Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 13 May 2026 – Friday, 15 May 2026

Virtual Meeting

Name of Registrant:	**James Cole**
NMC PIN:	16K0423E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 – 22 April 2017
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Liz Dux (Chair, lay member) Jennifer Portway (Lay member) Julia Briscoe (Registrant member)
Legal Assessor:	Angus Macpherson
Hearings Coordinator:	Samara Baboolal
Facts proved:	Charges 1, 2(a), 2(b), 2(c), 2(d), 3, 4, 6
Facts not proved:	Charge 5
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent on 27 January 2026 by secure email to the email address which Mr Cole had last used when communicating with the NMC (on 24 May 2025). He had informed the NMC on 3 April 2023 that his registered address '*is no longer* [his] *address'.* Mr Cole was informed by his NMC Case Officer that his case would be heard on or after 3 March 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

The panel took into account that Mr Cole responded to the correspondence from the NMC regarding this substantive meeting, to the effect that he is not currently practising as a nurse and does not wish to engage with or attend any proceedings.

In the light of all of the information available, the panel was satisfied that Mr Cole has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Application to amend the charge

The NMC made two applications pursuant to Rule 28 of the Rules 2004: the first to amend charge 6 to delete the number *3* as follows:

'Your actions in charges ~~3~~ and/or 4 above amount to dishonesty.

and to add the following '*and/or 5'*, so that the charge as amended reads:

'Your actions in charges 4 **and/or 5** above amount to dishonesty.'

the second to amend Charge 2 c) to include reference to the anonymised patient who is the subject of the charge, so that the charge as amended reads:

> On 11th July 2019, administered an incorrect dosage of PRN medication to a patient *KT*.

The panel accepted the advice of the legal assessor.

Notwithstanding that Mr Cole was not aware of the NMC's proposals to amend the above charges, the panel determined to accept the proposed amendments submitted by the NMC. The panel was satisfied that the amendments do not change the nature of the charges or cause any injustice or prejudice to Mr Cole. It was of the view that the proposed amendments would ensure clarity in relation to the charges.

Details of charge (as amended)

That you, a registered nurse, in your role as Band 5 Nurse:

1. On 8th August 2019, you failed to keep adequate record, in that you failed to record a prescription for IM medication in patient SD's handover notes. **[PROVED]**

2. You failed to follow medication policies in place at the relevant time, in that:
    a. On 5th October 2018 you administered controlled drugs without a witness; **[PROVED]**
    b. On 21st February 2019, you administered controlled drugs without a witness; **[PROVED]**
    c. On 11th July 2019, administered an incorrect dosage of PRN medication to a patient; **[PROVED]**
    d. On 11th July 2019 or soon after, did not complete an incident report or escalate to a senior member of staff once you were aware that you had administered the incorrect dosage of PRN medication to patient KT. **[PROVED]**

3. Charges 2 a), and/or b), and/or c) amount to a failure to preserve patient safety. **[PROVED]**

4. On 11th July 2019, amended the dosage of PRN medication on patient KT's medicine card in order to give the misleading impression that you had administered the correct dosage. **[PROVED]**

5. Amended the dosage of PRN medication on a patient's medicine card in order to give the misleading impression that you had administered the correct dosage on another, unknown, date. **[NOT PROVED]**

6. Your actions in charges 4 and/or 5 above amount to dishonesty. **[PROVED]**

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

Background

Mr Cole is a registered nurse who came onto the register on 22 April 2017. He was employed by Essex Partnership University NHS Foundation Trust ("the Trust") as a newly qualified Band 5 Staff Nurse from 2 May 2017.

On 21 May 2017 Mr Cole started work on Finchingfield Ward as a staff nurse. He was designated a supervisor when he first started on the ward and would meet monthly with his designated supervisor to discuss any issues he had or was having with learning requirements. During supervision, Mr Cole did not raise any issues or concerns that he had or indicate that he was struggling. He was placed on a preceptorship, which is a steppingstone from a newly qualified nurse to an autonomous clinical practitioner, on 12 March 2019 until July 2019 after it was discovered that he had not completed a preceptorship. During this period, he was prevented from performing any clinical competencies without supervision.

A referral was received by the NMC on 27 November 2019 from the Trust in relation to a number of concerns relating to Mr Cole's clinical practice

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 or the facts are true as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Catherine Manhood: Deputy Manager of Finchingfield Ward since February 2017, at the time of the incidents.
- Chloe Cawston: Matron at the Basildon Mental Health Unit, at the time of the incidents.
- Emma Clark: Deputy Ward Manager at East Essex Partnership University NHS Foundation Trust, previously Mr Cole's line manager.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

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

Charge 1

"On 8th August 2019, you failed to keep adequate record, in that you failed to

record a prescription for IM medication in patient SD's handover notes."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Ms Cawston and Ms Clark, and the contemporaneous documents before it, namely the handover notes, dated 8 August 2019, and the medication prescription and administration chart for Patient SD, dated 5 August 2019.

