Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Thursday, 22 October 2026 – Friday, 23 October 2026
Monday, 26 October 2026 – Thursday, 29 October 2026

Virtual Hearing

Name of Registrant:	**Ruba Kilani**
NMC PIN:	21H1375E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – September 2021
Relevant Location:	Stockport
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, lay member) Rashmika Shah (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Trevor Jones (22 October 2026 only) Gillian Hawken (23 October 2026 – 29 October 2026)
Hearings Coordinator:	Khatra Ibrahim
Nursing and Midwifery Council:	Represented by Stephen Earnshaw, Case Presenter (22 October 2026 – 29 October 2026) Benjamin D'Alton (29 October 2026)
Miss Kilani:	Not present and unrepresented at this hearing
Facts proved:	Charges 1, 2 and 3
Facts not proved:	**N/A**
Fitness to practise:	**Impaired**

Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**
Final outcome:	**FTP impaired - striking off order**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Kilani was not in attendance and that the Notice of Hearing letter had been sent to Miss Kilani's registered email address by secure email on 26 August 2026.

Mr Earnshaw, 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 accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Kilani's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Kilani has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Kilani

The panel next considered whether it should proceed in the absence of Miss Kilani. It had regard to Rule 21 and heard the submissions of Mr Earnshaw who invited the panel to continue in the absence of Miss Kilani. He submitted that Miss Kilani had voluntarily absented herself.

Mr Earnshaw referred the panel to an email from Miss Kilani to the NMC dated 18 October 2026, where she stated:

> *'I acknowledge receipt of the notice of hearing. I write to inform the NMC that I do not wish to attend the hearing and I do not intend to be represented. Please proceed in my absence.'*

The panel 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 one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Miss Kilani. In reaching this decision, the panel considered the submissions of Mr Earnshaw, the written representations from Miss Kilani, and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v Jones* 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 has been made by Miss Kilani, and she has not provided a reason for non-attendance;
- Miss Kilani has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, and any clients who need their professional services;
- The charges relate to events that occurred in 2023;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Kilani in proceeding in her absence. Although the evidence upon which the NMC relies was sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Kilani's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Miss Kilani. The panel will draw no adverse inference from Miss Kilani's absence in its findings of fact.

Details of charge

That you, a registered nurse, whilst working at Stepping Hill Hospital on 17/18 May 2023:

1) Between 19:45 and 04:00 did not monitor Patient A's blood pressure readings, every hour, as required.

2) Inaccurately recorded that you had monitored Patient A's blood pressure readings every hour between 19:45 and 04:00, in Patient A's observation chart.

3) Your actions in charge 2 above were dishonest, in that you falsified medical records, to misrepresent that you had monitored Patient A's blood pressure readings.

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

Mr Earnshaw told the panel that Miss Kilani informed the NMC that she denies charges 1, 2 and 3.

Background

On 18 October 2023, the NMC received a referral from Stockport NHS Foundation Trust (the Trust), about alleged concerns regarding Miss Kilani's nursing clinical practice.

It is alleged that during a night shift on 17/18 May 2023, whilst working as a registered nurse on the High Dependency Unit (HDU) at Stepping Hill Hospital (the Hospital), Miss Kilani failed to carry out observations as required. This includes the following allegations:

- Miss Kilani did not perform adequate monitoring on Patient A – who had arterial fibrillation and ST wave depression;
- Having not carried out the observations, Miss Kilani went on to falsify entries on Patient A's paper observation charts;

Following these alleged concerns being brought to Miss Kilani's attention, she maintained the position that she had completed the observations to the expected standards.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Miss Kilani.

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 Dorothy ‘Joe’ O’Brien: Matron for Clinical Care at the Trust at the time of the allegations
- Ms Amelia ‘Jade’ Moss: Critical Care Nurse at the Trust at the time of the allegations
- Ms Kelly Taylor: Band 6 Charge Nurse at the Trust at the time of the allegations
- Ms Sharon Haley: Matron at the Trust for the Surgical Gastroenterology and Critical Care Division at the time of the allegations
- Mr Syed Ahmed: Electronic and Biomedical Engineer at the Trust at the time of the allegations

The legal assessor drew the panel's attention to the decision in, and principles derived from the case of *Ivey v Genting Casinos* [2017] UKSC 67. She advised the panel that, in determining dishonesty, the panel should adopt a two-stage test. She advised that the panel firstly should consider Miss Kilani's actual knowledge or belief as to the facts at the time. Upon making its decision on this stage, the panel should then apply the standards of ordinary, decent people to judge whether the conduct was dishonest. She further referred the panel to the NMC Guidance, '*Making decisions on dishonesty charges and the professional duty of candour'* (FtP 2a-iii), which draws upon the same principles as *Ivey*.

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

Charge 1

That you, a registered nurse, whilst working at Stepping Hill Hospital on 17/18 May 2023:

> **1) Between 19:45 and 04:00 did not monitor Patient A's blood pressure readings, every hour, as required.**

This charge is found proved.

