Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Tuesday, 5 August 2025 – Friday, 8 August 2025

Virtual Hearing

Name of Registrant:	**Catherine Louise Smith**
NMC PIN:	92J0221W
Part(s) of the register:	Registered Nurse - Sub part 1 Adult Nursing – 31 March 1996
Relevant Location:	Carmarthenshire
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Sophie Agolini (Registrant member) Cerys Jones (Lay member)
Legal Assessor:	Alice Robertson Rickard
Hearings Coordinator:	Tyra Andrews
Nursing and Midwifery Council:	Represented by Lindsey McFarlane, Case Presenter
Miss Smith:	Not present and unrepresented at this hearing

Facts proved:	Charges 1 and 2
Facts not proved:	Not applicable
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Smith was not in attendance and that the Notice of Hearing letter had been sent to Miss Smith's registered email address by secure email on 4 July 2025.

Ms McFarlane, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Smith

The panel next considered whether it should proceed in the absence of Miss Smith. It had regard to Rule 21 and heard the submissions of Ms McFarlane who invited the panel to continue in the absence of Miss Smith. She submitted that Miss Smith had voluntarily absented herself.

Ms McFarlane submitted that there had been no engagement from Miss Smith with the NMC in relation to these proceedings since the last correspondence sent on 28 July 2025 and that there had been no application for an adjournment. As a consequence, there was

no reason to believe that an adjournment would secure Miss Smith's attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Miss Smith. In reaching this decision, the panel considered the submissions of Ms McFarlane, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Smith;
- Miss Smith has not engaged with the NMC since 28 July 2025 and the NMC has made reasonable efforts to inform Miss Smith about the hearing and when it will take place;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness is due to give evidence at this hearing and not proceeding may inconvenience the witness;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Smith in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any

inconsistencies in the evidence which it identifies. It also has the benefit of Miss Smith's written reflection, which it can consider alongside the other evidence.

Furthermore, the limited disadvantage is the consequence of Miss Smith's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not make oral submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Smith.

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

Ms McFarlane made a request that this case be held in private on the basis that proper exploration of Miss Smith's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 determined to go into private session in reference to [PRIVATE] as and when such issues are raised in order to protect Miss Smith's right to privacy.

Decision and reasons on application to admit the local statements of Mrs 1, Mrs 2 and Mrs 3

The panel heard an application made by Ms McFarlane under Rule 31 to admit the hearsay testimony of Mrs 1, Mrs 2 and Mrs 3 into evidence. Ms McFarlane submitted that Miss Smith has not disputed that she altered the fluid input chart for Resident A.

Therefore, this matter is not contentious, as the local statements provided by Mrs 1, Mrs 2 and Mrs 3 address actions by her which are not disputed.

Ms McFarlane submitted that Mrs 1, Mrs 2 and Mrs 3's evidence is highly relevant, and it would be fair to admit these local statements. She further submitted that due to the admissions of Miss Smith within Miss Smith's NMC reflective account, and the live evidence to be provided by witness 1, it would not be proportionate to call Mrs 1, Mrs 2 and Mrs 3 to give evidence.

In the preparation of this hearing, the NMC had indicated to Miss Smith in the Case Management Form (CMF) that it was the NMC's intention to rely on the local statements provided by Mrs 1, Mrs 2 and Mrs 3. Despite knowledge of the nature of the evidence to be given by Mrs 1, Mrs 2 and Mrs 3, Miss Smith made the decision not to attend this hearing, or to challenge their statements. On this basis Ms McFarlane submitted that it was fair to admit Mrs 1, Mrs 2 and Mrs 3's hearsay testimony into evidence.

The panel decided it was relevant and fair the admit the evidence of Mrs 1, Mrs 2 and Mrs 3.

Whilst it acknowledged that the charges in respect of which their evidence relates are serious and that the NMC had not attempted to secure their attendance, it considered this to be reasonable and proportionate in light of the fact that there was no challenge to the contents of their statements. Miss Smith had been made aware that it was the NMC intention to rely on their evidence and had not objected to it, and there was no suggestion that their statements had been fabricated

Further, their statements were not sole and decisive, but corroborated the admission made by Miss Smith and the evidence of Witness 1.

In these circumstances, the panel determined that it would be fair and relevant to admit into evidence the local statements of Mrs 1, Mrs 2 and Mrs 3, but would give what it

deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse, whilst working at [PRIVATE], on 21 June 2023:

1. Altered the fluid input chart for Resident A from 0ml to 200ml on four separate occasions between 8:00 and 13:00.

2. Your actions at charge 1 were dishonest in that you knew Resident A had not taken any fluids between 8:00 and 13:00 but you recorded this anyway.

