# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Thursday, 14 May 2026 – Friday, 15 May 2026**
**Monday, 18 May 2026 – Thursday, 21 May 2026**

Virtual Hearing

| | |
|---|---|
| **Name of Registrant:** | Mariya Holyanova |
| **NMC PIN:** | 07I0060C |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>Adult Nursing – (September 2007) |
| **Relevant Location:** | Kent |
| **Type of case:** | Misconduct |
| **Panel members:** | Rachel Carter (Chair, Registrant member)<br>Rashmika Shah (Registrant member)<br>Dino Rovaretti (Lay member) |
| **Legal Assessor:** | Neil Fielding (14 May 2026)<br>Oliver Wise (15 – 21 May 2026) |
| **Hearings Coordinator:** | Bethany Seed (14 – 18 May 2026)<br>Max Cojo-Buadi (19 May 2026)<br>Stanley Udealor (20 – 21 May 2026) |
| **Nursing and Midwifery Council:** | Represented by Leesha Whawell, Case Presenter |
| **Mrs Holyanova:** | Present and represented by Wafa Shah, instructed by the Royal College of Nursing (RCN) |
| **Facts proved by admission:** | Charges 1a, 1b, 1c, 2, 4 and 6 |
| **Facts proved:** | Charges 3, 5 and 7 |
| **Fitness to practise:** | Impaired |

| | |
|---|---|
| **Sanction:** | **Suspension order (6 months)** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Whawell, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 3.

The proposed amendment was to amend the word "*further*" to "*future.*" It was submitted by Ms Whawell that the proposed amendment would correct a typographical error and ensure clarity and accuracy in the charge.

> *'That you, a registered nurse:*
>
> *3) Your actions at charge 2 were dishonest because you knew your original entries were accurate and you intended a ~~further~~* ***future*** *reader to believe the amendments were accurate, when they were not.'*

Ms Shah, on your behalf, indicated that she did not oppose the 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 typographical and also in the interests 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 ensure clarity and accuracy.

**Details of charge (as amended)**

That you, a registered nurse;

1) Between 22 and 23 January 2024:
   a) Failed to administer the correct amount of oxygen to Child A. **[PROVED BY ADMISSION]**
   b) Failed to respond appropriately to Child A's deteriorating condition in that you did not call an ambulance. **[PROVED BY ADMISSION]**
   c) Failed to maintain clinical supervision of Child A on their journey to hospital. **[PROVED BY ADMISSION]**

2) On or after 25 January 2024 amended Child A's daily log notes for 22/23 January 2024. **[PROVED BY ADMISSION]**

3) Your actions at charge 2 were dishonest because you knew your original entries were accurate and you intended a future reader to believe the amendments were accurate, when they were not. **[PROVED]**

4) On 28 January 2024 submitted an inaccurate incident form to Unity Care Solutions. **[PROVED BY ADMISSION]**

5) Your actions at charge 4 were dishonest because you knew that the some or all of the details in the incident form were inaccurate and you intended a future reader of the incident form to believe the details were accurate. **[PROVED]**

6) On 12 February 2024 at the local investigation meeting, told the interviewers that you had amended Child A's daily log notes at 5am on 23 January 2024 when you had not amended the records at that time/date. **[PROVED BY ADMISSION]**

7) Your actions at charge 6 were dishonest because you knew you had not amended the daily log notes at that time/date and you intended the interviewers to believe you had amended them at that time/date. **[PROVED]**

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

**Background**

The charges arose whilst you were employed as a registered nurse by Unity Care Solutions (Unity Care). At the time the allegations arose, you were employed by Unity Care to provide one-to-one care for Child A. Child A had serious and ongoing health conditions and was ventilated at home via a tracheostomy.

On 22/23 January 2024, you documented that Child A's oxygen saturations levels were low and that you had increased his oxygen, but this did not improve his condition. You informed Child A's parents, and his father took him to hospital, and you followed them in a separate car.

On 23 January 2024, you spoke with Tracey Farrington, the Clinical Lead at Unity Care. She alleged that you told her that you had given higher levels of oxygen than were required in the care plan. Ms Farrington requested you to put the details down in writing in an incident form and in an email. In this email dated 24 January 2024, you wrote that you had checked the oxygen concentrator and it was on three L/min per minute (L/min). You wrote that Child A's saturation (SATs) monitor was on and reading between 82 and 84 and that you turned his oxygen up to five L/min. You further wrote that you told Child A's father that Child A needed to go to hospital, as you could not keep Child A on five or six L/min of oxygen at home.

In the incident report, dated 28 January 2024, you wrote that Child A's oxygen was at three L/min, and that he needed more than this and so he needed to go to the hospital so

he could receive more oxygen (around four to six L/min). It was suggested that this account differed from the account you provided to Ms Farrington, in which you confirmed that you had administered five L/min of oxygen at home. In Child A's care plan, it was written that if Child A is desaturating, his oxygen can be increased to three L/min, but if he is unable to be weaned back down to one L/min of oxygen within two hours, an ambulance should be called.

Due to these inconsistencies, you were invited to an investigation meeting at Unity Care on 7 February 2024 and these inconsistencies were raised with you. You were interviewed again on 12 February 2024 when you were asked about the inconsistencies. You explained that you could not explain why you had written four or five L/min, but that you had been busy. You also said that you changed the entry from five L/min to three L/min after you arrived at hospital with Child A, as writing five L/min was a mistake. You said that you changed the record at 05:00 on 23 January 2024 at the hospital. Unity Care confirmed that they had received a copy of the daily logs stating five L/min on 25 January 2024, and therefore you could not have amended the record on 23 January 2024 otherwise it would be noted down as three L/min. You then suggested that you could have amended the notes on 29 January 2024 or maybe later. You accepted in the interview that you did not follow the correct procedure for correcting a mistake.

The matter subsequently proceeded to a disciplinary hearing, and you were interviewed again on 19 February 2024. You provided a more detailed account but maintained that you had only administered three L/min, although you accepted that you told Ms Farrington you had administered five L/min, but you were unsure why.

