Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 8 December 2025 – Thursday, 18 December 2025

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Bethany Brent**
NMC PIN:	20C1708E
Part(s) of the register:	Registered Nurse - Sub part 1 Registered Nurse – Children; RNC (16 September 2020)
Relevant Location:	Plymouth
Type of case:	Misconduct
Panel members:	Clara Cheetham (Chair, Lay member) Anne Considine (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	William Hoskins
Hearings Coordinator:	Eyram Anka
Nursing and Midwifery Council:	Represented by Benjamin D'Alton, Case Presenter
Miss Brent:	Not present and unrepresented at this hearing
Facts proved:	Charges 1a, 1b, 2a, 2b, 3a, 3b, 4, 5, 6, 7a, 7b, 8, 9a, 9b, 10, 11a, 11b, 12, 13a, 13b, 14, 15a, 15
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 Brent was not in attendance and that the Notice of Hearing letter had been sent to Miss Brent's registered email address by secure email on 5 November 2025.

Further, the panel noted that the Notice of Hearing was also sent to Miss Brent's representative at the Royal College of Nursing (RCN) on 5 November 2025.

Mr D'Alton, 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 venue of the hearing, amongst other things, information about Miss Brent'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 Brent 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 Brent

The panel next considered whether it should proceed in the absence of Miss Brent. It had regard to Rule 21 and heard the submissions of Mr D'Alton who invited the panel to continue in the absence of Miss Brent.

Mr D'Alton referred the panel to a letter from the RCN dated 5 December 2025 which states,

‘Our member will not be attending the hearing, nor will she be represented. No disrespect is intended by her non-attendance. Our member has received the notice of hearing, and she is happy for the hearing to proceed in her absence.’

Mr D’Alton submitted that Miss Brent has elected to absent herself from these proceedings. He submitted that there would be no purpose served in adjourning today because the RCN have provided written representations on Miss Brent’s behalf and have not made an application for an adjournment. Furthermore, Mr D’Alton submitted that Miss Brent has given no indication that deciding not to procced would secure her attendance at a future date.

Mr D’Alton noted that, in a letter dated 5 December 2025, the RCN indicated that Miss Brent will not attend this hearing due to *[PRIVATE]*.’ The RCN also stated that *‘participating in the proceedings [PRIVATE]’*. In circumstances where Miss Brent has not asked for an adjournment based on her [PRIVATE], it was Mr D’Alton’s submission that the written representations indicating that she will not be attending due to her [PRIVATE] is of little weight when considering whether to proceed in her absence. Although Miss Brent has submitted a [PRIVATE], this was dated 21 July 2025 and expired on 1 August 2025. As such, in the absence of any issue surrounding capacity, Mr D’Alton asked the panel to consider that Miss Brent has decided not to attend this hearing voluntarily and invited the panel to proceed in her absence.

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’* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Miss Brent. In reaching this decision, the panel considered the submissions of Mr D’Alton, the representations made on Miss Brent’s behalf, and the advice of the legal assessor. It had regard to

the factors set out in the decision of *R v Jones* 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 the RCN on Miss Brent's behalf.
- The RCN informed the NMC that Miss Brent has received the Notice of Hearing and confirmed that she is content for the hearing to proceed in her absence.
- Although Miss Brent has submitted [PRIVATE], this has not been put forward as a reason to postpone the hearing.
- There is no reason to suppose that adjourning would secure her attendance at some future date.
- Nine witnesses are scheduled to attend to give live evidence.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that occurred in 2022 and 2023.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Brent in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her, she has made no detailed response to the specific allegations. 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. Furthermore, any disadvantage is the consequence of Miss Brent's decisions to absent herself from the hearing, waive her rights to attend,

and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Miss Brent. The panel will draw no adverse inference from Miss Brent's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse:

At Derriford Hospital

1) Between 20 August 2022 and 21 August 2022, recorded in Patient A's records:
   a) that you had administered the IV medication due at 20.00 hours to Patient A when you had not administered it;

   b) [Witness 3's] initials in the countersignature box to indicate they had been the second person who had checked the administration of Patient A's IV medication with you, when they had not done so.

2) Your conduct at charge 1a above was dishonest in that you:
   a) knew that you had not administered the IV medication to Patient A

   b) intended to create the misleading impression that you had administered the IV medication to Patient A.

3) Your conduct at charge 1b above was dishonest in that you:
   a) knew that [Witness 3] had not checked the administration of the IV medication to Patient A

   b) intended to create the misleading impression that [Witness 3] had checked the administration of the IV medication to Patient A

4) Between 21 August 2022 and 25 August 2022, crossed out [Witness 3's] initials on Patient A's records and/or wrote the initials [Witness 1] over [Witness 3's] initials.

5) Your conduct at charge 4 above lacked integrity as you sought to conceal your conduct in charge 1b above.

6) Between 20 August 2022 and 21 August 2022, inaccurately recorded [Person 1's] initials in the countersignature box in Patient B's records for checking the administration of Calvive for Patient B, when they had not done so.

7) Your conduct at charge 6 above was dishonest in that you:
    a) knew that [Person 1] had not checked the administration of Calvive to Patient B

    b) intended to create the misleading impression that [Person 1] had checked the administration of the Calvive to Patient B

At Livewell Southwest

8) On 31 August 2023, at a reflective discussion meeting for NMC revalidation, you shared a reflection "Reflective Account 5" with your proposed confirmer, which was not your own work.

9) Your actions at Charge 8 were dishonest in that you:

    a) Knew Reflective Account 5 was not your own work

    b) Intended to create the misleading impression that Reflective Account 5 was your own work.

10) On 31 August 2023, you provided an amended Reflection Account 5 to your proposed confirmer, which was not all your own work.

11) Your actions at Charge 10 above were dishonest in that you:

a) Knew the amended reflective account 5 was not all your own work
b) Intended to create the misleading impression that the amended Reflective Account 5 was all your own work.

12) On 22 September 2023, in response to a request from Livewell Southeast's investigation team to provide a copy of Reflective Account 5, you provided a different amended version of this reflection.

13) Your actions at Charge 12 were dishonest in that you:

a) Knew the different amended Reflective Account 5 provided on 22 September 2023 was not the Reflective Account 5 that you had shared at the reflective discussion meeting on 31 August 2023.

b) Intended to create the misleading impression that the different amended Reflective Account 5 was the Reflective Account 5 that you shared at the reflective discussion meeting on 31 August 2023.

14) On an unknown date between June 2023 and October 2023, you added a reflection containing a fabricated discussion between you and a female prisoner, to your Student Community Public Health Nurse training portfolio.

15) Your actions at Charge 14 above were dishonest in that you:

a) Knew that the account in your reflection was false

b) Intended to create the misleading impression that you had had a discussion with a female prisoner when you had not.

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

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

Mr D'Alton made an application for this case to be held partly in private on the basis that proper exploration of Miss Brent's case involves some reference to her health and private life. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr D'Alton took the panel through the RCN's application for this hearing to be held entirely in private. The letter states,

> *'The registrant instructs that a private hearing is required due to reasons of [PRIVATE], and she provides documentary evidence to support this request, enclosed. Miss Brent further instructs that she is not attending the hearing [PRIVATE], and that participating in the proceedings would have had a [PRIVATE].'*

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.

Having heard that there will be some reference to Miss Brent's health and private life, the panel determined to go into private session as and when such matters are raised to protect her privacy. The panel determined that there is no justification to hold the entirety of the hearing in private.

Application for non-publication of the outcome

Mr D'Alton took the panel to the RCN letter dated 5 December 2025 which included an application for non-publication of the outcome. The letter states,

'The registrant further requests that there will be no publication of the determination and/or any related documents in the public forum or on the NMC website. Miss Brent instructs that publication of the outcome would additionally have a [PRIVATE]. The panel is invited to review the enclosed [PRIVATE] as justification for the registrant's request.'

Mr D'Alton submitted that according to Article 22(9) of the Nursing and Midwifery Order 2001 ('the Order'), the NMC has a statutory duty to publish decisions made by a Fitness to Practise Committee. He submitted that the provisions of the statute can be interpreted as requiring the publication of all decisions except for those involving a registrant's physical and mental health. Accordingly, there would be both a private determination and a public (redacted) determination.

Mr D'Alton submitted that the NMC's statutory duty does not permit non-publication of an outcome merely to spare a registrant from the stress [PRIVATE] associated with a negative publication. He further argued that the evidence in support of this application is minimal and does not specifically address the impact publishing the determination would have on [PRIVATE]. He noted that the RCN provided an out-of-date [PRIVATE]. Mr D'Alton therefore asked the panel to reject the application as it is directly against NMC's statutory duty and is not supported by any substantive medical evidence.

The panel accepted the advice of the legal assessor.

