**IN THE POLICE MISCONDUCT HEARING**

PURSUANT TO THE POLICE (CONDUCT) REGULATIONS 2020 (AS AMENDED BY THE POLICE (CONDUCT) (AMENDMENT) REGULATIONS 2024

IN THE MATTER OF:

PC NASSAR KHAN
And
OFFICER A

DECISION OF THE PANEL

Commander Dominic Murphy (Chair), Mrs Rachel O'Connell (Independent Panel Member) and Ms Placida Ojinnaka (Independent Panel Member).

## INTRODUCTION

The misconduct hearing for PC Nassar Khan (The Officer) was held in public between 02-06 February 2026 at Palestra House, London. A notice of hearing was published in accordance with the Police (Conduct) Regulations 2020 ("the 2020 Regulations"). This was originally a hearing conducted for two officers, but a successful application for an adjournment on medical grounds was accepted for Officer A on the first day of the hearing.

## THE ALLEGATIONS

The Panel was referred to a Regulation 30 notice in respect of the Officer containing the allegations and that his conduct amounted to gross misconduct. The allegations were amended, following an application made on behalf of the Appropriate Authority, which was unopposed. The amended allegations are set out below. It was agreed that Allegation 4 solely related to Officer A and should not apply to PC Khan. The allegations are as follows:

Being members of the Metropolitan Police Service

Allegation 1

1. You both having attended on duty together at [REDACTED] on 13th March 2024 at around 1649 hours:

a. You both were informed of allegations that nurses on duty had witnessed Person B on the night of 12th/13th March 2024 improperly interfering with the ventilatory support system of a patient in the hospital, namely Person A, she being the then partner of Person A, she being in the [REDACTED] on life support at the time, and/or

b. You both were informed of allegations being made of domestic violence by Person B towards Person A, and/or

c. You both were informed of an allegation of Person B having caused criminal damage to Person A's mobile phone thus making it more difficult for her to have contact with other members of her family, and/or

d. You both were informed of an allegation that Person A had attempted to leave her partner Person B but had stayed with him following threats to her family

2. Having been provided with the above information in paragraph 1 above, in relation to those allegations, you both failed, whilst at the hospital and before leaving that location;

a. To conduct any and/or sufficient enquiries, and/or

b. To take statements from witnesses, and/or

c. To complete any and/or sufficient paperwork, including but not limited to:

i. Domestic Reports, and/or

ii. Crime Reports, and/or

iii. PNC checks, and/or

iv. Safeguarding reports, and/or

d. To secure any evidence, and/or

e. To take any and/or sufficient steps to safeguard Person A, and/or

f. To take any and/or sufficient steps to safeguard Person A's family members, and/or

g. To arrest the suspect Person B, and/or

h. To make contact with your supervisor to confirm your actions were appropriate, and/or

i. To appreciate the seriousness and/or gravity of the allegations being made

Allegation 2

1. Having returned to the police station on 13th March 2024 at around 1750 hours you both informed your supervisor PS Meletiou that you both had been informed of a domestic violence allegation whilst at the [REDACTED] that day but

a. that it did not need immediate attention and/or

b. was not urgent

2. You both failed to provide any and/or a complete and/or an accurate account of what had occurred at the [REDACTED] in that:

a. The information you both provided to PS Meletiou as to immediacy of attention and/or urgency was not correct and/or appropriate, and/or

b. You both should have but did not inform PS Meletiou that Person A's father and Person B were both present at the hospital when you both attended earlier that day at the hospital, and/or

c. You both should have but did not inform PS Meletiou of the details and/or sufficient details of the account given by Person C of allegations of domestic violence being made by Person D.