**Decision and reasons on facts**

At the outset of the hearing, the panel heard from Ms Shah, who informed the panel that you made full admissions to charges 1a, 1b, 1c, 2, 4 and 6.

The panel therefore finds charges 1a, 1b, 1c, 2, 4 and 6 proved in their entirety, by way of your admissions.

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

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 witness called on behalf of the NMC:

- Tracey Farrington: Clinical Lead and Nurse Case Manager at the time of the alleged incidents;

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel accepted the advice of the legal assessor, who advised the panel to have regard to the NMC Guidance DMA-8 *Making decisions on dishonesty charges and the professional duty of candour* (last updated: 6 May 2025).

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

**Charge 3**

3) Your actions at charge 2 were dishonest because you knew your original entries were accurate and you intended a future reader to believe the amendments were accurate, when they were not.

**This charge is found proved.**

In relation to the matter of dishonesty, the panel bore in mind the test in *Ivey v Genting Casinos* [2017] UKSC 67. It must first consider what your genuine state of mind was at the time of the incident. It must then determine whether your actions were dishonest by the standards of ordinary, reasonable and honest people. The panel considered these charges individually, but its findings remain similar for each of the disputed charges.

In reaching this decision, the panel took into account Child A's ventilation chart and daily logs, the evidence of Ms Farrington, the Investigation Meeting notes dated 7 February 2024, minutes of the investigation meeting on 12 February 2024, the email from you to Ms Farrington dated 24 January 2024, the incident report dated 28 February 2024 and your evidence.

In particular, the panel considered the background circumstances that you outlined during your evidence. The panel considered that at the time of the events, you described having been under pressure at work, having completed several long shifts and that you were particularly tired. The panel also considered that you explained having difficulties with the parents of Child A, who, you told the panel, did not readily accept your clinical opinion that Child A needed to go back to hospital. The panel further considered that you are an experienced nurse, who was familiar with Child A and his family, and that the alleged dishonesty did not occur within the moment on 22/23 February 2024. A few days later, sometime after the incident, you amended the logs. You also had not informed or discussed your reasons for making the amendments with Ms Farrington nearer the time that you had made them.

The panel bore in mind your alternative explanation for your actions. It noted that you said in evidence that you had given Child A between four to five L/min of oxygen on the relevant dates, and it further noted that you had originally accurately documented this in Child A's daily logs and ventilator charts. You told the panel that you had shared this information in a telephone call with Ms Farrington on 23 January 2024, and she asked why you had administered more than three L/min and requested that you send a statement to her detailing the events. You stated that you then reviewed the notes, and subsequently, you could not believe that you had given Child A between four and five L/min of oxygen. You told the panel that you corrected the ventilator charts and daily logs to reflect that you had given three L/min of oxygen. The panel considered that you appear to accept that you did amend the logs, but that you believed you were correcting a mistake, and you did not trust your records of the time.

However, the panel was of the view that your record keeping appears to be very thorough and detailed in respect of Child A in all other aspects. The panel therefore considered it would be illogical of you to review these logs and believe that you had made a mistake. The panel considered that it was implausible that you doubted your clinical notes in respect of Child A, as you did not amend them on the date in question, but a few days later and only after having spoken with Ms Farrington. The panel was of the view that, later amending the notes, which were kept in Child A's home, suggested that there was an element of trying to conceal your clinical mistake that you had recognised upon reviewing the care plan. The panel was satisfied that at the time you had a belief that your actions were dishonest.

The panel considered the sequence of events following you amending Child A's notes. It noted that in the Investigation Meeting on 7 February 2024, you did not tell Ms Farrington that you had amended Child A's notes. You told the panel that the reason you did not declare this was because the meeting was held at short notice and you did not realise what the meeting was about. The panel considered that the notice letter of this meeting was sent on 1 February 2024, and the panel was of the view that this was sufficient time to

consider explaining why you had amended the notes. In the investigation meeting notes dated 12 February 2024, it is noted that:

> *'Z.B asked her if she knew UCS policy about noting incorrect entries by putting a line through and signing to say she had made an incorrect entry. M.H confirmed she knew the policy and had made a mistake by not following it.'*

You also gave oral evidence that you knew the policy on how to properly amend mistakes in clinical records. The panel was therefore satisfied that you knew at the time that you had amended the notes, not in accordance with the policy, and you had not informed Unity Care about the amendments. The panel also considered that during these investigation meetings, you were not able to confirm the date on which you made the amendment. The panel considered that your answers to Ms Farrington appeared to be quite evasive, and this was another instance when you could have been honest but chose not to do so.

In light of the above, the panel determined that at the time of the incident, you knew that your actions were dishonest and that your original entries were accurate. The panel considered that you intended a future reader to believe the amendments were accurate, when they were not. The panel considered that your genuine belief was that you were being dishonest. The panel also considered that an ordinary, honest person would believe these actions to be dishonest. Therefore, the panel finds this charge proved.

**Charge 5**

5) Your actions at charge 4 were dishonest because you knew that the some or all of the details in the incident form were inaccurate and you intended a future reader of the incident form to believe the details were accurate."

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms Farrington, the email from you to Ms Farrington on 24 January 2024, the incident form dated 28 January 2024, the ventilation chart and daily logs of Child A and your evidence. The panel also considered its previous findings in respect of charge 3.

You completed the incident form four days after the incident on 28 January 2024. The incident arose when you recognised Child A's need to attend hospital for urgent assessment after administering four to six L/min of oxygen. You documented this over the course of the incident in Child A's ventilator chart and daily logs. You subsequently spoke with Ms Farrington on the phone the following day and the panel heard evidence that you reiterated that you had administered four to six L/min of oxygen. You followed this up with an email to Ms Farrington in which you again state that you had administered four to six L/min of oxygen. The panel concluded that up to this point in time your observations and recollections were consistent. The panel then considered that when recalling the details of the incident to Ms Farrington, both during telephone and email communications the following day, you relied upon your memory of the incident. The panel concluded that your memory at that time was that you had administered between four and six L/min of oxygen.