The panel considered that in the first instance it seemed unlikely that it had any power to deal with matters of publication and further that in any event any detraction from the statutory obligation would have to be exceptional. In the panel's judgement, no such evidence has been presented. The panel acknowledged [PRIVATE]. However, it determined that this alone does not justify preventing the NMC from publishing the decision. The panel concluded that it would be reasonable to allow the outcome to be published, provided appropriate redactions are applied.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr D'Alton under Rule 31 to allow the hearsay evidence of Ms 1, Witness 6 and Witness 1 into evidence.

In doing so, Mr D'Alton referred to the RCN's application to exclude documentation that could be construed as hearsay in its letter dated 5 December 2025,

> *'Further to the above, we would also ask that any evidence or concerns not charged and/or not relevant to the registrant's Fitness to Practise, as well as any hearsay or opinion evidence, included within the NMC witness statements and/or exhibits bundles, or any other documents before the panel, be omitted from evidence and/or redacted and not taken into consideration when deciding this matter. We make this request as such matters are not relevant to the 5 registrant's case and in turn the panel's decision, and to include such information within the case and/or as part of the panel's decision would be unjust, unfairly prejudicial and disproportionate.'*

In respect of Ms 1's hearsay evidence, Mr D'Alton submitted that the document is a brief recollection of events dated 29 August 2022. He stated that the NMC has not engaged Ms 1 to act as a witness on behalf of the NMC. It was his submission that it is accepted that the account provided in this document is hearsay.

In respect of the hearsay evidence of Witness 6, Mr D'Alton submitted that it relates to a passage in Witness 6's recollection of events in her local investigation statement dated 31 August 2022. He said that within said statement, Witness 6 refers to receiving handover from Ms 2, who is not an NMC witness. He submitted that Ms 2 refers to an account given to her by Witness 5 and noted that Witness 5 is an NMC witness. Mr D'Alton submitted that Witness 6 only mentions Ms 2 to indicate that she was alerted to concerns about documentation. He therefore submitted that the NMC are not seeking to rely on Ms 2's account for the truth of it but simply to provide context. Mr D'Alton submitted that he did not accept that this was hearsay but drew it to the panel's attention, given the broad nature of the RCN's application to exclude documentation that could be construed as hearsay.

Mr D'Alton submitted that Witness 1's hearsay evidence is contained within the Human Resources (HR) Interview Meeting notes dated 3 November 2022. In that interview, Witness 1 refers to Ms 3 and explains that she contacted Ms 3 to confirm that she had not prepared medication and left it on the side. Mr D'Alton acknowledged that Ms 3 is not being called as a witness and therefore accepted that this evidence is hearsay.

Mr D'Alton referred to *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and asked the panel to take the following factors into account:

1. Whether the statement is the sole and decisive evidence in support of the charges;
2. The nature and extent of the challenge to the contents of the statement;
3. Whether there was any suggestion that the witness had reason to fabricate their allegation;
4. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
5. Whether there was a good reason for the non-attendance of the witness;
6. Whether the regulator had taken reasonable steps to secure the witness's attendance; and
7. Whether the registrant did not have prior notice that the witness statement would be read.

Mr D'Alton submitted that the hearsay evidence of Ms 1 and Witness 1 are in no way sole and decisive in relation to any charge. He stated that their accounts merely indicate that they did not sign a particular document and were not involved in the preparation and administration of specific medication. He added that their evidence concerns a very narrow and limited issue. Furthermore, Mr D'Alton noted that other members of staff who were involved have been called as witnesses.

In relation of Ms 1's hearsay evidence, Mr D'Alton submitted that the panel would be assisted by the shift roster for 20 August 2022. He argued that this evidence

objectively supports Ms 1's assertion that she was not working on Saturday 20 August 2022.

Mr D'Alton submitted that there is no indication that Miss Brent challenges either of these accounts. He stated that the documents were provided to her and her representatives in sufficient time and that she has been given the opportunity to respond. Consequently, Mr D'Alton submitted that the panel is entitled to take the absence of any explicit challenge into account.

Mr D'Alton submitted that there has been no suggestion, on Miss Brent's behalf, that any of her colleagues had any reason to lie. He added that nothing in Miss Brent's local responses indicate that anyone acted with malicious intent; rather she suggested that there was a miscommunication.

Mr D'Alton accepted that the charges to which Ms 1 and Witness 1's evidence speaks to are serious, but he emphasised that their accounts form only part of the evidence. He submitted that while the evidence is relevant, it is not sole and decisive.

Mr D'Alton acknowledged that no steps were taken to secure Ms 1 and Ms 3 as witnesses. However, he stated that the panel will be aware that seven other witnesses were already scheduled to give evidence about the same events. He submitted that, as there has been no objection from Miss Brent, the NMC considered it disproportionate to call other witnesses when sufficient evidence was already available from those listed.

In all the circumstances, Mr D'Alton submitted that it would be appropriate, reasonable and in line with the principles outlined in *Thorneycroft* for the panel to admit the hearsay evidence. He noted that, although the RCN appears to oppose this application, they have done so only in broad and general terms and not pointed to any specific passages in the documentation. Mr D'Alton therefore asked the panel to consider the weight that can properly be attributed to such broad and all-encompassing objections.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether it is admissible in civil proceedings.

Decision and reasons on application to admit hearsay evidence

Recollection of events by Ms 1

The panel considered that the hearsay evidence is of Ms 1 stating that she did not check the medication to be given because she was not on duty. The panel had regard to a copy of the shift roster for 20/21 August 2022 which indicates that Ms 1 was not on duty and therefore could not have countersigned. The panel found that this evidence is relevant to the charges but is not sole and decisive.

The panel determined that this evidence does not appear to be controversial and noted that the RCN have not specifically identified areas that might be controversial. Furthermore, the panel considered that there are other witnesses attending who can speak to circumstances around this evidence. The panel noted that the NMC did not call Ms 1 to give evidence because it would not be proportionate to do so. The panel accepted that Ms 1 was not asked to give evidence on behalf of the NMC because her evidence speaks to a specific part of the evidence that has not been disputed.

Recollection of events by Witness 6

The panel considered that the passage that refers to Ms 2 is relevant in terms of outlining the events that triggered the involvement of other witnesses. However, it is not the sole and decisive evidence in respect of any of the charges. Furthermore, the panel bore in mind that Witness 6, the author of the statement will be attending to give evidence, therefore, questions can be put to her.

The panel determined that this is a minor piece of evidence that does not appear to be contentious. It noted that the RCN, in its broad application to exclude any

documentation that could be construed as hearsay, had not specifically identified areas that might be controversial. In the panel's view, given the limited significance of the evidence and the fact that there will be a witness attending to address the matter, it would be disproportionate to require Ms 2 to attend as well.

Witness 1's Interview Meeting notes dated 3 November 2022

The panel noted that the hearsay evidence in the meeting notes relates to Witness 1 mentioning that she contacted Ms 3 to check whether she prepared medication and left it on the side for someone else to administer. The panel determined that this is relevant to the charges but noted that it is very distinct. In the panel's judgement, this is not the sole and decisive evidence because the relevant witness (Witness 1) is attending and will have her evidence tested. Furthermore, the panel considered that the RCN did not specifically make any objection to this evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms 1, Witness 6 and Witness 1, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

Mr D'Alton made an application under Rule 28 of the Rules to amend the wording of charges 12, 13a and 13b. This application was made after hearing the oral evidence of Witness 8 and Witness 9.

Mr D'Alton referred to Witness 9's oral evidence, in which she explained that she had asked Miss Brent, as part of her investigation, for a number of documents including the original reflective account she shared on the screen with Witness 8 at the reflective discussion meeting for revalidation on 31 August 2023. He submitted that as this version of the reflective account was only shown on the screen, it was not provided to Witness 8 at the time or since. He reminded the panel that Witness 9

also asked for the amended reflective account 5 that Miss Brent later sent to Witness 8 on 31 August 2023.

Mr D'Alton referred the panel to an email sent by Miss Brent to Witness 9 on 22 September 2023, which contained two reflective accounts. He submitted that, at the top of the first account, Miss Brent wrote *'REFLECTION IS NOT MINE ATTACHED INTO REVALIDATION PORTOFLIO BY ERROR'*. Mr D'Alton further submitted that this was the first document she claimed to have shown Witness 8 on screen at the reflective discussion meeting on 31 August 2023. He stated that the second document was labelled '*REFLECTION SENT TO [WITNESS 8] VIA EMAIL ON 31.08.2023'.*

Mr D'Alton submitted that, as currently drafted, charges 12 and 13 allege that the second document does not align with the reflection emailed to Witness 8 following the reflective discussion meeting on 31 August 2023. He submitted that comparing the two documents shows that they are, in fact, identical. Mr D'Alton stated that, in her oral evidence, Witness 8 explained that the original document that Miss Brent displayed on the screen on 31 August 2023 was different in that it contained more detail about Miss Brent's own personal experiences. Mr D'Alton submitted that Witness 8 stated that the reflective account Miss Brent emailed to Witness 9 was substantively different from the one shown on the screen at the reflective discussion meeting on 31 August 2023. In light of this evidence, Mr D'Alton invited the panel to amend charges 12 and 13 to more accurately reflect the evidence.