The panel reminded itself that the burden of proof lies with the NMC, who were asking the panel to draw an inference that because the blood pressure (BP) readings between 19.45 and 04.00 were not available to be viewed on the bedside or central monitors, and no other method of taking the readings had been put forward by Miss Kilani, the BP readings had not been taken.

Before the panel could draw that inference and reach its conclusion, the panel considered the evidence before it, including the accounts offered by Miss Kilani, and any broader issues which may have affected the recording and retention of BP readings.

The panel accepted Ms Taylor's evidence that Miss Kilani was the nurse responsible for Patient A's care in Bed 17 on the night in question. This was consistent with Miss Kilani's acknowledgement, during the local investigation, that she was responsible for the care of Patient A at that time. The panel also heard that there was a requirement that Patient A should have hourly observations, as stated in Ms O'Brien's witness statement:

> *'The expectation for this patient was that he should have had his BP done every hour. He was in the high dependency unit (HDU) for close monitoring. There are some circumstances where you can reduce observations to four hourly but is done after speaking to the medics or Intensivist (consultants).'*

The panel noted that Miss Kilani also confirmed that she was responsible for the hourly observations, as noted in the local interview on 29 June 2023:

> *'**16*** **[Ms Haley]** ***How often do you do observations?***
> **[Miss Kilani]** *Hourly, but can be 4 hourly if wardable, I decided to keep to hourly.'*

Ms Moss gave evidence that she took on responsibility for Patient A's care whilst Miss Kilani took her break. At approximately 04.00, Ms Moss measured Patient A's BP using the BP cuff attached to the bedside monitor. Ms Moss told the panel that when she entered the bedspace, the BP cuff was not already on Patient A in bed 17, but was '*hanging over the top of the bed*'. When she measured the BP reading, Ms Moss could not find any readings since 19.00 displayed on the monitor. The reading Ms Moss measured at approximately 04.00 was displayed on the bedside monitor and retained. When she checked the patient's observation chart at the bedside, she could see that there was a handwritten record of Patient A's BP readings. Ms Moss escalated her concerns about the discrepancy and missing BP readings to the senior nurse, Ms Taylor. The panel heard from Ms Taylor in oral evidence that she looked at the bedside and central monitors, and the handwritten observations chart, and then spoke to Miss Kilani about the discrepancy when she returned from her break. At the end of the shift, Ms Taylor escalated the concerns to Ms O'Brien, the Matron.

The panel first considered the recordings that were on both the bedside and central monitors. The panel heard in oral evidence that Ms Taylor, Ms O'Brien and Ms Moss used these monitors in their day to day duties. The panel accepted the evidence of Ms Taylor, Ms O'Brien and Ms Moss that they looked for the BP readings on both monitors and satisfied themselves that there were no recorded BP readings between 19.45 and 04.00. The panel also noted that Ms O'Brien initially interrogated the bedside monitor in situ, took photographs of her findings, checked the BP cuff and the tubing, checked each component on another BP monitor, and confirmed they were functioning as expected. Ms O'Brien then isolated the bedside monitor, and contacted the Electronic and Biomedical Engineering workshop (EBME) for support, and was referred to Mr Ahmed – who was the engineer called to inspect the bedside monitor at the time. He was asked to attempt to locate the missing BP readings, and to confirm the monitor was working properly. Mr Ahmed confirmed that when he examined the bedside monitor, Patient A had been discharged from it and therefore, it no longer held any data for Patient A. He sought advice from the manufacturer of the monitors, recovered data from the central monitor and took photographs of the BP readings recorded. He gave oral evidence that he checked the central monitor, which held patient data for 120 hours, but was unable to locate any BP readings on that central monitor during the relevant time. However, the BP readings before and after that time were present. He also told the panel that he had taken the bedside monitor to the EBME workshop, and had carried out the functional checks – using a simulator – which confirmed the bedside monitor was capable of recording blood pressures, had no faults recorded, and was in good working order.

The panel did not have any evidence before it to determine that Patient A's BP readings had been taken and recorded on the monitor but then lost due to an IT issue. The panel noted that there were other readings, including the patient's heart rate recorded throughout this time and that the BP recordings before 19.45 and after 04.00 were still available on the monitors.

Therefore, the panel looked carefully at the accounts provided by Miss Kilani as to why the readings may have been absent from the monitor. Ms Taylor's evidence was that when she first spoke to her, Miss Kilani had informed her that the monitor was off for approximately 20 minutes, while she repositioned Patient A.