Despite these instances of documenting your clinical actions, it was your view that when you wrote the incident form on the 28 January 2024, you no longer trusted your memory, nor the documentation you had made up to that point. As such, your evidence was that your actions in submitting inaccurate information within the incident report, were based upon a change in your recollection and a personal view that you would not have administered oxygen outside of the prescribed range. The panel was of the view that this alternative explanation was wholly implausible and noted that the production of the incident form marked a shift in the way that you recounted the incident.

The panel considered that when you came to write the incident report, you must have considered the record keeping errors in light of what you knew had happened. Accordingly, this was your clear opportunity to uphold the duty of candour and to inform Ms Farrington or Unity Care of the errors you believed you had made. The panel therefore

concluded that at the time you completed the incident form, you knew that the some or all of the details in the incident form were inaccurate. As a registered nurse, you should have known the importance of recording accurate information in an incident form. The panel considered that by changing the narrative in the incident form, namely, amending the level of oxygen you had administered to Child A as three L/min, you intended a future reader of the incident form to believe the amended details were accurate. The panel also considered that an ordinary, honest person would consider your actions to be dishonest. Therefore, the panel determined that this charge is found proved.

**Charge 7**

7) Your actions at charge 6 were dishonest because you knew you had not amended the daily log notes at that time/date and you intended the interviewers to believe you had amended them at that time/date.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms Farrington, the minutes of investigation meeting dated 12 February 2024, the email from you to Ms Farrington on 24 January 2024 and your evidence.

The panel considered that in the investigation meeting notes dated 12 February 2024, you told Ms Farrington that you had amended the notes on 23 January 2024 at the end of your shift. You were subsequently shown copies of the unamended original daily logs, which were photographed and received on 25 January 2024, and therefore could not have been amended on 23 January 2024. You then stated that you were confused and could not recall when you amended the notes. The panel considered that this was consistent with your oral evidence to this panel.

However, the panel bore in mind its previous findings in relation to your dishonesty. The panel considered that you only stated that you could not remember when you made the

amendments after having seen evidence that contradicted your version of events. The panel considered that on 23 January 2024, you phoned Ms Farrington and then subsequently sent an email on 24 January 2024 confirming that you had administered between four and six L/min of oxygen to Child A. The panel considered that if you had amended the logs on 23 January 2024 it is unlikely that you would have stated in your initial phone call to Ms Farrington that you had mistakenly given four to six L/min of oxygen, and, in addition, reiterated this information to Ms Farrington the following day. The panel therefore considered that on the balance of probabilities, at the time of the interview, you knew that you had not made the amendments on 23 January 2024.

The panel was of the view that by stating that you had made the amendments at this time, you sought to conceal your clinical error by suggesting that you had identified a simple record keeping mistake during the shift on which the incident took place. The panel was of the view that this would be considered dishonest by the standard of an ordinary, honest person. Therefore, the panel determined that this charge is found proved.

**Fitness to practise**

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

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

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

The panel heard evidence from you under affirmation.

**Submissions on misconduct**

Ms Whawell referred the panel 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.'* She also referred the panel to the case of *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v GMC* [2004] EWHC 2317 (Admin).

Ms Whawell invited the panel to take the view that the facts admitted and found proved amount to misconduct as your actions fell below the standards expected of a registered nurse. Ms Whawell submitted that the following parts of the Code: Professional standards of practice and behaviour for nurses and midwives 2018 (the Code) are engaged in this case and have been breached. They are sections 10.3, 14.1, 14.2, 14.3, 20.1 and 20.2.

Ms Whawell submitted that your actions in charge 1 could have led to direct and possibly catastrophic consequences for Child A. She submitted that your dishonesty could have led to further complications as other professionals should be able to trust what is written in medical records and act accordingly.

Ms Whawell submitted that you failed to act with honesty and integrity and you were given ample opportunity to own up to your original error and you chose not to. She submitted that other professionals would find this deplorable.

Ms Whawell submitted that you had a decision to make at each stage of the process, to own up to your mistake and to apologise for it. She submitted that you, instead, chose to be dishonest and took a conscious decision to amend the records and conceal the truth of an incident. She submitted that this was against your nursing training and it was against the Code.

Ms Whawell submitted that your dishonesty is a particularly serious concern because it was repeated and sustained. She submitted that a fellow practitioner would find this sort of behaviour deplorable. She submitted that purposefully concealing an error, deceiving others into believing that accurate records were not accurate is nothing short of deplorable.

Ms Shah submitted that you accepted that your conduct in the charges found proved amount to misconduct.

**Submissions on impairment**

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

Ms Whawell submitted that all four limbs of *Grant* are engaged in relation to both past and future conduct.

Ms Whawell submitted that your conduct placed a patient at unwarranted risk of harm by giving a vulnerable child more oxygen than was prescribed, by not calling an ambulance as required by the care plan in the circumstances that were present, and by not maintaining clinical supervision of the patient as he travelled to hospital with his father.

Ms Whawell submitted that the panel may consider that the concerns have not yet been fully addressed. She referred the panel to your bundle containing your reflections and training certificates. She noted that, during your oral evidence at the facts stage, you showed some understanding in respect of the risk of harm posed to the patient. She invited the panel to consider whether this was fully developed insight.

Ms Whawell referred the panel to your reflective statement and submitted that you have concentrated more on how tired and overwhelmed you were, rather than taking the important step of looking back at the situation objectively. She submitted that your insight was not well developed and it was therefore not highly unlikely that the conduct will be repeated.

Ms Whawell submitted that your conduct has brought the reputation of the profession into disrepute due to the falsification of the clinical records and your lack of candour and dishonesty.

Ms Whawell submitted that your dishonest conduct in covering up an error had breached the fundamental tenets of the profession. She submitted that, unless and until you are able to demonstrate full developed insight into the seriousness of your conduct, then there is a risk of repetition in the future.

