Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 27 – Thursday, 30 October 2025
Monday, 3 – Wednesday, 5 November 2025

Virtual Hearing

Name of Registrant:	**Anna Marie Curran**
NMC PIN:	96I3585E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (27 September 1999)
Relevant Location:	Hertfordshire
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, lay member) Sophie Agolini (Registrant member) Olan Jenkins (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Franchessca Nyame
Nursing and Midwifery Council:	Represented by Unyime Davies, Case Presenter
Miss Curran:	Not present and unrepresented at the hearing
Facts proved:	Charges 1 in its entirety, 2 and 3
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on panel recusal

It was brought to the panel's attention that the findings of an internal investigation report regarding Patient A was included in the documentation before it for this hearing.

The legal assessor made reference to the case of *Enemuwe v NMC* [2015] EWHC 2081 (Admin) which stipulates that the findings and conclusions of an investigation report are inadmissible. He noted that the panel had previously read the documentation which included the internal investigation report and put forward that, if the panel could not put the findings of that report out of its minds, then it should recuse itself from this case in the interest of fairness.

Ms Davies, on behalf of the Nursing and Midwifery Council (NMC), acknowledged and agreed with the advice of the legal assessor. She assured the panel that it would be receiving a new bundle of documentation with redactions made, namely of the internal investigation report.

The panel heard and accepted the advice of the legal assessor.

The panel considered that it is an independent and professional panel. It determined that it could safely and fairly put the outcome of the internal investigation report out of its mind when making findings of fact in respect of the charges and rely solely on the evidence before it, which would consist of witnesses' oral evidence and the redacted bundle of documentation it would soon receive.

The panel therefore decided it was not necessary to recuse itself and proceeded with the hearing.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Curran was not in attendance and that the Notice of Hearing letter had been sent to Miss Curran's registered email address by secure email on 25 September 2025.

Ms Davies 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, date and that the hearing was to be held virtually and, amongst other things, information about Miss Curran'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 Curran 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 Curran

The panel next considered whether it should proceed in the absence of Miss Curran. It had regard to Rule 21 and heard the submissions of Ms Davies who invited the panel to continue in the absence of Miss Curran.

Ms Davies informed the panel that emails were sent to Miss Curran by her NMC Case Coordinator enquiring as to whether she was going to attend this hearing on 29 September 2025 and 21 October 2025. The NMC received a response from Miss Curran on 30 September 2025, in which she wrote:

'*I wish to voluntarily remove my name from the register.*'

Ms Davies highlighted that Miss Curran did not respond to the NMC's queries as to whether she would be attending the hearing, and therefore invited the panel to consider that she has voluntarily absented herself.

Ms Davies submitted that there has been minimal engagement from Miss Curran with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance at some future date. She further submitted that there is a strong public interest in the expeditious conclusion of cases like this, and also Miss Curran herself to reach a conclusion as to what is going on with her case.

Ms Davies also raised that there are three witnesses warned to attend this hearing, all of whom would be inconvenienced were this hearing to be adjourned for a later date when of course there has been no engagement from Miss Curran regarding whether she will be in attendance or if she wants the hearing adjourned.

Ms Davies therefore submitted that it is fair, appropriate and proportionate for all parties for this panel to decide to proceed in the absence of Miss Curran.

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Miss Curran. In reaching this decision, the panel considered the submissions of Ms Davies and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)*

(No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162, and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Miss Curran has not engaged with the NMC and her only response to the NMC was on 30 September 2025 to say that she wished to voluntarily remove her name from the NMC register;
- No application for an adjournment has been made by Miss Curran;
- There is no reason to suppose that adjourning would secure Miss Curran's attendance at some future date;
- A number of witnesses are due to attend this hearing 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 2021 so further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Curran in proceeding in her absence. Miss Curran will not be able to challenge the evidence relied upon by the NMC 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, the limited disadvantage is the consequence of Miss Curran'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 Curran. The panel will draw no adverse inference from Miss Curran's absence in its findings of fact. In drawing no adverse inference, the panel is cognisant that, in the fact-

finding stage, the burden is upon the NMC to prove each charge on the balance of probabilities. Further, the panel noted that, at this stage of the hearing, Miss Curran does not have to disprove the NMC's case.