The panel took into account that Ms Cawston's written witness statement details the incident. It states:

> *'8 August 2019 the registrant failed to record a change in prescription in the handover notes. The patient had been prescribed Olanzepine however following a ward review it was changed to Acuphase. The registrant sent a handover email but stated that Olanzepine was prescribed when this was not the case. The registrant then failed to mention the change until 2 days later. Both drugs are antipsychotic medications. Generally, there are a number of different medications that a consultant would try and if one doesn't work or seem not to be having the desired effect then it may change to another. The delay in giving the correct medication meant a delay in treatment which could have a detrimental effect on recovery being delayed and prolonged.*
>
> *I produce a copy of the handover from the registrant on 8 August 2019. Normally we have a nurse attend the care review for patients and send a summary of the outcome to the whole team. If a staff member is off when they come in the next day, there will be a summary of what is happening on what ward and review the actions needed to be picked up. The registrant in his email talks about the Olanzepine being prescribed when in fact it was Acuphase. […] [T]he prescription chart show[s] the change of prescription by Dr Fletcher from Olanzepine to Acuphase on 8 August 2019.'*

The panel had regard to the handover documents and the prescription chart which reflect Ms Cawston's account.

The panel also had regard to Ms Clark's witness statement, which states:

> '*James was allocated as the role of ward review nurse for the shift on 8 August 2019. The role involves carrying out the ward review with the ward consultant. During the review the patient's care is reviewed, and changes are made if needed. With the patient in question, the consultant decided to switch Olanzepine to Accuphase. It is the ward review nurse's responsibility following a review to handover the outcome via email to the nursing team. James sent out the email but failed to mention the change of medication to Accuphase. There were also patient notes that James failed to update. I produce a copy of the handover note and email sent to Matron Chloe Cawston when I notified her of the incident.*
>
> *The consultant attended the patient two days later on 10 August 2018 as staff were concerned that there was no change in patient's behaviour. It was discovered on 10 August 2018 that the patient's medication had changed to Accuphase meaning they had not yet received it. The consultant questioned James about what happened, and James denied knowing the change in plan.'*

The panel also took into account Mr Cole's investigation meeting with the Trust, dated 3 September 2019, wherein he made admissions to this charge. However, it also acknowledged his position that he was confused as to the outcome of his discussions during the review with the doctor, and that he claimed to misunderstand what the doctor had determined in the review. He stated:

> *'So my understanding is that there was a […] a misunderstanding from my part, on my part of what the plan was coming out of a review […] so the IM injection that they're talking about is the Acuphase which was, which I didn't realise at the time was written on the front of the […] meds cards as a stat dose. […] the Doctor had mentioned Acuphase but I didn't have, I wasn't under the understanding that he'd written it on the card so obviously when I handed I failed to handover that there was Acuphase that dose on the card because […] I wasn't 100% on the plan when I came out of the review.'*

However, the panel noted that the Doctor had changed the prescription on the patient's medication chart and that change was not recorded in the handover notes. It therefore determined that, factually, Mr Cole did fail to keep an adequate record, as he failed to record a prescription for IM medication in patient SD's handover notes.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2a)

> "You failed to follow medication policies in place at the relevant time, in that:
> On 5th October 2018 you administered controlled drugs without a witness'

This charge is found proved.

In reaching this decision, the panel took into account the DATIX records dated 5 October 2018, the Trust Policy for the Safe and Secure Handling of Medicines, and the witness statements of Ms Clark and Ms Manhood.

The DATIX form outlines that:

> '*A nurse administered a controlled drug to a patient without the presence of second rmn. Hours later, another rmn was asked to co-sign the medication when they had not been present when it was administered.'*

In Ms Clark's witness statement, she stated:

> *'On 5 October 2018 James administered a Controlled Drug (CD) alone and asked a colleague to sign for it afterwards.'*

In Ms Manhood's witness statement, she stated:

> *'On 5 October 2018, James administered a controlled drug without a second signature. Administration of a controlled drug must be witnessed by another nurse. The nurse must then sign the controlled drug book to evidence that they*

witnessed it. The incident happened during the night shift and was handed over to me when I arrived for morning handover the following day. I was informed by the site manager that James had been asking members of staff including the site manager to sign for administration of a controlled drug they hadn't witnessed. I was told by the site manager that James had told staff when they refused to sign, not to worry as I would do it.

James then proceeded to ask me to sign the book. I told James that I would not sign it and that I was going to complete a Datix to report the incident.'

The panel took into account that there is no evidence before it to suggest that the witness statements of both witnesses are fabricated or unreliable. It noted that the contemporaneous DATIX record for the incident reflects the accounts of both Ms Manhood and Ms Clark.

The panel therefore determined that there is sufficient and reliable evidence to support that Mr Cole did not follow the medication policies in place, in that he administered controlled drugs without another nurse present as a witness on 5 October 2018.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2b)

"On 21st February 2019, you administered controlled drugs without a witness"

This charge is found proved.

In reaching this decision, the panel took into account the written witness statements of Ms Manhood and Ms Clark, and the contemporaneous DATIX dated 21 February 2019.

Ms Manhood, in her written statement, noted that she could not recollect the incident, but that she did complete a DATIX following the incident to the effect that Mr Cole administered a controlled drug without a second signature.

In her written statement, Ms Clark stated:

'On 21 February 2019, there was a second incident where James administered a [controlled drug] alone . James was asked to re-book on the face-to-face medicines management training which is what I thought was required.'

The DATIX states:

'A staff nurse administered a controlled drug by themselves then asked another nurse to co-sign the chart. The nurse was spoken to by their supervisor about the incident as this is not the first time it has happened. Covering team leader was informed and recommended that the nurse not be allowed to administer medication without a second nurse present until the incident is investigated.'