Ms Whawell submitted that dishonesty is an attitudinal concern and therefore more difficult to address. She submitted that your dishonest conduct was not an isolated incident but occurred in three different forms over a significant period of time. She submitted that you had not shown any insight into the seriousness of your dishonest conduct and therefore you are more likely to act dishonestly in the future.

Ms Whawell submitted that a finding of impairment is required on public interest grounds in this case. She submitted that it was important to demonstrate that your actions jeopardises the trust placed on nurses and it should not be tolerated. She further

submitted that the conduct was so serious that a finding of impairment is necessary to maintain the public's confidence and trust in the professions and to uphold and declare and maintain professional standards.

Ms Whawell referred the panel to the NMC Guidance ‘Has the concern been addressed?’ (FtP-16b). She highlighted that the Guidance sets out how a practitioner could demonstrate insight and how a panel may assess the sufficiency and quality of any insight which includes assessing whether the acceptance of the concerns was at the beginning of any investigation. She noted that the Guidance also set out that a panel should consider whether the insight into risk of harm and damage to public confidence is comprehensive. Ms Whawell submitted that it was the NMC’s position that your insight into the risk of harm and damage to public confidence was not comprehensive.

Ms Whawell submitted that you have accepted that things did go wrong, but you have expressed very little understanding of how you will avoid repeating the behaviour if faced with similar circumstances in the future. She asserted that you failed to demonstrate any real insight into why you allowed your personal interest to outweigh your duty to be honest, open and truthful from the outset, or how you would avoid such behaviour in the future.

In conclusion, Ms Whawell invited the panel to find that your fitness to practise is impaired on the grounds of public interest and public protection.

Ms Shah invited the panel to consider the context of the incidents that led to your conduct, when making its decision on whether your fitness to practise is currently impaired. She highlighted that you stated that you had a number of consecutive night shifts which made you stressed. She noted that you also spoke about personal issues that were ongoing and stress that you were experiencing at the time of the incidents.

Ms Shah submitted that although such mitigating circumstances do not absolve you of wrongdoing, they could assist the panel in ascertaining the context in which the incidents

had occurred, and the context can sometimes flow into whether or not the panel finds that the conduct is remediable. She also invited the panel to consider your conduct throughout the NMC process. She highlighted that you have engaged fully with the NMC, you have developed insight during the course of these proceedings and you have wholeheartedly accepted the panel's findings on facts especially on dishonesty.

Ms Shah noted that although you had not admitted dishonesty at the start of the proceedings, the panel should bear in mind that current impairment is a forward-looking exercise and it was not an opportunity to punish a registrant for past wrongdoing. She submitted that the panel should consider your current insight as presented in your oral evidence. She noted that when you were asked how you could persuade the panel that you would not act dishonestly in future, you acknowledged that trust takes a long time to build, and that you need to continue to reflect and implement lessons learnt from these proceedings. Ms Shah submitted that this was a sign of somebody who has at the very least reflected deeply enough to fully acknowledge that there was no easy fix to having acted dishonestly whilst working as a nurse. She asserted that you have therefore demonstrated genuine remorse and insight.

Ms Shah highlighted that the first step to preventing repetition was acknowledging the impact of certain behaviours. She submitted that you have not only acknowledged the impact of your conduct on others, but you have also had genuinely learnt your lesson, acknowledged the full extent of your dishonesty and the reasons for your actions. Ms Shah highlighted that you acknowledged in an open and public hearing that your actions were driven by a need to preserve your position and arose from self-delusion. She submitted that your conduct in publicly and openly accepting accountability and the full gravity for your actions is also a guard against the risk of repetition.

Ms Shah submitted that there are reasons why it is unlikely for you to repeat your conduct. She submitted that you have fully acknowledged the impact of what you did and acknowledged your responsibility. She noted that you have not opted away from accepting difficult matter and your engagement demonstrated that you wish to reform yourself. She

highlighted that you acknowledged that it is a long process of repeatedly having to build trust in the future.

In respect of public interest, Ms Shah invited the panel to consider what an informed member of the public, fully appraised of all the facts and all the information that the panel has received, would determine in the circumstances. She noted that the panel may take the view that due to the repeated nature of the dishonesty and due to the gravity of the misconduct, that this is a case where there ought to be a finding of impairment on a public interest basis. She submitted that notwithstanding this, the panel should consider holistically your insight and steps taken to strengthen your practice.

In conclusion, Ms Shah invited the panel to find that the risk of repetition is low in this case and your fitness to practise is not impaired.

The panel accepted the advice of the legal assessor.

**Decision and reasons on misconduct**

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

The panel determined that your actions amounted to a breach of the Code. Specifically, the following sections of the Code:

> *'**Prioritise people***
> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***Practise effectively***

***10 Keep clear and accurate records relevant to your practice***

*This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

*To achieve this, you must:*

***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*

***Preserve safety***

***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***

*To achieve this, you must:*

***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*

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

*To achieve this, you must:*

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

***Promote professionalism and trust***
***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'*

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

**Charge 1a**

The panel took into account that Child A was a very vulnerable child placed under your care to provide support to him over the night of the incident in accordance with his Support Plan and Home Care Ventilation Plan. The panel was of the view that your failure to administer the correct amount of oxygen to Child A in accordance with the Home Care Ventilation Plan posed a risk of harm to him and demonstrated a careless disregard towards the support plans. The panel noted that Ms Farrington stated in her witness statement that '*if the plan is not adhered to, there is the potential for his health to deteriorate very quickly and leading to a possible respiratory arrest.'* In her oral evidence, Ms Farrington explained that giving Child A more than the prescribed amount of oxygen put him at risk of oxygen toxicity.

The panel accepted that you were under some stress due to previous night shifts, working in a challenging environment and facing difficult personal circumstances at the time of the incidents. It did not agree that this was the cause of your conduct as you had initially

suggested in your evidence. The panel noted that you were familiar with Child A, his support plans and his parents, and that at the impairment stage of the hearing you suggested this familiarity may have contributed to your failings.