Mr D'Alton submitted that there is no unfairness or injustice in amending the charge because the NMC is not seeking to change the underlying substance of what is alleged. He submitted that the amendments seek to correct an error made on behalf of the NMC which has been identified and further clarified in the oral evidence of Witness 8.

Mr D'Alton acknowledged that Miss Brent will not be able to respond to this application as she has chosen not to attend this hearing. However, he submitted that Miss Brent responded to broad concerns at a local level and prior to the charges being drafted but has not responded to the specific individual charges. He submitted

that a failure to amend charges 12 and 13 in the way proposed would risk these charges not being able to be found proved on a technical drafting error when there is clear evidence of mischief. Mr D'Alton therefore submitted that it is fair, appropriate and in interest of justice to make the proposed amendments.

Proposed amendment to charges 12, 13a and 13b

> *"That you, a Registered Nurse:*
>
> *12) On 22 September 2023, in response to a request from Livewell Southeast's investigation team to provide a copy of ~~amended~~* ***Reflective Account 5,*** *you provided a different amended version of this reflection.*
>
> *13) Your actions at Charge 12 were dishonest in that you:*
>
> *a) Knew the different amended* ***Reflective Account 5*** *provided on 22 September 2023 was not the ~~amended~~* ***Reflective Account 5*** *that you had ~~provided~~* ***shared at the reflective discussion meeting*** *on 31 August 2023.*
>
> *b) Intended to create a misleading impression that the different amended Reflective Account 5 was the amended Reflective Account 5 that you ~~provided~~* ***shared at the reflective discussion meeting*** *on 31 August 2023."*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for, were in the interests of justice and added clarity to the charges. The panel was satisfied that no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to reflect the evidence the panel heard, correct an error made by the NMC and ensure clarity and accuracy.

During its deliberations, the panel noticed that the word ‘amended’ in the penultimate line of charge 13b should be deleted to reflect the substance of this charge. The panel drew this to Mr D’Alton’s attention and accordingly made the appropriate amendment.

Background

The charges against Miss Brent relate to two separate referrals.

Referral 1

On 5 October 2022, the NMC received a referral from Plymouth Hospital NHS Trust (‘the Trust’) where Miss Brent was employed as a nurse on the Neonatal Ward at Derriford Hospital (‘the Hospital’). It is alleged that during the night shift from 20 to 21 August 2022, Miss Brent recorded inaccurate information in two patient records and forged the ‘second checker’ initials and signatures of her colleagues on the relevant drug charts.

Miss Brent resigned from the Trust on 28 August 2022.

Referral 2

On 19 December 2023, the NMC received a referral from Livewell Southwest (‘Livewell’), where Miss Brent had been employed as a Student Specialist Community Public Health Nurse since September 2022. Livewell commenced an investigation on 31 August 2023 after Miss Brent allegedly provided a fabricated

reflection during a meeting with her Team Manager to review her NMC revalidation application.

On 16 October 2023, a second allegation was added to the local investigation after it was identified that Miss Brent had included an alleged fabricated reflection in her Student Community Public Health Nurse (SCPHN) training portfolio.

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 Mr D'Alton on behalf of the NMC.

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

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 witnesses called on behalf of the NMC:

- Witness 1: Staff Nurse in the Neonatal Intensive Care Unit (NICU) at the Hospital
- Witness 2: Senior Sister in the NICU at the Hospital
- Witness 3: Sister in the NICU at the Hospital

- Witness 4: Matron in the NICU at the Hospital
- Witness 5: Nurse in the NICU at the Hospital
- Witness 6: Ward manager in the NICU at the Hospital
- Witness 7: Head of Nursing for Women and Children's Services at the Hospital
- Witness 8: Line Manager at Livewell
- Witness 9: Service Manager at Livewell

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

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

Charge 1a)

"That you, a registered nurse:

At Derriford Hospital

Between 20 August 2022 and 21 August 2022, recorded in Patient A's records:

a) that you had administered the IV medication due at 20:00 hours to Patient A when you had not administered it;"

This charge is found proved.

In reaching this decision, the panel considered Patient A's records between 20 and 21 August 2022 and noted that Drugs 1, 3 and 4 on the chart had to be administered Intravenously (IV).
Drug 1 – Benzylpenicillin
Drug 3 – Caffeine Citrate
Drug 4 – Hydrocortisone

The panel had regard to Witness 1's evidence that the initials in the relevant part of the drug chart, were Miss Brent's, as she had seen it written before. Witness 1 also stated that she clearly communicated to Miss Brent during handover as Miss Brent was taking over the care of Patient A, that Patient A's IV medication due at 20:00 needed to be administered. The panel considered that Witness 1 mentioned this in her local statement dated 28 August 2022, which reads as follows:

> *'On handover of HDU1 to the night nurse (Beth) in the evening of Saturday 20th , I reviewed the drug chart and informed her of the medications which I had given (benzylpenicillin and hydrocortisone) and the medications which were due to be administered on her shift, and the times they were due – to my recollection, these were IV benzylpenicillin, caffeine and hydrocortisone, and oral probiotics, all due at 20:00. I apologised for not having time to administer the IV medications, as I had hoped to administer these at the end of my shift, but I didn't get the chance to do this, and reiterated that they were due to be given at the start of her shift. Beth confirmed what I had said and was aware that they were due.'*

The panel noted the consistency of Witness 1's oral evidence, her NMC statement dated 6 May 2024, and her local statement dated 28 August 2022. It also considered that the drug chart does not contain Witness 1's initials which would have indicated that she had administered the medication before the handover to Miss Brent.

The panel considered Witness 5's account of the incident in her local statement dated 26 August 2022, in which she explains that she was on the same shift and working in the same room as Miss Brent (High Dependency Unit). Witness 5 states,

> *'At around 22:00 on 20.8.22 I realised that myself and the other nurse (BB) in high dependency hadn't checked some of the drugs which I was aware (due to being the second checker for those same drugs the previous night) were due at 20:00 for her patient in HDU7. I reminded nurse BB that we hadn't given the IV's due for hdu7 at 20:00 to which she said that the day staff had given them when they changed the fluids.'*

The panel also considered Witness 7's account set out in her NMC statement dated 6 October 2025,

> *'I called Bethany on the same day. She explained that there had been a misunderstanding, she had signed the wrong place, and the drugs had not been administered. I asked her if she gave any drugs. Bethany said she signed in the wrong box. I then asked her whether it would be usual practice to sign for dugs when they had not been given. At that point the phone went dead – the call cut off.'*

The panel had regard to Miss Brent's local responses to the allegations. In an undated statement Miss Brent wrote:

> *'I had taken handover from staff nurse [Witness 1], I was fully under the understanding the drugs prescribed on the drug chart were given with her on the day shift therefore I did not give any drugs overnight for that specific baby.'*

The panel considered that this directly conflicts with the account given by Witness 1, who had been consistent in her evidence. The panel noted that Miss Brent accepts that she did not administer Patient A's medication and has not challenged the fact that her initials appear in the relevant part of the drug record. Furthermore, Miss Brent's explanation in the statement above appears to contradict what she had told

Witness 5 on the shift. In her local statement dated 26 August 2022, Witness 5 states:

> *'At around 02:30am on 21.8.22 whilst nurse BB was on a break, I checked the drug chart for the patient in hdu7 to see if any drugs were due and noted that nurse BB had signed for the IV drugs which she had previously said were given by day staff. I had not seen nurse BB prepare or give these drugs and the counter-signature box was not signed.'*

The panel also took account of Miss Brent's recollection of events in the investigation interview dated 25 October 2022,

> *'Remember I said they had been done under my understanding. Thought they were done on the day shift. Came back from break, drugs chart, I signed accidentally. Later remember actually they were given on the day before. I FB messaged [Witness 1] to sign when next in. I genuinely believed [Witness 1] would sign when next on shift. 2nd night shift. Read out from statement. That is my recollection. Did not think anymore of it.'*

The panel considered the differing explanations Miss Brent provided to various colleagues. It determined that Miss Brent initially stated that Patient A's medication was given by day staff, but later said she accidently signed the drug chart but had not administered the medication. In light of this, the panel preferred the consistent and corroborative evidence of Witnesses 1, 5 and 7.

For these reasons, the panel found that charge 1a proved.

Charge 1b)

> "That you, a registered nurse:
>
> At Derriford Hospital

Between 20 August 2022 and 21 August 2022, recorded in Patient A's records:

b) [Witness 3's] initials in the countersignature box to indicate they had been the second person who checked the administration of Patient A's IV medication with you, when they had not done so."

