

**Nursing Council of Hong Kong**  
**Disciplinary Inquiry**  
**Nurses Registration Ordinance (Cap. 164)**  
**No.: NC 3201/7/B**

Date of Hearing: 26 January 2026

Defendant: Ms A

**DECISION**

1. Ms A is an enrolled nurse of enrolment no. [REDACTED].
2. A disciplinary inquiry is held against Ms A by reason of a complaint received by the Council alleging that Ms A was guilty of unprofessional conduct. The particulars of the complaint, as set out in the Notice of Inquiry, are that:

*“during the hospitalisation of Madam X (‘the Patient’) at St Paul’s Hospital, on 7 October 2020, [Ms A], being an enrolled nurse:*

- i) failed to ensure individual safety in the course of practice in that [she] wrongfully administered to the Patient medications that were prescribed for another patient; and/or*
  - ii) failed to ensure that the standard of practice is congruent with the standards of the profession in that [she] failed to verify the Patient’s identity in accordance with the principles of ‘Five Rights’ before administering medications.”*
3. Ms A has been an enrolled nurse since 15 May 1987. She admits the substance of the complaint at the stage of preliminary investigation and also before this Council at the outset of the inquiry. Be that as it may, the Council shall set out

the brief background facts to make the reasons for its decision on sentencing more understandable.

### **Background Facts**

4. On 16 September 2020, the Patient, aged 98 years, attended St Paul's Hospital ("**the Hospital**")'s outpatient department because of shortness of breath, worsening general condition and incoherent speech for a few days. She was admitted to the Hospital under the care of visiting cardiologist Dr. B ("**Dr B**"). Preliminary diagnoses included atrial fibrillation and congestive heart failure.
5. On 7 October 2020, the Patient was staying in bed 1507D of the Hospital. There were 3 other beds in the same room of 1507, one of which was bed 1507B. A patient was assigned bed 1507B on that day.
6. At around 09:13 hours that day, Ms A and a registered nurse ("**the RN**") wheeled a drug trolley into Room 1507 and checked the medications for the patient of bed 1507B. There was a checking of this patient's identity at that point of time.
7. However, the medications, involving tablets, required crushing for the patient's intake. According to Ms A, the tool for crushing the medicine was not on the drug trolley or nearby. It was placed quite far away from Room 1507.
8. After crushing, but before the patient of bed 1507B was given the crushed tablets, Ms A accompanied a doctor to go to another part of the ward to examine that doctor's patient(s). Ms A said the crushed tablets were put onto the trolley in a cup, and the cup was attached to the patient file of bed 1507B. The whole trolley was then wheeled back to the ward's nurse station.
9. At around 09:39 hours, Ms A finished the work of accompanying that doctor and returned to the nurse station. She noted the medications she handled earlier was

still on the drug trolley. Under the impression that she had already checked the identity of the patient against those medications, she did not check again. Although the cup containing the medications was actually attached to the patient file of bed 1507B, the Patient (1507D)'s file was also, at that time, placed on the same trolley. Being confused, Ms A took the medications prescribed for the 1507B patient to the Patient's bed, and gave them to her son.

10. The Patient took those medications. The mistake was discovered shortly afterward as the RN asked another nurse to countercheck the medications for the Patient (1507D). When those medications were handed to the Patient's son, which was just around 15 minutes after Ms A's handing of the incorrect medications to him, the son queried why the Patient was given two batches of medications within such a short timespan. The RN and Ms A were then informed of the situation.
11. According to Ms A, she admitted the mistake once she learnt about the son's query. Dr B was swiftly informed of the incident. The Hospital also informed the Patient's family members of the same. The Patient was transferred to the Intensive Care Unit of the Hospital later the same day.
12. The Patient was certified dead on 30 October 2020. A death inquest was held in 2023, in which Ms A, the Patient's son, Dr B, other nurses of the Hospital (including the RN), the doctor preparing the Patient's autopsy report and an expert witness gave evidence before a Coroner and a jury. The jury held that the Patient had a natural cause of death. Medical evidence available in the inquest showed that the medications wrongly administered by Ms A had reduced the Patient's blood pressure and heart beat rate, but the effect lasted until at most 17 October 2020. The mistaken intake of medications on 7 October 2020 did not cause the death of the Patient on 30 October 2020.