The panel was of the view that as a registered nurse, you had a duty of care towards Child A and your conduct amounted to a fundamental breach of such duty.

Consequently, the panel determined that your failings in charge 1a were sufficiently serious to amount to misconduct.

**Charge 1b**

The panel considered that it is basic clinical knowledge that when a patient's condition in a non-hospital setting deteriorates particularly a very vulnerable child, it is expected that emergency services/an ambulance should immediately be contacted by the registered nurse in charge of their care. The panel noted that these directions were also made explicit in the support plan. Rather than following the support plan and calling an ambulance, you agreed that the parents of Child A should take him to the hospital in their car without supervision.

The panel was of the view that your failure to immediately call an ambulance when you noticed Child A's deteriorating condition, placed him at risk of harm. The panel determined that your actions fell short of the standard of nursing care expected from a registered nurse and amounted to a fundamental breach of your duty of care to Child A.

Accordingly, the panel determined that your conduct in charge 1b was sufficiently serious to amount to misconduct.

**Charge 1c**

The panel found your failure to maintain clinical supervision of Child A on their journey to the hospital to amount to a dereliction of your nursing duties and that your failings fell far short of the fundamental obligations that registered nurses have to patients under their care. Although no actual harm was caused to Child A, the panel was of the view that your conduct posed a risk of harm to him. It noted that Ms Farrington stated in her witness statement that:

> *'Mrs Holyanova's actions put the client at serious risk of harm as he was already seriously unwell and, if his tracheostomy were to come out, he would most likely die. It would require a trained individual to replace a tracheostomy, hence the care plan required Mrs Holyanova's presence'*

The panel therefore determined that your failings fell short of the standard of nursing care expected from a registered nurse and amounted to a fundamental breach of your duty of care to Child A. Consequently, the panel determined that your failings in charge 1c were sufficiently serious to amount to misconduct.

**Charges 2, 4 and 6**

The panel took into account that although you earlier made the accurate entry in Child A's daily log notes, you amended it to cover up for your failings and you also submitted an inaccurate incident form.

The panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession. It was of the view that your failings would have deprived your colleagues, and the appropriate health professionals from being appraised with the relevant information pertaining to the care of Child A. The panel determined that this could have had a consequent impact on Child A's continuity of care and posed a potential risk of harm to him. The panel therefore determined that your actions constituted a serious

breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain.

The panel therefore determined that your actions in charge 2, 4 and 6 were sufficiently serious to amount to misconduct.

**Charges 3, 5 and 7**

The panel was of the view that your deliberate attempt to conceal your failings amounted to a breach of your duty of candour as a registered nurse and was dishonest. The panel considered honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found you have breached a fundamental tenet of the nursing profession. It noted that your dishonest conduct posed a risk of harm to Child A and demonstrated a lack of accountability and transparency on your part. The panel considered your dishonest behaviour to be unprofessional and would be seen as deplorable by other members of the profession and the public.

Therefore, the panel concluded that your actions in charges 3, 5 and 7 were sufficiently serious to amount to misconduct.

Consequently, having considered the proven charges individually and in totality, the panel determined that your actions in the charges found proved 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 January 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.'*

Registered 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, 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. At paragraph 74, she said:

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

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

*'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that 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 first considered whether any of the limbs of the *Grant* test were engaged as to your past conduct. The panel determined that your failings placed Child A at unwarranted risk of harm. The panel determined that you failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute. It determined that your misconduct constituted a serious breach of fundamental tenets of the nursing profession in that you failed to prioritise people, practise effectively, preserve safety, and promote professionalism and trust. The panel also found you to have acted dishonestly.

The panel therefore concluded that limbs a, b, c and d of the *Grant* test are engaged in respect of your past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* in which the Court addressed the issue of impairment with regard to the following three considerations:

a. *Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (reference: FTP-16).

The panel first considered whether your misconduct is capable of being addressed. In the NMC Guidance – Can the concern be addressed (reference: FTP-16a), the panel noted the following paragraph:

> *'In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*
>
> *Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *….*
> - *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*
>
> *Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*
>
> - *…..*
> - *poor record keeping*
> - *failings in a discrete and easily identifiable area of clinical practice'*

The panel was of the view that your misconduct with respect to your clinical failings and inaccurate record-keeping could be addressed through a process of insightful reflections, retraining in the areas of concern and evidence of good practice. Therefore, the panel determined that it is capable of remediation.

In respect of your dishonest conduct, the panel noted that the NMC Guidance set out that dishonesty was generally difficult to address. The panel noted that your dishonest conduct was deliberate, very serious, and repeated on more than one occasion, albeit it was limited to one episode of care. Having considered these factors, the panel decided that your dishonest conduct might be capable of remediation, but it is more difficult to remediate than your clinical failings.

The panel then went on to consider whether the concerns have been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed? (reference: FTP-16b). The panel took into account your oral evidence, your witness statement, your reflective accounts, your training certificates, your curriculum vitae and the various testimonials made on your behalf.

The panel also considered the context of the misconduct. It noted that you stated that you had worked a number of consecutive night shifts prior to the night in question which made you very tired, you were working in a stressful environment, and you were facing some personal difficult circumstances at the time of the incidents. Child A had previously had a child protection plan and had been recognised as a child in need. The panel recognised that you were working in a challenging situation with a young child on dangerously low oxygen levels. The panel acknowledged that these were challenging circumstances.

However, the panel was of the view that, given your experience as a registered nurse, those issues were not reasonable justifications for your misconduct.

Regarding insight, the panel considered that you made early admissions to some of the charges, shown genuine remorse and apologised for your actions. The panel took into

account that you have demonstrated some insight into the seriousness of your clinical failings and their impact on Child A, your colleagues, the nursing profession and the wider public. It noted that you have also set out what could have been done differently and how you would act in the future to prevent such a situation from recurring.