Allegation 3

1. Shortly before 1930 hours on 13th March 2024 you both were given directions by PS Meletiou, in relation to the allegations that had made to you both that day at the [REDACTED]:

a. To call the domestic violence unit to inform them of the allegations being made, and/or

b. To return to the [REDACTED] to obtain accounts from the nurses and/or from the family members who might be present there, and/or

c. To contact Essex Police to inform them of the allegations said to have occurred in Essex Police area and/or to ensure safeguarding by Essex Police of the family members, and/or

d. To check parties and addresses involved in the allegations, and/or

e. To carry out intelligence checks through the IIP system and/or the PNC system in relation to the allegations being made, and/or

f. To report back to PS Meletiou with the results of your enquiries

2. You both failed to undertake and/or undertake in a timely and/or complete and/or sufficient manner the above directions by 2045 hours that day.

Breaches of Standards

1. By reason of the matter above, either individually or cumulatively, your behaviour did not meet the standards required by the Standards of Professional Behaviour set out in Schedule 2 to the Police (Conduct) Regulations 2020 as to Duties and Responsibilities, in that you were not diligent in the exercise of your duties and responsibilities.

2. Your behaviour amounts to gross misconduct.

## REPRESENTATION

The Appropriate Authority ("the AA") was represented by Richard Milne of counsel. PC Khan was represented by Guy Ladenburg of counsel and Officer A was represented by Ailsa Williamson of counsel.

The Panel thanks the representatives for their assistance throughout the case, including the provision of the AA's opening note.

The Panel was assisted by Maurice Cohen, Legally Qualified Adviser.

## REGULATION 30 NOTICE

On the first morning of the hearing the Regulation 30 Notice, as set out above, was read out, by AA counsel and entered into evidence.

In his Regulation 31 response, PC Khan admitted that the standards of professional behaviour were breached in the majority of the three remaining allegations, but at the level of misconduct rather than gross misconduct.

## THE PANEL'S APPROACH

The Panel reminded itself it was: -

a. Required to consider the facts of the case and to make its findings of fact in relation to the allegations;
b. To determine whether those findings of fact found constitute a breach of the relevant standards;
c. To determine whether the conduct found proven against the Complainant amounted to misconduct or gross misconduct.

The Panel reminded itself that the burden of proof is on the AA throughout and the standard of proof is the balance of probabilities, namely 'what is more likely than not'.

The Panel approached its decision-making by keeping in mind the purpose of police misconduct proceedings. The primary purpose is not to punish the officer but to protect public confidence in, and the reputation of, the police service by holding officers accountable and making clear that improper behaviour will not be left unchecked. A second purpose is to declare high professional standards and the third purpose is to protect the public, which includes fellow officers and police staff, by preventing similar misconduct recurring in the future.

The Panel had regard to Bolton v Law Society [1993] EWCA Civ 32; Chief Constable of Dorset v PAT, Salter Interested Party [2011] EWHC 3366 (Admin) and R (Williams) v PAT [2016] EWHC 2708 (Admin).

The Panel also had regard to the following regulations and guidance:

a. The Police (Conduct) Regulations 2020 (amended) (the "Regulations"), including the Standards of Professional Behaviour at Schedule 2;
b. Home Office Guidance: Police Officer Misconduct… (2018) ("HOG"), including Chapter 1, Guidance on Standards of Professional Behaviour;
c. The definition of misconduct given at regulation 2(1) of the Regulations: "a breach of the Standards of Professional Behaviour that is so serious as to justify disciplinary action";

d. The definition of gross misconduct given at regulation 2(1) of the Regulations: “a breach of the Standards of Professional Behaviour that is so serious to justify dismissal”; and
e. The College of Policing Guidance on outcomes in police misconduct proceedings (2023).

The Panel listened carefully to the oral evidence and carefully considered all other evidence before it. It considered the totality of the evidence and submissions made. The Panel does not propose to deal with each and every aspect of the evidence or submissions made but states its main conclusions. The Panel heard submissions from both parties and received legal advice from the Legally Qualified Advisor.