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

Background

Miss Smith entered the NMC register on 31 March 1996. The NMC received a referral on 4 July 2023 from HC-One. The concerns relate to an incident whereby Miss Smith had allegedly altered four entries on a patient's fluid chart that were entered by another member of staff (Mrs 2).

Miss Smith had been employed by HC-One since 26 November 2018 and working in [PRIVATE](“the Home”).

It is alleged that on 21 June 2023, around 18:00, Mrs 3 at the home noticed four entries on ‘Resident A’s’ fluid chart for that day had been altered from ‘0ml’ to ‘200ml’.

It is further alleged that on being challenged about this, Miss Smith admitted altering the entries made to ‘Resident A’s’ fluid chart and stated that she did so because she thought it would look better for the inspectors and apologised.

Miss Smith provided responses to the NMC between August and November 2023 in which she addressed the allegations and raises contextual factors including an increased workload, lack of breaks and [PRIVATE]. Miss Smith denies that her actions were dishonest.

Decision and reasons on facts

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

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witness called on behalf of the NMC:

- Witness 1: Turnaround Manager for HC-One.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

"That you, a registered nurse, whilst working at [PRIVATE], on 21 June 2023:

1. Altered the fluid input chart for Resident A from 0ml to 200ml on four separate occasions between 8:00 and 13:00."

This charge is found proved.

In reaching this decision, the panel had particular regard to the fluid chart for Resident A, Witness 1's oral evidence and the reflective piece provided by Miss Smith. The panel also had regard to the supervision record dated 21 June 2023 and the local statement from Mrs 3.

The panel noted from the fluid chart that it had been altered on four occasions. The alterations had not been initialled, so it was not clear on the face of that document who had made the alterations.

The panel had regard to the local statement of Mrs 3 which stated:

'…[Resident A] hadn't taken any fluid from the period of 8am until 1pm with her personally and with myself personally so this intake had been changed the only other staff member to have seen these supplementary charts was the nurse in charge CC…'

The panel noted that Miss Smith had accepted during the supervision meeting with Witness 1 that took place on the day of the incident, that it was she who had altered the fluid chart.

The panel carefully considered the supervision record which stated:

‘Ask catherine has she altered fluid chart for [Resident A] on 21/6/23 she responded yes she thought it would look better for inspectors...’

The panel noted the signature at the bottom of the supervision record was Miss Smith’s which indicated that she agreed with the contents of the record. The panel further noted that Witness 1 was present when the supervision record was made and her oral evidence was consistent with what was recorded.

The panel acknowledged that Miss Smith had raised concerns regarding being coerced to sign the supervision record and had stated the following in her reflective account:

‘…[Witness 1] made me sign numerous supervision documents……’

The panel had the opportunity to question Witness 1 about this. She denied coercing Miss Smith to sign the supervision record and told the panel that if Miss Smith had not wished to sign the document, she would simply have recorded this.

The panel accepted Witness 1’s account that she had not coerced Miss Smith to sign the record. It found her evidence to be credible, consistent and measured. It further noted that in her reflective account, Miss Smith had at no point disputed altering the fluid chart. She stated as follows:

‘I accept I wrote on a fluid chart, this was then challenged by the carer on duty [Resident A] didn’t take that amount, chart was changed to reflect this… I felt extremely sorry for my actions…’

The panel acknowledged the consistency between the supervision record and Miss Smith’s reflective account in which she did not deny altering Resident A’s fluid chart.

The panel determined that this statement corroborated the oral evidence provided by Witness 1 in addition to the supervisory report and reflective account provided by Miss Smith.

Based on the evidence above, the panel was satisfied that Miss Smith had altered the fluid input chart for Resident A from 0ml to 200ml on four separate occasions. Therefore, the panel found charge 1 proved on the balance of probabilities.

Charge 2

That you, a registered nurse, whilst working at [PRIVATE], on 21 June 2023:

2. Your actions at charge 1 were dishonest in that you knew Resident A had not taken any fluids between 8:00 and 13:00 but you recorded this anyway.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's oral evidence and the reflective account provide by Miss Smith in addition to the local statements of Mrs 1, Mrs 2 and Mrs 3.

The panel carefully considered the reflective account provided by Miss Smith, in which she denied that her conduct in altering the fluid chart was dishonest. She raised various factors by way of explanation for her actions, including a heavy workload, lack of breaks and [PRIVATE]. There was no supporting evidence in respect of any of these, and Witness 1 gave evidence that Miss Smith had not reported any issues.