The panel considered Ms Taylor's witness statement, particularly:

> **'***She said that she'd turned the monitor off so I asked why would you turn the monitor off? She said it was alarming all the time. Nobody turns the monitor off. You can reset the alarm limit but if she was concerned, she could have spoken to me. I think I'm the sort of person you can talk to. Ruba said she had turned the monitor off for 20 minutes and that was her reasoning as to why the BPs weren't there. The machine always stores the readings, even if you turn it off or press discharge. I spoke to someone who services the monitors and she confirmed this.'*

The panel noted that on 18 May 2023 in her written statement, Miss Kilani stated the following:

> *'Throughout the night,* [Patient A] *slept deeply but was sleep talking, removing his gown as well as removing various wires, electrodes, and the saturation probe. This set off his monitor overnight regularly. As a result of this, he kept waking up the patients in the bay (bed 16 and bed 18) and they were getting irritated.* [Patient A] *also kept sliding down the bed which was exacerbating his COPD (wheezy).*
>
> *I turned off the monitor just so that I could slide* [Patient A] *up the bed, re-attach all the wires, electrodes and put his gown back on to avoid disturbing the other patients. I then turned back on the monitor – however, I cannot remember if I pressed 'discharge' patient or 'continue monitoring' this patient, or if I pressed anything at all.'* [sic]

The panel also considered Miss Kilani's local investigation interview dated 29 June 2023:

'*4* [Ms Haley] ***You said that the patient slept but kept on removing wires and nightgown. Is this unique or does it happen with ICU patients?***

[Miss Kilani] *It is normal for delirium or confusion in ICU or HDU. This patient was classed as wardable which means as soon as a bed becomes vacant they will be sent to the ward. I was worried about him being ready for the ward – why was he acting the way he was, he kept taking lines off and flinging them over the bed rails, it was not like he was in a deep sleep, he was quite aggressive – this is normal but not when patients are wardable.*

5 **[Ms Haley]** ***Did he disturb any of the other patients?***

[Miss Kilani] *Both patient 16 and 18 both said they would not get much sleep tonight – I asked them if I could draw the curtains for them. Fast forward to the end of the shift when bed 17 woke up he said "was I a bit loud", he was aware he knew he could have disturbed people. He said this was normal for him, he is like this at home. I was trying to assist in best practice by silencing alarms, I was very stressed and didn't want anybody to go to PALS to complain.*

6 **[Ms Haley]** ***Why did you turn his monitor off? Was it making a lot of noise?***

[Miss Kilani] *When I silenced the monitor this was for around 60 seconds. This was the time to get round the bed. I had to reposition every 20 minutes, and put electrodes and blood pressure cuff back on constantly. This patient has COPD I was worried the other patients would not get a good night sleep. Most of my attention was on bed 17.*

7 **[Ms Haley]** ***When you turn the monitor off do they automatically save readings?***

[Miss Kilani] *I don't know I've never done it before, I don't know what was going through my head*

8 **[Ms Haley]** ***When you turned the monitor off, when did you turn it back on?***

[Miss Kilani] *As soon as I had repositioned – it was minutes.*

9 **[Ms Haley]** ***In your statement you commented that you can't remember if you pressed discharge patient or continue monitoring. What does this mean? If you've discharged a patient would you need to re-admit?***

[Miss Kilani] *It flashes up on screen when you can choose admit, keep current or discharge. If you are not quick enough it goes off the screen before you can lock it. It was night time and low light.*

10 **[Ms Haley]** ***A following e:mail stated that non-invasive blood pressure was taken between 8 and 4, and this was recorded on the ICU chart paper copy. Was this done electronically or manually?***

[Miss Kilani] *Electronically attached to the back of the monitor, he kept taking off his cuff and each time I would have to put the cuff back on and click start there is a button with a picture of a cuff, this can also be used.*

11 **[Ms Haley]** ***Did you put the cuff at the back of the bed?***

[Miss Kilani] *No, I leave it on so not to keep waking him up every hour, the patient would fling it off to the back of the bed and I would keep going back and forth to put it back on.'*

The panel noted that Miss Kilani maintained throughout that she used the bedside monitor to measure Patient A's BP readings. Miss Kilani said that she did not need to confirm if

she had checked if the previous readings were being contemporaneously recorded when carrying out Patient A's BP checks. When asked if when the bedside monitor was switched on, and whether it would record each observation, Miss Kilani answered:

'*I do not check history each time, doing them hourly I did not need to check'.*

Miss Kilani suggested in the statement she made, on 18 May 2023, that the BP monitoring could have been impacted by Patient A removing wires, and that at one point, she decided to turn off the monitor so she could slide Patient A further up the bed. She also stated that she could not recall if she had pressed '*discharge'* or *'continue monitoring'*. In the same statement, Miss Kilani appeared to change her position, stating:

'*I am aware, on reflection that the monitor having been turned off inadvertently may have put* [Patient A] *at risk and I feel awful for this.'*

The panel also considered that during the formal investigation interview on 29 June 2023, Miss Kilani stated that Patient A was removing wires and '*flinging'* them over the bedrails and he was '*quite aggressive*'. Miss Kilani also stated:

'I was trying to assist in best practice by silencing alarms'

The panel noted that at this point, Miss Kilani maintained that she silenced the alarm for approximately 60 seconds, not the 20 minutes she had previously stated.

The panel considered whether Patient A's actions as described by Miss Kilani were a factor in the monitors not recording or storing the BP readings. The panel first looked at the evidence that dealt with Patient A's condition overnight.

