hcpts
health & care professions tribunal service

The fitness to practise adjudication service of the Health and Care Professions Council.

Investigating Committee Panel
NOTICE OF DECISION

Case Reference:	FTP.87277 [redacted]
Registrant:	Paul Aitken-Fell
	Paramedic
	PA21672
Date of Meeting:	8th September 2026

Tribunal:	
Panel Chair:	Miss Janette Brewer
Registrant Panellist:	Mr John McKenzie
Lay Panellist:	Mr Duncan Tilley

DECISION

The decision of the Health and Care Professions Tribunal, sitting as a Panel of the HCPC Investigating Committee, is that:

The Registrant has no case to answer, reasons as below.

Allegation (as put before the Registrant by the HCPC)

As a registered Paramedic (PA21672):

1. On or around 27 March 2019 you amended an investigation report in that you:

a. removed any and/or all the words set out in Schedule A
b. amended the conclusion as set out in Schedule B

2. Your conduct at Particular 1 was dishonest because you deliberately sought to conceal relevant information

3. Your conduct at Particular 1 and/or 2 breached your professional duty of candour

4. The matters set out in Particulars 1, 2 and/or 3 above constitute misconduct

5. By reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct.

Schedule A

"The only recorded ECG activity lasts for a total of 16 seconds (19:36:05-19:36:21) and on review does not indicate a reading of Asystole. It does indicate significant disturbance throughout with no rhythm recognition (Appendix 6 & 7)."

"There are additional concerns in that no efforts were made to clear the patient's airway, that Basic Life Support was not continued and Advanced Life Support was not attempted."

"Retrieval of this activity on the Zoll does not confirm this."

"When asked by the attending crew who were to remain with the patient, GW advised there had been a fault with the ZOLL printer."

"Subsequently GW has confirmed that on reflection he should have provided Advanced Life Support at this incident."

Schedule B

Original conclusion:

"In conclusion, in relation to this incident, the Investigating Officer has established that local procedures and JRCALC Guidelines with regards to Recognition of Life Extinct have not been applied correctly. Equally, the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard. Given the circumstances, recorded and explained by all who attended, Advanced Life Support could and should have been provided.

It is the Investigating Officer's recommendation that separate consideration as to all contributory factors involved in the decision-making at this Incident is taken into account in order to address the concerns"

Amended conclusion:

"In conclusion, in relation to this incident, the Investigating Officer has established that local procedures and JRCALC Guidelines with regards to Recognition of Life Extinct have not been applied correctly. However the decision not to start ALS upon reflection was the correct decision, the patient had fixed and dilated pupils, had absent pulses and purple ligature markings around the neck and CPR with ALS would not have had a positive outcome. It was found however during the investigation that the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard and further training is required to ensure these issues are addressed."

Reasons

1. In reaching its decision, the Panel carefully considered all of the documents provided by the HCPC and the Registrant.

2. The Panel was satisfied that the Registrant has received the Allegation and bundle of documents in support, and has had an opportunity to consider and comment upon the material before the Panel.

3. The Panel noted that at the relevant time the Registrant was employed as a Lead Consultant Paramedic at North East Ambulance Service (NEAS) NHS Foundation Trust (the Trust).

4. The documents provided by the HCPC included, but were not limited to, the referral from Person A dated 16 May 2023; [redacted]; witness statements and exhibits from Alan Potts; NEAS independent review report together with documentation from NEAS; independent report compiled by Rachel Birks; Independent Review of the Management of NEAS Coroner's Cases conducted by Nicola Richardson; correspondence regarding the Public Enquiry conducted by Dame Marianne Griffiths; and correspondence between the parties.

5. The Registrant, via his representative, provided the Panel with submissions together with appendices in response to the Allegation which the Panel has considered carefully.

6. [redacted]

[redacted]

Facts

7. The Panel first considered whether there is a realistic prospect that the HCPC, which has the burden of persuasion in respect of the facts alleged, would be able to prove those facts.

8. The Panel noted that in deciding whether there is a case to answer, it is required to apply the test as to whether there is a realistic prospect that the HCPC will be able to establish, at a final hearing, that the Registrant's fitness to practise is impaired. The test does not call for substantial enquiry, and nor does the Panel have to be satisfied on the balance of probabilities.

9. In reaching its decision the Panel noted that it is bound to have regard to the relevant HCPC standards and guidance, and the Panel also recognised that this is a paper-based exercise and thus it is a limited one.

10. The Panel noted that it is not able to make findings of fact. The Panel has, however, assessed the overall weight of the evidence provided to it and considered the Allegation as a whole.

11. The Panel noted that the Registrant admits the facts of Particular 1, but denies the remainder of the Allegation.

12. In relation to Particular 1 the Panel noted the admission made by the Registrant to the HCPC in response to the Allegation, together with the material provided by the HCPC as outlined above. The Panel considered that there is sufficient information to support Particular 1, and concluded that there is a realistic prospect that the HCPC may prove the facts of Particular 1 before a future substantive hearing.

13. In relation to Particular 2, the Panel noted that this Particular avers that the Registrant acted dishonestly in relation to his conduct at Particular 1.

14. The Panel noted the manner in which dishonesty is alleged, namely that the Registrant deliberately sought to conceal relevant information by his actions, albeit it noted that it is not clear from whom the relevant information was to be concealed or what that relevant information was.