Details of charge

That you, a registered nurse on 6 May 2021:

1. Falsified Patient A's MAR chart in that you recorded that:
    a) you administered 20ml Baclofen to Patient A at 18:00
    b) you administered 300mg Epilim to Patient A at 18:00
    c) you had administered 500mg Paracetemol to Patient A at 13:00 and 18:00
    d) you had administered 50mg Phenytoin sodium to Patient A at 14:00 and 18:00
    e) you had administered 100mg Thiamine to Patient A at 18:00
    f) you had administered 200ml Ensure Twocal at:
        i. 10:00
        ii. 12:00
        iii. 16:00
        iv. 18:00

2. Your conduct at one or more of Charges 1 (a) to (f) was dishonest in that you recorded that you had administered medication/nutrition to Patient A when you had not done so.

3. About 6 May 2021 failed to suction Patient A following a request from Person B, Patient A's relative.

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

Ms Davies made an application pursuant to Rule 19 of the Rules for all of Person B's oral evidence to be heard in private on the following bases:

- Due to the nature of Person B's evidence, [PRIVATE];
- [PRIVATE];
- [PRIVATE];
- Potential "*jigsaw identification*" of Patient 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 Ms Davies' reasoning for this application and the advice of the legal assessor, the panel decided to hear Person B's oral evidence wholly in private. [PRIVATE].

Background

Miss Curran was employed at Water Mill Care Home (the Home), operated by Carebase, as a Clinical Lead Nurse. Her role included the administration of medication and nutrition to patients, one of whom was Patient A.

Patient A was admitted to the Home on or around 13 April 2021, following a stroke that he had sustained in December 2020. Patient A was said to have limited function and was not able to self-communicate his needs. Person B is Patient A's wife, who visited him on a daily basis at the Home, where he was cared for in a private room.

Person B visited Patient A at the Home on 6 May 2021. She alleges that Patient A did not receive prescribed medication or nutrition on this day. It is alleged that Patient A did not receive suction care when requested some time before 6 May 2021. It is alleged that Miss Curran is the nurse that was required to administer medication/nutrition and suction care to Patient A on 6 May 2021.

The Medication Administration Record (MAR) charts and records from the Home's patient record system (Nourish) had allegedly been completed by Miss Curran. The MAR charts and records suggest that medication and nutrition was administered as prescribed to Patient A by an '*AC*' on 6 May 2021. Person B made a complaint regarding her allegation to the Home by email on 7 May 2021, then met with the Home Manager on 12 May 2021 to discuss the same. Miss Curran attended meetings with the Home Manager on 11 and 12 May 2021 to discuss the allegations. Miss Curran stated that she had administered medication and nutrition to Patient A, and that she delivered suction care as required.

Miss Curran was suspended from her position at the Home on 12 May 2021. On 14 May 2021, Miss Curran resigned. Nonetheless, the Home continued with its disciplinary process, which led to her employment being terminated on 21 May 2021 following a hearing the Deputy Manager.

Decision and reasons on application to admit the evidence of Witness 2

After the conclusion of witness evidence, Ms Davies made an application under Rule 31 to admit the written statement and associated exhibit of Witness 2 into evidence. She made reference to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and its principles:

- Whether the hearsay evidence was the sole and decisive evidence in relation the relevant charges;
- The nature and extent of the challenge to the hearsay evidence;
- Whether there was any suggestion that the primary witness had reasons to fabricate the allegation;
- The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
- Whether there was a good reason for the non-attendance of the primary witness;
- Whether the NMC had taken reasonable steps to secure the attendance of the primary witness.

Ms Davies submitted that Witness 2's evidence is clearly relevant to the allegations, in particular to Charges 1a to 1f, in that it is not the primary evidence which supports the allegation that Patient A's medication and nutrition was not administered as per the MAR chart.

Ms Davies further submitted that Witness 2's evidence is not the sole and decisive evidence but important supporting evidence in relation to the account of Person B.

Ms Davies stated that the existence of a good and cogent reason for the non-attendance of a witness is an important factor; however, the absence of a good reason does not automatically result in the exclusion of the evidence. She highlighted that Witness 2 was due to give evidence on 28 October 2025 and, despite the extensive efforts made to

contact the witness both on 27 and 28 October 2025, Witness 2 did not respond and did not provide a reason as to why they have not attended.

Ms Davies went on to submit that there is no reason whatsoever Witness 2 would have fabricated their evidence as they were a Health Care Assistant (HCA), thus there can be no suggestion of fault.

Ms Davies said that Miss Curran has not engaged with the NMC proceeding and chosen not to attend. As such, she submitted that nature of the challenge is an unknown factor and there is no direct challenge to the evidence of Witness 2.

