Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 14 September 2026 to Tuesday, 22 September 2026
and
Monday, 9 November 2026 to Friday, 13 November 2026

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

Name of Registrant:	**Serifat Oluwatoyin Oni**
NMC PIN:	09A1788E
Part(s) of the register:	RNLD: Registered Nurse (Sub part 1) Learning Disabilities – Level 1 18 April 2009
Relevant Location:	Stockport Metropolitan Borough
Type of case:	Misconduct
Panel members:	Pamela Johal (Chair, lay member) Melanie Lumbers (Registrant member) Matthew Clarkson (Lay member)
Legal Assessor:	Gelaga King (14 September 2026 to 22 September 2026) and Mr Christopher McKay (9 November 2026 to 13 November 2026)
Hearings Coordinator:	Mahee Vohra
Nursing and Midwifery Council:	Represented by Alex Radley (14 September 2026 to 18 September 2026) and Mr Richard Webb (21 September 2026 & 22 September 2026 and 9 November 2026 to 13 November 2026), Case Presenters
Ms Oni:	Not present and unrepresented (14 September 2026 to 22 September 2026). Present and unrepresented (9 November 2026 to 13 November 2026)
Facts proved:	**Charges 1 and 2**
Facts not proved:	**NA**

Fitness to practise:	**Impaired**
Sanction:	**Caution order (3 years)**
Interim order:	**NA**
Final outcome:	**FTP impaired caution order**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that you were not in attendance and that the Notice of Hearing letter had been sent to your registered email address by secure email on 11 August 2026.

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

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

The panel took into account that the Notice of Hearing was sent on 11 August 2026 for a substantive hearing commencing on 14 September 2026 and therefore provided more than 28 days' notice. The Notice provided details of the charge, the date, time and venue of the hearing and informed you of your right to attend, be represented, present evidence, call witnesses and cross-examine witnesses called by the NMC. It also informed you that the panel could proceed in your absence.

In the light of all of the information available before it, the panel was satisfied that you had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34 of the Rules. The panel therefore determined that there had been good service.

Decision and reasons on proceeding in your absence

The panel next considered whether it should proceed in your absence. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in your absence. Mr Radley submitted that there was a public interest in the expeditious disposal of proceedings and that you had been afforded sufficient opportunity to engaged with the NMC concerning this hearing.

Mr Radley submitted that you had not engaged with the NMC since 11 November 2025 and had not responded to any recent correspondence including emails and

phone calls, seeking confirmation of whether you intended to attend. He submitted that there was no information before the panel to suggest that an adjournment would secure your attendance on a future occasion.

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

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'.* The panel also noted the need to balance fairness to you and fairness to the public. The panel reminded itself that fairness to you was a prime consideration, while also taking into account the fairness to the NMC and the wider public interest. It was required ultimately to determine whether proceeding in your absence was fair, appropriate and proportionate.

The panel decided to proceed in your absence. In reaching this decision, the panel considered the submissions of Mr Radley and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment had been made by you;
- You had not engaged with the NMC and had not responded to any of the letters and/or emails sent to you since November 2025;
- You did not provide the NMC with details of how you may be contacted other than your registered email address or phone number;
- There was no reason to suppose that adjourning would secure your attendance at a future date;
- Two witnesses were in attendance to give live evidence, three more witnesses were due to attend during the course of the hearing;
- Not proceeding would have inconvenienced the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;

- The charges relate to events that occurred between June 2020 to June 2023;
- Further delay may have had an adverse effect on the ability of witnesses accurately to recall events; and
- There was strong public interest in the expeditious disposal of the case.

The panel recognised that proceeding in your absence placed you at a material disadvantage. The evidence relied upon by the NMC had been provided to you in advance of the hearing, but you would not be present to cross-examine witnesses, respond to matters arising during the evidence, give oral evidence yourself or make oral submissions. The panel determined that it would remain alert to the fact that the NMC evidence would not be challenged on your behalf and would scrutinise the evidence carefully, including any inconsistencies or matters capable of assisting you.

In these circumstances, the panel decided that it is in the public interest and fair to all parties to proceed in your absence. The panel will draw no adverse inference from your absence in its findings of fact.

When the hearing resumed on 9 November 2026, you attended the hearing and were unrepresented.

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

Mr Radley made an application that this case be held partly in private on the basis that proper exploration of your case involves reference to your [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

You were not present or represented and no submissions were received from you in relation to this application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel

may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to your [PRIVATE], the panel decided to go into private session as and when such issues are raised in order to protect your privacy. The panel considered the principle of open justice and determined that the hearing should remain in public so far as possible. However, it was satisfied that you had a legitimate interest in maintaining the confidentiality of [PRIVATE] information. The panel therefore determined that the hearing would move into private session only as and when evidence concerning [PRIVATE] was being considered. It considered that this limited departure from open justice was necessary and proportionate to protect your privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Radley under Rule 31 of the to admit the evidence of Ms Gunga Dongal ("Ms Dongal"), which consists of a witness statement and a local interview.

Mr Radley referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He submitted that this case laid out the following factors to be considered in admitting hearsay evidence. Mr Radley proceeded to address each of the factors:

i. Whether the statements were the sole and decisive evidence in support of the charges:
   Mr Radley submitted that the respective documents were not the sole and decisive evidence in support of the charges.

ii. The nature and extent of the challenge to the contents of the statements:
   Mr Radley submitted that you had not admitted to the contents of the documents, however, they have been addressed in a local investigation report where they were put before you for consideration. He submitted that the said contents were challenged by you during the local investigation, and it is likely that if you were

engaging with the present proceedings, you would have once again challenged the contents.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:
Mr Radley submitted that there is no evidence to suggest that Ms Dongal had fabricated her evidence.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:
Mr Radley submitted that he cannot speculate in this respect and would rely on the panel's discretion.

v. Whether there was a good reason for the non-attendance of the witness:
Mr Radley submitted that as he does not know the reason for non-attendance and hence would rely on the panel's discretion.

vi. The regulator had taken reasonable steps to secure the witness's attendance:
Mr Radley referred the panel to the numerous email correspondence and telephone logs from the NMC to Ms Dongal, as well as email correspondence from the tracing company, informing that they were unsuccessful in tracing the whereabouts of Ms Dongal. Mr Radley submitted that the NMC had taken all reasonable steps to secure the witness's evidence.

vii. Whether the registrant had prior notice that the witness statement would be read:
Mr Radley submitted that you had prior notice of the present application to admit hearsay evidence of Ms Dongal.

Additionally, Mr Radley referred to Rule 31 and submitted that, without prejudice to the above, the only requirement envisaged in Rule 31 for the admission of hearsay evidence is that it is fair and relevant.

The legal assessor advised the panel that under Rule 31 it could admit evidence, whether or not admissible in proceedings, provided that its admission was fair and

relevant. The legal assessor advised the panel to consider admissibility separately from the weight ultimately attached to the evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application including references to the cases of *NMC v Ogbonna* [2010] EWHC Civ 216, *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *El Karout v NMC* [2019] EWHC 28 (Admin). This included that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

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

The panel referred to Rule 31 and first considered whether Ms Dongal's evidence was relevant and whether its admission is fair. The panel noted that Ms Dongal's evidence directly addressed Charge 1 and hence was relevant to the proceedings. Further, the panel noted that the contents of the evidentiary documents were corroborative of the evidence of other witnesses and could be tested through their examination. The panel also noted that the documents had been served to you in advance of the hearing, such that you had been given notice of the evidence sought to be relied upon by the NMC and were aware that the NMC proposed to make the present application. The panel therefore considered that the admission of Ms Dongal's evidence was fair.

The panel referred to the *Thorneycroft* case and noted that although Ms Dongal's evidence cannot be challenged by you due to your disengagement with the proceedings, it is not the sole and decisive evidence towards the charges. The panel noted that Ms Dongal had explicitly stated in her written statement that she did not have any knowledge of Charge 2 and therefore had only provided evidence towards

Charge 1. The panel had no reason to believe that evidence given by Ms Dongal was fabricated.

Lastly, the panel noted that the NMC had taken all reasonable steps to locate Ms Dongal. The reason for her non-attendance was unknown and the panel cold not speculate; and that upon admission of Ms Dongal's evidence, the panel would be able to attach the appropriate weight to it.

Having considered all of these factors including the seriousness of the allegations, the inability to cross-examine Ms Dongal, the fact that her evidence was not sole and decisive, the reasonable efforts made to secure her attendance and the prior disclosure of her evidence to you, the panel determined that it was relevant and fair to admit Ms Dongal's evidence under Rule 31.

Details of charge

That you, a registered nurse:

1) Between 15 June 2020 and December 2022, left Elmswood Ward without a registered nurse for prolonged periods of time, on more than on occasion.