The panel noted that the DATIX was completed contemporaneously and was reliable. It was also satisfied that the witness statements are reliable, with no information to suggest fabrication.

The panel therefore determined that there is sufficient and reliable evidence to support that Mr Cole did not follow the medication policies in place, in that he administered controlled drugs without another nurse present as a witness on 21 February 2019.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2c)

"On 11th July 2019, administered an incorrect dosage of PRN medication to a patient"

This charge is found proved.

In reaching this decision, the panel took into account the written witness statements of Ms Manhood, Ms Cawston, and Ms Clark. It also took into account the MAR (Medication Administration Record) chart for Patient KT, the Medication register dated 8 to 15 July 2019, and an email from Ms Clark regarding the medication error dated 22 July 2019.

In her witness statement, Ms Manhood stated:

> *'There were two further medication incidents involving James that were again similar in nature. The first was on 11 July 2019 when James amended a patient's MAR to change (increase) the dose of a medication prescribed by a doctor. I produce a copy of the MAR. The highlighted section shows the amendment made by James. James was not authorised to change the prescription as this can only be done by a doctor. I initially thought it was the doctor who had changed the dose and approached them as they had not used the correct method of crossing out the previous entry and creating a new prescription. However, I was informed by the doctor that she hadn't changed the dose and that it was not her handwriting. I could see that James had administered the dose, so I asked him what happened, and James told me he had changed it. I asked doctor to complete an incident report however she didn't submit one as she said she didn't want to get James into trouble.'*

In her witness statement, Ms Clark stated:

> *'I was on annual leave when the incident on 10 July 2019 occurred returning on the 22 July 2019. On returning to work I was checking through my emails and noted that whilst on leave I had received an email from Catherine on the 12 July 2019. The email had also been sent to two deputy ward managers Julia Meredieth and Laurine Lartey. I produce a copy of the email with my response on 22 July 2019.*
>
> *Within the email it detailed concerns regarding James in relation to an incident concerning administration of medication as well as amending a drug chart without approval or guidance from a doctor. James had given 2mg of lorazepam to a patient when the prescribed dose was 0.5 -1mg. James then changed the 1mg to 2mg instead of escalating the medication error.*
>
> *On reading this email I was concerned that this had not been escalated further by any of the deputy ward managers. I spoke with my Matron Doreen Mhone*

("Doreen") on 22 July 2019 and expressed my concerns of the seriousness of the concerns that I had received.

I discussed with Doreen that James had already completed his medicines management competencies on two occasions due to previous medication errors and I now felt this required further escalation due to the nature of the concerns raised in the 12 July 2019 email.'

In her witness statement, Ms Cawston stated:

'During the night shift on 10 July 2019 the registrant gave the incorrect dose of medication to a patient. The medication was Lorazepam which is a PRN medication which means it is used as and when it is needed for instance when a patient becomes distressed extra medication is given to help calm the patient. It can be used for a number of reasons, but it is generally one that is on a medication card when patients are admitted and is used for anxiety and agitation.

The registrant gave a patient 2mg of Lorazepam but the medication card was written up by the doctor for 0.5 to 1mg. The registrant amended the medication card following the error by changing the 1mg written in by the doctor to 2mg. There were potential risks that could have resulted by the registrant's actions as it goes against guidance and could have caused counteractions and impacted on physical and mental state. Sometimes when patients are agitated the medication can make them more agitated.

I produce a copy of the medication administration register which is completed at the start of each shift to document who has completed the medication round. It is important that this is completed as it is a clear document that we can refer to if a patient raises a medication concern as we have a reference of who did the medication round. The night time medication round on 10 July 2019 was completed by the registrant. This was the night of the incident, and I am unsure why the registrant didn't complete it.

I produce a copy of the medication chart for the date of the incident. Under section 14 where it has been highlighted you can see that the 1mg dose has been changed to a 2mg. In the next section you can see that the registrant administered 2mg which has been signed by him.

The registrant admitted that he had amended the chart and had taken the assumption before checking the chart that that was the prescribed dose. The registrant shrugged off what happened and just said that he had amended it. There was no emotion attached to it and because he had admitted it his attitude was that was that. We talked to the registrant about implications and risks. He appeared to take it on board but didn't really contribute much to the conversation.'

The panel took into account that the witness accounts corroborated one another. Those accounts were reflected in the documentary evidence. There was no information before it to suggest that the witnesses were unreliable, or had fabricated their statements.

The panel took into account that although the patient's medication card was written up at 0.5 – 1 mg, Mr Cole administered the incorrect dosage of 2 mg. The panel took into account the transcript of the Trust investigation meeting, dated 3 September 2019, in which Mr Cole said that he should have not changed the number, and that in the future he would "*make sure [you were] reading the cards correctly*" and report the error on DATIX. Mr Cole acknowledged that, as a nurse, he was not qualified to amend any dose on a card. He acknowledged that he should have told the doctor that he administered 2mg when the doctor had written it to be *"up to 1"* mg.

In light of Mr Cole's admission at the interview, as well as the evidence presented by the witnesses, the panel was satisfied that there is sufficient evidence before it to support that he did administer the incorrect dosage of PRN medication on 11 July 2019.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2d)

"On 11th July 2019 or soon after, did not complete an incident report or escalate to a senior member of staff once you were aware that you had administered the incorrect dosage of PRN medication to patient KT."