In relation to the steps the NMC has taken to secure Witness 2's attendance, Ms Davies noted that Witness 2 had engaged with the NMC previously because their witness statement is signed and dated 15 March 2024. She submitted that the Hearings Coordinator made extensive efforts to secure Witness 2's attendance, but all attempts to contact from them unfortunately proved unsuccessful.

Ms Davies therefore invited the panel to admit the evidence of Witness 2.

The panel heard and accepted the legal assessor's advice on the factors 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 or not it is admissible in civil proceedings.

The panel considered Witness 2's statement and accompanying exhibit to be relevant to the charges as their evidence speaks to 6 May 2021 as the witness was on duty that day and spoke directly to Miss Curran and other witnesses.

The panel considered the evidence before it and, in light of that all other evidence, determined that Witness 2's evidence is not sole or decisive.

The panel was mindful that there would be no gain for Witness 2 given their role as a HCA. As such the panel was satisfied that there was no reason to think the witness fabricated their evidence.

The panel noted that the last known engagement from Witness 2 was 15 March 2024. It took into account that the NMC tried hard from 27 – 28 October 2025 make contact with and secure the attendance of the witness to no avail, and that the witness has not given a reason for their non-attendance. It also noted that Witness 2 is not a registered nurse and therefore cannot be summoned to attend and give oral evidence.

The panel considered that, due to Witness 2's non-attendance, their evidence cannot be directly challenged or cross examined. However, the panel has had sight of Person B's evidence who speaks directly about reporting and raising the concerns with a HCA. The panel was of the view that it was unfortunate that Witness 3 could not recall their discussion with Miss Curran, however it could be confident that the discussion did happen as it was documented and exhibited by Witness 3. The panel was therefore satisfied that Witness 2's evidence could be tested.

The panel acknowledged the seriousness of the charges, particularly those which relate to dishonesty. The panel considered that a finding on a charge of dishonesty is capable of having a significant and adverse effect on Miss Curran and her practice.

The panel also took into consideration that there was a public interest in the charges being explored fully which supports the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to admit into evidence the written statement and accompanying exhibit of Witness 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

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

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

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: The wife of Patient A referred to as Person B.

- Witness 3: The Home Manager at the time of the incident.

The panel also took into consideration and ascribed what weight it thought fit to the hearsay evidence of Witness 2.

It considered the above witness evidence and the documentary evidence from those witnesses and other documentary evidence in the NMC Exhibit bundle.

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

The panel then considered each of the charges separately and made the following findings:

Charges 1a – 1e

"That you, a registered nurse on 6 May 2021, falsified Patient A's MAR chart in that you recorded that:

a) you administered 20ml Baclofen to Patient A at 18:00."
b) you administered 300mg Epilim to Patient A at 18:00.
c) you had administered 500mg Paracetemol to Patient A at 13:00 and 18:00.
d) you had administered 50mg Phenytoin sodium to Patient A at 14:00 and 18:00.
e) you had administered 100mg Thiamine to Patient A at 18:00."

These charges are found proved.

Whilst the panel noted that each charge should be considered separately, it noted when considering sub-charges 1a to 1e that they are based on a consideration of the same evidence. Consequently, the panel carefully considered the evidence and decided these sub-charges together.

In reaching this decision, the panel had regard to Patient A's MAR chart dated 6 May 2021, the investigatory meeting notes dated 7 May 2021, Person B's witness statements and oral evidence, Witness 3's witness statement and oral evidence, Witness 3's notes from their meeting with Person B dated 12 May 2021, and the witness statement of Witness 2.

Falsification has no legal meaning, but ordinarily means to alter, in this case a document, so as to mislead. Noting this ordinary meaning, the panel decided that falsification, in the context of this particular case, meant the act of making a false record in relation to Patient A's MAR chart, which includes recording something was administered when it was not,

recording the wrong time something was administered, and/or recording the wrong dose that was administered.

The panel had sight of Patient A's MAR chart. It noted it was signed with the initials 'AC'. In Witness 3's oral evidence, they verified the signature belonged to Miss Curran. The panel had no other evidence before it to suggest that it was not Miss Curran's signature. The panel had regard to Miss Curran's rota for 3 – 30 May 2021 and noted that the signatures corresponded with the days she was on duty and was satisfied that the signature was hers.

During the internal investigation meetings on 11 and 12 May 2021, Miss Curran did not deny she was the nurse in charge of Patient A's care on 6 May 2021. The duty rota also confirmed that she was on duty on this day. The panel was therefore satisfied that Miss Curran was the nurse in charge of Patient A's care on 6 May 2021.