2) On the nightshift commencing on 12 Jun 2022, slept whilst on duty.

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

Background

The NMC received a referral from Priory Hospital Cheadle Royal ("the Hospital") on 15 September 2023 where you had been employed as a registered nurse on the ward Elmswood House ("Ward") from 15 June 2020 to 29 August 2023.

Allegations were raised that you would leave the ward for prolonged periods of time and visit the quiet lounge during your night shifts for prolonged periods between 15 June 2020 and December 2022.

It was also alleged that on 12 June 2023, you went into the quiet lounge and were found asleep whilst on duty by a member of staff.

When taking witness statements from four healthcare assistants ("HCAs"), the evidence suggested that while working on the Ward, you would frequently go to the quiet lounge for prolonged periods of time during your working hours and would also go on daily prayer/[PRIVATE] walks in the grounds of the Hospital.

Further, it was alleged that you would also go to a neighbouring building to cook food for yourself during working hours, leaving the Ward with no registered nurse.

An internal investigation was undertaken, followed by a disciplinary hearing on 24 August 2023.

Registrant's Bundle

At the conclusion of the NMC's case, Mr Radley drew the panel's attention to a bundle that had been submitted by you at the investigation stage. Mr Radley submitted that although you had not expressly given your consent to the bundle being used during the hearing, he would not object if the panel determined to receive the document into evidence.

The panel determined that in the interest of fairness, it would admit the documents as in your absence, it was material that could be used in a way that was favourable to you.

Decision and reasons on admission of additional evidence

Mr Radley made an application before the panel to amend Charge 2. While deliberating on this application, a new document on your behalf i.e., a form

containing a detailed reflective statement ("Reflective Statement") came to light. Upon advice of the legal assessor, the panel paused their deliberation, and the new document was sent to Mr Radley and the legal assessor.

Upon review of the document, the NMC's position was that the said document was irrelevant to the present proceedings. Mr Radley submitted that the assertions made by you in your Reflective Statement could not be challenged in any form, that your assertions had essentially changed the shape of the case but cannot be addressed as you had not engaged with the present proceedings.

Mr Radley submitted that a number of issues raised in the Reflective Statement had already been addressed, for instance, the missing CCTV footage, which was addressed by the NMC, the legal assessor, as well as the panel.

Mr Radley referred to your statements in the Reflective Statement that the allegations levelled against you were baseless and arose from some personal vendetta. He submitted that the witnesses who gave evidence in the present proceedings were reluctant and had only done so as a matter of duty. From the reluctance of the witnesses, it is apparent that they harboured no ill-will towards you. That the witnesses are unqualified HCAs and their response(s) had already been noted in the local investigation reports.

The panel considered reviewing the document and its contents before ruling on its relevance. Subsequently, the panel decided that the document was relevant as it spoke directly to the charges. The panel noted that you had put forward a positive defence that there was a motive behind the evidence given by the witnesses in the present proceedings.

The panel reminded itself that it may admit documentary evidence where it was fair and relevant and the ultimate decision on weight is a matter for the panel. The fact that the NMC did not consider the document relevant is a factor to be taken into account, but it is not determinative.

The panel considered that the Reflective Statement was relevant because it was not confined to reflection. You expressly addressed the allegation that you slept whilst

on duty, denied that allegation and gave your own account of what had occurred on the relevant night. You described the allegation as unfounded and referred to the circumstances surrounding the incident, including your account that you had only taken a brief break.

The panel also considered the provenance of the document. It was completed on an NMC fitness to practice reflective account form, identified you by name and contained the correct case reference. The panel also identified that the originating email address corresponded with yours. Although the document was unsigned, the panel considered that this went principally to the weight and reliability to be attached to it, rather than rendering it inadmissible.

The panel recognised that some matters contained within the reflective account had not been put to the NMC witnesses, including assertions concerning the circumstances in which the allegation arose, the absence of CCTV footage and the possible motives of another individual. The panel therefore distinguished between admitting the document and the weight that could properly be attached to particular assertions within it. It determined that it would not treat any untested allegation as established fact and, where a matter might materially affect the credibility or reliability of a witness, fairness required that the relevant witness be given an opportunity to respond.

Balancing all of these matters, the panel concluded that excluding the document altogether would deprive it of potentially relevant evidence concerning the very allegation it was required to determine. The panel was satisfied that the reflective account was relevant and it was fair to admit it pursuant to Rule 31. It would assess the appropriate weight to attach the document in the context of all of the evidence, taking into account its provenance, consistency with your previous accounts and the extent to which any disputed factual assertions were capable of being tested.

Decisions and reasons subsequent to admitting your Reflective Statement

The panel considered that the newly admitted Reflective Statement contained a number of factual assertions which have not previously been put to NMC witnesses. In particular, you continued to deny sleeping whilst on duty, gave an alternative

account of what you said occurred on the relevant night and raised concerns about the circumstances and possible motivation behind the allegation.

The panel considered that some of those matters were potentially material to its assessment of the credibility and reliability of the evidence, particularly in relation to Charge 2. It determined that it would be unfair simply to take those assertions into account when assessing the NMC witnesses without affording the relevant witnesses an opportunity to respond. Equally, it considered that it would be unfair to you, to simply disregard potentially relevant matters contained in your Reflective Statement because you were absent from this hearing at that stage.

The panel was particularly mindful that you were neither present, nor represented, however, having proceeded in your absence, the panel considered that it was required to scrutinise the evidence carefully and ensure that material matters capable of affecting its findings were properly explored before reaching any conclusions on the disputed facts.

Recall of NMC witnesses and request for additional evidence

Having balanced fairness, proportionality, the inconvenience of recalling witnesses and the need to avoid unnecessary delay, the panel concluded that recalling the witnesses was the fairest course and would enable it to make a fully informed decision. The questioning would be confined to new matters arising from the reflective account and any necessary clarification flowing from those matters. The panel therefore determined that Ms Horner, Mr Heathcote, Mr Bell, Ms Ward and Mr Barber should be recalled.

The panel also considered the need to explore other documentary evidence, particularly in relation to matters surrounding the CCTV for the Ward. The panel had requested supporting documents in relation to the CCTV policy, maintenance records and clarification around storage and retention. The panel determined that these records would enable the panel to test witnesses account of the relevant events.

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Radley to amend the charges, namely, to amend the date mentioned in Charge 2. He referred the panel to Rule 28 of the NMC Fitness to Practise Rules [2004] (the Rules).

Mr Radley submitted that he was applying to change the year mentioned in Charge 2 from '2022' to '2023':

*2. On the nightshift commencing on 12 June ~~**2022**~~ **2023**, slept whilst on duty.*

Mr Radley submitted that this amendment was simply to correct a typographical error, that had likely occurred in the written statement of Ms Barbara Horner as well.

Mr Radley referred to the Management Report dated 19 July 2023, which referred to a supervision record completed by Ms Jade McNally on 16 October 2022. That record documented that an allegation had previously been reported that you had slept whilst on duty and had been absent from the Ward for a period of time. You had denied that allegation at the time. Mr Radley submitted that this earlier reported concern was separate from the incident subsequently investigated as having occurred on 12 June 2023, shortly before you had tendered your resignation. The panel determined that it would attach no significance to this supervision note at the time of considering the charges, as this remained an allegation and had never been proved.

Mr Radley referred to the minutes of the investigation meeting dated 10 August 2023 between you and Mr Jonathan Heathcote. He submitted that during this meeting, you were questioned about sleeping on whilst on duty on 12 June 2023. He submitted that in view of this, you were well aware that the referred investigation and the subsequent fitness to practice proceedings were concerning the incident that occurred in 2023 and not 2022. Mr Radley therefore submitted that the misdate error was administrative, and you had knowledge of the correct date of the incident alleged in Charge 2.

Mr Radley submitted that in the present circumstances, there would be no injustice caused to you as you were given the opportunity to attend the present hearing, contest the charges and provide appropriate explanations. However, you did not respond to any communication by the NMC, let alone ask for the date in Charge 2 to be corrected.

Mr Radley submitted that in light of the evidence and the explanation advanced by you, the date of the Charge is not crucial in terms of having a fair hearing.

In response to the panel's questions, Mr Radley submitted that like all witnesses, Ms Barbara Horner had adopted her witness statement to be read in evidence. All witnesses simply confirmed the contents of their statements as they could not be expected to recollect the technical specifications of the incident and could be mistaken about the dates due to a lapse in time since the statements were drafted. He further submitted that had the present application been an application for no case to answer, then the date would have been crucial, however, this discrepancy was raised by the panel and hence Mr Radley relies on the panel to consider it.

Lastly, Mr Radley submitted that it is an established legal precedent that any issues in dates are considered remediable and technical irregularities should not be used to dismiss the case.