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Ms Clark. It also had regard to the transcripts from Mr Cole's investigation interview.

In her witness statement, Ms Clark stated:

'I spoke with James regarding the medication incidents on Finchingfield ward. James appeared to have a very laid-back approach to this discussion. When we spoke about changing the medication chart he grinned and stated 'I thought I would be a doctor for the day' then stated he was joking and understands it shouldn't be done. It was following these discussions that I spoke with my line manager, and it was agreed that because James did not appear to have insight into the seriousness of the concerns, he would be redeployed to non-clinical duties.'

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In the Trust investigation interview, Mr Cole said that he should have escalated the error, recorded it on a DATIX, or informed the doctor that the dosage was changed. The panel was of the view that, by acknowledging that he should have done these things, and would do so in the future, Mr Cole was acknowledging that he did not create an incident report nor escalate the medication error to other colleagues.

The panel was satisfied that there is clear evidence from discussions with Ms Clark, and the Trust investigation interview, that Mr Cole chose to amend the medication documents and sign it, and did not complete an incident report or escalate to a senior member of staff although he was aware that he had administered the incorrect dosage of PRN medication to patient KT.

The panel therefore found this charge proved on the balance of probabilities.

Charge 3

"Charges 2 a), and/or b), and/or c) amount to a failure to preserve patient safety."

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Ms Clark, Ms Manhood, and Ms Cawston. It also took into account the Trust Policy for the Safe and Secure Handling of Medicines.

The panel first considered charges 2a) and 2b), which pertain to the administration of controlled drugs.

In her witness statement, Ms Clark stated:

> *'All [Controlled Drugs] need to be administered with another nurse present. There is a signature sheet with the time, date, patient, dosage. There is space for two nurses' signatures. The second checker needs to ensure the right dose is administered to the right patient and whether the patient received the [Controlled Drug].'*

In her witness statement, Ms Manhood stated:

> *'On 5 October 2018, James administered a controlled drug without a second signature. Administration of a controlled drug must be witnessed by another nurse. The nurse must then sign the controlled drug book to evidence that they witnessed it.*
>
> *I was concerned by James' attitude towards what happened as he appeared very Bláise [sic]. He didn't appear concerned that what he had done was wrong and a breach of the Trust's policy. It was a serious incident which is why I had to complete the Datix.'*

The panel took into account the Trust policy on controlled medication which provides:

'15.16.1 Administration of Controlled Drugs

The administration of a controlled drug must be witnessed by a second practitioner, one of whom must be a registered nurse or doctor. In addition to the normal steps of the administration process described in section 15.13 an entry must be made in the CD Record Book, including:

- *The date and time of administration*
- *The name of the patient*
- *The dose administered*
- *The **full** signatures of both the witness and the person administering the drug.'*

The panel concluded that the Trust policy is clear that a second checker must be present in order to ensure and preserve patient safety. This is standard practice.

The panel was of the view that Mr Cole's failure to have a second checker present during the incidents outlined in charges 2a and 2b are clear failures to preserve patient safety as the witnesses have stated and as clearly set out in the Trust's policy on administration of controlled drugs.

The panel next considered charge 2c), which pertains to the incorrect dosage of PRN medication.

In her witness statement, Ms Clark stated:

> *'James should have let the patient know the error then informed the doctor and checked the patient's vital signs before completing a Datix. He could have at the very least left a note after giving the dose to explain.'*

In her witness statement, Ms Manhood stated:

> *'James once again didn't appear to think this was an issue and his attitude about what had happened was very casual. James understood he wasn't allowed to change it, but his attitude was completely indifferent. I was aware that it has still not been reported and I felt the issue needed to be raised as it concerned patient safety.*

Nurses are allowed to administer medication within the dose range prescribed on a MAR, which is documented under the 'dose given' tab. Nurses are not permitted to amend the original prescription as written on the MAR by thr [sic] doctor.'

In her witness statement, Ms Cawston stated:

'During the night shift on 10 July 2019 the registrant gave the incorrect dose of medication to a patient. The medication was Lorazepam which is a PRN medication which means it is used as and when it is needed for instance when a patient becomes distressed extra medication is given to help calm the patient. It can be used for a number of reasons, but it is generally one that is on a medication card when patients are admitted and is used for anxiety and agitation.

The registrant gave a patient 2mg of Lorazepam but the medication card was written up by the doctor for 0.5 to 1mg. The registrant amended the medication card following the error by changing the 1mg written in by the doctor to 2mg. There were potential risks that could have resulted by the registrant's actions as it goes against guidance and could have caused counteractions and impacted on physical and mental state. Sometimes when patients are agitated the medication can make them more agitated.

The panel took into account that, while charge 2c) does not relate to the administration of a controlled drug, changing the dosage on the patient records was clearly outside Mr Cole's scope of practice as a nurse. Ms Clark and Ms Manhood's statements explain that the correct and standard procedure for this type of error is to inform the patient, the doctor, and record the incident in a DATIX. Further, the panel took into account that the witnesses make clear that nurses should administer the medication dose indicated on a MAR, under *'dose given*', and are '*not permitted to amend the original prescription as written on the MAR by the doctor'.*

The panel also took into account Ms Cawston's statement, which outlines the potential for harm that such an error has on the patient. She stated that the medication could have impacted the patient's mental and physical state. It also noted that Dr Malte Flechtner, in their local statement, stated that the patient was in a *'hypomanic state'*, and was agitated,

shouting, and had to be restrained. Ms Cawston's statement highlighted that the incorrect dosage had the potential to exacerbate agitation in patients.

