Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 26 – Thursday, 28 August 2025

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

Name of Registrant:	Henry Harrison-Redmond
NMC PIN	16D1701E
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (10 November 2016)
Relevant Location:	Plymouth
Type of case:	Misconduct
Panel members:	Chris Weigh (Chair, Lay member) Claire Cawley (Registrant member) Margaret Stoddart (Lay member)
Legal Assessor:	Alice Robertson Rickard
Hearings Coordinator:	Nicola Nicolaou
Nursing and Midwifery Council:	Represented by Marcia Persaud, Case Presenter
Mr Harrison-Redmond:	Present and not represented at the hearing
Facts proved by way of admission:	Charges 1, 2a, 2b, and 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Ms Persaud, on behalf of the Nursing and Midwifery Council (NMC) made a request that this case be held entirely in private on the basis that your case is [PRIVATE] The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel accepted the advice of the legal assessor.

The panel was mindful of the general principle that hearings should be held in public, however, in this case the panel determined to go into private session as and when matters regarding [PRIVATE] are raised in order to protect your privacy.

Details of charge

That you, a registered nurse:

1) On 23 November 2019, in respect of Patient A, changed the dialysis needle size, without the correct clinical authorisation and/or supervision.

2) On or around 23 November 2019:

    a) altered Patient A's treatment record in that the pump speed record was changed from 450 ml/min to 350 ml/min;

b) failed to record a dialysis flow until directed to do so by Colleague 1.

3) Your actions in charge 2 were dishonest in that you wanted to conceal from a future reader of the records that you had used the wrong needle.

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

Background

You self-referred to the NMC on 26 February 2020. At the time of the referral, you were employed by University Hospitals Plymouth NHS Trust ('the Trust') as a Dialysis Nurse.

It is alleged that on 23 November 2019 whilst you were working on the Dialysis Unit, you cannulated Patient A with a larger 14-gauge needle instead of a 15-gauge needle. You then dishonestly altered Patient A's medical records in order to conceal that you had used a larger needle without the correct clinical authorisation and/or supervision.

Agreed Facts

The facts of this case are set out in an agreed statement of facts signed by you on 11 July 2025 and by the NMC on 15 July 2025:

'7. On 23 November 2029, Mr Harrison-Redmond was working the early shift (from 07:00 to 15:00) on the Dialysis Unit. He connected Patient A to the dialysis machine between 08:00 and 09:00. Patient A had end stage renal failure as well as cardiac issues. Patient A is now deceased.

8. Later that shift, it was identified that Mr Harrison-Redmond had cannulated Patient A with a larger 14-gauge needle instead of a regular 15-gauge needle.

9. A colleague nurse, Witness 2, noticed that Patient A's dialysis machine was alarming because the pressure was too high, so they checked what was wrong. Witness 2 says they reduced the pump speed from 450 ml/min to 400 ml/min so that Patient A's venous pressure settled and to stop the machine alarming. Witness 2 had not realised Patient A was on the wrong needle prescription at that time.

10. Subsequently, on inputting the post-dialysis record, Witness 2 noted from Patient A's previous records and from their prescription that a size 15-gauge needle had been used. Witness 2 asked Mr Harrison-Redmond why he had used the bigger needle, and he replied that that he had previously seen someone cannulating Patient A with bigger needles and that he had seen an entry on the computer system saying Patient A should be tried cannulating with bigger needles. Mr Harrison-Redmond also told Witness 2 Patient A "is a big chappy that needs a better clearance".

11. Towards the end of the shift, Witness 2 informed Colleague 1 of the incident. Colleague 1 was the junior sister who was coordinating and monitoring the morning shift. Colleague 1 noted that the correct size of needle to use was not noted on Patient A's prescription. Colleague 1 also noted on the prescription chart that dialysate flow previously used was 500 ml/min which suggested that regular size needles should have been used in this case as larger needles would require a minimum dialysate flow of 700 ml/min. Colleague 1 confirms that if there is no needle size stated on the prescription the usual practice for a junior nurse is to use a regular sized needle, but not a larger sized needle without consulting a doctor.

