and to yourself in the way you lifted him.

Accordingly, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

<u>Charges 2a) and 2b)</u>

These charges relate to dishonesty and an intention to mislead.

The NMC has a high standard of expectation for nurses when it comes to honesty. Having reviewed NMC guidance, which clearly states that nurses are meant to act with integrity at all times, the panel concluded that being dishonest is a significant and fundamental breach of the nursing profession. Patient A's care plan was explicitly clear about the liquid intake

needed to ensure safe care and that the specified amount was not administered. Further, continuous observations were essential to Patient A's wellbeing and you did not monitor him consistently.

The panel acknowledges however that these matters are restricted to a single patient on one shift.

The panel accepted that whilst you now appreciate the magnitude of your failings, you in fact had attempted to mislead others. The consequence of your dishonesty could have impacted negatively on Patient A's care, namely in that his records would have wrongly shown that he was receiving the required care for his needs when he was not. As such, the panel concluded that your conduct in respect of the making of inaccurate records breaches professionalism, nursing ethics and the trust that the public has for nurses.

Accordingly, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 3a)

In relation to charge 3a), this similarly refers to a failure of record keeping in relation to Patient B, which were matters of high importance. For the same reasons as the previous record keeping failures, the panel determined that your 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, your fitness to practise is currently impaired.

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

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

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

In this regard the panel considered 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 of *Grant* are engaged in your case as a result of the findings set out above.

The panel finds that patients were put at unwarranted risk of harm in the past. As a result, your conduct also brought the profession into disrepute by breaching fundamental tenets of the profession. The panel had also found dishonesty in respect of your inaccurate record keeping. The panel next considered whether your fitness to practise is currently impaired and considered the tests as outlined in *Cohen*.

The panel was of the view that the concerns are of themselves possible to remediate. The nature and context of the failures in the safe care of Patient A however are fundamental and serious and include a finding of dishonesty. This, in the view of the panel, is an attitudinal issue and therefore more difficult to remediate. This is especially so because your dishonesty was not general but related to your clinical practice. However, as already found it was limited to one patient on one shift. The panel also heard from you that you have tried to update your training and practice and you say that you are now following more standard procedures.

The panel next considered the nature and extent of your insight, and concluded that it is limited at this stage. In oral evidence, you stated that your insight was triggered when you [PRIVATE]. Your insight was not as a result of what you had learnt from your own professional failings. With regards to your reflective account, the panel was of the view that it was sincere, reflected remorse, but ultimately insufficient in the circumstances. While you do show some remorse about some aspects of care, and provided the panel with contextual explanations, it was not satisfied that you understood the full impact of your actions on patients, their families and the wider nursing profession.

The panel next considered the steps you have taken to strengthen your practice. It noted that you are not currently working as a registered nurse. You gave a detailed response regarding the mandatory training you have undertaken as a Healthcare Assistant, including manual handling. The panel noted that you made attempts to procure information about your training from your employer. It has had sight of a one hour course on professional ethics and workplace integrity course. However, given the seriousness of the allegations made, and the facts proved, you have failed to provide sufficient written or oral reflections on how you have applied any learning from this training into your daily practice. Ultimately, given the period of time that has lapsed (five years) you have failed to provide evidence of sufficiently detailed insight. In those circumstances, the panel is not satisfied that you have done enough to strengthen your practice and that you are ready to return to working as a registered nurse without restrictions.

The panel heard you say that you aspire to return to nursing and heard accounts relating to your personal circumstances at the time. You also told the panel about steps you have since taken to receive help, including [PRIVATE]. Given its findings in relation to the lack of insight or remediation, the panel is not sufficiently assured that there is no risk of repetition of one or more of the failings it has identified.

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 also required because of the dishonesty found and the deplorable nature of the concerns identified.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 9 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Benzynie submitted that the following aggravating features are present in your case:

- An abuse of a position of trust;
- Deliberate breaches of the Code;
- A possible pattern of misconduct over a period time;
- Limited insight into the regulatory concerns.

Mr Benzynie submitted that the following mitigating features are as follows:

- Early admissions of the facts;
- Relevant training and certificates within your registrant's bundle;
- Your reflective accounts within your August registrant's bundle and a recent reflection dated 9 March 2026;
- [PRIVATE].

Mr Benzynie submitted that given there being a finding of a risk of harm, it would not be appropriate to either make no order or to impose a caution.

Mr Benzynie referred the panel to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c). He submitted that a conditions of practice order may not meet the allegation of dishonesty and the conditions would need to be monitored and assessed. Mr Benzynie also submitted that the panel will be advised that any conditions should be proportionate, workable and measurable.

Mr Benzynie submitted that a suspension order is appropriate in these circumstances, given the findings of the panel in relation to charge 1a) and the subsections. He submitted that the charges found proved are serious and are towards the upper end of the spectrum. Mr Benzynie invited the panel to make a suspension order for a period of nine to twelve months with a review.

Mr Trussler echoed the panel's findings on misconduct and impairment, namely that the matters are capable of remediation and that you have some albeit limited insight at this stage. He submitted that it is your wish to return to the nursing profession and you wish to undertake a Return to Nursing Course.