The contemporaneous HDU patient notes created by Miss Kilani at 06.30 on 18 May 2023, before it became clear that there would be an investigation, recorded that:

'*...Pt slept comfortably overnight'* [sic]

The panel also noted Ms Moss' statement on 18 May 2023, where she stated:

> *'Within my and my colleagues bay all 3 patients were very settled, sleeping most of the shift. My colleague spent a majority of time sat at the nurses station due to the patients sleeping… Earlier in the shift the patients saturation probe was not on. He had been fidgety earlier and I was aware that he kept removing it, when I put it on him his sats were 77%. Myself and the nurse in charge repositioned the patient at this time and put on 4L (36%) oxygen via nasal cannula which improved his oxygen levels within the normal range.'* [sic]

The panel concluded that Miss Kilani's contemporaneous HDU patient notes and the witness evidence were consistent and showed that Patient A had not been '*removing wires*', '*thrashing'* or '*flinging'* them, nor behaving aggressively at the relevant time. He is described by Ms Moss, who was the other nurse in the bay as '*fidgety'* and she stated that he had been removing his saturation probe earlier in the evening, but no other challenging behaviour was noted. Therefore, the panel determined that Patient A's behaviour did not prevent Miss Kilani from measuring BP readings, or prevent the readings taken from registering on the monitors.

The panel concluded in any event, that for a BP reading to be measured, the equipment would need to be connected correctly, which would then result in a BP recording on the monitors. From the evidence given to the panel, there is no causal link between a patient removing wires and a BP reading (obtained through the monitor) failing to be stored in its memory. Miss Kilani stated in her accounts that she did go into Patient A's bedspace each hour to measure his BP. The evidence of Ms O'Brien, Ms Taylor and Ms Moss was that if the readings are measured using the equipment attached to the bedside monitor, they would be recorded and retained on it, and that is how the nurse would obtain the readings in order to record them by hand on a patient's observation chart.

The panel noted Ms Taylor's evidence that if there were issues in obtaining the BP readings, Miss Kilani would have been expected to speak with her, as the senior nurse on duty, to resolve those issues. Ms Taylor stated that Miss Kilani did not make her aware of any issues with the BP monitoring. Neither did Miss Kilani's contemporaneous HDU patient notes record any difficulties with obtaining BP readings or any challenging behaviour.

The panel next considered whether turning off the bedside monitor, deliberately or inadvertently, or if the discharge button was accidentally used, would have prevented the BP readings obtained through the bedside monitor from being stored on either the bedside monitor or the central monitor.

The panel noted that in response to a question, Miss Kilani stated in her local interview that:

> *'9* **[Ms Haley]** ***In your statement you commented that you can't remember if you pressed discharge patient or continue monitoring. What does this mean? If you've discharged a patient would you need to re-admit?***
>
> **[Miss Kilani]** *It flashes up on screen when you can choose admit, keep current or discharge. If you are not quick enough it goes off the screen before you can lock it. It was night time and low light.'*

The panel noted that this was a suggestion, and not a definitive account from Miss Kilani. It also considered further questions put to Miss Kilani at the investigation on 29 June 2023:

> ***'24*** **[Miss Haley]** ***Can I ask you to be open and honest .. did you knowingly falsify the readings?***
>
> **[Miss Kilani]** *No, especially not with heart patients, I never have and never would. I really care for patients and my job, it was a relapse in my judgement to turn it off.*

25* [Miss Haley] *If the monitor was on and you were doing a blood pressure would they record on the monitor?

[Miss Kilani] *Yes*

26* [Miss Haley] *Did you turn the monitor off each time?

[Miss Kilani] *No*

27* [Ms Haley] *So, if the monitor was on it would record each observation?

[Miss Kilani] *I do not check history each time, doing them hourly I did not need to check. When I told Kelly of ST depression she probably looked at history to see when the depression happened, that was when it was noted that blood pressure had not recorded.*

28* [Ms Haley] *Could there be a chance that the blood pressure monitor was faulty as nothing was recorded?

[Miss Kilani] *For me it was fine and working. The patient was thrashing about he could have pulled the wires out of the back of the monitor.*

29* [Ms Haley] *Could you not take a recording if the wires were not intact?

[Miss Kilani] *It was the same shift as any other, I did observations like I always do the observations.'*

The panel heard evidence from Ms O'Brien, Ms Moss, Ms Taylor and Mr Ahmed, who confirmed that if the bedside monitor was turned off, the BP recordings would not be lost from either monitor within the first 24 hours. Ms O'Brien explained in oral evidence that

this was essential for patient safety, so data would not be lost even in the event of a power cut. If the discharge button is pressed, Mr Ahmed confirmed that the data would be lost from the bedside monitor, but would be kept on the central monitor for 120 hours, and so would have been accessible. The panel further noted that the monitor successfully recorded and retained BP readings before 19.00 and after 03.57 for staff who had used the same monitor, including Ms Moss. Ms Taylor gave oral evidence that she spoke to Miss Kilani about the missing BP readings when she returned from her break. Subsequently, Miss Kilani continued caring for Patient A, using the same bedside monitor, and her BP readings thereafter were also recorded and retained.