As you were not attending and were unrepresented, your consent or objection to the application could not be recorded.

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

While deliberating, new evidence on your behalf came to light. Upon advice of the legal assessor, the panel paused the deliberations to consider the new evidence. For reasons stated in this determination, the panel admitted the new evidence on your behalf and recalled the witnesses.

Due to Mr Radley's unavailability, Mr Webb stepped into the role of the Case Presenter on behalf of the NMC on day 6 of the hearing. After re-examining the

witnesses, Mr Webb made further submissions in relation to the application to amend Charge 2. He proposed that Charge 2 be amended in the following manner:

> *2. On the nightshift commencing on **or around** 12 June ~~**2022**~~ **2023**, slept whilst on duty.*

Mr Webb adopted the submissions advanced by Mr Radley and submitted that the proposed amendment is fair and should be allowed in accordance with the case of *Dutta v. General Medical Council 2020 EWHC 1974 (Admin)*.

Mr Webb submitted that the NMC relied on the contemporaneous documents as mentioned by Mr Radley. He further referred to the witness statement and oral evidence of Ms Barbara Horner ("Ms Horner")and submitted that although Ms Horner could not recall the exact date of the incident, as can be expected since the incident had occurred a few years prior, however, she recalled the incident in detail in that what she witnessed, the action she took and the effect of her action.

In view of the above submissions, Mr Webb submitted that the amendment would accurately reflect the evidence, the events as detailed in the charges. He submitted that there would be no prejudice or injustice caused to you, as the proposed amendments do not materially alter the substance of the allegations.

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

The panel noted the contemporaneous evidence, namely, the minutes of the local investigation meeting and the management report, which noted the date specified for Charge 2 and also put to you was indeed 2023. The panel further noted that as the alleged incident occurred on a night shift which by its nature involves two dates, the addition of "on or around" was reasonable.

The panel was of the view that the amendment would not cause injustice to you. It was satisfied that the amendment did not introduce a new allegation or refer to a different incident or an independent factual scenario, rather it corrected the year

attached to the same incident which was locally investigated and substantively answered by you.

The panel was satisfied that there was no material before the panel suggesting that you had advanced a defence specific to the original charge i.e., 2022, which would be lost or prejudiced by the amendment. The panel was conscious of the need to balance accuracy in the charge with fairness to you, specifically as you were not attending and were unrepresented.

The panel concluded that the allowing the amendment would not cause injustice to either party and accordingly, the panel decided to allow the NMC's application.

Details of charge (as amended)

That you, a registered nurse:

1) Between 15 June 2020 and December 2022, left Elmswood Ward without a registered nurse for prolonged periods of time, on more than on occasion.

2) On the nightshift commencing on or around 12 June 2023, slept whilst on duty.

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

Decision and reasons on facts

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

The panel also took into account the registrant's bundle as well as the live evidence given by you when the hearing resumed on 9 November 2026. The panel drew no adverse inference from your non-attendance when the hearing commenced in September 2026.

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

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

- Ms Horner: Ms Horner was a HCA on the Ward at the time of the incident.
- Annette Ward (Ms Ward): Ms Ward was a HCA on the Ward at the time of the incident.
- Jonathan Heathcote (Mr Heathcote): Mr Heathcote was the Investigation Manager at the Hospital at the time of the incident.
- Shaun Barber (Mr Barber): Mr Barber was Clinical Nurse Specialist and Practice Education Facilitator at the Hospital at the time of the incident.
- Ian Bell (Mr Bell): Mr Bell was

a HCA on the Ward
from February 2022
onwards.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel reminded itself that the burden of proof remained throughout on the NMC and that you were not required to prove your account. In assessing the evidence, the panel considered both, honesty and reliability and considered the witnesses' accounts by reference to contemporaneous documentation, previous accounts, internal and external consistency, the passage of time, the possibility of mistake, any potential motive and the overall probabilities. The panel also reminded itself that no final factual conclusions had been reached before the additional evidence emerged and it therefore reconsidered all of the evidence afresh.

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

Charge 1

'That you, a registered nurse,

1. *Between 15 June 2020 and December 2022, left Elmswood Ward without a registered nurse for prolonged periods of time, on more than one occasion.'*

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of the witnesses as well as their written statements and accompanying exhibits. The panel also took into account the submissions made by Mr Radley.

The panel referred to the Management Report of the Hospital and confirmed that you were indeed in employment on the Ward between 15 June 2020 and December

2022. From the written witness statements and oral evidence advanced on behalf of the NMC, the panel understands that you were referred to as “Sheri” by your colleagues and subsequently as “Toyin”.

The Ward sat within the footprint of the extensive Hospital grounds and was one of many independent buildings.

Through its questioning of the witnesses, the panel was able to establish the layout of the Hospital grounds, including the location of the Wards, gardens, walking pathways, and their proximity to one another. This assisted the panel in determining the geographical extent of the Ward on which you were working. The panel determined that the small, enclosed and gated garden, the quiet lounge and both the floors form part of the Ward. The area designated as the Ward both for welfare and protection of patients and staff was covered by a CCTV system, the live streaming was visible in the staff office. There was also a panic alarm system which would alert staff to emergencies on the Ward. The audio and visual alerts would only be seen or heard by staff who were present on the Ward. Staff away from the Ward would not be alerted to any activation.

The panel concluded that the adjoining garden and the quiet lounge formed part of the Ward and hence any visits by you to these areas would not amount to leaving the Ward without a registered nurse, as you physically remained present and available to fulfil your role as the nurse in charge.

The panel heard evidence regarding the patients cared for on the Ward. Their needs varied with a number being described as vulnerable. Some patients required frequent observations and may unexpectedly require nursing intervention. Patients were not confined to their rooms during the night and were able to move about the Ward, with the exception of the treatment room and back office.

The panel first considered the contemporaneous record of the investigation meeting with Mr Heathcote on 10 August 2023. You had accepted that you went “off ward” on occasions, although you maintained that you remained on the Hospital site, informed colleagues where you were going and carried your personal mobile phone so that

you could be contacted. The panel treated this as an admission that you physically left the ward on occasions. It did not treat it as an admission that those absences were prolonged. The relevant excerpt states:

"…

JH: Thank you, Second issue is going missing from your ward when not on a break. Been reported that this happens on multiple occasions. Your events on this?

SO: Agree to going off ward, however never off premises. If ever go outside ward it is due to [PRIVATE] *and needing fresh air. This is how I deal with it when I have stress, it helps reduce stress. Would never want it to affect my work, always tell staff on shift where I am going.*

JH: Just to clarify, why do you leave wards?

SO: To manage [PRIVATE]*."*

The panel also considered the minutes of the meeting dated 24 August 2023 between you and Kate Herod, Hospital Director. At this time, you once again acknowledged you left the Ward to heat up food, pray, meditate and [PRIVATE]. The relevant excerpt is as follows:

"…

KH: How often would you go in the quiet room?

SO: [PRIVATE]*, which is why I turn the lights off. I would go to the quiet room after medication is done. Observation time is 12pm and I cannot sleep when it is my observation time. Since I qualified as a Nurse, I have never experienced this.*

When I went to Elmswood, I was asked to go to Pankhurst because there was an agency worker there. That worker should have been sent away but

instead I was sent to Pankhurst and to support with PICU. I do all my shifts ethically and I go out of my way for my clients.

I go outside for [PRIVATE]*, to get some fresh air and to meditate and pray. I do not complain about staff that go outside to have a cigarette, I do not smoke so I go out for fresh air.*

KH: How many times do you go outside for fresh air?

SO: Sometimes never, sometimes 2-3 times. I am from Africa so my food is spicy so I cannot heat the food up as it affects my colleagues so I go to the main building to heat the food.

…

KH: How long do you stay outside for?

SO: 20 Minutes, depends how I feel."

The panel considered the arrangements which you said you put in place when you left the Ward. You stated that you would inform the staff where you were going and would carry a mobile phone in case of an emergency. The panel considered your own account was consistent with the accounts given by the HCAs that have given evidence.

"JH: As you are the nurse in charge, expected to stay on the ward. What arrangements in place when you are leaving the ward?

SO: Tell staff where I am going, whether it be outside, etc. Would never leave without letting other staff know, have phone on me in case of an emergency."

Further to determine the frequency and time periods of your walks, the panel noted the following questions addressed by Mr Heathcote to you:

"…

JH: How often and how long?

SO: Sometimes few minutes, sometimes never go out.

JH: On average?

SO: Depends, may be once or twice a shift. Sometimes never

JH: How long?

SO: Sometimes 15 minutes, sometimes couple of minutes, depends how I feel."