The panel considered that you had completed various training courses in the relevant areas of concern. The panel also noted that you have been practising as a registered nurse for the past two years since the incident, without any further concerns raised about your nursing practice. In this regard, it had sight of the various positive references made on your behalf, although it noted that one of your references stated that you are still developing your nursing practice.

In respect of your dishonest conduct, the panel considered that you recognised the seriousness of your misconduct at the impairment stage of the hearing. At this time, you stated that you had chosen to be dishonest about your clinical actions because you feared losing your job. You also stated that you continued the dishonesty because you felt ashamed of your conduct that followed the incident.

Nevertheless, the panel noted that, in your oral evidence, you still failed to recognise the importance of prioritising your patients' interests above your interest. It was of the view that you are yet to demonstrate full insight into the impact of your dishonest conduct on Child A and its attendant risk of harm posed to him, the impact of your dishonesty on your colleagues, the nursing profession and the wider public. The panel considered that your journey of remediation requires you to reflect more on your dishonest conduct, which you have failed to do until recently. The panel therefore determined that your insight into your dishonesty is insufficient and still in its early stages.

In light of this, the panel was not satisfied that your misconduct has been fully remediated. Accordingly, the panel determined that there is a risk of repetition, and limbs a, b, c and d of the *Grant* test are engaged in the future.

The panel therefore concluded 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 are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel had regard to the serious nature of your misconduct and the public protection issues it had identified. It determined that public confidence in the profession, particularly as the misconduct involved risk of harm to a very vulnerable child and dishonesty, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

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

**Sanction**

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

**Submissions on sanction**

Ms Whawell submitted that the most appropriate and proportionate sanction in this case is a striking-off order. She referred the panel to the NMC Guidance '*The purpose of and*

*approach to sanctions* (reference: SAN-1) which confirms the purpose of the imposition of a sanction is to meet the NMC's overarching objective to protect the public. She stated that sanctions are imposed to protect the public from a professional who is currently unable to practise safely without restriction or to maintain the public reputation of their profession. She submitted that the aggravating features of this case were:

- an abuse of position of trust.
- limited insight.
- vulnerability of the person receiving care.
- the dishonesty was planned and sustained in order to conceal a clinical mistake.
- this was conduct which put people at risk of suffering harm.

Ms Whawell highlighted that the NMC Guidance further stated the absence of insight or very limited insight is likely to be a significant aggravating factor. This is because it is very difficult for a professional to address the concerns without insight into what has happened in the first place.

Ms Whawell submitted that the mitigating features of this case were:

- early admission of some of the allegations, albeit this is limited because of the very late acceptance of the dishonesty matters.
- evidence that you have kept up to date with your practice.

Ms Whawell submitted that, in considering the available sanctions from the least restrictive order, taking no action would not be appropriate in this case. She highlighted that the NMC Sanction Guidance '*Taking no further action'* (reference: SAN-2a) states that although the panel does have a discretion to take no further action, this would only be used in exceptional cases, and the reasoning must be very clear. She asserted that taking no further action would not be appropriate in this case due to the limited insight shown and the fact that there is a risk of repetition. She submitted that taking no further action in this

case would neither be appropriate nor proportionate, particularly as there are no exceptional circumstances in this case.

Ms Whawell submitted that a caution order would not be appropriate in this case, as this would not mark the seriousness of the conduct and it would not be sufficient to maintain high standards within the profession or the trust the public places in the profession. She highlighted that the NMC Guidance '*Caution order'* (reference: SAN-2b) states that such an order is only appropriate if the case is at the lower end of the spectrum of fitness to practice and where there is no risk to the public. She asserted that, given the panel's findings on impairment, this case is not at the lower end of the spectrum and that the panel had earlier determined that there is a risk to the public. She submitted that a caution order would therefore not be appropriate nor proportionate in this case.

Ms Whawell noted that the NMC Guidance '*Conditions of practice order'* (reference: SAN-2c) sets out some of the circumstances where this may be an appropriate sanction. She submitted that although some of the concerns in this case could be addressed by retraining, there was evidence of a deep-seated personality or attitudinal problem which renders this sanction inappropriate. She asserted that there were no relevant, proportionate, workable or measurable conditions which could be imposed that would adequately address the risk of repetition given the seriousness of the attitudinal concerns.

Ms Whawell submitted that a suspension order would not be an appropriate or proportionate sanction in this case. She highlighted that the NMC Guidance '*Suspension order'* (reference: SAN-2d) states that a suspension order may be appropriate in cases where impairment is very serious but not fundamentally incompatible with continued registration and where an outcome less severe than striking off would satisfy the overarching objective. She submitted that the impairment in this case is fundamentally incompatible with continued registration. She highlighted that the NMC Guidance '*Sanctions for the highest risk cases'* (reference: SAN-4) states that honesty is of central importance to the professional's practice and that those who have been found to have acted dishonestly will always be at risk of being struck off. She noted that the NMC

Guidance confirms that the panel will of course need to consider this with care but that a deliberate breach of the professional's duty of candour by covering things up when they have gone wrong, especially if this would cause harm to people receiving care, is particularly serious. She submitted that your dishonest conduct was planned, repeated and longstanding. She argued that none of the features of less serious dishonesty were present in this case. She invited the panel to consider that a rejected defence to dishonesty is an aggravating feature with careful consideration of the factors within the NMC Guidance at SAN-4.

Ms Whawell submitted that a less severe sanction than a striking-off order would not satisfy the public interest considerations in this case. She highlighted that the NMC Guidance '*Striking-off orders'* (reference: SAN-2e) states that this is the most appropriate sanction in this case where the charges found proved raise fundamental questions about the registrant's professionalism and where public confidence cannot be maintained if the professional is not removed from the register. She noted that the NMC Guidance states that cases involving dishonesty or a breach of professional duty of candour are most likely to result in striking-off order.