This charge is found proved.

The panel bore in mind that the preparation and administration of IV medication requires two people: one to prepare and administer the medication and a second to act as the checker and countersign on the drug chart.

The panel established from the roster for that shift that there is only one person with Witness 3's initials and she was on duty in the Intensive Care Unit (ICU), a different room to Miss Brent and Witness 5 who were in the HDU (High Dependency Unit). In her oral evidence, Witness 3 was adamant that she did not act as the second checker for Miss Brent.

Witness 5, who was also present, describes this incident in her local statement dated 26 August 2022,

'I had not seen nurse BB prepare or give these drugs and the counter-signature box was not signed. I asked Nursery Nurse [Ms 6] if she had seen nurse BB prepare or give these drugs, which she had not. Nursery nurse [Witness 2] asked the nursing staff present in intensive care at the time ([Ms 4] and [Witness 3]) if they had personally checked any drugs with nurse BB, they stated that they had not. On return from her break at 03:00, I questioned nurse BB as to who she had checked the drugs with, she replied 'It was [Witness 3].'

Witness 5 reaffirmed this in her oral evidence, stating that Miss Brent had told her that Witness 3 was the second checker. However, Witness 5 explained that she had

already spoken to the other nurses, including Witness 3. She told the panel that Witness 3 informed her that, although those were her initials, she had not acted as the second checker. This is consistent with Witness 3's local statement in which she stated,

> *'I explained it wasn't me as I was busy at the time I was "meant" to have checked the drugs and that could I see the chart. We both looked at the drug chart and I explained that yes it looked like my initials but it wasn't my writing.'*

The panel had regard to Miss Brent's local responses to the allegations. In an undated statement Miss Brent wrote:

> *'I had taken handover from staff nurse [Witness 1], I was fully under the understanding the drugs prescribed on the drug chart were given with her on the day shift therefore I did not give any drugs overnight for that specific baby.'*

Bearing in mind the inconsistencies in Miss Brent's account in comparison to the consistent accounts of Witnesses 3 and 5, the panel determined it is more likely than not that Miss Brent recorded Witness 3's initials in the counter signature box to indicate she had been the second person who had checked the administration of Patient A's IV medication with Miss Brent, when she had not done so.

The panel therefore found charge 1b proved.

Charge 2a)

> "Your conduct at charge 1a above was dishonest in that you:
>
> a) knew that you had not administered the IV medication to Patient A"

This charge is found proved.

In reaching this decision, the panel took into account that Miss Brent accepted that she did not administer Patient A's IV medication on that shift. In her undated local statement she stated,

> *'I had taken handover from staff nurse [Witness 1], I was fully under the understanding the drugs prescribed on the drug chart were given with her on the day shift therefore I did not give any drugs overnight for that specific baby.'*

The panel considered that in the same statement, Miss Brent also wrote,

> *'Overall, I admit and hugely apologise I had signed accidently for drugs I had not given, getting confused with myself, thinking I had given the drugs when infact(sic) I hadn't. Later remembering they were given the day before under my understanding.*

The panel determined that Miss Brent's admissions in the statements above indicate that she was aware at the time that she had not administered the medication. The panel does not consider Miss Brent's explanation that she *'accidentally'* signed the drug chart to be plausible. That explanation also differs from another equally implausible explanation offered to Witness 7, which was that she signed in the wrong box on the drug chart.

Accordingly, the panel found charge 2a proved.

Charge 2b)

> "Your conduct at charge 1a above was dishonest in that you:
>
> b) intended to create the misleading impression that you had administered the IV medication to Patient A"

This charge is found proved.

The panel considered Witness 1's evidence that she informed Miss Brent during handover that she needed to administer Patient A's IV medication at 20:00. Witness 1's local statement dated 28 August 2022 stated,

> *'I reviewed the drug chart and informed her of the medications which I had given (benzylpenicillin and hydrocortisone) and the medications which were due to be administered on her shift, and the times they were due – to my recollection, these were IV benzylpenicillin, caffeine and hydrocortisone, and oral probiotics, all due at 20:00. I apologised for not having time to administer the IV medications, as I had hoped to administer these at the end of my shift, but I didn't get the chance to do this, and reiterated that they were due to be given at the start of her shift. Beth confirmed what I had said and was aware that they were due.'*

The panel considered the timeline of events as detailed in Witness 5's NMC statement dated 21 May 2024. It reads as follows:

> *'At around 22:00, I realised that Bethany and I had forgotten to administer IV medication to Patient A ( ) at 20:00. I remembered this because I was the second checker for drugs for the same patient the night before. When I spoke to Bethany, she said that the day staff had already given the medication when they changed Patient A's fluids. This seemed plausible so I didn't query it and I carried on with my shift.*
>
> *At around 2:30, Bethany took her break and I cared for her patients in her absence. I reviewed the drug charts for Patient A to see if any drugs were due and saw that Bethany had signed for the IV drugs which she had told me were given by day staff. I had not seen her prepare or give these drugs and the counter-signature box was not signed. Thinking there had been a miscommunication, I approached several nurses, and all said they had not seen Bethany prepare the drugs or check them with her.*
>
> *When Bethany returned from her break at 3:00, I questioned who had checked the drugs with her and she said that it was [Witness 3]. I became*

concerned as [Witness 3] already confirmed that she did not check the drugs with Bethany and had been in ITU, the next nursery over.

After I returned from my break at around 4:30, I looked at the Patient A's drug chart again and noticed that the initials [Witness 3] were in the countersignature box on for the IV medication.'

The panel also took into account Witness 6's account set out in her NMC statement dated 17 September 2025,

'Later that evening, I spoke to Bethany. The conversation was not very long. Bethany said that she did not want to cause any trouble for us as it was her last shift. She said she couldn't remember what had happened. When I tried to probe more, she was sort of getting agitated and kept repeating that she could not remember. I couldn't get an answer from Bethany as to what happened, and I couldn't understand how she could not remember.'

The panel considered Miss Brent's explanation in her undated local statement,

'Speaking to band7 Nurse [Witness 6] feeling very anxious and worried because I knew I had signed for drugs I had not given accidentally…'

The panel considered that Miss Brent told Witness 6 that she could not remember what happened yet wrote that she had known the drugs were not given, but that she was feeling anxious about her actions. In the panel's judgment, the only plausible explanation is that she had intended to create the misleading impression at the time that she had administered the IV medication to Patient A.

Charge 3a)

"Your conduct at charge 1b above was dishonest in that you:

a) knew that [Witness 3] had not checked the administration of the IV medication to Patient A."

This charge is found proved.

The panel considered that Miss Brent accepted she had not administered Patient A's IV medication but claimed she had signed the drug chart by mistake. The panel determined that, by admitting she had not administered the medication, there was nothing for another nurse to check and sign for.

The panel also took into account Witness 3's evidence, which was consistent in stating that she did not check this medication with Miss Brent and had not countersigned the drug chart for Patient A.

For the same reasons set out in charge 1b, the panel determined that Miss Brent's conduct was dishonest in that it is more likely than not that she knew that [Witness 3] had not checked the administration of the IV medication to Patient A.

Charge 3b)

"Your conduct at charge 1b above was dishonest in that you:

b) intended to create the misleading impression that [Witness 3] had checked the administration of the IV medication to Patient A"

This charge is found proved.

The panel found that there is no plausible explanation for Miss Brent signing Witness 3's initials as the second checker, other than an intention to create the misleading impression that Witness 3 had checked the administration of the IV medication to Patient A.

Charge 4

> "Between 21 August 2022 and 25 August 2022, crossed out [Witness 3's] initials on Patient A's records and/or wrote the initials [Witness 1] over [Witness 3's] initials."

This charge is found proved.

The panel took into account Patient A's medication administration record (the drug chart) and determined that it appears that [Witness 3's] initials have been crossed out.

The panel considered the timeline of events as detailed in Witness 5's NMC statement dated 21 May 2024, as set out above in charge 2b.

The panel also had regard to Witness 1's local statement dated 28 August 2022, in which she stated,

> *'On Thursday 25 th August, I liaised with [Witness 3] in ITU about the matter, as it was her initials documented that had been crossed off. I said that I was being asked to sign for IVs that I didn't check or give, and asked if she had, despite her signature being crossed off. She said that she hadn't, and reviewed the chart herself. She then asked me to look at the signature boxes for oral probiotics prescribed for the same time and date. It appears that the initials [Witness 3] were initially signed, with the initials [Witness 1] (my initials) written over the top. I had not checked this medication, nor did I administer it.'*

The panel had regard to Miss Brent's undated local statement in which she states that she was advised to cross out the signature in the checker's box. She stated,

> *'Speaking to band7 Nurse [Witness 6] feeling very anxious and worried because I knew I had signed for drugs I had not given accidentally. I was advised to cross out that signature from the checker's box.'*

The panel therefore determined that it is more likely than not that between 21 August 2022 and 25 August 2022, Miss Brent crossed out [Witness 3's] initials on Patient A's records and/or wrote the [Witness 1's] initials over [Witness 3's]. The panel found charge 4 proved.