From the above minutes of meeting dated 10 August 2023 between you and Mr Heathcote, the panel confirmed by your own admission that you had left the Ward without a registered nurse being present, on numerous occasions to go on walks for up to fifteen minutes. The panel considered your account established that you physically left the Ward on numerous occasions. However, during your live evidence, you did not accept that those particular absences were prolonged, and you described them as lasting six minutes or longer.

The panel took into account the evidence of Ms Horner. She stated that you would regularly leave the Ward outside of your designated break time to either go on a prayer walk, meditate, [PRIVATE], to cook or work on patient notes or care plans in another building close by, or to visit your friends in the main Hospital building which was a 10 minute walk from the Ward. Ms Horner also stated that your absence was a cause of stress amongst her and the other HCAs as in case of emergency. You would have to first be located and requested by phone to come back to the Ward to assist with any duty as you were the only staff member who held the keys to the medication storage, being the only registered nurse on the Ward.

The panel noted that although you would inform the staff that you were leaving the Ward and would always be reachable by phone, it cannot be equated with you actually being present on the Ward.

Ms Horner's statements were further supported by Ms Ward's, Mr Bell's and Mr Barber's oral and written evidence. The panel found Ms Ward to be a credible witness and considered that she sought to give an accurate account within the limits of her recollection. The panel noted Ms Ward is an experienced HCA since 2004, having worked on the Ward since 2017 until the present day. She acknowledged that if she was at a different floor within the Ward, she would not necessarily know what you were doing and she accepted that HCAs were carrying out their own duties rather than monitoring your movements or recording the precise times when you left or returned. The panel noted that Ms Ward appropriately qualified her estimates of duration and made clear that they were approximate. She did not seek to support Charge 2 beyond her knowledge and did not claim to have seen you asleep whilst on duty. The panel considered that these concessions enhanced rather than diminished Ms Ward's credibility as it demonstrated that she was willing to identify the limits of what she could reliably remember. Her broad account concerning your use of the quiet lounge, visits to the adjacent building and prayer and [PRIVATE] walks were consistent with the account of other HCAs. The panel considered that therefore accepted Ms Ward to be an honest and credible witness.

The panel found Mr Heathcote to be a credible witness in relation to the investigation he conducted. The documents he produced and his knowledge of the professional and operational context at the Ward. His evidence concerning the investigation was recorded in an investigation report which included contemporaneous minutes of his interview with you. The panel considered that Mr Heathcote gave his evidence from the perspective of an experienced registered nurse of twenty-two years and was able to assist the panel as to the roles and responsibilities of the nurse in the charge and the circumstances in which a registered nurse would be required to remain on the Ward. The panel nevertheless distinguished the matters with which Mr Heathcote personally knew and matters which had been reported to him by other members of staff. The panel did not treat the conclusions reached in the employer investigations as proof of the charges and reached its own findings in the evidence presented to it.

The panel therefore considered Mr Heathcote credible and reliable in relation to the conduct of the investigation but did not treat him as a direct witness to you leaving the Ward or sleeping on duty.

The panel noted the following relevant excerpt from Mr Heathcote's written statement:

> *"18. …*
>
> *While there is no specific policy for prayer and meditation at the Priory Group, any such breaks should be taken in accordance the Policy – Employment Contracts 11.2, section below. Any prayer or meditation breaks should be no more than the allowed break.*
>
> *…*
>
> *21. Additionally, nurses should be readily available on the ward, including during their breaks so they can respond to a medical emergency need be. Sometimes the nurse in charge is also required on hand for events that fall short of a medical emergency, such as a patient having side effects from medication, and require a PRN medication which is administer on a needs be basis."*

Through the internal policies of the Hospital and the evidence provided by Mr Heathcote, the panel noted that there were no written policies for prayers/praying at the Hospital however, there were provisions available that would have allowed you to pray in the quiet lounge, as was done by other staff members, and you did not have to leave the Ward to do so. Further, [PRIVATE], or to pray, you had access to the secure, gated garden adjoining the Ward and could have contained your walks to the said garden, or arranged cover with the night manager.

In summary, the panel noted that you had admitted to leaving the Ward for the purposes of:

i) Prayer walks: you had the option of using the quiet lounge as well as the adjacent garden for your prayers/prayer walks respectively and should not have to leave the Ward.

ii) [PRIVATE], getting fresh air and exercise: the adjoining garden to the Ward was available for this purpose. From the evidence of Mr Bell, the panel understands that the mentioned adjoining garden was used by other staff members for getting fresh air and exercise. This allowed staff to be immediately accessible in a case of emergency and remain on the Ward.

iii) Cooking: There were facilities available to you in the Ward. In any case, if you wished to visit the other building for cooking purposes, you could have done so in your designated break time, and having arranged suitable nursing cover.

iv) Writing patient notes, care plans, etc.: From the evidence of Ms Horner, Ms Ward, Mr Barber and Mr Bell, the panel noted that the other registered nurses would use the office for this purpose which formed part of the Ward. You also would have been able to do so.

v) Allegedly visiting friends in the Hospital: The panel considered the allegation that you visited friends in the Hospital. However, the panel noted that this allegation was inconsistent with the evidence of the other witnesses. In your live evidence, you stated that you often visited the Hospital for patient reviews. In those circumstances, the panel did not find that the allegation that you went to visit friends was made out.

In light of the admission by you and the evidence given by Ms Horner, Ms Ward, Mr Barber, Mr Bell and Mr Heathcote, the panel was satisfied that you indeed left the ward unattended on numerous occasions between 15 June 2020 and December 2022.

Having established that you left the Ward unattended on numerous occasions, the panel then considered whether the time period for which you left would be considered ‘prolonged.’

The panel noted that no definition of ‘prolonged’ has been provided by the NMC and considered that the meaning should be assessed by reference to context, rather than by any arbitrary or predetermined duration of time. The panel considered that the

meaning of ‘prolonged’ must be understood in a clinical context where even a relatively short absence may be significant given that a staff member or a patient may unexpectedly require emergency assistance at any time. The panel heard evidence that the Ward should never be left without a registered nurse in attendance

The panel noted that at any given time, you were the only registered nurse on duty on the Ward during the night shift and therefore undertook the role of a nurse in charge. You would work with two or three HCAs during your shift. It was the operating procedure of the Hospital that a registered nurse must be present on the Ward at all times. Contingencies were in place whereby night managers who were also registered nurses could attend wards and cover for the nurse in charge so they could leave the ward. Mr Barber in his oral evidence indicated that should you wish to leave the Ward for any reason, you could contact a night manager who would attend and ensure there was registered nurse present on the Ward, as required.

The panel found Mr Barber to be a credible witness but recognised that his evidence assisted the panel in understanding the referral to the NMC, the relevant employer documentation, hospital policy and procedures, and the provenance of documents produced during the local investigation. The panel found his evidence to be clear and consistent with the documentary material before it. The panel therefore accepted Mr Barber’s evidence in relation to those matters within his personal knowledge.

The panel heard evidence from senior staff at the Hospital regarding registered nurses leaving the Ward for any reason. The panel were informed there were no occasions when a ward should be without a registered nurse. Policies and procedures were in place whereby the floating night managers, who were registered nurses, would attend and ensure cover on the Ward. This policy was in place to mitigate any risk of harm to patients and colleagues. You acknowledged that you were aware of this policy, however you did not, on any occasion when leaving the ward, arrange for suitable cover. The panel determined that in light of this policy, any period of time away from the Ward would be deemed prolonged due to the risks associated with the absence of a registered nurse.

Keeping all of the above in mind, the panel was of the view that in a clinical context an emergency situation can unexpectedly arise at any time. This may require immediate attention by a registered nurse. In such circumstances, your absence from the Ward for any period of time, for reasons unrelated to your nursing duties and responsibilities, leaving the Ward with no registered nurse, would be classified as prolonged and would put patients at risk of harm.

The panel noted the evidence of Ms Horner whereby she stated that you would leave the ward for 30 to 60 minutes at a time. Ms Ward referred to your absence from the Ward as 'prolonged'. The panel noted the evidence of Ms Dongal regarding the time period of your absences; the relevant excerpt is as under:

> *"11. … It happened so often that we wouldn't check how long she'd been gone away for. Sheri started doing her prayer walks immediately following her transfer to Elmswood, and it was part of her religion.*
>
> *12. … I'd give her a call, and she'd be back at the Unit quite quickly, and within a few minutes (less than 10 minutes)…. On one occasion I had to call Sheri's second phone number to get through to her. The signal is really bad around Elmswood House, as there's big trees in the area.*
>
> *…*
>
> *15. I don't recall Sheri being away from the Unit for prolonged periods of time for any other reason than being in the quiet lounge, going to the Allendale building, or going on prayer walks."*

The panel was mindful that Ms Dongal's evidence was hearsay and had not been tested through questioning. It considered her evidence as a whole, including her statement that you generally returned within a few minutes when contacted and that she was unaware of any adverse patient-care incident. The panel therefore approached her evidence with appropriate caution and did not rely upon it as primary evidence establishing the precise duration of your absences.