12. Colleague 1 checked the computer and saw that Mr Harrison-Redmond had recorded a blood flow for Patient A as 450 ml/min and that the fluid flow had not been documented on Patient A's dialysis record. Colleague 1 asked Mr Harrison-Redmond what fluid flow he used to which he responded 700 ml/min which was correct for large sized needles. Colleague 1 asked Mr Harrison-Redmond to record this fluid flow in Patient A's dialysis record. Colleague 1 also asked Mr Harrison-Redmond why he had used the large

needle on Patient A, as usual practice when the size of needle is not noted was to use a medium 15-gauge needle. Mr Harrison-Redmond told Colleague 1 that Patient A's clearance "wasn't good", so he thought he would try a bigger needle. Colleague 1 explained to Mr Harrison-Redmond that it was not up to him to make a decision to use a different size needle and that he needed to seek authority from a senior member of staff for this.

13. Prior to the above incident. Mr Harrison-Redmond was provided with the necessary relevant renal training pack, and it was Mr Harrison-Redmond's responsibility to complete the training pack and to have his competencies in this area signed off.

14. It was later identified by Colleague 1 that Patient A's clinical record had been changed to suggest that the pump speed had been 350 ml/min. Colleague 1 also identified that a note had been put on the clinical encounter which stated that Patient A had been asked regarding the needle size and they had told Mr Harrison-Redmond they were "on 14g needles" (bigger needles), "and unsure why he [Patient A] hasn't been using them" previously and that a 14g needle was used at the pump speed of 400 ml/min on 23 November 2019. These changes were made under Mr Harrison-Redmond's computer log in details.

15. Colleague 1 confirms that Patient A did not know the size of the needles used for their dialysis. Colleague 1's assertion is based on their conversations with the patient prior and after the above incident on 28 November 2019 when Colleague 1 documented Patient A's first response to being asked what needles they normally had, was that they "did not have a clue" and later stating, "normal needles".

16. When this discrepancy was raised with Mr Harrison-Redmond he stated that someone had gone on his computer and changed the entry as Mr Harrison-Redmond had left his computer open. Therefore, someone must have changed the details to get Mr Harrison-Redmond into trouble.

17. The Trust's internal investigation was carried out when it was established that the following changes to Patient A's dialysis record were made on 23 November 2019 at the times listed below under Mr Harrison-Redmond's computer log in details:

a) 08:07:01 – no mention of the fields for Blood Flow or Fluid Flow
b) 08:26:56 – Blood Flow was set to 450 ml/min
c) 14:02:21 – Blood Flow was updated to 400 ml/min d) 14:10:05 -- Blood Flow was updated to 350 ml/min and Fluid Flow to 700 ml/min

18. During the investigation process, it was identified that changes had been made to the patient record within 30 seconds of an entry Mr Harrison-Redmond accepts he had made. Witness 5, technical director who carried out an analysis of the user activity for Mr Harrison-Redmond on the relevant computer data system. confirms that based on how the computer system works, the same user would have made the entries.

19. The Trust's disciplinary hearing was held on 4 February 2020. During the hearing Mr Harrison-Redmond accepted that he had made an error regarding the size of needle used on Patient A and denied having changed anything on the patient record. Mr Harrison-Redmond maintained that anybody could have gone onto the records and changed it as he had left his computer logged on.

20. Mr Harrison-Redmond also stated to the hearing panel that he had been victimised and bullied whilst employed on the unit. Mr Harrison-Redmond further stated that he had been treated differently due to [PRIVATE] *The Trust's hearing was adjourned as the panel wished to consider Mr Harrison-Redmond's allegations of bullying and poor culture in the workplace. It was reconvened on 26 February 2020.*

21. During the reconvened hearing further information regarding the data that had been changed on Patient A's record was heard. Mr Harrison-Redmond admitted that he had made a change in the record of the pump speed from

400ml/min to 350ml/min but he did not make the same change 30 seconds later on the part of the system which should not be changed.