Charge 5

> "You conduct at charge 4 lacked integrity as you sought to conceal your conduct in charge 1b above."

This charge is found proved.

Having found charge 4 proved, the panel determined that Miss Brent's conduct in crossing out Witness 3's initial on the drug chart lacked integrity as she sought to conceal that she had recorded [Witness 3's] initials in the countersignature box as the second checker of Patient A's IV medication when Witness 3 had not done so.

The panel considered Miss Brent's evidence stating that she was advised by Witness 6 to cross out the name in the checker's box.

However, in her NMC statement Witness 6 gave a conflicting account, stating,

> *'Bethany asked me whether she should cross out the signature. I can't remember which signature she was referring to due to the passage of time, but I assume she may have been referring to both her own signature and [Witness 3's]. I categorically told her no. I explained that she could not do that and the chart needs to be photocopied. The reason for this is it is not right to change a document like that. We cannot just change what was written on the drug chart after the event, as it would look like one was falsifying or damaging the document. These types of medical document needs to be as original as possible.'*

The panel noted that Witness 6 was adamant that she did not tell Miss Brent to cross out any initials and reiterated this in her oral evidence. The panel preferred the evidence of Witness 6 because she was consistent in her account and in the panel's view, it is highly unlikely that, as a Senior Sister, she would advise Miss Brent to tamper with an official document and, in any event, there was no reason for her to do so. On consideration, the panel was mindful of the requirement to uphold the ethical standards mandatory in the nursing profession and noted that altering clinical records in this manner and against clear instructions to the contrary from a senior member of staff constitutes a clear breach of those standards.

Accordingly, the panel found charge 5 proved.

Charge 6

> "Between 20 August 2022 and 21 August 2022, inaccurately recorded [Person 1's] initials in the countersignature box in Patient B's records for checking the administration of Calvive for Patient B, when they had not done so."

This charge is found proved.

The panel bore in mind that the preparation and administration of IV medication requires two people: one to prepare and administer the medication and a second to act as the checker and to countersign on the drug chart.

The panel had regard to Patient B's drug administration record for the relevant dates and noted that Person 1's initials are written in the countersignature box as having checked he administration of Calvive for Patient B. However, according to the roster, Person 1 was not on shift. The panel also considered Witness 5's NMC statement dated 21 May 2024, which references this incident:

> *'Patient B ( ) was also being care for by Bethany. When Bethany was on her break at 2:30, I reviewed Patient B's drug charts and noticed that she was due oral medication at 12:00 but there was no signature showing that this had*

been given. I debated whether to administer this medication but did not want to double up if it had already been given by Bethany and just not signed for. I decided to wait for Bethany to come back from her break. On return from her break, Bethany said the drugs had been given but she had just forgotten to sign them.

When I was checking other drugs with Bethany at around 6:00, I noticed that checker signatures for the drugs on Patient B's chart. I noticed that the initials '[Person 1]' which I believe are the initials of [Person 1], a nurse who previously worked with on the NICU but had left before the incident occurred. I did not specifically ask who Bethany who had checked the oral drugs with but I had already asked the nurses in ITU if they had checked any drugs with her during that shift and they had all said no.'

In her local statement dated 26 August 2022, Witness 5 also mentions that she '*noticed since reviewing the drug chart of the patient in hdu8 that initials of staff who were not present on that shift have also been used as counter-signatures alongside nurse BB'.*

The panel determined that it could not have been Person 1 themselves who signed their initials as several of the witnesses confirmed to the panel in evidence that Person 1 had left the department some weeks before and there is no reason or evidence to suggest that another nurse would sign Person 1's initials instead of their own. In light of this, the panel found charge 6 proved.

Charge 7a)

"Your conduct at charge 6 above was dishonest in that you:

a) knew that [Person 1] had not checked the administration of Calvive to Patient B"

This charge is found proved.

The panel determined that, based on Witness 5's evidence, it could be inferred that Miss Brent would have been aware that Person 1 was no longer working in the department. Moreover, there was no other nurse with the same initials a Person 1 on the roster for that shift. The panel noted that Miss Brent has not answered this specific charge and has not identified any other person with these initials. As such, the panel determined that it is more likely than not that Miss Brent was dishonest in that she knew that Person 1 had not checked the administration of Calvive to Patient B.

Charge 7b)

"Your conduct at charge 6 above was dishonest in that you:

b) intended to create the misleading impression that [Person 1] had checked the administration of the Calvive to Patient B"

This charge is found proved.

The panel determined that there was no plausible explanation for Miss Brent recording Person 1's initials other than an intention to create the misleading impression that Person 1 had checked the administration of Calvive to Patient B.

Charge 8

The panel's understanding of the different versions of Reflective Account 5 is that, in essence, there are three versions. The first (version 1), is the reflective account Miss Brent shared on the screen in her reflective discussion meeting with Witness 8 on 31 August 2023. Version 2 was the account Miss Brent emailed to Witness 8 approximately 20 minutes after that meeting. Version 3 is the account provided to the investigation team on 22 September 2023, which Miss Brent claimed was the original version shown on the screen to Witness 8.

"On 31 August 2023, at a reflective discussion meeting for NMC revalidation, you shared a reflection "Reflective Account 5" with your proposed confirmer, which was not your own work."

This charge is found proved.

The panel was satisfied that the reflective discussion meeting took place on 31 August 2023 with Witness 8 for the purpose of Miss Brent's NMC revalidation.

The panel had regard to Witness 8's NMC statement dated 24 April 2024, which details the incident, stating,

> *'When I challenged Bethany, she said that she had attached someone else's work by mistake as another student had shared their reflection with her. I knew that this was not a reasonable excuse as Bethany had titled the document 'Reflection 5' and clearly intended to pass the work off as her own. When I asked Bethany where her own work was, she became flustered and pretended to look for a document which obviously did not exist. I ended the meeting and said I was not comfortable with continuing. I told Bethany to find her reflection and send it to me.'*

The panel took into account the transcript of the investigation meeting held on 22 September 2023 with Miss Brent, Witness 9 and Ms 5, during which Miss Brent stated,

> *'That's not my reflection. I'm really sorry I've attached the wrong reflection into My Portfolio.'*

The panel determined that Miss Brent appears to accept that she shared a reflective account with her confirmer that was not her own. Accordingly, the panel found charge 8 proved.

Charge 9a and 9b

"Your actions at charge 8 above were dishonest in that you:

a) Knew Reflective Account 5 was not your own work

b) Intended to create the misleading impression that Reflective Account 5 was your own work."

These charges are found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

Witness 8 in her oral evidence stated that Miss Brent presented Reflective Account 5 as part of the revalidation portfolio as it was the fifth reflective account in the series of reflections for the revalidation document. The panel heard that during this meeting when it was noticed that reflection 5 was not Miss Brent's own work, she was unable to locate her own reflection 5 in her laptop at the meeting. This was despite being assisted by Witness 8 when she suggested that Miss Brent make a search for it in the search bar.

In relation to Miss Brent's intention to create a misleading impression that Reflective Account 5 was her own work, the panel had regard to an email Witness 8 sent to Miss Brent after the reflective discussion meeting on 31 August 2023. Witness 8 stated,

'It was not until I challenged you further on that this was not your own reflection did you admit it was not.'

In the panel's view, it should have been immediately obvious to Miss Brent during her meeting with Witness 8 that Reflection Account 5 (version 1) was not her own work as they were both reading it on screen together. However, the evidence

suggests that she only admitted to it not being her own work when challenged by Witness 8.

The panel noted that Miss Brent has not specifically answered this charge in terms of the inconsistencies other than to state that it was an administrative error.

For these reasons, the panel determined that Miss Brent's actions at charge 8 were dishonest in that she knew Reflective Account 5 (version 1) was not her own work and intended to create the misleading impression that it was. The panel therefore found charges 9a and 9b proved.

Charge 10

> "On 31 August 2023, you provided an amended Reflection Account 5 to your proposed confirmer, which was not all your own work."

This charge is found proved.