The panel considered the evidence before it, and preferred the evidence of Ms Taylor, Ms Moss, Ms O'Brien and Mr Ahmed over that of Miss Kilani. The panel considered Miss Kilani's evidence to be inconsistent, including in relation to her descriptions of Patient A's condition overnight; the different time durations that she gave around her decision to switch off Patient A's bedside monitor; and her change in position that the monitor was switched off '*inadvertently'*, suggesting that this was not intentionally done. The panel determined that it is more likely than not that the absence of BP readings being recorded and retained on the monitors between 19:45 and 04:00 was the result of those readings not having been measured by Miss Kilani. It therefore concluded that Miss Kilani did not monitor Patient A's blood pressure readings, every hour, as required.

Accordingly, on the balance of probabilities, the panel found charge 1 proved.

Charge 2

That you, a registered nurse, whilst working at Stepping Hill Hospital on 17/18 May 2023:

> **2) Inaccurately recorded that you had monitored Patient A's blood pressure readings every hour between 19:45 and 04:00, in Patient A's observation chart.**

This charge is found proved.

In reaching its decision, the panel considered Patient A's observation chart dated 17/18 May 2023, where handwritten recordings of the patient's BP are noted. Miss Kilani confirmed at the local investigation that she was responsible for Patient A's care between 19.45 and 04.00, and that she measured his BP hourly. The panel also heard from Ms Taylor, who further confirmed in oral evidence that Miss Kilani was responsible for the care of Patient A, and that the patient chart was kept in Patient A's bedspace. The panel had regard to Ms Taylor's witness statement:

> *'I asked to speak to Ruba in private when she came back from her break. I told her that we'd gone to do the observations and noticed that there were no recordings. I asked her "did you do your blood pressures?" because what was documented on the chart, the BP readings, I didn't know where she'd got them from if they weren't on the monitor. She seemed a bit shocked so I asked her again and she said yes.'*

The panel also considered the investigation interview notes, dated 29 June 2023, where Miss Kilani consistently maintained that she took the BP readings. However, the panel noted that in response to the following question, Miss Kilani stated:

> ***'*39 [Ms Haley]** ***One thing I need to try and understand - the recordings were on the sheet so why not on the monitor, and there was no history?***
>
> **[Miss Kilani]** *I did not check, I genuinely did them so I don't know. I am just starting out and want to do the best job I can do and learn as much as I can.'*

The panel noted that Miss Kilani maintained that she measured the hourly BP readings between 19.45 and 04.00. However, the panel determined that the normal method to obtain BP readings on HDU was electronically using the cuff attached to the bedside

monitor. Although there may have been alternative methods by which Miss Kilani could have recorded Patient A's BP – including moving Patient A to another bedspace or using a manual machine (Sphygmomanometer) – she was consistent in her accounts that she used the same bedside monitor in Bed 17 to measure Patient A's BP readings. The panel concluded that those BP readings were not measured, and so consequently the handwritten BP readings on Patient A's observation chart between 19.45 and 04.00 were inaccurately recorded by Miss Kilani.

Accordingly, on the balance of probabilities, the panel determined that Miss Kilani inaccurately recorded that she had monitored Patient A's blood pressure readings every hour between 19:45 and 04:00, in Patient A's observation chart, and therefore found charge 2 proved.

Charge 3

That you, a registered nurse, whilst working at Stepping Hill Hospital on 17/18 May 2023:

> **3) Your actions in charge 2 above were dishonest, in that you falsified medical records, to misrepresent that you had monitored Patient A's blood pressure readings.**

This charge is found proved.

In reaching this decision, the panel took into account its decision in relation to charge 2 above. The panel considered the two-stage test, pursuant to *Ivey*, in determining this charge.

The panel first considered Miss Kilani's state of mind at the time. Given the panel's previous decisions on charges 1 and 2 that Miss Kilani did not monitor Patient A's BP every hour as required and inaccurately recorded that she had, the panel was satisfied

that these were deliberate acts, in that Miss Kilani knew the recorded BP readings were inaccurate. The panel therefore determined that, on the balance of probabilities, Miss Kilani was aware that she was falsifying medical records, to misrepresent that she had monitored Patient A's blood pressure readings.

The panel next considered whether Miss Kilani's conduct would be regarded as dishonest by the standards of ordinary, decent people. The panel determined that her conduct – namely that she falsified medical records, to misrepresent that she had monitored Patient A's blood pressure readings – would be regarded as dishonest. The panel further concluded that Miss Kilani's dishonest conduct was serious, as she was caring for a vulnerable patient on HDU, and her actions were carried out in order to misrepresent that she had monitored Patient A's BP readings every hour between 19:45 and 04:00, in Patient A's observation chart.

Accordingly, the panel found charge 3 proved, on the balance of probabilities.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Kilani's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Earnshaw invited the panel to find the charges found proved amounted to misconduct.