The panel considered whether a stock take at the Home could indicate whether or not Miss Curran did or did not administer Patient A's medication. However, it was Witness 3's evidence that stock take was done at the end of following day and not the day of the incident. Witness 3 was also not able to say when the previous stock take had taken place. Furthermore, the panel considered that any number of nurses could have had access to the medication. Therefore, due to the lack of detail and certainty, the panel did not rely on any evidence related to stock takes when considering Charges 1a – 1e.

Person B brought forth the allegation that Miss Curran did not administer medication to Patient A on 6 May 2021. It is Person B's evidence that she arrive at the Home at 09:30 and had to wait in reception before she was picked up by Miss Curran and taken to Patient A's room, where she stayed from 10:00 until 19:00. The panel noted that Person B was emphatic about her times at the Home, and that it had no evidence before it to suggest otherwise. Due to COVID restrictions in place at the time, Person B was not allowed to go elsewhere in the Home, and, if she left the room for personal care to be delivered, she had to wait directly outside the room in the corridor next to the door. Her evidence was also

corroborated by Witness 3. The panel accepted Person B's evidence in relation to her timings at the Home as her account was consistent and she was actually where the alleged incidents occurred for a prolonged period of time.

The panel next considered if medication could have been given to Patient A without Person B knowing. Witness 3 informed the panel of the layout of Patient A's room, and that normal procedure would be to acknowledge relatives and converse with them or ascertain information pertaining to Patient A, because he could not speak. Moreover, Person B was Patient A's '*wife and essential caregiver*' who visited him at the Home '*very regularly*', and was therefore very familiar with his care needs. Person B had also raised concerns regarding Patient A's care before, thus she would have had heightened awareness and likely been paying attention to the care that was given.

The panel acknowledged that Miss Curran denied not giving Patient A his medication on 6 May 2021 in the investigatory meeting notes dated 11 May 2021. In their witness statement, Witness 3 said that, in the follow-up meeting on 12 May 2021:

> '*…Ms Curran, she became highly emotional and cried a lot and admitted to failing to provide the relevant medication, nourishment and suction care to Patient A…Ms Curran's response was to burst into tears and become hysterical. I felt that it was to deflect the uncomfortable situation. Ms Curran did not deny anything…*'

Witness 3 reiterated the above in their witness statement and oral evidence, and was consistent in many other aspects of their evidence. However, the panel noted that there were other times they could not give an explanation for, or misinterpreted/ misremembered, what was in investigatory meeting notes. The panel was of the view that this was not a reflection of the investigation meetings notes being inaccurate but rather the inaccuracy of some of Witness 3's interpretations. The meeting notes set out questions asked by Witness 3 and answered by Miss Curran. The panel was of the view that, if Miss Curran had made admissions, they would have been recorded and reviewed by Witness

3. The panel was therefore satisfied that the interview meeting notes on 11 and 12 May 2021 are an accurate reflection of events.

The panel gave careful consideration to all the above.

The panel had sight of the MAR chart for 6 May 2021. It took note of the medications which were prescribed for Patient A, and that Miss Curran had signed the MAR chart. Person B alleges that Miss Curran attend to Patient A all day and she raised this with the HCA (Witness 2) around 16:30. Shortly after this, Miss Curran attended and gave two bottles of Twocal feed, but no medication. The panel gave more weight to the evidence of Person B as she was in the room at the time of the incident and very familiar with Patient A's care. Person B's account of events were also consistent and supported by the evidence of Witness 3.

The panel heard from Witness 3 the process for administering medications, which was done via PEG tube and took approximately 10 – 15 minutes. The panel was of the view that, on the balance of probabilities, the medication could not have been delivered without Person B knowing. Person B was consistent in her oral evidence that Miss Curran did not give Patient A his medication at 13:00, 14:00 and 18:00 because she was in the room or immediately outside and had not witnessed it. The panel noted that Miss Curran documented on the MAR chart for 6 May 2021 that she had administered the medication for Patient A at 13:00, 14:00 and 18:00 when she had not.

Therefore, on the balance of probabilities, the panel was satisfied that it was more likely than not that Miss Curran falsified the MAR chart dated 6 May 2021 in respect of each of the sub-charges 1a – 1e.

As such, the panel found Charges 1a – 1e proved.

Charge 1f

"That you, a registered nurse on 6 May 2021, falsified Patient A's MAR chart in that you recorded that:

f) you had administered 200ml Ensure Twocal at:

i. 10:00
ii. 12:00
iii. 16:00
iv. 18:00."