The panel had regard to Miss Brent's email to Witness 8 sent 20 minutes after their meeting in which she then claimed that this now contained the correct reflective account 5. It reads as follows:

> *'I have had a quick look and have just found the correct reflection on my home laptop which I do most of my SCPHN work on.*
>
> *Huge apologies for the hiccup – I attached someone else's reflection by accident and did not read it through before showing you.*
>
> *Attached is the correct reflection which is mine of which I have now attached to me revalidation portfolio which I will show you tomorrow.'*

Witness 8 told the panel that the amended reflective account (version 2) sent following the meeting on 31 August 2023 was not the same as the one that was

shown on the screen (version 1). Witness 8 was able to explain in detail that version 1 included references to Miss Brent's children, but these references were not in version 2. Witness 8 stated to the panel that it had been these references that had first alerted her to the account not being Miss Brent's own work as she was aware that Miss Brent did not have children. The panel also took into account Witness 8's supplementary NMC statement dated 14 August 2025 which states,

> *'The use of the terminology, brachycephaly, in the second reflection made me believe that she had cut and pasted the first reflection, and tried to amend it, rather than provide a different reflection. In the conclusion of her second reflection, I would have expected her to discuss child obesity, nutrition, and give evidence-based advice, rather than talk about the shape of the child's head. There was no reason for the word, brachycephaly, to be included in her second reflection, especially when talking about the nutritional advise for a child.'*

The panel also took into account an email Witness 8 sent to Miss Brent after the reflective discussion meeting on 31 August 2023. Witness 8 stated,

> *'The reflection you then emailed to me has continued to raise my concerns, as it appears to be cut and paste from the original one I read with yourself.'*

The panel preferred the evidence of Witness 8 as she was detailed and consistent in her oral evidence and in her correspondence with Miss Brent about the inconsistencies in the reflective accounts she was providing. The panel therefore found that it is more likely than not that Miss Brent provided an amended Reflective Account 5 (version 2) to Witness 8, which was not all her own work.

The panel found charge 10 proved.

Charge 11a)

> "Your actions at charge 10 above were dishonest in that you:

a) Knew the amended reflective account 5 was not all your own work”

This charge is found proved.

The panel determined that Miss Brent knew the amended Reflective Account (version 2) was not her own work at the time she sent it to Witness 8. The panel noted that when Miss Brent submitted version 2 to Witness 8, she had been given time to locate the correct copy and had stated in her email to Witness 8 that it was correct. The panel determined that Miss Brent knew that it was still not her own work because, according to Witness 8 (who had read through version 1 on screen), version 2 was largely the same as the first reflective account (version 1) as it contained sections that had been copied and pasted from version 1 and also contained a reference to Brachycephaly which, according to Witness 8, was out of context. In the panel’s view, this demonstrates that Miss Brent was aware that version 2 was not her own work.

For these reasons and for the reasons set out in charge 10, the panel found charge 11a proved.

Charge 11b)

“Your actions at charge 10 above were dishonest in that you:

b) Intended to create the misleading impression that the amended Reflective Account 5 was all your own work”

This charge is found proved.

The panel determined that there is no plausible reason for Miss Brent submitting version 2 of Reflective Account 5 as her own while knowing that it was not, other than an intention to create the misleading impression that it was all her own work. The panel therefore found charge 11b proved.

Charge 12

> "On 22 September 2023, in response to a request from Livewell Southeast's investigation team to provide a copy of Reflective account 5, you provided a different amended version of this reflection."

This charge is found proved.

The panel considered the email Miss Brent sent to Witness 9 on 22 September 2023 which she claimed contained the relevant documents requested during her investigation interview earlier that day.

The panel took into account Witness 8's oral evidence during which she was shown version 3. Witness 8 was adamant that the reflective account she saw on the screen during the meeting with Miss Brent (version 1) on 31 August 2023 was not the account Miss Brent submitted to the investigation team as evidence on 22 September 2023 (version 3), but it was sent as though it was. She explained that she noticed differences between the Reflective account version 3 that was emailed to Witness 9 and version 1 that was shown to her on the screen at the reflective discussion meeting on 31 August 2023. She stated that one difference was that version 1 included the following:

> *'I did reassure one mum advising my children had this and it is very common'.*

However, version 3 stated,

> *'There were other concerns from two separate mums regarding their babies having flat shaped heads.'*

Witness 8 told the panel that she remembers version 1 in detail because she had *"never experienced anything like this"* so she ended the meeting because she needed advice from Human Resources (HR). Witness 8 recalls what she felt was

“disbelief” that someone could act in this way. The panel gave weight to Witness 8’s evidence because she was detailed in her recollection of version 1 and was consistent and clear in identifying the inconsistencies in version 3.

The panel determined that it is more likely than not that Miss Brent, in response to a request from Livewell Southeast’s investigation team to provide a copy of Reflective account 5, provided a different amended version of this reflection. The panel therefore found charge 12 proved.

Charge 13a)

> “Your actions at charge 12 were dishonest in that you:
>
> a) Knew the different amended Reflective Account 5 provided on 22 September 2023 was not the Reflective Account 5 that you had shared at the reflective discussion meeting on 31 August 2023.”

This charge is found proved.

The panel determined that Miss Brent must have known that version 3 was not the same reflective account 5 she showed Witness 8 in the reflective discussion meeting on 31 August 2023 (version 1) because it had been amended and submitted by her.

In the transcript of the local investigation meeting on 22 September 2023, the panel noted that Miss Brent is made aware that the investigation team does not have any of the reflective accounts and she agrees to send both versions by email, which she did. However, Witness 8 informed the panel that the version sent to the investigations team (version 3) was not the same as version 1.

The panel determined that it is more likely than not that Miss Brent knew that version 3 was not the same as version 1 when she sent the reflective account to the investigation team. The panel therefore found charge 13a proved.

Charge 13b)

"Your actions at charge 12 were dishonest in that you:

b) Intended to create the misleading impression that the different amended Reflective Account 5 was the amended Reflective Account 5 that you shared at the reflective discussion meeting on 31 August 2023."

This charge is found proved.

The panel determined that there is no plausible reason for Miss Brent providing version 3 of Reflective Account 5 and claiming that it was the same as version 1, other than an intention to create the misleading impression that the two versions were the same. The panel therefore found charge 13b proved.

Charge 14

"On an unknown date between June 2023 and October 2023, you added a reflection containing a fabricated discussion between you and a female prisoner, to your Student Community Public Health Nurse training portfolio."

This charge is found proved.

The panel concluded that the reflection describing a discussion between Miss Brent and a female prisoner was fabricated as it heard in evidence that the prison she claimed to have visited was a male only prison. During the investigation meeting on 22 September 2023 with Witness 9, Miss Brent confirmed that this was the only prison she had visited, which indicates that the alleged interaction could not have occurred.

The panel therefore found charge 14 proved.

Charge 15a)

"Your actions at charge 14 above were dishonest in that you:

a) Knew that the account in your reflection was false"

This charge is found proved.

The panel determined that Miss Brent knew the account in her the reflection was fabricated because Witness 9, in the investigation meeting held 22 September 2023, informed Miss Brent that the prison she referred to in her reflection was in fact an all-male prison. Upon hearing this, Miss Brent changed her account and claimed that her reflection was in reference to the experience of a male prisoner's female partner when previously she had recorded her detailed conversations with a female prisoner. In light of this, the panel determined that Miss Brent's actions at charge 14 were dishonest in that she knew the account was false.

The panel therefore found charge 15a proved.

Charge 15b)

"Your actions at charge 14 above were dishonest in that you:

b) Intended to create the misleading impression that you had had a discussion with a female prisoner when you had not."

This charge is found proved.

The panel determined that, in the light of the evidence, it could not draw any conclusion other than that Miss Brent intended to create a misleading impression that she had had a discussion with a female prisoner and, when challenged with the

fact that the prison she referred to was an all-male prison, accepted that there was no female prisoner.

The panel therefore found charge 15b proved.

In his closing submissions, Mr D'Alton submitted that the evidential principle of cross-admissibility was applicable both to the charges relating to clinical records (on the basis of lack of coincidence) and to the charges relating to revalidation materials (on the ground of propensity). The panel has reached its conclusions in relation to each of these charges by considering them separately. However, it did conclude that there was a sufficient connection and similarity between (respectively) the allegations relating to clinical records and the allegations relating to revalidation materials to render respectively cross admissible the evidence in relation to these charges. However, this conclusion only reinforced the panel's primary findings based on the strength of the evidence in relation to each individual charge.

The panel also bore in mind the evidence of Miss Brent's previous good character. However, it did not consider that this fact was sufficient to outweigh the factual evidence in relation to each charge.

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 Brent'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 Brent's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr D'Alton referred 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.'* He also referred to the cases of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Mr D'Alton invited the panel to take the view that the facts found proved amount to misconduct. Mr D'Alton referred to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified the specific and relevant sections of the Code that were breached as a result of Miss Brent's conduct: 1.2, 1.4, 8.2, 8.3, 8.5, 8.6, 10.1,10.2, 10.3, 10.4, 20.1, 20.2.

Mr D'Alton submitted that Miss Brent's actions in the charges found proved in relation to Patients A and B, clearly demonstrates breaches of the sections of the Code requiring the fundamentals of care to be delivered effectively and the treatment be provided without undue delay.