Mr Earnshaw referred the panel 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. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

Mr Earnshaw also referred the panel to the cases of *Nandi v GMC* [2004] EWHC 2317 and *Calhaem v GMC [2007] EWHC 2606 (Admin)*, where in the latter case, Mr Justice Jackson commented on the definition of misconduct as:

> '*It connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'*

Mr Earnshaw submitted that in regard to the facts found proved, they all, individually and cumulatively, amount to misconduct. He referred the panel to the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives 2015*' (the Code). He identified the specific and relevant standards and submitted that Miss Kilani's actions amounted to misconduct. He submitted that in relation to charges 1 and 2 Miss Kilani's conduct was very serious, in that she failed to measure BP for an elderly HDU patient over a period of eight hours. He submitted that this was made much worse by the falsification of Patient A's BP readings and subsequently, Miss Kilani's dishonest conduct

in charge 3. He submitted that this was a serious breach. In particular, he stated that Miss Kilani had breached the following sections of the Code: 1, 3, 10 and 20.

Mr Earnshaw submitted that the Code set out the professional standards of practice and behaviour for nurses, midwives and nursing associates. He also referred the panel to other sections of the Code, as aforementioned, and submitted that given the findings of facts, Miss Kilani clearly failed to keep to and uphold the standards and values as set out in the Code. He reminded the panel of its decision on the facts, and submitted that Miss Kilani demonstrated dishonest and unsafe behaviour, and that she failed to acknowledge how her actions and behaviours affected the care of a particularly vulnerable patient. He also submitted that as a result, her actions fell far below the standards expected of a registered nurse.

Mr Earnshaw submitted that when taking the charges both individually and collectively, they amount to serious misconduct, and invited the panel to make a finding of misconduct.

Submissions on impairment

Mr Earnshaw submitted that if the panel find that any of the charges found proved amount to misconduct, it should then also find Miss Kilani's current fitness to practise impaired. He submitted that current impairment is not defined in the NMC's Rules, and that instead, it has defined fitness to practise as:

> *'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.'*

Mr Earnshaw referred the panel to the judgement of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

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

Mr Earnshaw submitted that limbs a, b, c and d are engaged in this case.

Mr Earnshaw also referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* and submitted that Miss Kilani has not remedied the concerns identified. He submitted that to date, there is no evidence before the panel to demonstrate any insight, remorse or training, and that she has not provided any reflective pieces. He further submitted that the panel cannot be satisfied that Miss Kilani's conduct is highly unlikely to be repeated (as per *Cohen*) due to her significant lack of insight. He submitted that Miss Kilani has not demonstrated any understanding or acceptance of her actions and failures. He submitted that due to a lack of said evidence, there is nothing else before this panel that would mitigate the concerns, and therefore repetition is likely in the future.

Mr Earnshaw reminded the panel of its previous findings on the facts, and submitted that Miss Kilani's fitness to practise is impaired on the grounds of public protection.

Mr Earnshaw submitted that if the panel were not to find Miss Kilani's fitness to practise impaired, this decision would undermine the proper professional standards, and the public's confidence in the NMC, as Miss Kilani's regulator. He submitted that the public's confidence in the nursing profession as a whole would also be undermined. He further submitted that where such charges have been found proved, members of the public would expect a finding of impairment to be made. He submitted that Miss Kilani's fitness to practise is also impaired on the grounds of public interest.

Mr Earnshaw submitted that, for these reasons, Miss Kilani's fitness to practise is impaired on the grounds of public protection and also in the wider public interest. He invited the panel to make the same finding.

The panel accepted the advice of the legal assessor.

Decisions and reasons on misconduct

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

The panel determined that Miss Kilani's actions amounted to breaches of the following paragraphs of the Code:

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

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times…

The panel was of the view that Miss Kilani's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Kilani's actions amounted to breaches of the Code. It appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively as well as the circumstances of the case as a whole.

The panel took into account its previous decisions on the facts, in that Miss Kilani had not measured Patient A's BP, and had inaccurately and dishonestly recorded false BP readings.

The panel considered accurate and honest record-keeping as one of the fundamental tenets of the nursing profession. It noted that Miss Kilani's conduct would have deprived her colleagues and the appropriate health professionals of the information they needed in order to deliver effective and safe care to Patient A. The panel determined that this could have had a consequent impact on Patient A's continuity of care and therefore posed a risk of harm to him.

Although there was no evidence of actual harm, the panel determined that Miss Kilani's misrepresentations, inaccurate records and dishonesty posed a risk of harm to Patient A, given he was an 81 year old patient on HDU, with atrial fibrillation and ST wave depression.

The panel also considered honesty, integrity and trustworthiness to be fundamental tenets of the nursing profession. Miss Kilani's dishonesty was directly linked to patient care and her duties as a registered nurse. It noted that Miss Kilani's dishonest conduct demonstrated a lack of accountability and transparency on her part. The panel determined that her dishonest behaviour would be viewed as deplorable and unprofessional by other members of the nursing profession and the public. Miss Kilani's initial dishonesty occurred on one shift but over a period of nine hours, and consisted of a repeated decision not to monitor Patient A's BP and to inaccurately record false readings. When challenged by Ms Taylor, Miss Kilani's decision to deny this behaviour may have been spontaneous, but she continued with her dishonesty through the Trust's investigation despite many opportunities to correct her account of events. During the investigation, she sought to shift blame onto Patient A.