With the exception of Mr Bell, all the other HCAs giving evidence stated that they felt vulnerable when you left the Ward. Mr Bell was unsure of timings because he was in a new role, on a new ward, stating that he was focused on getting used to his new job, and as such paid little or no attention to timings when you left the Ward.

The panel found Mr Bell to be a credible and balanced witness. He spoke positively about you and described having a good working relationship with you. There was nothing before the panel to suggest that he bore any animosity towards you or had any reason to fabricate or exaggerate his evidence. The panel considered it significant that Mr Bell was willing to make concessions which did not assist the NMC's case. Mr Bell did not seek to exaggerate the consequences of you being away from the Ward. He said that he had not personally needed to contact you while you were away and did not recall an incident in which patient care was adversely affected due to your absence. The panel considered that the balanced nature of his account supported his credibility. The panel nevertheless recognised the limits of Mr Bell's evidence, in particular his evidence was of limited assistance in establishing the precise duration of absences away from the Ward, because he was very much focused on his own new role and responsibilities within the Ward.

The panel considered Mr Bell to have given a balanced account. When recalled, he candidly stated that he could no longer independently remember the relevant events in detail and that his memory had been better at the time he made his earlier statement. The panel did not regard his present lack of recollection as demonstrating that his earlier account was inaccurate. However, it limited the weight which could safely be attached to his evidence concerning precise duration. In particular, his earlier estimate of approximately 15 to 45 minutes had itself been described by him as a "guesstimate" because he had not timed you. The panel therefore did not rely upon Mr Bell as providing precise evidence of the duration of any particular absence from the Ward.

The panel considered the submissions of Mr Radley that when you visited the quiet lounge for your prayers, or any other reason, you 'emotionally' left the Ward. The panel was of the view that for the purposes of this charge, the panel would not consider this as leaving the Ward unattended as you were present on the Ward to

perform your duties and address any concerns that arose. The panel is also mindful of the fact that there was no reference to ‘emotionally leaving’ the Ward in the papers that were served to you.

When the hearing resumed on 9 November 2026, you engaged with the proceedings and formally denied the charges. You also gave evidence under oath. In your oral evidence, you conceded that you did leave the ward on multiple occasions but disputed that the length of time you were off the ward amounted to ‘prolonged period’. You stated that you would leave the Ward for conducting ‘seclusion reviews,’ heating food, getting fresh air, meditation, prayer and [PRIVATE].

You stated that your absences from the Ward were for not more than six to ten minutes when you were preparing food in the neighbouring building and unspecified times while conducting reviews at the main Hospital, a ten minute walk away. You admitted that you would not arrange for the Ward to be covered by another registered nurse, as the ward was a rehabilitation unit and most of the patients were settled and sleeping; and also, because you informed staff where you were going and would be contactable on your mobile phone should they need you.

The panel considered your explanation that registered-nurse cover was unnecessary because the Ward was a rehabilitation unit, you ensured routine medications had been administered and patients were settled before leaving, and you remained contactable by telephone. The panel did not accept that explanation. Notwithstanding the rehabilitation setting, patients could unexpectedly require registered nursing assessment, intervention or medication, including PRN medication. The HCAs remaining on the Ward could not undertake all of the functions of a registered nurse. The panel further considered that you did not sufficiently consider the potential risk of harm in leaving the Ward without a registered nurse, even for a short period of time.

In view of the above, the panel found Charge 1 proved.

Charge 2

‘That you, a registered nurse,

2. *On the nightshift commencing on or around 12 June 2023, slept whilst on duty.’*

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written statement of Ms Horner, the relevant excerpt is as under:

“9. On 12 June 2022, following her medication round at 09:00PM, Sheri went into the quiet lounge until 12:00AM. A patient requested some medication so I had to go to the quiet lounge to wake her up. I knocked on the door to the quiet lounge and Sheri was asleep in the chair, with the lights turned off and curtains drawn in the quiet lounge. I told her that a patient needed medication. Sheri woke up quickly, and quickly got up and gave the patient their medication. I didn’t observe Sheri asleep in the quiet lounge on any other occasion.”

The panel recalled Ms Horner who again gave live evidence consistent with her statement. Ms Horner, when questioned by the panel stated that you appeared asleep in the lounge and it took her three attempts at calling out your name to rouse you from your sleep. Ms Horner remained firm about the core event she said to have personally observed. She could not independently identify the year or date of the charge, but when the alternative explanations of resting or praying were specifically explored, she remained firm that you were asleep and appeared startled upon being woken up. She rejected the possibility of any alternative explanations being true and stated that you were on duty at the time and not on any authorised break.

The panel noted that Ms Horner was the only witness who gave direct evidence of personally observing you asleep on the alleged date. The panel found Ms Horner to be a credible and generally a reliable witness. She had worked at the Ward for

twenty-one years and had worked a number of night shifts with you. The panel considered that she gave evidence about matters which she had personally observed and did not seek to exaggerate her account. In particular, although she alleged that she had seen you asleep whilst on duty on the shift commencing 12 June 2023, she expressly stated that she had not seen you asleep on any other occasion. The panel considered that this limitation supported the measured nature of her evidence. The panel also noted that Ms Horner gave some evidence which was favourable to you. She stated that when you were required to perform nursing duties while you were in the quiet lounge, you would usually come out immediately, if alerted by the HCAs who were caring for the patients.

The panel also heard evidence from Ms Ward, Mr Barber and Mr Bell whereby they detailed your general routine. They stated that your shift would start at 7:30pm. After a short handover, you would go on a medication round at approximately 8pm and then you would generally visit and remain in the quiet lounge from 9pm to 12am, unlike any other registered nurses in charge of night shifts who would carry out work in the back office. This account of events corroborates the evidence of Ms Horner to the extent that you regularly visited the quiet lounge to rest for long periods of time.

The panel was also mindful of the break that you were entitled to during your night shift and heard evidence from Ms Horner, Ms Ward and Mr Barber in this regard. They stated that you, as well as other staff members took their breaks in the early hours of the morning, after midnight, and even if a staff member were to take an earlier break, it would still be post-midnight. Further, as your shift would have started 1.5 hours before you were found asleep, it was not likely that you would have taken an authorised break this early. This assured the panel that indeed if Ms Horner had witnessed you asleep in the quiet lounge, it would not have been during your designated break hour.

When giving oral evidence before the panel at the resumed hearing, you unequivocally denied sleeping whilst on duty on or around 12 June 2023. You maintained that you had not been asleep and rejected Ms Horner’s account of having to wake you in order for you to attend to medication.

The panel also took into account the minutes of the meeting dated 10 August 2023, held between you and Mr Heathcote whereby you denied ever falling asleep whilst on duty. The relevant excerpt is as under:

"JH: … Explained reason for meeting – two issues raised, one for leaving the ward for long periods of time when not on break. Secondly, falling asleep during night shift on 12th June 2023 in the quiet lounge. Do you remember this?

SO: 12th June 223 – Did not fall asleep, was relaxing in the quiet lounge, and was after medication rounds were completed. Aware there is a camera in their so wouldn't fall asleep. Told other staff that I was going in there, sometimes sleep on break but never on shift.

…

JH: Been reported that a member of staff had come to wake you up to do the medication round, is this true?

SO: No, was not woken up to go and do medication rounds had already done them

JH: Do you have any memory of staff waking you up in the quiet room?

SO: No"

The panel also took into account the Investigation Meeting Notes dated 24 August 2023, where the meeting was attended by the director of the Hospital Ms Kate Herod, you and an HR administrator. In this meeting, you stated, *"I never slept on duty, I do not lie."* The panel therefore noted that your denial of sleeping whilst on duty was consistently maintained from your local investigation through to your live evidence before the panel and was not an account advanced for the first time during the resumed hearing.

The panel also enquired with Ms Horner regarding Datix i.e., the internal reporting system for any incident that needs to be reported to the management. This query

was raised in response to concerns raised by you in your documentary evidence provided to the panel. The panel was informed that at the time of the incident, HCAs did not have access to Datix and it was only the registered nurse during that shift that could report any incidents. The panel noted that this would have prevented HCAs from reporting incidents in this manner. You also raised concerns that the sleeping incident was reported to the ward manager and not the night manager. The panel heard evidence from Mr Barber that the procedure at the time was to report any incidents to the ward manager, and Ms Horner's report of this incident was in line with the internal procedure.

During your live evidence under oath on 9 November 2026, you stated that this was your second shift on the Ward since your return from your secondment to another ward, and your colleagues appeared unhappy upon learning that you intended to stay on the Ward. You informed the panel that during your secondment, one Andy Grimshaw who worked day shifts was working in your stead and it was your belief that your colleagues preferred working with him.