Mr D'Alton further submitted that Miss Brent's actions ensured that incorrect information was handed over to colleagues on the following shift in respect of the care of both vulnerable babies (Patients A and B). He put to the panel that this clearly represents a lack of proper cooperative working and a breach of the requirement to share and identify information to reduce risk. Additionally, Mr D'Alton submitted that Miss Brent's failure to clearly and accurately record essential information required for patient care and the falsification of patient records had the potential to have a serious impact on patient care.

Mr D'Alton submitted that Miss Brent's actions in respect of both referrals represents a lack of honesty and integrity. He submitted that, in essence, Miss Brent's actions do not uphold the values set out in the Code.

Mr D'Alton submitted that Miss Brent's actions are incredibly serious acts which fall short of what would be expected of any registered professional. It was Mr D'Alton's submission that Miss Brent made mistakes in respect of medication administration for Patients A and B. Moreover, rather than owning up to her mistakes, identifying them so that they could be rectified and acting in the best interest of patients, it was Mr D'Alton's submission that Miss Brent acted in her own best interest and attempted to conceal her actions by dishonestly amending patient records.

In respect of referral 2, Mr D'Alton reminded the panel that Miss Brent lied in multiple reflective pieces and attempted to present matters as her own lived experiences. He submitted that Miss Brent lied as part of the NMC revalidation process, which is intended to ensure that registrants remain appropriately up to date with their practice and remain safe and effective practitioners. However, Mr D'Alton's submission was that, by acting dishonestly, Miss Brent acted in her own interest rather than in the interests of the wider profession and patients.

Mr D'Alton submitted that Miss Brent's actions, both individually and collectively, represent a serious departure from the standards expected of a registered nursing professional and therefore amounted to misconduct.

Submissions on impairment

Mr D'Alton 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.

Mr D'Alton took the panel through the limbs set out by Dame Janet Smith in the Fifth Shipman Report and set out in the case of *Grant* [2011] EWHC 927 (Admin):

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'*

Mr D'Alton submitted that all four limbs are engaged in this case. He took the panel through each limb and answered in the affirmative in terms of Miss Brent's actions in the past and the likelihood of repetition in the future.

Mr D'Alton submitted that Miss Brent's dishonesty indicates underlying attitudinal concerns that create a serious risk of harm to patients. He stated that it is fundamental to this practice that a registrant can be relied on to be open and honest and put the needs of the patients above their own individual needs, particularly with fundamentals of care such as medication administration and the associated record keeping. Mr D'Alton said that it is essential that a registrant can be relied on to administer medication and for it to be accurately recorded. He submitted that although no actual harm was observed with respect to Patients A and B, missing medication administration or carrying out the administration without a second checker creates a risk of serious harm to patients.

Mr D'Alton acknowledged that mistakes do occur in medication administration but submitted this is why honesty is such a fundamental aspect of nursing practice. It was Mr D'Alton's submission that in this case, instead of acknowledging any errors in her actions, Miss Brent on each occasion, lied and sought to cover up her actions. Mr D'Alton submitted that Miss Brent's conduct in respect of referral 1, could be regarded as a single instance as it occurred on a single shift and, as such, may not

be indicative of a broader attitudinal concern. However, it was his submission that her actions in respect of referral 2 suggests deep seated attitudinal issues as the charges found proved indicate that Miss Brent appears to have an underlying and fundamental issue with openness and honesty.

Mr D'Alton asked the panel to consider that Miss Brent, to date, has not presented any substantive reflection or insight to demonstrate that she has addressed the underlying concerns. Mr D'Alton therefore submitted that there remains a serious risk of similar conduct being repeated. As such, he invited the panel to make a finding of impairment on the ground of public protection.

Mr D'Alton submitted that acting with honesty and integrity is a fundamental tenet of the nursing profession. He stated that repeatedly lying both in a clinical context and when completing her revalidation, demonstrates a serious departure from these fundamental requirements. In acting in the way she did, Mr D'Alton submitted that Miss Brent has brought the nursing profession into disrepute.

Mr D'Alton stated that members of public place their trust in nurses and rely on them when they are most vulnerable. It was his submission that members of the public, aware that a registered nurse had repeatedly lied to cover up both clinical errors with highly vulnerable patients and falsely claimed work as her own during the revalidation process, could lose faith in the nursing profession and the NMC as its regulator if a finding of impairment was not made. He further submitted that a member of the public would be concerned that Miss Brent's actions in referral 1 put newborn babies, in the HDU, at risk of harm. In light of this, Mr D'Alton submitted that finding of impairment is also required on public interest grounds.

The panel accepted the advice of the legal assessor.

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 Brent's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Brent's 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

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay'

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

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk.'

*'**10 Keep clear and accurate records relevant to your practice***

To achieve this, you must:

10.1 complete 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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has noy 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 time and do not include unnecessary abbreviations, jargon or speculation'

*‘**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, treating people fairly without discrimination, bullying or harassment.’

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

Referral 1

The panel took into account the particular vulnerability of the babies (Patient A and Patient B) who Miss Brent was caring for at the time. The panel heard in evidence that the staff to patient ratio in the HDU was at most 1:2 and it is aware that the medication was prescribed and had to be administered to the babies at certain times of the day. The panel considered that Miss Brent was well aware of her responsibilities, as a nurse who had previously been deemed competent to work on this specialist ward. Despite Miss Brent’s awareness of the risks of not following these instructions, she failed to administer the IV medication to both Patients A and B. Furthermore, the concerns were compounded by Miss Brent’s falsification of two drug charts and subsequently lying to her colleagues, including senior managers. The panel determined that there was a significant risk of harm to both Patient A and Patient B. Although this was a single shift, there were multiple instances and actions of dishonesty.

Referral 2

The panel determined that as a registered nurse, Miss Brent is expected to demonstrate safe and effective practice and part of that process is revalidation and submitting the necessary documentation. In the panel’s view, Miss Brent’s actions indicate a disregard for the principles that are put in place to uphold standards of professional practice and to keep patients safe. The panel considered that Miss Brent’s dishonesty was sustained by repeatedly submitting reflective accounts that

she knew were not her own work with an intention to create a misleading impression that they were her own as well as fabricating a discussion with a female prisoner in her training portfolio.

The panel took the view that fellow practitioners would find Miss Brent's conduct deplorable. Accordingly, the panel found that Miss Brent's actions in the charges found proved fell 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 Brent's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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 the limbs of *Grant* are relevant and engaged in this case.

In the panel's judgement, Miss Brent's misconduct put Patients A and B at an unwarranted risk of harm. The panel determined that Miss Brent's repeated and deliberate dishonest conduct brought the profession into disrepute and breached the fundamental professional tenets of preserving safety and promoting professionalism and trust. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

There has been no recent nor substantial response from Miss Brent addressing the specific concerns, as such, the panel determined that she is liable in the future to put patients at an unwarranted risk of harm, breach the fundamental tenets and bring the nursing profession into disrepute.

The panel had no evidence of insight, remorse or remediation and considered that Miss Brent has not provided a comprehensive response to the charges that would lead the panel to find that she no longer poses a risk. In the panel's judgment, Miss Brent has not demonstrated an understanding of how her actions put the Patients A and B at risk of harm, nor has she demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel determined that Mrs Brent's misconduct in this case may be capable of being addressed. However, in light of the long-standing pattern of deliberate and pre-meditated deception and the underlying attitudinal concerns identified, the panel determined that Miss Brent's misconduct would be more difficult to remediate. Notwithstanding, the panel noted that Miss Brent has not provided any evidence of remediation, no comprehensive reflection addressing the specific concerns and no evidence of strengthened practice or relevant training. The panel noted that it has no information detailing what Miss Brent is currently doing in terms of professional practice and is therefore unable to determine how she might handle similar situations in the future.

Given the lack of information, the pattern of dishonesty and the absence of insight, the panel can only conclude that Miss Brent's state of mind remains the same as it was when these incidents occurred. Accordingly, the panel determined that there is a high likelihood of repetition. The panel therefore decided that a finding of impairment is necessary on the ground 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.

In the panel's view public confidence in the nursing profession would be seriously undermined if a finding of impairment were not made in this case, given the seriousness of the charges found proved and the deep-seated attitudinal concerns relating to dishonesty. The panel concluded that Miss Brent's misconduct combined with the risk of repetition, makes a finding of impairment on public interest grounds necessary in order to uphold proper professional standards of conduct and performance.

Having regard to all of the above, the panel was satisfied that Miss Brent'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 Brent off the register. The effect of this order is that the NMC register will show that Miss Brent 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

Mr D'Alton informed the panel that in the Notice of Hearing, dated 5 November 2025, the NMC had advised Miss Brent that it would seek the imposition of a striking off order if the panel found Miss Brent's fitness to practise currently impaired.