Ms Whawell submitted that a striking-off order is the only appropriate and proportionate sanction in this case where the dishonesty is so serious and repeated and in order to cover up a clinical failing. She asserted that no amount of insight and reflection could mitigate the public interest considerations in this case. She noted that the public expect nurses to be honest and trustworthy, especially when something has gone wrong. She highlighted that you provided only late reflective statements in this matter, your insight remains limited and insufficient despite two years after the incident. She asserted that given the significant passage of time, you are unlikely to gain further developed insight during any period of suspension.

Ms Whawell highlighted that the NMC Guidance '*Deciding between suspension and strike off'* (reference: SAN 3) confirms that the panel should consider the aggravating and mitigating features, address the issue of insight and whether insight is likely to develop

further during a period of suspension. If it is unlikely that the professional will try to address the concerns, the suspension then may not be appropriate. Ms Whawell submitted that, in this case, you have had ample time to address the concerns and show full insight, but you have failed to utilise such opportunity. She asserted that insight, particularly as it relates to dishonesty, would therefore be unlikely to develop further during a period of suspension.

In conclusion, Ms Whawell invited the panel to impose a striking-off order as the most appropriate and proportionate sanction in this case.

Ms Shah submitted that, although the panel had made a finding that there is current impairment on both public protection and public interest grounds, a suspension order is the most appropriate and proportionate sanction in this case given that you have developed insight into the concerns.

Ms Shah noted that where misconduct and, in particular, the impairment is such that it is fundamentally incompatible with remaining on the register, the only appropriate sanction is indeed a striking off order. She however submitted that your impairment was not fundamentally incompatible with remaining on the register given your developing insight. She argued that although the NMC had stated that there was nothing to suggest that your insight would improve if a suspension order was imposed, it should be noted that your insight has developed even during the course of these proceedings. She highlighted that your insight had developed to the extent where you were able to acknowledge why you acted dishonestly. She asserted that there was therefore evidence to indicate that you were capable of developing the right level of insight.

Ms Shah referred the panel to NMC Guidance '*The purpose of and approach to sanctions* (reference: SAN-1). She highlighted that the NMC Guidance states that the purpose of a sanction is to protect the public and to promote the aims of the NMC. She noted that sanction is not a means of punishment and it also aims to promote the public interest. Ms Shah submitted that there was a public interest in an experienced nurse who has

remediated the concerns, recognised failures and developed insight, to return to the register if a panel can determine that nurse could practise safely. She submitted that although this does not apply in this case, there is certainly a public interest in allowing a registrant further time to develop her insight, if there was evidence that insight was developing.

Ms Shah reminded the panel that it ought only to impose the minimum possible sanction or the least restrictive sanction that could achieve the aims of the NMC. She submitted that a suspension order would restrict you from practising in any nursing role for a period of time and this would satisfy the public interest in that it ensures that a nurse without sufficient remediation and insight is not allowed to practise. She argued that, if a striking-off order was imposed, it would go against the principle that full consideration should be given to the least restrictive sanction that achieves the aims of the NMC. She submitted that a suspension order would give you further time to reflect and it will enable another reviewing panel in the next twelve months to review your level of insight. She asserted that the imposition of a suspension order would enable the panel to achieve the aim of providing the opportunity for you to demonstrate that you have fully remediated the concerns and practise safely as a registered nurse.

In conclusion, Ms Shah invited the panel to impose a suspension order rather than to take the last resort action of a striking-off order.

The panel accepted the advice of the legal assessor.

**Decision and reasons on sanction**

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

The panel identified the following aggravating features:

- Your misconduct placed Child A at unwarranted risk of harm.
- Child A was a vulnerable child with complex needs.
- Your three acts of dishonesty arising from a single incident and your breach of duty of candour.
- Your insufficient insight into your dishonesty and its impact on others.
- Your late acceptance of your dishonest conduct.

The panel identified the following mitigating features:

- Early admission to some of the charges.
- You have shown genuine remorse and apologised for your actions.
- You have shown some insight into your clinical failings.
- You have practised in a senior nursing role for two years since the incident without any further concerns.
- Some evidence of steps taken to remediate the concerns through training courses in relevant areas of concern and positive testimonials made on your behalf.

The panel had regard to the NMC Guidance on Sanctions for the highest risk cases, in particular, Cases involving dishonesty (reference: SAN-4). The panel noted that your dishonest conduct amounted to a breach of your professional duty of candour by attempting to cover up how things went wrong at the time of the incident, for your personal gain. Your dishonest conduct was pre-meditated and posed a risk of harm to Child A.

However, the panel was of the view that your dishonest conduct was not longstanding but consisted of three episodes of dishonesty arising from a single clinical incident. It noted that you have actively engaged with these proceedings, you have shown remorse and have now recognised that you have acted dishonestly. You have further shown some

insight into the root causes of your dishonesty and steps you will take to prevent it from recurring.

Having balanced these factors, the panel found the dishonesty, albeit serious in this case, not to be at the most serious end of the spectrum.

The panel first considered whether to take no action but concluded that this would be inappropriate and not proportionate in view of the seriousness of the case. It had found that there is a risk of repetition, that you breached fundamental tenets of the nursing profession, and that your misconduct would undermine the public confidence in the nursing profession if you were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be 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) 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 decided that your misconduct was not at the lower end of the spectrum and that an order that does not restrict your nursing practice, in view of the seriousness of the case, and the public protection issues identified, would not be appropriate nor proportionate in the circumstances. The panel therefore determined that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be appropriate and proportionate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (reference: SAN-2C) in which the following factors on when a conditions of practice order may be appropriate are set out:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *….*
- *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 was of the view that although the clinical concerns in this case could be addressed through retraining, your dishonest conduct and the attitudinal concerns identified in this case (though not deep-seated) could not be addressed through retraining. The panel therefore determined that given the seriousness of the misconduct, the attitudinal concerns and your still developing insight into these concerns, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, and this poses a risk of harm to patients' safety and the public. Consequently, the panel decided that a conditions of practice order would not protect the public and would not reflect the seriousness of your misconduct nor be in the public interest.