In any event, the panel did not accept any of these factors as credible explanations for Miss Smith's actions. It found that her contemporaneous explanation for her actions – namely that she had altered the fluid chart so that it would look better for the inspectors – to be far more credible.

The panel found that Miss Smith's state of knowledge was that she knew that Resident A had not taken any fluids but deliberately altered the record to show that she had done so. By her own admission, her motivation for doing this was so that it would look better.

The panel found that Miss Smith's conduct, which involved falsifying a record made by another health professional, would be regarded as dishonest by the standards of ordinary decent people.

The panel therefore found charge 2 proved on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Smith's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise 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. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Smith's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms McFarlane invited the panel to take the view that the facts found proved amount to misconduct and to have 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 McFarlane referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms McFarlane submitted that nurses are obliged under the Code to always act honestly and with integrity. She submitted that Miss Smith dishonestly altered four entries on Resident As fluid intake chart on 21 June 2023, and this was done knowingly. Miss McFarlane highlighted that Miss Smith's reason for altering the records was to mislead inspectors and submitted that this was particularly concerning. This was because it indicated an intention to deceive those whose role is to maintain the safety and care of vulnerable residents.

She further submitted that Miss Smith's actions are a serious departure from the professional standards and behaviour expected for a registered nurse and therefore amount to serious misconduct.

Submissions on impairment

Ms McFarlane 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms McFarlane submitted that Miss Smith is not currently fit to practise unrestricted and all four limbs of the test in the case of '*Grant'* have been engaged. Ms McFarlane submitted that Miss Smith's actions occurred in a clinical context and involved dishonesty by altering four entries on a vulnerable resident's fluid chart, thereby, causing a risk of harm.

Ms McFarlane further submitted that Miss Smtih had demonstrated a lack of candour towards those monitoring the care of vulnerable patients by altering other colleague's record to *'look better for inspectors'*. She submitted that Miss Smith's actions demonstrated a complete disregard for regulation and safeguarding. Further, the lack of insight and strengthening of practice by Miss Smith means that she is liable in the future to act in a manner which puts patients at a risk of harm.

Ms McFarlane therefore submitted that a finding of impairment is necessary on public protection founds as well as in the wider public interest, to uphold standards and maintain confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin). *Cheatle v GMC [2009] EWHC 645, Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council, Paula Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

*'**8 Work co-operatively***

To achieve this, you must:

…8.2 maintain effective communication with colleagues.

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:

… 10.2 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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed…

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…

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people…

…20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to…'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the breaches in this case were extremely serious and amounted to misconduct. Miss Smith dishonestly falsified a patient record on four occasions and her actions put a vulnerable patient at risk of harm.

The panel determined that Miss Smith's actions would be seen as deplorable by other professionals. It therefore found that Miss Smith's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, 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.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found that all four limbs of the '*Grant Test'* were engaged in this case. Patient A who was a vulnerable patient with [PRIVATE], was put at risk of harm as a result of Miss Smith's misconduct. Dishonestly altering their medical records breached the fundamental tenet of the nursing profession, to act with honesty and integrity, and therefore 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 extremely serious.

Regarding insight, the panel acknowledged that Miss Smith had apologised for her actions but determined that she had not demonstrated any insight into her behaviour. The panel determined that Miss Smith had not grasped the seriousness of her misconduct and had referred to [PRIVATE] and work conditions in her reflective account which does not provide any rationale for deliberately and falsely altering records. Moreover, the panel was not provided with any evidence from Ms Smith regarding [PRIVATE] nor was there any evidence of unsafe working conditions on the day concerned. On the contrary, Witness 1 stated that nursing staff plan their breaks around their workload and if Miss Smith had raised any issues regarding being unable to take her break, then the deputy manager could have provided cover for Ms Smith as she, deputy manager, was supernumerary at the time.

The panel noted that Miss Smith also referred to her misconduct as a mistake, which demonstrated a lack of insight, given that she had falsified the record on four occasions.

The panel is of the view that there is a risk of repetition based on the lack of insight demonstrated by Miss Smith. The panel considered that Miss Smith has not sufficiently reflected on her misconduct and the potential impact and risk her actions could have caused to a vulnerable patient. The panel considered that Miss Smith's reflection was insufficient to lead the panel to conclude that her actions would not 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 determined that a finding of impairment on public interest grounds is required because Miss Smith's misconduct falls far short of the professional standards expected from a nurse. The panel therefore concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Smith's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Smith's 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 Miss Smith off the register. The effect of this order is that the NMC register will show that Miss Smith has 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 McFarlane informed the panel that in the Notice of Hearing, dated 4 July 2025, the NMC had advised Miss Smith that it would seek the imposition of a striking-off order if it found Miss Smith's fitness to practise currently impaired.