22. Following the conclusion of the disciplinary process Mr Harrison-Redmond, was re-deployed into the research department at the Trust.'

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you admitted the charges.

The panel therefore finds charges 1, 2a, 2b, and 3 proved by way of your admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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 and that this misconduct is serious. Secondly, only if the facts found proved amount to serious misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Persaud invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Persaud identified the specific, relevant standards which she submitted had been breached, and where your actions amounted to misconduct. She submitted that your actions were a significant departure from the standard expected of a registered nurse. Ms Persaud submitted that you are an experienced nurse who was working in an environment with vulnerable patients who relied on you for their care. She submitted that your conduct suggests an underlying attitudinal concern and could have a serious impact on the protection of the public.

Ms Persaud submitted that your actions would be regarded as deplorable. She submitted that you have breached fundamental tenets of the nursing profession. She submitted that your actions seriously undermine public trust in the nursing profession and the NMC as the regulator.

Submissions on impairment

Ms Persaud moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Persaud referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

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.'*

Ms Persaud submitted that all four limbs of the *Grant* test are engaged in this case. She submitted that you have breached fundamental tenets of the nursing profession and brought the profession into disrepute. She submitted that your actions fell far below the standard expected of a registered nurse and that you failed to ensure the safety of the patients in your care.

Ms Persaud submitted that although there is no evidence before the panel to suggest that actual harm came to patients, there was a potential for your actions to cause harm. She submitted that Patient A was vulnerable, and that you were the nurse responsible for Patient A at the time. She submitted that by changing the size of the dialysis needle without correct clinical authorisation and/or supervision, Patient A could have come to harm.

Ms Persaud submitted that in relation to your dishonesty, you demonstrated a lack of professionalism and trust.

Ms Persaud acknowledged that you have engaged with the NMC regarding this process, and that you have provided a reflective statement in relation to your

conduct in this case, but that the panel will make its own decision as to whether you have demonstrated any insight or remorse.

Ms Persaud submitted that the misconduct in this case is serious, and that there is a real risk of repetition and consequent harm to patients. She therefore submitted that a finding of current impairment is necessary on the ground of public protection.

Ms Persaud submitted that your actions in this case are so serious that public confidence in the nursing profession and the NMC as the regulator would be undermined if a finding of current impairment were not made. Ms Persaud therefore submitted that a finding of current impairment is also in the public interest.

Your submissions

You told the panel that you wish to rely on your written submissions, including your reflective piece and the testimonials from your colleagues.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel had regard to the terms of the Code.

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.2** make sure you deliver the fundamentals of care effectively*

8 Work cooperatively

To achieve this, you must:

***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

***8.2** maintain effective communication with colleagues*

***8.6** share information to identify and reduce risk*

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:

***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

***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*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

***14.1** act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

***14.2** explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

***14.3** document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

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

To achieve this, you must:

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

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 appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it found that your actions did fall seriously short of the conduct and standards expected of a registered nurse. The panel considered that changing the dialysis needle size without the correct authorisation and then altering patient records to conceal your actions was particularly serious and could have led to patient harm. Such conduct would be considered by fellow practitioners to be deplorable and is 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, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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.

The panel considered that all four limbs of the *Grant* test were engaged in this case.

The panel considered that whilst there is no evidence before it to suggest that actual harm came to patients, the patients in your care were put at risk of harm.

It noted the agreed statement of facts which says as follows:

> *'**23.** There is no evidence to suggest that Patient A came to harm as a result of the*
> *above incident.* [Colleague 1] *states that most of the time there is minimal risk of harm to*
> *patients if the wrong needle is used. But sometimes if patients have heart problems, it can place a lot of strain on the body. This patient did have heart problems and had a heart attack in the past.* [Witness 2] *states that the risks of using*
> *the wrong sized needle would be breaking the fistula.*
> ***24.** The treatment and amendments to the record was spotted the same day. Generally amending a patient's records after the event, could lead to risk of patient harm.'*

It further considered that your misconduct had breached the fundamental tenets of the nursing profession in failing to prioritise Patient A, practise effectively, preserve safety, and promote professionalism and trust. Your misconduct also brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty to be extremely serious, particularly where you falsified a vulnerable patient's records in order to conceal your error.