In considering 2a, 2b, and 2c, the panel found that the policies around the administration of PRN and controlled drugs were standard medication safety procedures that would have been clear to Mr Cole. By failing to adhere to policies which are in place to safeguard and protect patients, and by acting outside of his scope of practice, the panel was of the view that Mr Cole failed to adhere to standard practice for safe medication administration at the Trust, and as a consequence, failed to preserve patient safety.

The panel therefore found this charge proved in relation to 2a, 2b, and 2c.

Charge 4

> "On 11th July 2019, amended the dosage of PRN medication on patient KT's medicine card in order to give the misleading impression that you had administered the correct dosage."

This charge is found proved.

In making its decision, the panel took into account Ms Clark's witness statement, and the transcripts from the Trust investigation interview.

In her witness statement, Ms Clark stated:

> *'I spoke with James regarding the medication incidents on Finchingfield ward. James appeared to have a very laid-back approach to this discussion. When we spoke about changing the medication chart he grinned and stated 'I thought I would be a doctor for the day' then stated he was joking and understands it shouldn't be done. It was following these discussions that I spoke with my line manager, and it was agreed that because James did not appear to have insight into the seriousness of the concerns, he would be redeployed to non-clinical duties.'*

The panel also noted Mr Cole's own admission to changing the medication dosage on the patient documentation, as recorded in the Trust investigation interview. He stated that he should have informed the doctor that the dosage was changed. He was aware that he had made an error, and chose to amend patient records to cover up this error.

The panel also took into account the email from Ms Manhood to Ms Clark, dated 12 July 2019. The email stated:

> *'[…] The next day, Dr Stanley was asked to review the chart for additional PRN and when we got it back, the dose of lorazepam had been overwritten to be 0.5-1mg. I queried this as it made it look like James had given more lorazepam than had been prescribed. Dr Stanley said that she had prescribed lorazepam as 0.5mg – 1mg and that her handwriting had been amended to make the dose 0.5 mg to 2mg which she did not authorise.*
>
> *I spoke to James when he came in for the night shift last night and asked him if he had changed the dose on the chart. He asked what I meant, so I showed him the chart and he said yes, and that he'd given the patient 2mg lorazepam then realised afterwards that it was only prescribed up to 1mg at a time. He changed the prescribed dose instead of asking the duty doctor for a stat dose.'*

The panel noted that this is a contemporaneous account, dated the following day after the incident.

The panel determined that Mr Cole was aware that he made a medication error and administered the incorrect dosage, however, rather than taking responsibility for the error and escalating it to his colleagues and completing a DATIX, he amended patient records. The panel was of the view that Mr Cole was attempting to create a misleading impression by amending the doctor's handwritten entry to change the dosage, so that it would appear that he had given the correct dosage.

The panel therefore found this charge proved on the balance of probabilities.

Charge 5)

"Amended the dosage of PRN medication on a patient's medicine card in order to give the misleading impression that you had administered the correct dosage on another, unknown, date."

This charge is found NOT proved.

The panel considered this charge, however, it was of the view that there is insufficient evidence before it to support the charge.

The panel noted that there were no contemporaneous documents to support this charge, and the details of the charge had not been put to Mr Cole during the Trust investigation interview. The panel further noted that there are no particularised details in relation to dates, medications, or patients, on which it could find this charge proved on the balance of probabilities.

The panel determined that the NMC has failed the discharge the burden of proof in relation to this charge, and found it not proved.

Charge 6)

"Your actions in charges 4 and/or 5 above amount to dishonesty."

The panel found this charge proved.

The panel considered this charge in relation to charge 4 only, as it did not find charge 5 proved. In reaching its decision, the panel took into account the evidence before it in relation to charge 4, and the test set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

The panel first considered Mr Cole's knowledge or belief at the time of the incidents in charge 4. It took into account that he informed Ms Manhood, as detailed in her email to Ms Clark dated 12 July 2019, that he realised after administering the wrong dosage of medication that the prescription was for no more than 1mg. Mr Cole was therefore aware that he had made

a medication error. However, instead of escalating this, he amended the medication charts to reflect the incorrect dose which he had administered, and by doing this he was attempting to cover up and mislead colleagues as to the dosage that the doctor had prescribed. The panel considered that Mr Cole had made an assumption as to what the dose of medication was, then discovered that his assumption was incorrect, and made a conscious decision not to escalate this error or complete an incident report. He chose to change the dosage on the MAR chart. He did this in order to give a false impression that he had administered the correct dose, when he had not.

The panel next considered whether Mr Cole's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that ordinary, decent people would find that covering up a medication error by amending a doctor's prescription within patient records, and not acting in accordance with his duty of candour and admitting his mistake to the patient and to his (senior) colleagues was dishonest conduct. Mr Cole put the patient at risk of harm by intentionally covering up his medication error, and chose not to act with candour and report the error to his supervisors.

In light of all the above, the panel was satisfied that Mr Cole's action in charge 4 amounts to dishonesty. As such, this charge is found proved on the balance of probabilities.