Ms McFarlane submitted that Miss Smith's actions placed a patient at risk of harm. She further submitted that the vulnerability of the patient due to their [PRIVATE] increased the risk of harm, and that this and Miss Smith's lack of insight were aggravating factors. She acknowledged that Miss Smith had apologised in both her responses at the local level and in her responses to the NMC and that the panel may consider this to be a mitigating factor.

Ms McFarlane also acknowledged the contextual factors raised by Miss Smith but said it was the NMC's position that these should be given little weight in these proceedings.

Ms McFarlane submitted that taking no further action or imposing a caution order would not be appropriate in this case. This was because Miss Smith's misconduct and dishonesty posed an ongoing risk to patients due to the fact that Miss Smith had not provided evidence of insight, remediation or strengthening of her practice. Nor would it be sufficient, appropriate or proportionate to impose a conditions of practice order.

Ms McFarlane further submitted that a suspension order would not be appropriate in consideration of the extremely serious charges found proved in this case. She further stated that Miss Smith's lack of insight, reflection and remediation means that there remains a high risk of repetition of similar concerns. Therefore, temporary removal from the register would not be sufficient to protect the public from harm or meet the wider public interest given the circumstances of the case.

Ms McFarlane submitted that Miss Smith's actions were dishonest and demonstrated a disregard for the safeguarding regulatory process and the safety of patients. She submitted that a member of the public would be concerned if a registered nurse who was found to have falsified multiple entries on a vulnerable patient's record were allowed to continue to practise. Given the lack of insight, meaningful reflection, strengthening of practice and the disengagement with the NMC, Ms McFarlane submitted that a striking-off order would be the only appropriate sanction.

Decision and reasons on sanction

Having found Miss Smith's 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:

- Risk of patient harm
- Vulnerable patient
- Lack of insight
- Miss Smith was a senior nurse in a position of trust
- This was a deliberate act of falsification

The panel considered the following to be a mitigating feature:

- Apology within the reflective account

The panel noted the contextual factors raised by Miss Smith, concerning [PRIVATE] and what she said was a heavy workload. However, in light of the lack of evidence to support them, the panel was unable to place any weight on them. In any event the panel did not accept that these matters played any part in the misconduct.

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 Miss Smith's 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 determined that Miss Smith's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate and insufficient.

The panel next considered whether placing conditions of practice on Miss Smith's registration would be a sufficient and appropriate response. The panel considered that although record keeping is considered clinical and can in some cases be improved via training, in this particular case, the failing involved deliberate falsification rather than an error or omission. It therefore concluded that there were no practical or workable conditions that could be formulated to remediate the dishonesty found within Miss Smith's misconduct. Furthermore, the panel noted that Miss Smith's registration has lapsed, and she has not engaged with the NMC. The panel therefore also determined there is no evidence to suggest Miss Smith would be willing to comply with any conditions should they be formulated and imposed. In any event, the panel concluded that the placing of conditions on Miss Smith's registration would not adequately address the seriousness of this case and would not protect the public.

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 has insight and does not pose a significant risk of repeating behaviour.*

Although there were four amendments of the record, the panel acknowledged that this had occurred on one shift, and to that extent, this could be categorised as a single instance of misconduct. It further acknowledged that there was no evidence that the behaviour had been repeated since the incident.

However, because the amendments that had been made were a deliberate falsification of the record in order to mislead inspectors, the panel found that this was indicative of harmful deep-seated or attitudinal problems.

Furthermore, the panel found that Miss Smith lacked insight into her actions and into why she acted dishonestly. The explanation she gave for it at the time is hard to comprehend. Without any real explanation from her as to why she acted as she did, the panel found that there was a significant risk of her repeating her behaviour. Nor had she demonstrated any real understanding of the risk her conduct posed to the patient and the impact that the dishonest falsification of patient records would have on the reputation of the profession.

The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *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 found that Miss Smith's actions were significant departures from the standards expected of a registered nurse and raise fundamental questions about her professionalism. It was satisfied that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. It was further satisfied that a strike-off was the only sanction that would be sufficient to protect patients, members of the public and to maintain professional standards.

The panel considered that this order was necessary both to protect the public, to maintain 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.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Smith's 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 McFarlane. She applied for an interim suspension order for a period of 18 months. She stated that this was necessary for the protection of the public and the public interest.

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 due to the seriousness of the facts found proved. It is necessary in the public interest and for public protection to grant the interim suspension order.

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

That concludes this determination.