The panel then considered the factors set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). It first considered whether the misconduct is capable of being addressed. It concluded that whilst the clinical failing relating to the use of the wrong needle is capable of being addressed, dishonesty is much more difficult to remediate.

It then looked at whether you have in fact remediated the concerns in this case, and concluded that you had not. In terms of the clinical failing, it had not been provided with evidence to demonstrate that you had undertaken relevant training. Whilst the panel acknowledged that you have provided positive references from the care home in which you now work, neither the Head of Unit, nor the Student Nursing Associate who have written the references are registered nurses so cannot assess your clinical competence. Nor can they attest to your clinical abilities in relation to cannulation as you are no longer working in this area. You have therefore not demonstrated a strengthening of your practice in this regard.

In terms of the dishonesty, the panel took into account your reflective pieces in which you acknowledge that your actions were wrong and demonstrate some understanding of how being dishonest can impact patients and the wider public. However, it also noted that you had continued to deny that you had altered the patient records for a considerable period of time, and had even claimed that you could not have altered the records as you were not in the building. It considered that this may be indicative of attitudinal concerns.

The panel went on to consider whether your misconduct was highly unlikely to be repeated, and decided that there remained a risk of repetition. It noted in your reflection that you had referred to this as a one-off incident and said that there had been no further concerns raised since. However, the panel noted that further wide-ranging concerns were raised after you were re-deployed into a new post in the research department on 17 August 2020. The panel took into account a letter from the Trust dated 1 March 2022 which stated:

'[…] *We do have concerns regarding his conduct; specifically around his inappropriate behaviour in the clinical environment* […] *I have also received a complaint from a member of team regarding Henrys attitude and behaviour towards her. Specifically, he was failing to follow out her instructions, ignoring her and generally not having an appropriate attitude for a work place* […] *I do have some overall concerns regarding his professionalism* […]*'*

The panel had full regard to the contextual matters that you had raised in relation to the working environment on the renal unit. However, after you were redeployed to the research role, the evidence provided shows that you felt 'very supported'. It was therefore of concern that even after moving to a different environment, which you considered to be supportive, concerns were continuing to be raised regarding your conduct, behaviour, and professionalism. In particular, your attitude when you disagree with a policy, procedure, or colleague is of concern. For example, the panel noted that in a meeting held on 18 June 2021, concerns were raised about your *'lack of respecting the Trust values in* [your] *everyday work.'* There were also concerns raised about your failure to follow Trust policies in a meeting dated 17 June 2021. Additionally, the panel noted concerns raised in relation to you misleading the Head of Nursing in relation to your Covid-19 risk.

In light of the above, the panel cannot be satisfied that the misconduct in this case is highly unlikely to be repeated. The panel therefore decided 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; 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 concluded that a member of the public would be troubled, and the public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that a fellow practitioner would find your misconduct

to be deplorable. The panel therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Persaud informed the panel that in the Notice of Hearing, dated 24 July 2025, the NMC had advised you that it would seek the imposition of a suspension order for a period of 12 months if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that a striking-off order may be more appropriate in light of the panel's findings.

Ms Persaud submitted that taking no further action or imposing a caution order would not be appropriate in this case given the nature and seriousness, and the public protection and public interest concerns identified.

Ms Persaud submitted that a conditions of practice order would not be appropriate given the dishonesty element.

Ms Persaud submitted that a suspension order may be appropriate in a case where there is a single instance of misconduct and no evidence of deep-seated personality problems.