## EVIDENCE

The Panel was provided with the following documents:

Regulation 30 Bundle, comprising, inter alia, the Regulation 30 allegations, IO’s Report, PC Khan’s Regulation 31 response, officer’s witness statement, Officer A’s witness statement and interview record; witness statements of PS Meletiou (x2); DS Darren Warner (x2); Nurse 1; Nurse 2 and Nurse 3; policy documents; CAD report; misconduct interview under caution. The Panel were additionally provided with PC Khan’s HR training records; ciphers for named persons; digital material comprising Body worn video (BWV) footage and a character bundle.

## THE BACKGROUND

PC Khan grew up on a rough estate in Walthamstow, where there were problems with gang violence and drugs. He expressed a desire to take a different path in his life and he became a police cadet when young and subsequently a Special Constable, a position he held for approximately 2 years from 2017 during which he undertook approximately 2000 hours of voluntary work in this capacity. He did this with a view to becoming a police constable and was duly appointed in 2020. He undertook the appropriate training, although shortened due to Covid restrictions and was mainly online. He was initially attached to the safer neighbourhood team and then

permanently posted to the response team at Havering. He completed his probation in 2022.

On 13 March 2024, Officer A and PC Khan were crewed together since they were both fasting due to Ramadan. Their shift started at 1400 hours. No supervisor was present at their duty parade so an experienced PC assigned their duties and crewed them together, conscious of the need for both to break fast and pray at sunset. They initially undertook patrol duties in a police vehicle.

At 16:06 a CAD was created in respect of an incident at [REDACTED] following a call from nurses at the hospital. The incident was assigned to PC Khan and Officer A at 16:26 hours. A CAD is a command and control system that records calls from the public and assignments for response officers.

The CAD indicated that information had been received in respect of a patient at the hospital, Person A, whose partner Person B, was accused of causing domestic violence against her. Person A had a brain injury and was about to die. The report suggested that Person B had knocked Person A's breathing tube out twice when he had been left on his own with her. Person B is reported to have said that he had taken life insurance out in respect of Person A. [REDACTED] Possible safeguarding issues relating to four children were noted by the caller to police.

The officers subsequently attended the hospital. Person A was on life support. They met with a number of the nurses and some of the meeting was captured on the officers' BWV. The very start of their discussion may not have been. The officers were informed by nurses that the patient's partner had been in her room when he knocked her [REDACTED] from her on 2 occasions during the previous evening. Person A's father (known as Person C) informed the officers that Person B was said by her child, Person D, to have assaulted Person A, by punching her to the face/head a number of weeks previously, causing her to bleed from the ear. He was additionally accused of having smashed her mobile phone, preventing her from having any contact with family and friends. As well as interviewing the nurses about these matters, the officers learned that Person C was present at the hospital and they undertook a short interview with

him, also captured on BWV. He provided evidence concerning the previous assault and property damage.

Having spoken to Person C, the officers returned to their base at East Area BCU, being Jack Brown House, Havering. Upon returning they reported to the Sergeant that assumed responsibility for the area at short notice, PS Meletiou. They are said to have returned at approximately 17:50 when they asked PS Meletiou if they could take a break in order to break their Ramadan fast and pray. She consented to the same. PS Meletiou indicated that as an afterthought, PC Khan, advised her that they would speak to her later about a domestic violence incident which did not require her immediate attention. At approximately 19:15 hours, over one hour later, the officers returned to her and provided details concerning the CAD and reports that they had taken at the hospital. She read the CAD herself. She advised the officers that she was unhappy with their lack of action, particularly noting the safeguarding issues arising from the report. She told them to call the P.P (Public Protection - domestic violence unit) straight away. She additionally advised them to call Essex police to make them aware of allegations arising relating to their area and undertake appropriate checks.

PC Khan did not speak to and was not present when Officer A subsequently spoke to DS Darren Warner from PP, who was deeply unhappy in respect of the officer's lack of action at the hospital and ordered them to remain at the hospital and take witness statements. He was clearly not aware they had left, it being standard practice in such scenarios for officers to call a supervisor before leaving such an incident. DS Warner subsequently telephoned PS Meletiou in order to ensure that the officers conducted enquiries as directed as he felt that Officer A had appeared reluctant to do so. He advised Officer A has briefed him that the suspect, Person B and father, Person C remained at the hospital, facts of which she had not been appraised.