You alleged that your colleagues had underhandedly manufactured this allegation to have you removed from the Ward, in order to have Andy Grimshaw appointed to the night shift. To support your statements, you stated that Ms Horner had reported the alleged incident to a ward manager instead of the night manager, which was irrational. Further, you stated that it was suspicious that the camera in the lounge was not working on the day of the alleged incident. You insisted that the CCTV footage would have aided you in disproving the charge.

In response to the panel's questions regarding Ms Horner witnessing your sleeping, you stated that on your shift on 12 June 2023, you may have been praying, meditating or listening to music with your earphones in your ears, due to which you may not have responded to Ms Horner instantly.

The panel weighed Ms Horner's evidence against your live and consistent denial. It did not make a general finding that Ms Horner was truthful and you were not. Rather, it assessed the specific factual dispute by reference to the content of both accounts, the contemporaneous documentary evidence, the chronology, the absence of CCTV footage, the possibility of mistake, the alleged motive and the limitations in the

respective evidence. Having done so, the panel considered the central features of Ms Horner's direct evidence concerning the particular incident to be sufficiently reliable.

In respect of the Ward's CCTV, the panel examined documents provided by the Hospital and heard live evidence from Mr Heathcote, that indicated that as soon as the technical issues were discovered, immediate arrangements were made to resolve the issue. This included the matter being outsourced to an independent external company. Although it has not been possible to determine how long the Ward CCTV was not recording, the panel heard evidence that the live stream was still available for viewing within the back office. The panel is satisfied that the CCTV malfunction is not related to the allegations against you.

The panel also considered your evidence that a colleague wanted your night shifts and that the allegations formed part of a conspiracy to remove you from those shifts. The panel considered the conspiracy allegation because it was potentially relevant to the origin of the concerns and to the reliability of the evidence. It considered the responses of the recalled witnesses and the evidence concerning relationships on the Ward. The panel did not speculate on matters for which there was no evidence. Having considered the material before it, the panel was not satisfied that there was sufficient evidence to establish that Ms Horner fabricated the sleeping allegation or that the witnesses had acted as part of a conspiracy against you.

The panel prefers the evidence of Ms Horner over the statements by you in the local investigation meetings as Ms Horner's evidence is direct, specific and consistent. Ms Horner described you to be asleep on a chair, with the lights turned off and the curtains drawn. She stated that she called out to you several times, upon which you woke up with a start.

The panel is of the view that Ms Horner did not embellish her account and explicitly stated that she never witnessed you sleeping whilst on duty on any other occasion. The panel also noted that Ms Horner's account had been consistent throughout the local investigation, in her written statement, as well as her oral evidence before the panel. Therefore, on the balance of probabilities, the panel found Charge 2 proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Webb 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 (2015)' (the Code) in making its decision.

Mr Webb identified the specific, relevant standards where your actions amounted to misconduct namely, 1.2, 8.5, 11.2, 20.1 and 25.1. It was the NMC's position that your conduct in the facts found proved fell seriously short of what is expected and

required of a registered nurse and that fellow practitioners, and the public, would consider such actions as found proved to be deplorable.

Mr Webb referred to the NMC Guidance on Misconduct (Reference: FtP – 2a) and submitted that registrants must act in line with the NMC Code and if their conduct falls short of the requirements of the Code, it could amount to serious professional misconduct. He submitted that your actions whereby you left the Ward on multiple occasions for various reasons, whilst being the sole nurse in charge, and on one occasion slept whilst on duty, amounted to you abandoning your duties and abusing your position of trust.

Mr Webb submitted that your conduct demonstrated a disregard for the safety of, and prioritising yourself over, those in your care. He therefore submitted that such actions bring the reputation of the profession into disrepute and fall far short of the conduct and standards expected of a nurse and amount to misconduct.

You gave evidence under oath.

You stated that at the time of the incidents, you did not consider your actions to constitute misconduct. You explained that the wards were frequently understaffed with you being the only registered nurse covering two wards, and that whenever you left the Ward to undertake medication rounds or perform other duties, the other ward would inevitably be left unattended.

You stated that your employer had never raised concerns with you about this practice or given you an opportunity to understand and rectify any concerns before referring the matter to the NMC. You also highlighted what you considered to be inconsistent treatment as the wards were permitted to be left unattended when you were carrying out your duties elsewhere, but this was considered unacceptable when you left to prepare food or get fresh air.

You maintained under oath that by leaving the Ward, you did not put patients at risk as you were just outside the Ward and were contactable by phone.

You acknowledged that you have since learnt from the experience and that the matter had particularly affected you because of the impact on your family. You stated that you accepted the panel's findings as its determination on facts, while maintaining your own account and continuing to dispute the allegations that you slept whilst on duty.

In your written submissions where you further reflected on the concerns, you acknowledged that your leaving a ward without a registered nurse could place patients at risk particularly if a patient is deteriorating, required medication or needed immediate assistance. You acknowledged that colleagues and HCAs could be affected as they would be unable to perform certain duties without a registered nurse present, and that members of the public and patients' families could lose confidence in the safety of the Ward.

Submissions on impairment

Mr Webb also addressed the panel on the issue of impairment and 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) where Cox J had set out the following questions for a panel to consider when determining whether a registrant's fitness to practice is impaired. The panel should ask itself whether the registrant

i) *"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*

ii) *Has in the past brought and/or is liable in the future to bring the professions into disrepute; and/or*

iii) *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the professions …"*

It is the NMC's position that all three limbs are engaged.

First limb: Although there was no actual harm caused, there was risk of potential harm. Further, your colleagues were also impacted by your conduct in that, your absences placed unnecessary pressure on them. Mr Webb submitted that in relation to future risk of harm, your conduct evidences an attitudinal issue and that you are likely to repeat your conduct in the future.

Second limb: Mr Webb submitted that your conduct fell significantly below the level expected of a nurse and you are likely to bring the nursing profession into disrepute.

Third limb: In this regard, Mr Webb submitted that by leaving patients without a registered nurse readily available for their care, you breached fundamental tenets of the profession of prioritising people and promoting professionalism and trust.

Mr Webb referred to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), and submitted that you offered limited insight in your initial responses to the NMC, relied on medical conditions for leaving the Ward however, failed to provide any documentary/independent evidence supporting your [PRIVATE], and also accepted that there were reasons other than [PRIVATE] due to which you would leave the Ward.

Mr Webb acknowledged the positive evidence you have provided i.e., the reference letter from your current manager who spoke highly of your practice over the past three years as a nurse. However, he submitted that the evidence in support of your current safe practice does not dilute the seriousness of the misconduct in this case. He urged the panel to consider your reflection on, and insight into, that misconduct and assess the risk of repetition and ongoing public protection concerns associated with your practice.

Mr Webb referred to the NMC Guidance on Impairment (Reference: DMA-1) and submitted your misconduct demonstrates a pattern of behaviour that amounts to wilful neglect of your patients at the Ward and indicates a deep seated attitudinal issue on your part. He submitted that as the concerns are attitudinal in nature, they

are less likely to be rectified with training or supervision. Mr Webb therefore submitted that there is high likelihood of repetition should you be allowed to continue to practise as a nurse without restriction, which would place the public at risk of harm.

Mr Webb once again referred to the case of *Grant* and Article 3(4A) of the Nursing and Midwifery Order 2001 and submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.

The panel heard live evidence from you as well as your current manager Ms Charlotte Casson (Ms. Casson).

After the NMC's submissions, you then submitted your own written submissions which included further insight and reflection.

You are currently employed as a mental health liaison practitioner working within the general hospital accident and emergency setting, working predominantly night shifts, where your duties differ from those you previously undertook on the Ward. You relied upon your current practice and the evidence of your manager as demonstrating a sustained period of safe professional practice.

You confirmed that you have undertaken online and in-person mandatory training by your current employer. You also confirmed that you work night shifts on a rotational basis alongside HCAs and other registered nurses, and that you have access to colleagues for support when required.

You informed the panel that the current proceedings have had a significant impact on you and prompted considerable reflection on your practice. You acknowledged that at the time, you had not fully appreciated the impact your actions may have had on your colleagues but now recognise the importance of communication and following policies.

You stated that you have learnt from this experience and would approach similar situations differently in the future, including seeking appropriate cover and informing your employer if you needed to leave.