13. Be that as it may, with Ms A's admission of the facts alleged, this Council finds the situation plainly constituting an "unprofessional conduct" under section 17(1)(b) of the Nurses Registration Ordinance ("NRO"). The conduct was a clear departure from the professional standard expected of an enrolled nurse. The charge in the Notice of Inquiry is proved, such that the Council may, in its discretion, make an order under that provision to suitably reflect the seriousness of the incident.

### **Mitigation and Sentencing**

14. The Council has heard Ms A's oral submissions in mitigation. The Council has also considered the documents from the said death inquest (including, amongst others, the verdict and the transcript of proceedings), the Hospital's written explanations and Ms A's written explanations and reference letters.
15. The Council takes into account the following factors:
  - (a) Ms A did not have any prior disciplinary record. She had a long unblemished career since 1987 until the subject incident in 2020;
  - (b) The Council can feel Ms A's true remorse from her letters and performance in the inquiry. She honestly and promptly admitted her mistake. The Council accepts that Ms A committed a serious mistake, but it was not because she did not treat her work seriously. The incident arose from a momentary neglect or misjudgement;
  - (c) Ms A has also genuinely reflected on why she committed the mistake and how to avoid it. The Council takes note of Ms A's suggestion that, systemically, a nurse discharging drug administration duties should wear a specific gown to inform other persons that he or she should not be bothered during such duties. With hindsight, Ms A said she should not

leave such duties in the middle to take care of other matters, even though those other matters might also be important; and

(d) Shortly after the incident, Ms A resigned from her role in the Hospital, a place she had worked for long time. She stopped any nursing work for around half a year, and later took up an employment in an elderly home. She disclosed her mistake to her current employer and was still given the chance to continue her care for the elderly. There is no information suggesting that she has committed further mistake since the incident.

16. Having heard Ms A's description of what happened on the day of the incident, the Council considers her workflow very problematic.
17. First, Ms A (and in fact also the RN) should not separate the process matching the patient to the medications from the process of actually handing the medications to the patient, and she should not handle other duties in between. Secondly, according to the evidence, the drug trolley was wheeled back to the nurse station by the RN while Ms A was away, and apparently the crushed tablets were left in a cup on the trolley unattended and unlocked in the nurse station before Ms A came back to the nurse station. The Council finds such practice unacceptable. Thirdly, before Ms A took the medications to the Patient's son, she should appreciate that the checking had been conducted a while ago already. She should redo the checking process to ensure that there was no mistake. In fact, these were exactly the recommendations made by the jury of the death inquest.
18. In these circumstances, despite the existence of some mitigating factors, the Council considers it appropriate to make an order removing Ms A from the roll of enrolled nurses for a specified period of time under section 17(1)(e)(ii) of NRO. To safeguard professionalism and patients' interest, the Council considers

a reprimand not sufficient to reflect the seriousness of the unprofessional conduct in this case.

19. Having compared with similar cases (such as NC 485/7/B and NC 371/1/B, the judgments of which are available on the Council's website), the Council adopts a starting point of 3 months' removal from the roll. On discretion, the Council reduces the period of removal to 2 months in view of Ms A's genuine remorse, honest admission of mistake and passion to the nursing profession.
20. The order of removal shall be published in the Gazette as per the legal requirement under section 17(6) of NRO. Moreover, the Council decides that an account of the proceedings at the inquiry should be published together with the order in the Gazette. The account should contain sufficient particulars to acquaint the public with the nature of the unprofessional conduct to which the order relates.
21. The Council orally announced its order right after the hearing on 26 January 2026 with reasons reserved. A copy of these reasons for decision is served together with a copy of the order under section 21(1) of NRO. The appeal period under section 22(3)(c) will only start to run after the service of a copy of the order together with these reasons.

Professor Agnes TIWARI

Chairman, Nursing Council of Hong Kong