PS Meletiou later spoke again with DS Warner and advised him that Person B had been accused of having tampered with Person A's ventilator tubing, which he had not been appraised of. She and DS Warner separately advised Inspector Leeke of all matters and he agreed that Person B needed to be arrested for GBH as well as any other offences that were apparent. The officers were directed and subsequently conducted this arrest.

In a 2nd witness statement, PS Meletiou indicated that she had to ask the officers very intrusive questions in order to get full details of the incident. They appeared to have only undertaken cursory enquiries and failed to appreciate the seriousness of the incident and potential risks arising therefrom. They failed to take appropriate actions. Officer A indicated that he failed to appraise DS Warner some of the pertinent details from the CAD, he indicated that it was because DS Warner was firing questions at him and he became confused and forgot. Neither officer told her that the suspect had been on the scene the whole time that they were at the hospital. She was advised of this the first time by DS Warner.

PS Meletiou tellingly, states “in my opinion, the officers had no idea what they were doing at the hospital and did not understand any direction given by me or DS Warner, even though they were simple instructions to follow and this would not be the first serious DV they would have been to as ERPT police officers”.

In his witness statement, DS Warner recounts his knowledge of and involvement in the incident. He indicates that he was the Detective Sergeant for safeguarding covering the London Borough of Havering on the day of the incident. He indicates that on learning of the risks presented at the hospital that he contacted Inspector Leeke, advised him of concerns. The officers were reassigned to the hospital to safeguard the victim and her family and preserve the scene and locate the suspect if he was still present. DS Warner attended the hospital himself and spoke with numerous people whilst there.

A later statement was prepared by one of the nurses, Nurse 1, she indicated that the ventilator tubing was disconnected but the endotracheal tube remained in place. This appeared to have been caused by accident when Person B tried to take the railing down to the bed without assistance. She responded to an alarm from the medical equipment and gasp from one of Person A’s friends who was also present in the room. Checks were made and there was no desaturation of Person A’s oxygen and the monitors were normal.

In his witness statement, PC Khan gave his account of events. He indicates that upon returning to the hospital that he arrested Person B for GBH, ABH and criminal damage.

A misconduct interview was conducted under caution on 7 August 2024. PC Khan denied breaching the standards of professional behaviour in respect of the allegations. He denied failing to submit a domestic report before being instructed to do so and suggested he had acted appropriately on information to protect someone from harm. He denied failing to carry out appropriate checks. He provided his account of the incident. He indicated that information provided to them was hearsay and he did not think that they can act upon it. He did not consider that Person A or any other family members were at risk. He indicated that when he was at the hospital the first time that he was told that the disconnection of the ventilator tubing was accidental. It was put to him that this could not be heard on the BWV at which juncture he indicated that he could not recall when he was told that. He stated that it was an accident connected with the (bed) railings being taken up and down. He reiterated that if the tube was knocked out, it was accidental.

PC Khan indicated that on the day he was working the late shift being from 2 PM to 11 PM. He acknowledged that he was advised of a hearsay account in respect of Person B being accused of assaulting Person A on the head causing her to bleed from the ear which emanated from a 13-year-old child, Person D. He made no attempt to contact Essex Police or the child at the time.

PC Khan indicated that he did not consider that there were any safeguarding concerns or risks at the time because it was in a hospital who had a safeguarding lead, their own security and a 24-hour watch with a nurse. If there were any safeguarding issues, he was sure that the hospital would have taken appropriate action. He was happy with his decisions and those of Officer A at the time.