You also submitted written submissions:

> *"My final submission and reflection on this case is that I apologise for any mistakes I made. I promise that such mistakes will not happen again.*
>
> - *Having reflected carefully on the panel's findings, I acknowledge the seriousness of the concerns raised about my professional conduct.*
>
> - *I recognise that, as a registered nurse, I have a duty of care to protect patients and ensure their safety at all times.*
>
> - *I understand that leaving the ward without ensuring appropriate cover could place vulnerable patients at risk, even if there was no intention to cause harm.*
>
> - *On reflection, I appreciate the importance of professional accountability and exercising sound judgement. I recognise that I should have ensured appropriate arrangements were in place before leaving my clinical area.*
>
> - *Although I was not sleeping, I appreciate the concerns and risks that would have been if a qualified nurse were to be sleeping on duty.*
>
> - *I understand the concerns regarding sleeping on duty and recognise that nurses must remain alert, attentive and responsive to patients' needs at all times.*
>
> - *On reflection, I recognise that* [PRIVATE] *ability to remain fully alert.*
>
> - *I understand the importance of recognising* [PRIVATE] *and taking appropriate steps to ensure they do not compromise patient safety.*

- *If I experience* [PRIVATE] *or feel unable to perform my duties safely due to* [PRIVATE]*, I will immediately inform the nurse in charge and seek appropriate support and ensure that patient safety remains my priority. I will also seek appropriate* [PRIVATE] *and discuss any necessary workplace adjustments to help me manage* [PRIVATE] *while maintaining the professional standards expected of me as a registered nurse.*

- *In the future, before leaving the ward for any reason, I will inform the nurse in charge, ensure that appropriate staff cover is arranged and confirm that patient safety will not be compromised.*

- *I recognise the importance of effective communication, following workplace policies and maintaining professional boundaries and responsibilities.*

- *I have reflected on how my actions, or failures to take appropriate precautions, could affect patients, colleagues and public confidence in the nursing profession.*

- *I understand that having no intention to cause harm does not remove my professional responsibility to prevent foreseeable risks.*

- *I am committed to applying the lessons learned from these proceedings to my future professional practice.*

- *I respectfully ask the panel to consider my insight, reflection, professional experience and any evidence of strengthened practice when assessing my current fitness to practise.*

- *I remain committed to the NMC Code, professional accountability, patient safety and maintaining public confidence in the nursing profession.*

In conclusion, I want to plead with the panel: please temper justice with mercy.

My entire family have devoted their lives to taking care of people in the community, especially the vulnerable people.

My daughter is a qualified nurse with 15 years of caring for the public.

My husband is a clergyman caring for the vulnerable people in the community.

Since I began working with vulnerable people in 2000, with the British Home and Hospital for the Incurables as a Health Care Assistant (HCA) and a registered nurse to date, I have been caring for the public with great concern for their well-being, with no case to answer.

Thank you for your support from the beginning, considering that I am not supported by my union. I am indeed very grateful."

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Rylands v General Medical Council* [1999] Lloyd's Rep Med 139.

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

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8 Work co-operatively

To achieve this, you must:

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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

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

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

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, after considering both the charges separately, the panel was of the view that the charges found proved, both individually and collectively, amount to misconduct.

In reaching its decision, the Panel acknowledged that there was no evidence of actual harm, and took into account the explanations provided by you, including that you had informed colleagues of your whereabouts and remained contactable. However, the Panel emphasised that these factors did not remove your professional responsibility for the foreseeable risk to patient safety arising from your actions. The panel also heard evidence that phone signal was poor. This could have impacted HCAs' ability to contact you on your personal phone.

The panel considered each charge separately, having regard to the nature, frequency and seriousness of the conduct, the impact upon colleagues, the risk created for patients, and your fundamental responsibilities as a registered nurse.

Charge 1

The panel found your conduct in Charge 1 amounted to serious misconduct. The panel acknowledged the explanations provided by you for leaving the Ward, however, it was of the view that these explanations did not sufficiently mitigate the seriousness of your actions.

As the sole registered nurse in charge, you held responsibility for ensuring that appropriate nursing cover was maintained at all times. The presence of HCAs did not relieve you of this responsibility, as they could not provide the nursing assessment and intervention required in the event of an unexpected emergency. The panel noted that alternative arrangements could have been made, including seeking cover from any of the night managers who were also registered nurses.

The panel was particularly concerned as this was not an isolated occurrence, but a repeated pattern of conduct between June 2020 and December 2022, with you leaving the Ward on multiple occasions, sometimes at your own admissions, for a period of up to 20 minutes, and witnesses stating up to 60 minutes. The panel

considered that this fell significantly below the standards expected of a registered nurse and created unacceptable risk to patient safety.

The panel considered that your absences placed additional pressure on the HCAs that remained on the Ward. Although no actual harm occurred, the absence of harm did not remove the foreseeable risk created by the absence of you as the only registered nurse on shift. By leaving the Ward without arranging appropriate cover, you failed to discharge an important professional responsibility with your role as the sole registered nurse in charge.

The panel considered that you had prioritised your needs over your professional responsibilities and had failed to maintain a safe nursing environment. It therefore concluded that your conduct as mentioned in Charge 1 amounted to serious misconduct.

Charge 2

The panel found your conduct in Charge 2 did not occur during your designated break and amounted to serious misconduct. The panel noted that this was a single incident and there was no evidence of actual harm. It also took into account that when alerted to the patient's needs, you attended to the patient immediately. Further, the panel noted that Ms Horner had not alleged that she had previously witnessed you sleeping whilst on duty.

Nevertheless, the panel considered that remaining aware and alert whilst on duty is a fundamental responsibility of a registered nurse. By falling asleep whilst responsible for patient care, you created a risk that patients requiring nursing intervention may not receive timely assessment or treatment.

The panel noted that the incident arose when a patient required medication and Ms Horner had to call your name several times before you responded. The panel considered that this demonstrated the potential for delay in accessing nursing assistance where the registered nurse on duty was asleep. The seriousness of Charge 2 lay in your unavailability to respond immediately whilst responsible for

patient care. The panel did not draw any inference from the dim lighting and drawn curtains in the quiet lounge.

The panel considered that you had a responsibility to raise any [PRIVATE] concerns that could affect your ability to practise safely. It was of the view that had you done so, your employer may have been able to offer [PRIVATE] support or consider reasonable adjustments to assist you in managing [PRIVATE] whilst fulfilling your duties. The panel took account of your evidence that some of the occasions on which you left the Ward were associated with managing [PRIVATE]. It's treated that evidence as relevant context. It made no finding that your [PRIVATE] caused the conduct on either charge or did not treat any failure to discuss [PRIVATE] with your manager as a separate matter for consideration. Your later reflection and/or oral submissions concerning how you would manage any future [PRIVATE] is assessed separately when determining current impairment.

The panel noted that while your conduct in Charge 2 was a single incident and that no actual patient harm had been identified, the failure to remain alert whilst on duty and the wider impact on colleagues represented a significant departure from the standards expected of a registered nurse.

Accordingly, the panel found your conduct in Charge 1 and 2 amounted to serious misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and ensure safety of their patients. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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.'*

The panel took into account your current insight, the extent to which the concerns were remediable, the evidence of your sustained practice, the need to protect the public and the need to maintain public confidence in the nursing profession.

The panel considered your level of insight and acknowledged that this had developed through the regulatory proceedings. It noted that although you continued to dispute that you had been asleep on duty, you were able to understand objectively that the concerns identified could give rise to potential risks to patients and colleagues.

The panel took particular account of your written submissions which incorporated some reflection, in which you acknowledged your mistakes, apologised and recognised the potential risks to patient safety arising from your actions. You also demonstrated an understanding that leaving the Ward without appropriate nursing cover could place vulnerable patients at risk, even where no actual harm had occurred. You accepted that you should have ensured appropriate arrangements were in place whenever you left the Ward and explained what steps you would take

to manage a similar situation in the future namely, informing your manager and arranging suitable qualified cover prior to leaving.

The panel noted that your insight had developed relatively late in the regulatory process, following the panel's findings on facts. It considered the timing of the written submissions which contained additional new reflection was relevant but not determinative of the weight that could be attached to it. The panel considered the NMC's submission that your conduct amounted to wilful neglect and reflected a deep seated attitudinal issue. The findings of fact did not establish deliberate neglect of patients, a conscious disregard for their welfare or an ingrained attitude fundamentally incompatible with professional practice. The panel nevertheless recognised seriousness of the conduct and went on to assess your current insight and strengthened practice.

The panel applied the NMC Guidance on Insight (Reference: 16b). It considered whether you were able to step back and view the concerns objectively, and recognised the professional problem, understand your responsibilities, identify what should have been done differently, and explain how you would avoid similar concerns in the future. The panel considered that your final written reflections/submission addressed each of those matters. You recognised the risk in leaving the Ward without appropriate nurse cover, the possible impact upon patients and colleagues and the effect upon public confidence. You identified the need to arrange appropriate cover before leaving a ward and explained how you would seek support and appropriate workplace adjustments for the preparation of meals, or to address [PRIVATE] affecting your ability to practice safely. In relation to Charge 2, although you continued to deny sleeping, you demonstrated an understanding of why sleeping whilst responsible for patients would present a serious concern.