Mr D'Alton submitted that the aggravating factors in this case are as follows:

- No evidence of insight, remorse or remediation
- Deep-seated attitudinal concerns
- Sustained dishonesty
- Conduct which placed vulnerable patients at risk of harm

Mr D'Alton submitted that there are no particular mitigating features in this case aside from the fact that there have been no previous regulatory findings against Miss Brent, though it should be borne in mind that this case relates to two separate referrals.

Given the extremely serious nature of Miss Brent's conduct, Mr D'Alton submitted that no order other than a striking off order would be appropriate in this case.

Mr D'Alton submitted that taking no further action or imposing a caution order would be inappropriate in this case. He stated that the NMC guidance (SAN 3a and SAN 3b) makes it clear that they should be imposed in cases where the registrant's conduct is at the lower end of spectrum of seriousness. It was his submission that this is a case which cannot be said to fulfil this criteria and as such, the public protection would not be satisfied by the imposition of these orders.

Mr D'Alton argued that a conditions of practice order could not be formulated in this case, given the nature and seriousness of the charges found proved. In particular, the matters relate to underlying attitudinal concerns and multiple instances of dishonesty. He submitted that, in light of the high likelihood of repetition, there are no

workable, measurable or proportionate conditions capable of addressing Miss Brent's misconduct. Mr D'Alton further submitted that there is clear evidence of deep-seated attitudinal concerns and no indication of a willingness to comply with conditions; accordingly, the imposition of conditions would present a risk to patients.

Mr D'Alton submitted that Miss Brent's misconduct involved multiple instances of dishonest conduct which persisted across two separate cases and with two separate employers. He reminded the panel that there is evidence of attitudinal concerns and a distinct lack of insight and submitted that a suspension order would therefore not be appropriate in this case. Furthermore, Mr D'Alton stated that this is a case where, even if there was a reasonable prospect of remediation, Miss Brent has expressed no desire to address these concerns. Mr D'Alton therefore questioned what purpose a suspension order would serve, in a circumstance where, in all likelihood, the position would remain unchanged after a review of the sanction.

Mr D'Alton referred to the NMC guidance on striking off orders (SAN-3e) and took the panel through the three primary considerations, as follows:

- *'Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not struck off from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

In respect of the first question, Mr D'Alton submitted that the nature of Miss Brent's misconduct does raise serious and fundamental questions about her professionalism. He stated that honesty and integrity are fundamental tenets of the nursing profession which Miss Brent has breached on multiple occasions over a sustained period of time by lying repeatedly and putting her interests above the interests of patients and the wider profession.

In respect of the second question, Mr D'Alton submitted that public confidence could not be maintained by a suspension order as Miss Brent's actions fall into the most serious category involving repeated dishonesty. He reminded the panel that the NMC guidance SAN-2 makes clear that dishonesty can be assessed as less or more serious, depending on a range of factors. He submitted that several factors indicating increased seriousness are engaged in this case, including dishonesty that has the potential of harm to a patient, sustained or repeated dishonesty and dishonesty carried out for the registrant's own benefit.

Mr D'Alton submitted that a member of the public would be deeply troubled that a registered nurse would undertake such conduct and might question the integrity of the register if Miss Brent was permitted to continue to practise. He added that it would have the potential to damage public confidence in the nursing profession.

In respect of the third question, Mr D'Alton submitted that Miss Brent has not demonstrated any desire or effort to address the underlying misconduct. He stated that there is no evidence in this case of remorse, insight or remediation and no evidence to suggest that in due course this position will change. Mr D'Alton reminded the panel that these charges date back to 2022 and 2023 respectively. He submitted that the issues were first raised with Miss Brent at the time of these events, meaning she has had over three years to reflect on her conduct and take some action to strengthen her practice. It was Mr D'Alton's submission that, to date, the panel have no evidence that she has done so. In this context, it was submitted that there is no reasonable prospect of Miss Brent gaining any level of remediation and imposing any lesser order than a striking off order would serve no real purpose.

Mr D'Alton put to the panel that it is also worth considering the effect of these matters on Miss Brent's health. He reminded the panel that Miss Brent has said that the fitness to practise process is having a [PRIVATE], which is why she has not engaged with this hearing. He submitted that the NMC would question whether imposing an order other than striking off order, which would require further engagement from Miss Brent at a review, might be [PRIVATE], in circumstances where she has expressed no desire to continue practising. He submitted that any order with a review, would leave these matters as an outstanding question over Miss

Brent's head, rather than bringing the matter to a substantive conclusion, as a striking off order would. However, Mr D'Alton acknowledged that imposing a striking off order may also have a detrimental impact on Miss Brent.

Mr D'Alton submitted that a striking off order is the only appropriate order, in line with the evidence before the panel and the findings the panel has already made.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Brent'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 took into account the following aggravating features:

- Lack of insight and remediation
- A pattern of misconduct over a period of time
- Sustained and premeditated dishonesty
- Conduct which put particularly vulnerable patients at risk of suffering harm
- Reckless disregard of safety procedures and processes
- Deep-seated attitudinal concerns

The panel determined that there are no mitigating features in this case. Although the panel recognised that Miss Brent has had no previous regulatory findings against her practice, it did not consider this to be a mitigating feature in this case.

The panel had regard to the NMC guidance SAN-2 (Sanctions for particularly serious cases) and considered that several factors indicating increased seriousness are engaged in this case, including:

- *'deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *…*
- *vulnerable victims*
- *…*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception'*

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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 Brent'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 considered that Miss Brent's 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 it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Brent's 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 serious nature of the charges in this case. The panel noted that there is no indication of a willingness by Miss Brent to comply with conditions if they were to be imposed.

Moreover, the misconduct identified in this case was not something that can be addressed through retraining. The panel therefore concluded that the placing of conditions on Miss Brent's registration would not address the concerns identified or 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 or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel is of the view that none of the factors above are engaged in this case. Miss Brent's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Brent's actions is fundamentally incompatible with Miss Brent remaining on the register. In light of the repeated and premeditated dishonesty and the lack of insight, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering 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?*

Miss Brent's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Brent's actions were extremely serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel considered the seriousness of Miss Brent's misconduct, which involved multiple instances of dishonesty across two employers and, in the case of referral 1, put particularly vulnerable patients at serious risk of harm. The panel determined that Miss Brent's actions were self-serving and demonstrate a disregard for professional standards. The panel noted the lack of meaningful reflection or insight into the seriousness of her actions, despite three years having passed since the first incident occurred.

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

The panel considered that this order was necessary 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 Miss Brent in writing.

Renewed application for non-publication

Mr D'Alton brought to the panel's attention a further email from the RCN dated 9 December 2025 in which Miss Brent provided more information about her current health. The email is as follows:

'[PRIVATE]'

Mr D'Alton also brought to the panel's attention a further email from Miss Brent dated 16 December 2025 which reiterated the above.

Mr D'Alton submitted that the NMC reaffirms that the panel should have further consideration of this issue. Although it is for the Adjudications Team's to make the final decision on publication, any opinion given by the panel would be given significant weight.

Mr D'Alton submitted that the panel has not been provided with any information to effectively undermine the panel's original decision, as outlined earlier in this determination. He stated that the only medical information from Miss Brent remains a [PRIVATE] from earlier this year. He submitted that Miss Brent has not provided any means of obtaining further [PRIVATE] and has not given consent for the NMC to obtain further information [PRIVATE]. It was his submission that, [PRIVATE] do not justify non-publication of these matters. Mr D'Alton put to the panel that although Miss Brent has reiterated her position, it is no further forward than what has already been considered.

The panel accepted the advice of the legal assessor.

The panel acknowledged the renewed communication from Miss Brent. However, the panel remains of the view that it would be inappropriate to provide any direction or opinion with regard to the question of publication.

First of all, the panel has no power under the Nursing and Midwifery Order 2001 to direct publication or non-publication of its determination. The statutory responsibility for publication is placed upon Council.

Secondly, the panel has no material before it which is not equally available to the Council.

Thirdly, the panel has no medical evidence before it to authenticate Miss Brent's assertions with regard to [PRIVATE] and the impact that publication may have.

Accordingly, the panel does not consider that it would be appropriate for it to provide any opinion in relation to publication.

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 Brent's own interests until the striking-off sanction takes effect. The panel accepted the advice of the legal assessor.

Submissions on interim order

Mr D'Alton invited the panel to impose an 18-month interim suspension order to protect the public and maintain public confidence, as well as to cover any appeal period. He submitted that there are clear public protection and public interest concerns given the risk of repetition that the panel has identified and the finding of impairment. He submitted that an interim conditions of practice order would not be appropriate in this instance.

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 for the time that may be taken before an appeal can be heard. Not to do so would be inconsistent with the sanction imposed.

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

That concludes this determination.