In his Regulation 31 notice, PC Khan accepted that he failed to properly appreciate the seriousness of the situation, particularly in respect of the safeguarding of Person A and her children. He accepted that he should have contacted a supervisor and/or Domestic Violence Unit Supervisor from the hospital in order to receive advice as to the most appropriate course of action. Many of the alleged breaches flowed from this

failure. PC Khan accepted that he breached the standards of duties and responsibilities. With hindsight, PC Khan recognised that he failed to properly distinguish between an immediate need for safeguarding and evidence gathering measures on the one hand and the need for detailed secondary investigation in due course on the other.

PC Khan indicated that he had maintained his position in interview but, as a result of the misconduct proceedings, had since reflected on his conduct and in hindsight he now realised that he should have done much more than he did. He had learnt valuable lessons as a result of the misconduct proceedings. A number of admissions were made to the allegations, but at the level of misconduct, not gross misconduct.

**Evidence before the Panel**

PS Meletiou gave evidence before the Panel. The evidence was very much in accordance with her witness statements. She indicated that she was shocked by the fact that the officers did not call her or a Public Protection (PP) Sergeant from the hospital to seek further instructions. She felt that the officers very much downplayed the nature of the DV concerned in this case, when PC Khan mentioned it in passing with the implication that it was a non-violent DV. When she advised the officers of the appropriate actions they acted accordingly.

PC Khan indicated that he was a relatively junior officer. Officer A was more experienced than him. PC Khan recognised with hindsight that he should have done more at the hospital. He described himself as experiencing exhaustion and thirst which may have clouded his judgement a little bit. He denied that this impacted upon his work obligations and stated that he was not in a rush to leave the job in order to eat. Under questioning, PC Khan reflected that he felt that he missed out of the depth of training afforded to others as a result of his basic training being under Covid restrictions. He did not claim this related to any specific shortfall relating to Domestic Violence and safeguarding awareness.

PC Khan, in response to Panel questions and the initial detail contained in the CAD being quoted to him, clearly indicated that he recognised matters of some seriousness.

He could not recall if he had read them in detail or read them out to Officer A but acknowledged now that they did indicate a level of seriousness to the investigation. He stated that it had been categorised by the operator as “S” class meaning to be responded to within one hour rather than the highest grade of urgency which is “I” class being immediate.

**Half-time submissions**

Mr Ladenburg made submissions in respect of allegation 3 following the evidence of PC Meletiou having been given. He indicated that the evidence demonstrated that it could not be said that PC Khan had failed to undertake any of the actions set out in allegation 3 in the manner alleged. The evidence did not support the allegation being found and invited the Panel to dismiss allegation 3. He made reference to appropriate case law being **R v Galbraith [1981] 1 WLR 1039**. Mr Milne opposed the application. The Panel received legal advice.

The Panel had previously determined that allegation 3 (1) related to Officer A alone and did not apply to PC Khan. The Panel found that there was evidence to demonstrate that PC Khan (and Officer A) returned to [REDACTED] when instructed to do so by DS Warner in order to obtain accounts from the nurses and/or family members present there and therefore determined that there was no evidence to substantiate this allegation and therefore that there was no case to answer in respect of the same.

The Panel therefore found that there was no case to answer in respect of allegations 3 (1) a and b. It found that allegations 3 (1) c, d, e and f were supported by sufficient evidence such that a properly directed Panel could find the allegation proved and therefore refused the application to strike out these allegations.

**The Panel’s Analysis of the Evidence**

**PS Meletiou**

In respect of PS Meletiou, the Panel found that she had given measured, balanced and credible evidence. There was no indication that the Sergeant had any “agenda” against PC Khan. Her evidence was considered to be consistent with her previous statements. She indicated that she was genuinely shocked when she learned of the nature of the allegations made in respect of Person B relating to domestic violence which were not disclosed to her when the officers returned to the police base. She considered that the allegations were of some severity and that there were significant potential safeguarding risks. The officers should have telephoned her from the hospital and/or contacted a PP supervisor in order to obtain further instructions in respect of next steps. She further indicated that information and a full account appears not to have been disclosed either to her or to DS Warner and the full picture only emerged when they spoke with each other. She conceded that once she advised the officers of the steps that she expected from them, they started to undertake them. PC Khan’s investigations were interrupted following DS Warner’s orders for him and Officer A to return to the hospital, arrest Person B and undertake further investigations.