The panel referred to the NMC Guidance on Insight (Reference: 16b) to determine whether you have demonstrated sufficient insight. The Guidance 16b states that '*A nurse, midwife or nursing associate who shows insight will usually be able to:*

- *step back from the situation and look at it objectively*
  Panel referred to your written submissions where you stated:

“Having reflected carefully on the panel's findings, I acknowledge the seriousness of the concerns raised about my professional conduct.

I recognise that, as a registered nurse, I have a duty of care to protect patients and ensure their safety at all times.

…

I understand that leaving the ward without ensuring appropriate cover could place vulnerable patients at risk, even if there was no intention to cause harm.

Although I was not sleeping, I appreciate the concerns and risks that would have been if a qualified nurse were to be sleeping on duty.

I understand the concerns regarding sleeping on duty and recognise that nurses must remain alert, attentive and responsive to patients' needs at all times.

I recognise the importance of effective communication, following workplace policies and maintaining professional boundaries and responsibilities.’

- *recognise what went wrong*
  Panel referred to your written submissions where you stated:
  “…
  I understand that leaving the ward without ensuring appropriate cover could place vulnerable patients at risk, even if there was no intention to cause harm.

  On reflection, I recognise that [PRIVATE]*, can affect my wellbeing and ability to remain fully alert.*

  I understand the importance of recognising [PRIVATE] *and taking appropriate steps to ensure they do not compromise patient safety.”*

- *accept their role and responsibilities and how they are relevant to what happened*
  Panel referred to your written submissions where you stated:
  “…

I have reflected on how my actions, or failures to take appropriate precautions, could affect patients, colleagues and public confidence in the nursing profession.

I understand that having no intention to cause harm does not remove my professional responsibility to prevent foreseeable risks."

- *appreciate what could and should have been done differently*
  Panel referred to your written submissions where you stated:
  "…
  On reflection, I appreciate the importance of professional accountability and exercising sound judgement. I recognise that I should have ensured appropriate arrangements were in place before leaving my clinical area."

- *understand how to act differently in the future to avoid similar problems happening.*
  Panel referred to your written submissions where you stated:
  "…
  If I experience [PRIVATE] *or feel unable to perform my duties safely due to* [PRIVATE]*, I will immediately inform the nurse in charge and seek appropriate support and ensure that patient safety remains my priority. I will also seek appropriate* [PRIVATE] *and discuss any necessary workplace adjustments to help me manage* [PRIVATE] *while maintaining the professional standards expected of me as a registered nurse.*

  In the future, before leaving the ward for any reason, I will inform the nurse in charge, ensure that appropriate staff cover is arranged and confirm that patient safety will not be compromised.

  I am committed to applying the lessons learned from these proceedings to my future professional practice."

The panel was therefore satisfied that you have demonstrated objective, developed insight into the professional concerns arising from both charges. It did not regard

your continued denial of sleeping whilst on duty as preventing you from demonstrating insight into the risk which such conduct would create.

The panel noted that you had undertaken mandatory online and in-person training required by your current employer. It recognised that the training was not presented as targeted remediation of the specific concerns in this case. The panel therefore placed greater weight upon the content of your reflection, the practical changes you identified and the evidence of your subsequent safe clinical practice.

The panel then considered the evidence of your current sustained practice. It noted that you had been practising safely in your current role (as an agency and bank nurse before being in substantive full time employment since February 2026) for three years. It placed significant weight on the positive evidence provided by Ms Casson, your current manager, who regarded you as a valuable member of the team and confirmed that no concerns had been raised about your practise during this period.

The panel considered that the concerns identified were capable of remediation, as they primarily related to your professional judgment, appreciation of risk, understanding your responsibilities as a nurse in charge and the importance of ensuring appropriate nursing cover. The panel was satisfied that these matters are capable of, and have been addressed by reflection, developed insight and strengthening of practice. It considered that the evidence of sustained safe clinical practice, together with the developed insight demonstrated that you had taken the steps to address the concerns identified.

In considering the public protection limb, the panel acknowledged that your conduct at the time of the incidents had placed patients at a risk of harm. However, the panel is tasked with determining whether there remained a real risk of repetition in the present.

The panel took into account your insight, your understanding of the potential risks associated with your conduct and the steps you stated you would take to avoid similar circumstances arising in the future. It also placed considerable weight on the

evidence that you had practised safely in your current role for about three years, with no concerns raised by your current employer. In these circumstances, the panel was satisfied that the concerns have been sufficiently addressed and that there was no continuing risk to public protection. Accordingly, the panel concluded that your fitness to practise was not currently impaired on public protection grounds.

The panel then considered that public interest limb. It recognised that your misconduct was serious and represented a departure from fundamental professional responsibilities and the standards expected of a registered nurse. The panel also acknowledged that the absence of actual physical harm did not diminish the seriousness of the misconduct or the potential risks created.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in circumstances involving such serious misconduct. It considered that an informed member of the public would expect the regulator to uphold the standards of the nursing profession and mark the seriousness of your conduct through a finding of impairment.

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

Sanction

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

Submissions on sanction

Mr Webb informed the panel that in the Notice of Hearing, dated 11 August 2026, the NMC had advised you that it would seek the imposition of a conditions of practice order for 12 months if it found your fitness to practise currently impaired. During the

course of the hearing, the NMC revised its proposal and submits that a caution order for a period of three years is more appropriate in light of the panel's findings.

Mr Webb referred to the NMC Guidance on Sanction and invited the panel to consider certain aggravating and mitigating circumstances. He submitted that considering the nature of the charges and the panel's findings, taking no further action would not be appropriate, conditions of practice would be untenable and suspension or strike off order would be wholly disproportionate and punitive.

You did not oppose the sanction proposed by Mr Webb.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- abuse of trust (as you were the only registered nurse on duty),
- you were the sole registered nurse on duty in the Ward, and your absence left the Ward without a registered nurse,
- a pattern of misconduct over a sustained period of time which placed the patients at unacceptable risk,
- your conduct created foreseeable risk to the patients,
- your absence placed undue pressure on the HCAs who remained on the Ward,
- you prioritised your own needs over the needs of your patients and colleagues,

- the patients in your care were mental health patients and hence particularly vulnerable.

The panel also took into account the following mitigating features:

- there was no evidence of actual harm,
- your misconduct in Charge 2 was a single incident,
- you apologised to the panel for your conduct,
- you demonstrated objective developed insight,
- you demonstrated three years of safe practice after the misconduct, without incident, through reference and evidence from your current manager,
- you have taken specific practical steps to prevent similar concerns,
- no further concerns have been reported to the NMC since your referral three years ago.

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 considered that in view of its finding of impairment on public interest grounds, an order of no further action would not appropriately address the public interest concerns and would not uphold professional standards.

The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

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

The panel noted that you have shown insight into your conduct. The panel noted that you apologised to this panel for your misconduct, showing evidence of genuine remorse. You have engaged with the current proceedings, albeit at the latter stages. The panel was told that there were no adverse findings in relation to your practice either before or since these incidents.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel was of the view that a conditions of practice order would serve no regulatory purpose as the panel found no current or ongoing public safety risk. The panel concluded that the concerns had been remediated and determined repetition was highly unlikely.

There was therefore no identifiable area in the clinical practice requiring restriction, supervision, assessment or retraining. Furthermore, the panel's finding of impairment was based solely in public confidence and professional standards. The NMC guidance recognises that conditions of practice are unlikely to be appropriate where impairment is found on public interest grounds alone. The evidence to the panel is that you have practiced safely and effectively and without concerns since your referral three years ago.

The panel also considered that a suspension order was not necessary. The panel found you were able to practice safely and effectively without restriction. The concerns had been addressed and repetition was highly unlikely. The panel considered that there was no public protection need to remove you temporarily from professional practice. The panel considered whether the misconduct was so serious that public confidence could only be maintained by temporarily preventing you from practising, it concluded that it was not. The panel therefore concluded that suspension was disproportionate and punitive.

The panel concluded that the least restrictive sanction sufficient to maintain public confidence in the nursing profession and to declare and uphold proper professional standards was a caution order for a period of three years. A short caution would not adequately reflect the sustained and repeated nature of Charge 1 together with the separate concern arising from Charge 2.

However, a caution exceeding three years would go further than necessary given the absence of actual harm, your developed insight, sustained safe practice, remediation and the finding that repetition was highly unlikely. The panel was satisfied that no restriction upon your practice was required. The panel therefore imposed a caution order for three years to mark the seriousness of the concerns.

Therefore, for the next three years, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. The caution order would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

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

This decision will be confirmed to you in writing.

That concludes this determination.