Mr Trussler further submitted that work needs to be undertaken and if it could be undertaken in the Return to Nursing Course, then you will be able to show insight and have the benefit of peer guidance. He invited the panel to impose a conditions of practice order to address the seriousness of the concerns.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Patient A was a vulnerable child;
- The facts found proved are serious and there was a risk of harm;
- Limited insight into the regulatory concerns;
- Multiple and deliberate breaches of the Code;
- Dishonesty regarding Patient A's records;
- A breach of trust.

The panel also took into account the following mitigating features:

- Early admission of some of the facts;
- Some insight and remorse
- Some evidence of training courses and certificates
- In oral evidence, you spoke about how you would avoid similar failings arising in the future;
- You provided two reflective pieces which are relevant to the regulatory concerns.

The panel also took into account your personal circumstances at the time of the incidents. It noted from your oral evidence that you now have a better understanding of your stressors and [PRIVATE]. Whilst the panel did not see written evidence in the form of a [PRIVATE], it was satisfied that you have shown insight into the context and circumstances at the time, and demonstrated to the panel that you now have better awareness about when to seek help if required.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, and the fact that the public as well as patients using services provided by you, would not be protected from the risks you would continue to represent if you were allowed to practise without restrictions. The panel therefore 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 your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. It noted the training and the reflection you provided to the panel, but it was not satisfied that the accounts were sufficient for it to conclude that the likelihood of repetition is low at this stage. The panel determined that a sanction that does not restrict your practise would not protect the public.

The panel therefore determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had particular regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and considered the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*

- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel took into account that at the time of the facts found proved, you were working as a lone worker for a period of five months. It noted that the incidents were not isolated, and involved two vulnerable patients. It concluded that by this stage you had had enough experience that you could have drawn on, in order to ensure you were more alert to the nursing requirements and standards expected on the shift with Patient A in particular.

The panel found that at the fact finding stage, you had demonstrated attitudinal concerns but it concluded that these were not deep seated. It considered that you had shown a change in understanding and greater sensitivity to the impact your actions could have on patients, their families, carers and/or the public. To this extent, the panel accepts that you have started to show some progress with the underlying attitudinal concerns, but in the view of the panel, these have still not been sufficiently remedied. Furthermore, the panel accepts that in your oral evidence, you demonstrated sincere remorse about your past failings. You also gave oral evidence regarding seeking support from your colleagues and had reflected on ways you would avoid these mistakes in the future. You emphasised this particularly in relation to concerns around record keeping and safety training. For the panel, this demonstrates a growing awareness about your past failings.

The panel also took into account the testimonials which speak to your good character. However, the testimonials were not from senior staff or any registered professionals.

The panel noted from your oral evidence that you have since explored different ways to ensure effective record keeping. However, it concluded that this was presented by you as evidence of a general improvement in the basics of record keeping, but did not reflect adequately that your actions were undertaken specifically to address the failings identified in the allegations made against you.

Allegations of particular concern were failing to follow agreed policies, Patient A's care plan and in the case of Patient B, a safety check list. The panel finds that your deviation from these core standards of nursing practice to be serious and pose a continuing risk to patients and the public in the future. As such, the panel determined that the risk has not been mitigated at this stage.

The panel also acknowledged that you are aware that in any event, you will need to undertake a Return to Nursing course, which consists of supervised practice.

In light of the regulatory concerns and the charges they gave rise to, and given the panel's findings on impairment, it concludes that there is an inadequate basis to formulate a comprehensive, set of relevant, proportionate, workable or measurable conditions that would protect the public and patients in your care from future risk of harm.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public interest, especially given the findings of dishonesty and misleading conduct.

The panel next 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 was satisfied that in this case, your misconduct is not fundamentally incompatible with you remaining on the register. It considered that a period of suspension would both mark the seriousness of the regulatory concerns and afford you enough time to strengthen your nursing practice in quite specific and targeted ways. This in the panel's view would provide a future reviewing panel with assurance that you understand the gravity of the concerns it raises in the eyes of the nursing profession and to vulnerable patients in your care.

Finally, it went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, in line with NMC guidance and the mitigation provided, it concluded that it would be disproportionate. Whilst the panel acknowledges

that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 9 months was appropriate in this case.

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A further reflective statement which considers the relevant training you have already taken and will undertake in the future; focusing on how you will embed the learning from this into your daily practice as a nurse and in your current role as a Health Care Assistant.
- You demonstrating how you have developed your insight through a reflective statement which addresses the reputational damage your misconduct has had on colleagues and the wider nursing profession.

- Testimonials from your employer and anyone supervising you about the specific issues identified in this case, for example record keeping, following a care plan, wearing PPE and moving and handling.
- [PRIVATE].

This will be confirmed to you in writing.

Interim order

As the suspension 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 your own interests until the suspension 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 Mr Benzynie. He invited the panel to make an interim suspension order for 18 months on the grounds of public protection and public interest.

Mr Benzynie submitted that the nine month suspension order does not come into effect straight away. A letter is sent to you which can take up to five days and there is a period in which an appeal can be lodged, namely 28 days. Therefore, an interim suspension order of 18 months is being sought to cover these two periods and the period during which any appeal would take to be determined. That period could be up to 18 months.

Mr Trussler did not oppose the application.

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 result of the risk to patient safety that you continue to present as set out in its substantive decision.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order of suspension. The panel therefore impose an interim suspension order for a period of 18 months to cover the appeal period.

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

That concludes this determination.