15. The Panel directed itself to the test for dishonesty set out in the case of Ivey v Genting Casinos [2017] UKSC 67. It noted that it has to determine firstly the Registrant's state of mind, and his knowledge or belief as to the facts, and

secondly to determine whether the Registrant's conduct was dishonest by the standards of ordinary decent people. The Panel reminded itself that there is no requirement that the Registrant's belief must be reasonable, the question is whether it is genuinely held. It also noted that there is no requirement that the Registrant should appreciate that what he is alleged to have done is dishonest by the standards of ordinary decent people. The Panel recognised that dishonesty may take the form of an act or an omission, and that it is possible to conceal or to seek to conceal a fact by an omission to disclose that fact.

16. The Panel carefully considered the manner in which dishonesty has been averred in this case. It noted that it is suggested that the Registrant acted as one of a number who decided to amend a report concerning a colleague's actions on that colleague's attendance at the scene of a traumatic death.

17. The Panel noted that the report that was amended was authored by another individual. That other individual reached a conclusion which was not accepted in its totality by a senior management group which scrutinised the original report.

18. The Panel noted that the Registrant appears to have been requested to amend the report by the Medical Director of the Trust. Coincidentally, the Registrant agreed with the suggested amendment to the report. The Registrant amended the report, as he has admitted, with the knowledge of the original author and in accordance with the instructions of the Medical Director of the Trust.

19. Having carefully considered the material before it, the Panel considered that, at the relevant time, it was the genuine belief of the Registrant that to make an amendment to the report was a reasonable and proper thing to do, however unreasonable that belief may appear to have been with the benefit of hindsight.

20. The Panel also noted that the Registrant did not act autonomously in reaching the decision to amend the document, but rather it was the joint decision of a senior management group to do so. The Panel was not persuaded that the Registrant could or should be held solely accountable for the joint decision of himself and other senior personnel within the Trust.

21. The Panel was not persuaded that, in the circumstances of this case, ordinary decent people would consider the conduct of the Registrant to be dishonest because he was not acting in isolation, but made the amendment in accordance with a group decision of senior management and at the request of the Medical Director of the Turust.

22. The Panel concluded that there is not a realistic prospect that the HCPC may prove the fact of dishonesty in relation to the Regisstant's conduct in Particular 1.

23. In relation to Particular 3, the Panel carefully considered the Registrant's professional duty of candour, and noted that a Registrant is required to be open, honest and candid when something has gone wrong with the care, treatment or other services that he or she provides. Having carefully considered the factual matrix upon which this Allegation is based, the Panel was not persuaded that it has been provided with sufficient information to support the suggestion that the Registrant has, himself, failed to act with the required candour expected of him.

24. The Panel noted that the papers furnished to it may refer to a number of potential systemic failures within the Trust. However, it noted that it is not required to consider those matters. The Panel, having directed itself solely to the alleged conduct of the Registrant, concluded that there is not a realistic prospect that the HCPC may prove the facts of Particular 3 before a future substantive panel.

25. After reviewing all the information provided by the HCPC and the Registrant, the Panel has concluded that there is a realistic prospect of proving the facts of Particular 1 of the Allegation, but that there is not a realistic prospect of proving the facts of Particulars 2 and 3.

Statutory Grounds

26. Having found a realistic prospect in respect of those facts, the Panel went on to consider whether the facts alleged, if proven, would amount to the statutory ground of misconduct.

27. The Panel noted that following a strategy group meeting, and a group decision of senior figures within NEAS, the Registrant is alleged to have amended an investigation report to redact some words and to amend the conclusion when requested to do so by the Medical Director of the Trust. The panel noted that those amendments did not suggest that the Trust was absolved of any responsibility for any failures that may be deemed to have occurred, and recognised that there were learning and training opportunities as a result of the factual matrix leading to the amended report.

28. Ground of misconduct: The Panel considered that the alleged conduct of the Registrant appeared to be part of a more comprehensive review that may have raised serious questions about the manner in which the Trust for whom the Registrant was working at the relevant time, had conducted a number of investigations into alleged failures of patient safety and governance.

29. Having carefully considered the conduct of the Registrant, and the circumstances in which he was requested to amend the report by a senior management group, the Panel considered that the Registrant may have, inadvertently, become involved in

some wider institutional attitudinal problems/failures.

30. However, the Panel noted that the Registrant was acting upon a request made to him by senior management to amend a report, in circumstances in which the original author of the report was made aware of the suggested amendments and permitted the amendments to be made. The decision to amend the original report rather than to prepare an addendum or supplemental document may have been misjudged and/or ill-conceived, however the Panel noted that the material appears to demonstrate that that decision was not the decision of the Registrant alone, but was a decision by a group, which included the Registrant but also included a number of more senior figures within the organisation.

31. In the circumstances, and having carefully considered the test for misconduct, the Panel was not persuaded that the conduct of the Registrant amounted to an act which departs significantly from what would be proper in the circumstances, or conduct that a fellow practitioner would consider to be deplorable. The Panel concluded there is not a realistic prospect that Particular 1 could amount to misconduct.

Impairment

32. Given the decision set out above, the Panel was not required to consider impairment.

33. Taking account of the Allegation as a whole, the Panel concluded that there is not a realistic prospect of establishing that the Registrant's fitness to practise is impaired.

3 YEAR RULE

In accordance with Rule 4(6) and (7) of the Health and Care Professions Council (Investigating Committee) (Procedure) Rules 2003, the Registrant is given notice that, if within three years of this decision, another Allegation is made against the Registrant, these concern/s may be taken into account and relevant documentation may be provided to the Investigating Committee Panel as part of the bundle. In those circumstances the ICP can decide if, in light of the new Allegation, there is then also a case to answer in respect of this concern. If the ICP decide there is no case to answer in respect of this concern, it will remain closed and will not be referred to a final hearing.

Signed: Jan Brewer Panel Chair

Date**:** **8 September 2026**