The panel therefore determined that Miss Kilani's conduct fell seriously short of the standards of nursing care expected from a registered nurse and amounted to a breach of her fundamental duty of care, especially towards a vulnerable patient on HDU. Consequently, the panel determined that Miss Kilani's actions in charges 1, 2 and 3 were sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

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

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

The panel first considered whether any of the limbs of the Grant test were engaged as a result of Miss Kilani’s misconduct. The panel determined that her failing to monitor BP readings, inaccurate recordings and dishonesty placed Patient A at unwarranted risk of harm.

The panel determined that Miss Kilani’s misconduct constituted a serious breach of fundamental tenets of the nursing profession in that she failed to prioritise people, practise effectively, preserve safety, and promote professionalism and trust. It determined that Miss Kilani failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that limbs a, b, c and d of the Grant test are engaged in respect of Miss Kilani’s past conduct.

The panel next considered whether the limbs of the *Grant* test are engaged as to the future. In this regard, the panel considered the case of *Cohen v GMC* [2008] EWHC 581 (Admin) in which the Court addressed the issue of impairment with regard to the following three considerations:

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

b. *Has it in fact been remedied?*

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

The panel first considered whether Miss Kilani's misconduct is capable of being addressed. The panel was of the view that her misconduct with respect to failing to monitor Patient A's BP was attitudinal, but could be addressed through a process of insightful reflections and evidence of good practice.

However, in respect of Miss Kilani's dishonest conduct, the panel noted that the NMC Guidance sets out that dishonesty is generally difficult to address. The panel considered that whilst dishonesty can be difficult to address, there is a wide spectrum of dishonest behaviours and that the nature and extent of her dishonesty had to be considered with care. The panel determined that Miss Kilani's dishonesty was deep seated. The panel considered that Miss Kilani's dishonesty was a deliberate breach of the professional duty of candour as she attempted to misrepresent that she had accurately recorded Patient A's BP, when she had not. It noted that Miss Kilani's dishonesty was related to her clinical practice and posed a risk of harm Patient A, and that this was only brought to light as a result of another nurse escalating the missing readings. Miss Kilani's initial dishonesty occurred on one shift but over a period of nine hours, and consisted of a repeated decision not to monitor Patient A's BP and to inaccurately record false readings. When challenged by Ms Taylor, Miss Kilani's decision to deny this behaviour may have been spontaneous, but she continued with her dishonesty through the Trust's investigation despite many

opportunities to correct her account of events at the time and during the local investigation.

In light of this, the panel was not satisfied that any of the concerns had been remediated or that Miss Kilani has strengthened her clinical nursing practice. Accordingly, the panel determined that there is a real risk of repetition.

The panel therefore concluded that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

Mr Earnshaw submitted that the NMC had advised Miss Kilani in the Notice of Hearing that it would seek the imposition of a Striking Off order if the panel found Miss Kilani's fitness to practise impaired.

Mr Earnshaw invited the panel to consider the Sanction Guidance (SG), and submitted that a striking off order is proportionate, fair and would adequately address the public protection and public interest concerns in this case.

Mr Earnshaw submitted that the aggravating features of this case include:

- Dishonesty;
- Risk of harm to Patient A;
- No relevant training, evidence of strengthening of practice or remorse; and
- Deliberate breaches of the Code.

Mr Earnshaw submitted the following mitigating feature has been identified:

- A brief apology to Patient A during the local investigation.

Mr Earnshaw submitted that a striking off order is the most appropriate and proportionate order. He submitted that in this case, a conditions of practice order would be inappropriate. He also submitted that if the panel were to impose a suspension order, this would not adequately protect the public, or serve the wider public interest in regard to this case.

Mr Earnshaw referred the panel to the NMC guidance, namely SAN-2d, and invited it to consider this when making its decision:

- *'A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour; and*
- *In cases where the only issue relates to the nurse, midwife or nursing associate's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions.'*

Mr Earnshaw submitted that this case does not involve an isolated incident of misconduct, and that Miss Kilani's dishonest actions related to the care of an elderly vulnerable patient on HDU, which aggravates the overall seriousness. He submitted there is a risk of repetition.

Mr Earnshaw submitted that there is evidence before the panel, as indicated by the charges found proved of a deep-seated attitudinal problem, which would make a suspension order inappropriate.

Mr Earnshaw submitted that the most appropriate sanction would be that of a striking off order. He referred the panel to the NMC guidance.

Mr Earnshaw submitted that the charges found proved have raised serious concerns and questions in relation to Miss Kilani's professionalism. He reminded the panel of its decision on the facts, where it found proved that Miss Kilani falsified BP readings, and was dishonest about this. He submitted that this raises fundamental questions around Miss Kilani's professionalism as a nurse.