Fitness to practise

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

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

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

Representations on misconduct and impairment

The 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 NMC code of professional conduct: standards for conduct, performance and ethics' ("the Code") in making its decision.

The NMC written submissions on misconduct and impairment are as follows:

> *'36. We consider the following provisions of the Code have been breached in this case:*
>
> *1. Treat people as individuals and uphold their dignity*
> *1.2 Make sure you deliver the fundamentals of care effectively*
> *1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *10. Keep clear and accurate records relevant to your practice*
> *10.1 Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> *10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
> *13 Recognise and work within the limits of your competence*
> *13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
> *14. Be open and candid with all service users about all aspects of care*

and treatment, including when any mistakes or harm have taken place
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly
20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

37. We submit that Mr Cole's conduct is serious and falls far short of what is expected of a registered nurse. His conduct is a serious departure from expected standards. Further, his conduct in relation to the administration of medication placed patients at unwarranted risk of harm. By failing to ensure that a second checker was present in the administration of controlled drugs, Mr Cole placed patients at risk of medication errors which could have affected their wellbeing. Moreover, by giving a patient the wrong dosage, Mr Cole placed the patient at risk of harm.

38. Honesty is of central importance to a nurse, midwife or nursing associate's practice thus allegations of dishonesty will always be serious.

39. In the case of Khan v GMC [2015] EWHC 301 (Admin) the court said at para. [6]:

> ***"The findings of this court have demonstrated that a very strict line has been taken in relation to findings of dishonesty. This court […] has repeatedly recognised that for all professional men and women, a finding of dishonesty lies at the top end of the spectrum of gravity of misconduct."***

40. It is submitted that Mr Cole's conduct in respect of charge 6 is serious and is a flagrant departure of the standards expected of nurses. He was dishonest on more than one occasion and despite being spoken to initially following the October 2018 incident, he proceeded to repeat his conduct.

Impairment

Limb 1

45. Mr Cole placed patients at unwarranted risk due to his failure to follow the relevant Trust policies on medicine management. As a result of Mr Cole failing to record a prescription change for IM medication in the handover notes, the patient continued to experience psychotic episodes for a further two days. The error made by Mr Cole was discovered only as a result of staff raising concerns about the patient's disposition with the consultant. It is submitted that had those concerns not been raised, the patient's treatment would have continued to be delayed and would have continued to experience psychotic episodes.

46. Further, by not ensuring a second checker was present, Mr Cole placed patients at unwarranted risk of receiving the incorrect dosage due to a lack of additional checks in accordance with the Trust's policy on controlled drugs. He also failed to address the medication error made in respect of the administration of PRN Lorazapine, which placed the patient at risk of harm.

47. It is submitted that he is liable in the future to act so as to put patients at risk of unwarranted harm. There were clear, well established and unambiguous process and policies in place which Mr Cole failed to follow despite also receiving training on more than one occasion. His conduct was over a lengthy period of time and was repeated. He had been spoken to by his supervisor following the first incident in October 2018 and had proceeded to repeat the conduct.

Limb 2

48. It is submitted that Mr Cole has brought and is liable in the future to bring the profession into disrepute. Registered professionals occupy a position of privilege and trust in society and are expected at all times to be professional. Members of the public must be able to trust registered professionals with their lives and the lives of their loved ones. Repeated failures in ensuring the medication is properly administered in accordance with the Trust policies and

procedures and nurses failing to be open and honest are capable of seriously undermining the public confidence in the nursing profession. Even where actual harm did not occur, the potential for harm in this case was significant as patients were administered controlled drugs without the appropriate checks to ensure the correct dosage was being given, a patient's treatment was delayed as a result of the registrant's conduct and there were repeated acts of dishonesty.

Limb 3

49. It is submitted that Mr Cole has breached the fundamental tenets of the nursing profession and is liable in the future to breach fundamental tenets of the profession.

50. The Code divides its guidance for [nurses] into four categories which can be considered as representative of the fundamental principles of [nursing] care.

51. These are:

51.2. Prioritise people;

51.3. Practise effectively;

51.4. Preserve safety and

51.5. Promote professionalism and trust

52. As outlined above, Mr Cole's conduct was in breach of Codes 1, 10, 13, 14 and 20 of the NMC Code of Conduct. He therefore failed to prioritise people, to practise effectively, to preserve the safety of patients and to promote professionalism and trust. It is submitted that although not all breaches of the Code require a finding of impairment, the breaches of the Code in this case are significant and serious. It is submitted that the breaches of the Code placed patients at unwarranted risk of harm and thus the Committee should conclude that a finding of impairment is required to mark the profound unacceptability of the behaviour, to emphasise the importance of the fundamental tenets breached and to reaffirm the proper standards and behaviour.

Limb 4

53. The NMC Code requires professionals to act with honesty and integrity. It is submitted that Mr Cole has acted dishonestly and is liable in the future to act dishonestly.