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) 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 took into account that your misconduct involved three episodes of dishonesty arising from a single incident. The panel was of the view that although your dishonest conduct is attitudinal in nature, there was no evidence before it to indicate any harmful deep-seated attitudinal concerns in this case. It took into account that you have been practising as a registered nurse for the past two years and there was no evidence of repetition of the concerns nor were there any further concerns raised about your nursing practice. It noted that you have actively engaged with the NMC and these proceedings.

The panel considered that you had demonstrated some developing insight into your misconduct, had apologised and shown remorse for your actions. It considered that you had taken steps to strengthen your nursing practice through relevant training courses in the areas of concern and presented evidence of good practice. The panel was provided with some references from senior staff members at your current workplace, where you had been employed for the past two years. It noted that the references were recent and that the length of time you were employed provided adequate time for staff to observe both your clinical practice and your character in relation to the issues of honesty and integrity.

The panel took into account the testimonial made by the Health Coordinator dated 3 March 2026, particularly:

*'Importantly I would highlight her professional integrity and honesty. she has shown a willingness to reflect on her practice, accept feedback and engage positively with learning and improvement processes.'*

The panel took into account the testimonial made by one of the clinical leads dated 24 April 2026, particularly:

*‘I have observed that Mariya acts with professionalism and prioritises the safety and wellbeing of residents even if this then puts her in an uncomfortable position. Mariya is supportive of those she works alongside and is firm and fair in her role as duty manager.*

*….it would be a loss if Mariya was to lose her pin, as she really does put the residents and their needs first and has their best interest at the centre of their care towards them.’*

The panel took into account the testimonial made by the Registered Manager dated 23 April 2026, particularly:

*‘Mariya supports and guides her team with patience and is well respected in return. When Mariya is on shift I am confident that the residents are in safe hands, and that Mariya will escalate any concerns appropriately and will seek advice if she is unsure.’*

The panel took into account the testimonial made by the Duty Manager dated 2 May 2026, particularly:

*‘On occasions where residents have required urgent intervention, I have seen her appropriately contact emergency services (999), remain with the patient, and provide clear and structured handover to paramedics and hospital staff.’*

The panel carefully considered the submissions of Ms Whawell in relation to the imposition of a striking-off order in this case. It also considered following paragraphs of the SG (reference: SAN-3e) with respect to imposing a striking-off order:

- *‘Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

The panel gave serious consideration to the imposition of a striking-off order given the serious nature of your misconduct. However, in taking account of all the evidence before it, comprising of the evidence of your current good practice, the positive references, the steps you had taken to strengthen your nursing practice, and your developing insight; the panel concluded that a striking-off order would be disproportionate.

Although your misconduct raises questions about your professionalism, it was, in the panel's view, not to the extent that required your removal from the register. The panel was not satisfied that a striking-off order was the only sanction sufficient to protect the public and to address the public interest considerations in this case. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive and disproportionate in this case to impose a striking-off order at this time. It was of the view that a striking-off order could deprive the public of an experienced nurse of 20 years, who has practised for the past two years without any further concerns, has the potential to further reflect and strengthen her nursing practice as well as return to safe and effective practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Consequently, the panel was satisfied that, in this case, the misconduct is not fundamentally incompatible with you remaining on the register and that public confidence in the nursing profession could be maintained if you were not removed from the register.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of six months is

necessary in order to provide you with an adequate opportunity to reflect and demonstrate evidence of sufficient insight into your misconduct, and that your fitness to practise is no longer impaired.

The panel was satisfied that a suspension order for a period of six months is sufficient in order to provide you with an adequate opportunity to develop further insight and demonstrate evidence of strengthened practice. The panel noted that it was clear from your reflective statement that this process is already ongoing as you stated:

> *'I understand that a finding of dishonesty can have a significant impact on public perception of the profession. I am committed to rebuilding trust through consistent, safe, and transparent practice. I deeply regret my past actions and the impact they may have had. I am fully committed to ensuring that my future practice consistently demonstrates honesty, integrity, accountability, and professionalism in line with the NMC Code.*'

In addition, the panel noted that you have practised safely and without any concern for two years. As evidence of this, you have provided several testimonials from colleagues and managers that demonstrate your improved practice in four key areas: clinical competence, honesty, professionalism and your empathy towards patients.

The panel noted that your dishonest conduct arose from one incident rather than from a repeated pattern of dishonesty, and you have shown deep remorse for your actions. It was of the view that, now that you have openly acknowledged your dishonesty, a remediation period of six months would be sufficient. The panel decided that a twelve-month suspension order would be excessively punitive and that such a long period of time may lead to a degradation of your clinical skills. In addition, the panel considered that a member of the public would deem a suspension order an appropriate mark of the seriousness of the misconduct but would prefer to see a nurse, who has strengthened her practice, return to practice as soon as possible.

The panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse. The panel concluded that a period of six-month suspension would be sufficient to uphold public confidence and mark the seriousness of your dishonest conduct.

The panel noted the hardship a suspension order will inevitably cause you, however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

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:

- An updated reflective statement:
  a) demonstrating sufficient insight into the gravity of the concerns.

  b) demonstrating sufficient insight into the impact of the concerns on patients, your colleagues, the nursing profession and the public.

  c) demonstrating sufficient insight into the importance of honesty and integrity at the workplace.

- Any updated references or testimonials attesting to your capability to perform your duties, in whatever role, professionally in any paid or unpaid work, following this hearing.

- Evidence of up-to-date relevant training courses undertaken in the areas of concern including on duty of candour, and honesty in the workplace.

- Your continued engagement and attendance at any future review hearing.

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.

**Submissions on interim order**

The panel took account of the submissions made by Ms Whawell. She submitted that given the panel's earlier decisions, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. She submitted that not to impose an interim suspension order would be inconsistent with the panel's earlier decisions.

Ms Shah stated that it was a matter for the panel to determine whether an interim order is required.

The panel accepted the advice of the legal assessor.

**Decision and reasons on interim order**

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 was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

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 because it is otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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.