Mr Earnshaw submitted that the public's confidence would not be maintained if Miss Kilani were not struck off the register. He submitted that a striking off order is the only order that would sufficiently protect the patients, members of the public and maintain professional standards.

Mr Earnshaw submitted that it is for the panel to impose whatever order it deems most appropriate, having considered all of the evidence from the NMC.

Mr Earnshaw, in light of the panel's findings thus far, submitted that the appropriate order in this case is a striking-off order. He invited the panel to do so.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

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

Having found Miss Kilani's fitness to practise currently impaired, the panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG, including SAN-3 and SAN-4 *(Deciding between suspension and strike off* – last updated 28/01/2026, and *Sanctions for the highest risk cases* – last updated: 31/07/2026).

The panel took into account the following aggravating factors:

- Miss Kilani's actions created a misleading impression of Patient A's clinical condition, who was in HDU, thereby putting the patient at a significant risk of harm;
- Deliberate breaches of the Code;
- Dishonesty, which occurred over a period of nine hours, during one shift;
- Dishonest accounts maintained during the local investigation to misrepresent her actions; and

- Absence of insight, strengthening of practice, remorse and lack of meaningful engagement in this Fitness to Practise process.

The panel could not identify any mitigating features in this case.

The decision on sanction is a matter for the panel independently exercising its own judgement.
The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case, and the risk to patients and public safety. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

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

The panel considered that Miss Kilani's actions were not at the lower end of the spectrum, and it found that there is a risk of repetition, and therefore a risk to patient and public safety. It therefore determined that a sanction that does not restrict Miss Kilani's practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on Miss Kilani's registration. In considering whether conditions of practice are appropriate, the panel had

regard to the factors set out in the NMC Guidance on '*Conditions of practice order*' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel noted that conditions of practice usually relate to clinical concerns, and not to deep-seated attitudinal issues. The panel bore in mind that it had earlier identified deep-seated attitudinal concerns in this case, including dishonesty on Miss Kilani's part that was directly related to the care of a vulnerable patient. It was of the view that these deep-seated attitudinal concerns are difficult to remediate. The panel was not satisfied, in the absence of any meaningful engagement from Miss Kilani, that there was any evidence to demonstrate that Miss Kilani would comply with any conditions of practice imposed.

The panel considered the seriousness of the concerns, the deep seated attitudinal issues and Miss Kilani's lack of insight into the severity and the potential impact of her actions on the public and the nursing profession. It determined that there were no relevant, proportionate, workable and measurable conditions that could be formulated to address the risk of repetition and risk of harm to patients. Consequently, the panel determined that a conditions of practice order would not protect the public nor be in the public interest.

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

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

The panel also noted the following non-exhaustive list of circumstances that may make a suspension order an appropriate sanction:

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

The panel noted that this was not a single instance of dishonesty, but rather a sustained pattern over a shift, and during the local investigation. It had found that Miss Kilani failed to demonstrate insight into the severity and the potential impact of her actions on Patient A, the public and the nursing profession. Although there is no evidence of repetition of the concerns since the incident, the panel had found that Miss Kilani's actions are suggestive of deep-seated attitudinal concerns which heightens the risk of repetition.

The panel also considered NMC Guidance, specifically SAN-3 *'Deciding between suspension and strike off'* (Last updated 28/01/2026):

- *'Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*

- *Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

Miss Kilani has not demonstrated any insight or evidence that she has already or is willing to address the concerns. Furthermore, she has not meaningfully engaged with her Fitness to Practise proceedings. Accordingly, the panel determined that a period of suspension would not be a sufficient, appropriate or proportionate sanction. It would neither protect the public nor satisfy the public interest consideration in this case.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 31/07/2026), and determined that this case falls within the definition of being a '*highest risk case'*.

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

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

The panel was in no doubt that the charges found proved raise fundamental questions about Miss Kilani's professionalism. The panel concluded that the serious breach of

fundamental tenets of the profession, evidenced by Miss Kilani's actions and dishonest conduct, together with the absolute absence of insight on her part, is fundamentally incompatible with Miss Kilani remaining on the register. The panel considered Miss Kilani's insight and attitude to addressing the concerns, and whether it would be realistically possible that these will change positively during a period of suspension. The panel concluded that there is no realistic possibility in light of the information before it. The panel was satisfied that to allow Miss Kilani to continue practising would undermine public confidence in the nursing profession and in the NMC as a regulatory body.
Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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

This will be confirmed to Miss Kilani in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Kilani's own interests until the striking-off sanction takes effect.

Submissions on interim order

Mr Earnshaw invited the panel to impose an interim suspension order for a period of 18 months. He submitted that an interim suspension order for a period of 18 months is

necessary given the panel's findings in order to protect the public and meet the wider public interest. Further, he submitted that this was required to cover the 28-day appeal period and, if Miss Kilani wishes to appeal the decision, the period for which it may take for that appeal to be heard.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

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

That concludes this determination.