54. Mr Cole breached the professional duty of candour to be open and honest when he erroneously gave the incorrect dosage of PRN Lorazepine (sic) to the patient. He

sought to cover up his conduct by dishonestly changing the prescription dosage on the patient's medication card, thereby falsifying records and putting the patient at risk of harm as another nurse may have administered the incorrect dosage relying on the amendment made by Mr Cole. Further, he sought to falsify the controlled drugs book by indicating that he would sign the controlled drugs book himself when he did not have a second checker and asked colleagues who had not witnessed the administration of controlled drugs

55. Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

56. We consider that the concerns are not easily remediable as they include dishonesty-related concerns that were repeated and directly linked to Mr Cole's professional practice as a nurse. Mr Cole has not taken any steps to remediate the concerns. He has not engaged in the regulatory process, save as to inform the Council that he has not worked as a nurse since 2019 and that he has no intention of working as a nurse in the future. He has not provided any reflections to demonstrate that he understands the impact of his conduct on patients and the nursing profession. He has also not provided any reflections which demonstrate his remorse and steps taken to address the concerns.

57. Mr Cole has also not undertaken any relevant training in respect of the issues of the concerns and has expressed that he has no intention of continuing a career in nursing.

58. We consider that there is a continuing risk to the public due to Mr Cole's lack of insight, disengagement with the NMC regulatory proceedings and lack of any training to strengthen his practice.

59. For the reasons referred to above, it is submitted that a finding of impairment on public protection grounds is necessary.

Public Interest Ground

60. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

"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."

61. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

62. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. A concern which has not been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

63. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

64. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. Mr Cole has not taken any steps to put right the regulatory concerns. Mr Cole's conduct was also significantly serious such that it would be an unacceptable conclusion if a finding of impairment was not made. He placed patients at unwarranted risk of harm, he acted dishonestly and his conduct was repeated despite being spoken to, being provided with support and undertaking training following the initial concerns being raised. It is submitted that his conduct fails to promote and maintain professional standards and public trust in the profession.'

The panel accepted the advice of the legal assessor.

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

Decision and reasons on misconduct

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

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

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

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

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

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

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'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered the charges found proved and determined whether or not they amounted to a finding of misconduct.

Charges 1, 2a), 2b), 2c), 2d), and 3

The panel considered these charges together as they relate to medication and drug errors. The panel took into account that Mr Cole would have been well appraised of Trust policy on the safe administration of controlled drugs and PRN medication. He was given support by his Trust in the form of extra drug courses, and the dangerousness of making errors were highlighted to him.

In relation to charge 1, the panel accepted Mr Cole's explanation, as set out in the Trust investigation interview, that he had misinterpreted the doctor's instructions. However, the panel took into account that this incident, on 8 August 2019, was preceded by the previous errors which took place in October 2018, and July 2019. At this point in time, Mr Cole had already been provided with extra medication training on two occasions. The panel was of the view that Mr Cole ought to have understood the doctor's instructions, and his failure to do so was serious. He did not seek further clarification or reflect this in his hand over. The panel determined that Mr Cole's conduct in charge 1 amounted to serious misconduct.

The panel was of the view that administering controlled drugs to patients without the presence of a second checker, against standard Trust policy, amounted to serious misconduct. Mr Cole's actions in charge 2 in its entirety put patients at an unwarranted risk of harm, and fell seriously short of the conduct and standards expected of a registered nurse. In relation to charge 3, the panel found that failing to follow Trust policy and thereby failing to preserve patient safety amounted to serious misconduct.

Charge 4)

The panel was of the view that Mr Cole's conduct, in amending the dosage on a PRN card in order to give the misleading impression that he had administered the correct dosage, when he had not, fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct. Mr Cole acted in a misleading manner and by doing so, put a patient at unwarranted risk of significant harm. It was of the view that medical professionals and members of the public would find Mr Cole's conduct deplorable. Amending the dosage could have had a serious impact on patient safety, and this was not properly escalated to colleagues.

Charge 6)

The panel, having found that Mr Cole's actions at charge 4 amounted to dishonesty, determined that this charge amounted to serious misconduct. The panel noted that dishonest conduct is regarded as very serious, and would be considered deplorable by fellow practitioners. Further, the panel took into account that Mr Cole's dishonest amendment of a doctor's prescription, in order to cover up a drug error, is a breach of duty of candour and professionalism. His conduct put a patient at unwarranted risk of significant harm, as the patient received an incorrect dosage of medication which could have impacted their physical or mental state, and this was not properly escalated.

In light of all the above, the panel found that Mr Cole's actions in charges 1, 2a, 2b, 2c, 2d, 3, 4, and 6 fell seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Cole's 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/their fitness to practise is impaired in the sense that she/he/they:

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 was satisfied that all four limbs of the Grant test, in relation to the past, was engaged in this case. The panel found that patients were put at risk of harm as a result of Mr Cole's misconduct, which involved drug administration errors and a failure to follow policy around the administration of controlled the drugs. The panel took into account the seriousness of Mr Cole's administration of 2mg of a PRN medication to a patient, when the doctor had prescribed 0.5mg to 1mg dosage.

The panel determined that Mr Cole's misconduct breached the fundamental tenets of the nursing profession, including the duty of candour, and therefore brought its reputation into disrepute. The panel also took into account that, by amending the doctor's prescription in order to cover up his medication error, Mr Cole acted dishonesty.

In considering whether the Grant test applies in the future, the panel first considered whether the concerns are remediable. It was satisfied that the concerns relating to the medication errors have the potential to be remediated.