**PC Khan**

In respect of the evidence given by PC Khan, the Panel found that some elements of his account were unconvincing. He was unable to provide a logical or credible account of why he lacked sufficient insight at hospital on the evening of the incident. He was also unable to explain why, at his misconduct interview in August 2024, he was still not able to recognise his errors. This, despite his obvious failings having been identified by PC Meletiou and DS Warner at the time of the incident. It was clear from his evidence in the hearing that with more time to reflect, he now accepted that he had not grasped the significance of the of the incident at the time. He regretted that and informed the Panel that he now recognised what he had missed on the night. He did not seem able to explain the difference in position that he took between his August 2024 interview and the hearing beyond more time to reflect. His counsel did indicate that the significance of the hearing was a factor.

Furthermore, the Panel notes that whilst PC Khan indicated that his training in respect of the areas of DV and safeguarding had been limited, by virtue of his probationer training being during Covid. The panel noted that PC Khan has not taken any pro-

active remedial action such as undertaking relevant online learning to seek additional personal development in the areas safeguarding or domestic violence.

The Panel found that PC Khan's responses in some areas of reflection were unconvincing, and he appeared to routinely provide answers learned by rote, rather than giving cohesive and considered responses demonstrating full insight after the events. This was especially the case when considering how he might use his reflections to respond differently to a similar incident in the future.

Despite the above, the Panel noted that at the time of the allegations, PC Khan was a relatively junior officer. He was partnered with a slightly more experienced officer, in Officer A, and they had started their shift in the absence of any local leadership. No Sergeant had commenced duty with the shift and the constables had taken care of their own assignments.

The Panel have noted the character evidence provided on behalf of PC Khan, which includes 2 inspectors. It is apparent that since being placed on restricted duties and to some extent beforehand, PC Khan is considered to be a highly capable, self-motivated, diligent and enthusiastic officer who goes beyond what has been asked of him. The actions and inactions at the time of the allegations appeared very much to be a "one-off" incident of relatively short duration.

**Findings of Fact**

**Allegation 1**

1. a-d Statements of fact

2. a-i Found proven by way of admission

Allegation 2

1. a-b Found proven by way of admission

2. a-c Found proven by way of admission

Allegation 3

1.

a. No case to answer

b. No case to answer

c. This allegation relates to PC Khan's actions once he had returned to the police base and was instructed to undertake further actions by PS Meletiou. PC Khan indicates, and it is accepted by the Panel, that he had started trying to take appropriate action, as directed, the first being to check MPS records in respect of the parties involved and named in the allegations. Before he had the opportunity to contact Essex Police, he and Officer A were ordered to return to the hospital to arrest Person B and undertake further investigations. The Panel accepted PC Khan's evidence and in the circumstances do not find this allegation proved.

d. For the same reasons as indicated above, the Panel do not find this allegation proved.

e. For the same reasons as indicated above, the Panel do not find this allegation proved.

f. For the same reasons as indicated above, the Panel do not find this allegation proved.

2. For the same reasons as indicated above, the Panel do not find this allegation proved.

**Breaches of the professional standards**

The Panel finds that PC Khan's actions were, cumulatively, a clear breach of the Standard of Professional Behaviour in respect of duties and responsibilities.

PC Khan was not diligent in the exercise of his duties and responsibilities in respect of the incidents pertaining to allegations 1 and 2. His actions fell far short of those expected and required of a competent serving Police Constable of the Metropolitan Police Service.

**The Panel's Decision on Misconduct/Gross Misconduct**

The Panel next considered whether the allegations found proved amount to misconduct or gross misconduct.