Ms Persaud submitted a suspension order may not be appropriate in this case as further wide-ranging concerns were raised after you were moved to a different post, and there is evidence of attitudinal concerns. In the circumstances, the panel may feel that the only appropriate sanction is a striking off order, in order to maintain public confidence in the nursing profession. However, Ms Persaud submitted that whatever sanction is imposed is ultimately a matter for the panel.

You told the panel that you acknowledged its findings.

You submitted that using the wrong needle was a genuine clinical mistake and that you did not have a good recollection of matters surrounding it, which had led to some of your answers. [PRIVATE]

You submitted that there were significant issues at the dialysis unit, and you had requested help, but the culture valued speed over patient safety. You said that patient prescriptions were never fully completed so you would not have the cannula size or pump speeds and would base your decisions on what the patient asked for.

You said you recognised that you required significant support and oversight and that you requested redeployment to mitigate future risk. You addressed the concerns raised after you were redeployed and said that they were a result of [PRIVATE].

You had therefore moved from the NHS to the private sector, where you have had no issues. You did not wish to go back to the NHS as you did not want to be in a position where you could cause patient harm or bring the profession into disrepute.

You said that you regarded nursing as not just a profession, but a calling and a privilege.

You said that you had kept up to date with your training and were willing to undertake any further training that was deemed to be appropriate. You said that you had also taken action to address [PRIVATE].

You said that you thought that you were now a safer practitioner and took pride in the relationship you had with your patients and their families, who trusted you.

In conclusion, you said that you had never wanted to do anything other than nursing and would like to continue in the nursing profession. Conditions of practice would enable you to do this.

Decision and reasons on sanction

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

The panel considered the following to be aggravating features:

- Lack of insight into failings
- Conduct which put a vulnerable patient at risk of suffering harm
- Deflection of blame
- Attempted to conceal your actions for a long period of time

The panel considered the following to be mitigating features:

- Admissions to the facts
- Personal mitigation including [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that a caution order would not protect the public or be in the public interest.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. It considered that the dishonest element of the misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *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 or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The panel acknowledged that the misconduct in this case occurred on one shift and related to one patient. However, you altered the patient records to conceal your error and positively maintained your concealment for a lengthy period. The panel has already indicated that it considers that your stance in relation to this suggests attitudinal issues. Further, the panel noted that there is evidence of further concerning behaviour since the incidents in November 2019. The panel is therefore not satisfied that you have insight and do not pose a significant risk of repeating your behaviour.

The panel carefully considered your submission to the panel and the fact that you say you have addressed the underlying issues by [PRIVATE]. It also bore in mind your written reflections. However, you did not support your submissions with [PRIVATE].

However, the panel could not be satisfied that you had addressed what caused you to act dishonestly, as it did not accept that [PRIVATE] explained an active decision by you to falsify patient records. It considered that your actions were deliberate and that your dishonesty was maintained. In altering a vulnerable patient's records to conceal your error, you were placing your own interests above those of the patient. It considered that you lacked genuine insight into your conduct, which was a significant departure from the standards expected of a registered nurse.

In light of the guidance, the panel concluded that a suspension order would not sufficiently protect the public, or meet the public interest, and therefore, it would not be a sufficient, appropriate or proportionate sanction.

The panel then considered the SG in relation to a striking-off order, and took note of the following paragraphs:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that the findings in this particular case do raise fundamental questions about your professionalism. It determined that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel recognised that this decision would inevitably cause you hardship and that you would no longer be able follow your chosen profession. However, it considered that this order was necessary to protect the public, to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to you 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 your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Persaud. She submitted that an interim suspension order is necessary to protect the public and meet the public interest. She invited the panel to make an interim suspension order for a period of 18 months to allow time for any possible appeal.

You asked the panel not to impose an interim order, and instead to allow the striking off order to come into effect at the end of the 28-day appeal period. You told the panel that [PRIVATE] and that not having an interim order on your registration would allow you time to safely hand over your patients and give you an opportunity to find alternative employment.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. 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 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 to allow time for any possible appeal.

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

That concludes this determination.