The panel next considered whether the concerns have been remediated. The panel took into account that Mr Cole has not engaged with these proceedings or his regulator, and has not provided any evidence of developed insight, remorse, or strengthening of his practice. The panel also took into account the emails from Mr Cole in relation to these proceedings, dated 3 April 2023, which stated:

'I want to voluntary [sic] pull out of any investigation. […] I am not willing to engage with any investigation as of this point.'

The panel also considered that the dishonesty in this case is very serious, and suggests that there is a deep-seated attitudinal concern. Mr Cole deliberately amended patient

records. His dishonesty put a patient at an unwarranted risk of harm. The panel was of the view that deep-seated attitudinal concerns and dishonesty are difficult to remediate, and noted that Mr Cole has neither provided any evidence of reflection into this dishonest conduct, nor demonstrated remorse.

The panel also took into account the repeated nature of the medication errors. Mr Cole was put on notice, and provided extra training courses in an attempt to remediate and address the concerns in relation to his medications administration. However, the errors persisted despite this support. Mr Cole is no longer practising as a nurse, and has not demonstrated that he has strengthened his practice and clinical skills, and has not provided evidence of further training to address the misconduct.

In light of all the above, the panel determined that there is a real risk of repetition in this case. As such, it determined that the four limbs of the Grant test, in relation to the future, are engaged. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel determined that a finding of impairment on public interest grounds is also required, as public confidence in the nursing profession would be seriously undermined if a nurse who dishonestly amended a patient record in order to cover up their drug error, were allowed to practise without a finding of impairment. It also took into account that public confidence in the nursing profession would be seriously undermined if a nurse who failed to follow Trust policy around medication administration, and consequently failed to preserve patient safety, were allowed to practise without a finding of impairment. The panel was satisfied that the misconduct in this case is very serious, and therefore determined that a finding of impairment would uphold the public confidence in the nursing

profession and the NMC as its regulator. It therefore finds Mr Cole's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, the NMC had advised Mr Cole that it would seek the imposition of a strike off order if the panel found Mr Cole's fitness to practise currently impaired. The panel had regard to the written submissions provided by the NMC.

Decision and reasons on sanction

Having found Mr Cole's 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 panel took into account the following aggravating features:

- Absence of insight into failings
- Conduct which deliberately or recklessly put people receiving care at direct risk of suffering harm
- Multiple deliberate breaches of the Code
- deliberate and dishonest falsification of medical records to cover up wrongdoing
- Failure to act on supervision guidance and training
- A pattern of misconduct over a period of time
- Failure to engage in the Fitness to Practise (FtP) process
- Deep-seated attitudinal concerns

The panel also took into account the following mitigating features:

- Admissions at local level

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

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

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

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

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

The panel took into account that Mr Cole has not provided any evidence of insight and remediation, and has stated that he will is longer engaging with his regulator. The panel also took into account Mr Cole's correspondence with the NMC, which states:

> *'I haven't worked as a nurse since 2019. I have no intention of working as a nurse in the future. So any decision and work you do is irrelevant.'*
>
> *'I want to voluntary pull out of any investigation I have never worked as a nurse or for the NHS since the dates I was dismissed, and I am no longer a nurse since December 2018 my pin has been deactivated for years. I'm currently working as a recruitment consultant. I am not willing to engage with any investigation as of this point.'*

In light of the lack of insight, remorse and remediation, and in light of Mr Cole's disengagement from the NMC and his intention not to return to nursing, the panel determined that conditions of practice would not be appropriate in this case. The panel also took into account the seriousness of the misconduct in charges 4 and 6, which relates to dishonest conduct which put a patient at an unwarranted risk of harm.

Having regard to the nature and seriousness of Mr Coles conduct, and the dishonesty in this case, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

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

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

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

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

Whilst the panel acknowledged that the risks identified could be managed by Mr Cole being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Mr Cole's disengagement, absence of insight, lack of remorse, together with no evidence of training and development, the panel considered that there is no realistic possibility that he would address the concerns to such a level where he could return to practise safely. The panel also acknowledged that Mr Cole is not currently practising as a nurse or in a clinical

setting, and has expressed that he not longer wishes to return to nursing. The panel also bore in mind that dishonesty and deep-seated attitudinal concerns of are very serious.

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

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

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

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

The panel found that Mr Cole's dishonesty in amending patient records to mislead colleagues and cover up his medication error raises fundamental questions about his professionalism. He has not provided any reflective pieces or evidence of remorse and insight into his misconduct. The panel also took into account that, following the incidents, witnesses described Mr Cole as '*blasé*'. It noted that, when asked about the dishonesty, he told his manager that he '*wanted to play doctor for the day*'.

The panel also took into account that Mr Cole would have been aware of the standard practice and Trust policy around the safe administration of medications and controlled

drugs. He did not follow this policy, and did not ensure that he had a second checker present when administering medications. Mr Cole has not demonstrated any insight and reflection into this, and did not incorporate the training and support he received from his employer into his practice.

In light of the pattern of misconduct, the seriousness and nature of the misconduct, and the deep-seated attitudinal concerns in this case, the panel found it was unlikely that Mr Cole could realistically have gained insight and reflection to mitigate the risk of harm, following a period of suspension.

Mr Cole's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with his remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Cole's actions were serious and that to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mr Cole in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the

protection of the public, is otherwise in the public interest or in Mr Cole's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim order is necessary to protect the public during the 28-day appeal period and any other period of appeal.

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, during any period of appeal. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.