In making this assessment, the Panel had regard to the College of Policing Guidance on outcomes in police misconduct proceedings (2023). Thus, the Panel assessed the seriousness of the proven conduct by analysing PC Khan's culpability for that conduct and the harm caused by that conduct.

The Panel went on to consider seriousness.

**Culpability**

PC Khan was responsible for his own actions and inactions on the day of the allegations. The Panel acknowledges that PC Khan was relatively junior in experience, but nonetheless find from the information contained in the CAD that there were obvious risks and safeguarding issues which were highlighted from the outset to which he should have realised and responded to.

The Panel acknowledge that these incidents occurred at the time of Ramadan when PC Khan had been fasting since sunrise and his submissions that this may have been a factor.

The Panel considered that PC Khan did not recognise the obvious “red flags” highlighted in the CAD. PC Khan did not recognise his responsibility to engage with a supervisor whilst at the hospital and this in turn, led to the other allegations being proven.

Despite the above, there are some mitigating factors. The Panel considered that the lack of early supervision was a factor in the overall approach by PC Khan. No expectations had been set by a Sergeant at the start of the shift and the Panel have seen no evidence that a Sergeant was monitoring the CADS and assignments at the time PC Khan and Officer A were assigned to this incident. The Panel notes that PC Khan did conduct investigations at hospital, using BWV well. PC Khan responded to the actions by PS Meletiou and DS Warner and arrested the subject and his statement was well drafted. The Panel noted that the incident occurred over a relatively brief duration and the shortfalls in PC Khan’s response, while significant, were not intentional but as a result of a lapse in focus and diligence. His character evidence suggests this is out of character.

In the light of the above, the Panel find PC Khan’s culpability to be medium in nature.

**Harm**

The Panel considered the harm caused by the omissions in PC Khans response.

The relevant parties in this incident did not suffer direct harm as a result of the officers’ inaction. There was potential for harm to be caused as a result of the lack of safeguarding action by PC Khan. PC Khan did establish that the children were in a place of safety, albeit via nurses rather than through direct contact. Person A was apparently already gravely ill and unlikely to survive, which the nurses indicated was unlikely to be connected to the domestic violence [REDACTED]. It is acknowledged by the AA that the officer’s actions did not in any way contribute to Person A’s subsequent death.

The Panel considers that public trust and confidence could be harmed if they became aware of PC Khan's lack of appropriate actions including in respect of safeguarding at the time of the incident.

In the light of the findings above, the Panel finds that the harm caused in this case is medium in nature.

On balance, the Panel finds that PC Khan's breaches of the code of conduct in respect of this case are not of such seriousness that they could lead to his dismissal. They are concerning and deficient, but the Panel find that there is sufficient mitigation for his conduct and accept that his actions and inactions were largely caused due to oversight and misjudgement rather than a deliberate act. In the light of these factors, the Panel find that PC Khan's actions in respect of the allegations found proved amount to misconduct.

**Outcome**

In considering outcome the panel has taken account of the College of Policing Guidance on outcomes in police misconduct proceedings (2023). The Panel has borne in mind that the purpose of police misconduct proceedings is threefold:

i. To maintain public confidence in and the reputation of the police service.
ii. To uphold high standards in policing and deter misconduct.
iii. To protect the public.

The Panel had regard to its findings in respect of culpability and harm above which for the sake of completeness are reiterated below:

**Culpability**

PC Khan was responsible for his own actions and inactions on the day of the allegations. The Panel acknowledges that PC Khan was relatively junior in experience, but nonetheless find from the information contained in the CAD that there were

obvious risks and safeguarding issues which were highlighted from the outset to which he should have realised and responded to.

The Panel acknowledge that these incidents occurred at the time of Ramadan when PC Khan had been fasting since sunrise and his submissions that this may have been a factor. In the Panel's view this is not a factor for consideration in the overarching responsibility for PC Khan to maintain his professionalism as an officer.

The Panel considered that PC Khan did not recognise the obvious "red flags" highlighted in the CAD. PC Khan did not recognise his responsibility to engage with a supervisor whilst at the hospital and this initial failure, contributed the other allegations being proven.

Despite the above, there are some mitigating factors. The Panel considered that the lack of early supervision on the day in question was a factor in the overall approach by PC Khan. No expectations had been set by a Sergeant at the start of the shift and the Panel have seen no evidence that a Sergeant was monitoring the CADS and assignments at the time PC Khan and Officer A were assigned to this incident. The Panel notes that PC Khan did conduct investigations at hospital, using BWV well. PC Khan responded to the actions by PS Meletiou and DS Warner and arrested the subject and his statement was well drafted. The Panel noted that the incident occurred over a relatively brief duration and the shortfalls in PC Khan's response, while significant, were not intentional but as a result of a lapse in focus and diligence. His character evidence suggests this is out of character.

In the light of the above, the Panel find PC Khan's culpability to be medium in nature.

## Harm

The Panel considered the harm caused by the omissions in PC Khan's response.

The relevant parties in this incident did not suffer direct harm as a result of the officers' inaction. There was potential for harm to be caused as a result of the lack of safeguarding action by PC Khan. PC Khan did establish that the children were in a place of safety, albeit via nurses rather than through direct contact. Person A was apparently already gravely ill and unlikely to survive, which the nurses indicated was unlikely to be connected to the domestic violence [REDACTED]. It is acknowledged by the AA that the officer's actions did not in any way contribute to Person A's subsequent death.

The Panel considers that public trust and confidence could be harmed if they became aware of PC Khan's lack of appropriate actions including in respect of safeguarding at the time of the incident.

In the light of the findings above, the Panel finds that the harm caused in this case is medium in nature.

## Aggravating features

The panel find that PC Khan's actions constituted a significant deviation from instructions. Policy dictated in the circumstances, particularly noting that the victim and suspect were both present at the hospital, that PC Khan was required to make contact with an Inspector, which he failed to do.

Furthermore, PC Khan's actions demonstrated a failure to raise concerns or seek advice from a senior colleague. The panel found that all breaches flowed from this fundamental failure.

In addition to the above, the panel find that the vulnerability of the potential victims in this case was significant as they were extremely vulnerable children and noting that Person A was at risk of having her death hastened by way of the **potential actions of Person B.**

Additionally, the panel find that the potential victims in this case had characteristics which touch upon a significant national concern, being violence against women and girls and the police's response to domestic violence.

Finally, the panel note the additional misconduct matter of which they were notified, being a written warning for a period of 18 months in respect of an on duty driving offence. Whilst the panel acknowledge that the warning post-dated the allegation the conduct pre-dated the same and was of some further concern to the panel.

In light of the factors identified above, the panel find that there are significant aggravating features in this case.

In respect of mitigating features PC Khan has not previously faced a disciplinary hearing. Substantial positive character references indicate that PC Khan is a dedicated, capable and self-motivated officer. The panel note personal mitigation has limited weight in light of the public interest.

The panel acknowledge that PC Khan admitted the core allegations before them and has demonstrated some but not full insight. The panel finds that there is some mitigation in this case.

The panel considered the outcomes in ascending order of seriousness. The outcome should be the least severe that adequately deals with the issues identified, while protecting the public interest.

In respect of sanction the panel find that a written warning would not adequately reflect in particular the aggravating features of this case. The panel note that the conduct in respect of the allegations found proved was undertaken after PC Khan was aware that his conduct in respect of the driving offence was subject to disciplinary action. In the light of all of these factors, the panel conclude that the appropriate and proportionate outcome in this case is a final written warning for a period of 2 years.

The panel orders publication pursuant to regulation 43 (6) of The Police (Conduct) Regulations 2020 save that all parties and witnesses referred to therein shall be anonymised with reference to regulation 43 (9) of the Regulations for reasons previously determined.