This charge is found proved.

In reaching this decision, the panel took into account Patient A's MAR chart dated 6 May 2021, the investigatory meeting notes dated 7 May 2021, Person B's witness statements and oral evidence, Witness 3's witness statement and oral evidence, Witness 3's notes from their meeting with Person B dated 12 May 2021.

It was previously established that the signature on Patient A's MAR chart was Miss Curran's, and so she signed the MAR chart to document that she had allegedly given feed to Patient A.

The panel questioned Witness 3 about the procedure for administering nutrition and gathered that it would take approximately 15 – 25 minutes to prepare and administer feed. Witness 3 also went into detail about what would be prepared and the noise levels involved. The panel was satisfied, on the balance of probabilities, that Miss Curran could not have given Patient A his feed without Person B noticing.

On the basis of Person B's witness statement and Witness 3's note on their meeting with Person B, Miss Curran was busy with the GP prior to picking up Person B from reception at 10:00. As a result, Miss Curran could not have also been administering Patient A's feed at 10:00. Person B also alleges that she then waited for Patient A to be administered his

10:00 and he was not. Given all the evidence, on the balance of probabilities, the panel determined it is more likely than not the 10:00 feed did not take place.

The panel was satisfied that the feeds scheduled for 12:00 and 16:00 did not occur for the same reasons as outlined for Charges 1a – 1e.

Person B was consistent in her oral evidence that Miss Curran did not give Patient A his feed at 18:00 because she was in the room, or immediately outside, and had not witnessed it. It was stated in Person B's witness statement and oral evidence that Miss Curran gave Patient A two 200ml bottles of feed at once sometime around 17:00. In which case, neither the dose, nor times given, correlated with Patient A's prescribed feeding regime. As this was not documented on the MAR chart, the panel determined that this amounted to Miss Curran falsifying the record.

The panel therefore found this charge proved.

Charge 2

> "Your conduct at one or more of Charges 1 (a) to (f) was dishonest in that you recorded that you had administered medication/nutrition to Patient A when you had not done so."

This charge is found proved.

When considering the issue of dishonesty, the panel applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67:

> '*1. The Panel must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his/her belief is a matter of evidence going to whether he/she held the belief, it is not an*

additional requirement that his/her belief must be reasonable; the question is whether it is genuinely held;

2. Once his/her actual state of mind as to knowledge or belief as to facts is established, the question whether his/her conduct was honest or dishonest is to be determined by the Panel by applying the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what he/she has done is, by those standards, dishonest.'

The panel noted that when considering a charge of dishonesty that this is a particularly serious allegation which must be supported by cogent evidence before it is proved.

The panel first considered Miss Curran's subjective state of mind and what she knew during her shift on 6 May 2021.

The panel noted that Miss Curran knew and accepted that she was the nurse in charge of Patient A's care on 6 May 2021 because, when questioned about it in the internal investigation meetings on 11 and 12 May 2021, she did not go behind this fact. Furthermore, the panel regarded the Carebase job description outlining key responsibilities for nurses under its employment, in particular:

'*To dispense and administer medication to residents as prescribed, accurately maintaining appropriate records in line with current legislative guidelines.*'

In effect, the above stipulates a duty all nurses would be under when employed by Carebase, including those working at the Home. As such, the panel inferred that Miss Curran would have known that she had a duty to administer medication and nutrition to Patient A as prescribed and maintain an accurate record of it. This was a key part of her duty as a registered nurse on shift.

The panel found that Miss Curran failed to give Patient A his medication and nutrition on 6 May 2021 and falsified his MAR chart. The panel was mindful that the administration of medication and nutrition is an invasive procedure which requires deliberate planning and careful consideration as it is a long process with multiple stages. In light of this, the panel considered it unlikely that Miss Curran would have forgotten she did not provide such care to Patient A. Additionally, the panel took into account the number of falsified entries on the MAR chart before it. Taken together, the panel determined that Miss Curran could not have held any belief other than that she did not administer the medication and nutrition to Patient A on 6 May 2021.

The panel was therefore satisfied that Miss Curran's subjective state of mind was motivated by an intention to record that she had administered medication and nutrition to Patient A when she had not.

The panel was of the view that members of the public would expect that medical records must be accurate to ensure patient safety, and that Miss Curran's failure to provide care to Patient A had the potential to have a serious negative impact on his health and her career. Consequently, the panel was satisfied that Miss Curran's state of mind would be regarded objectively as dishonest by the standards of ordinary decent people.

The panel considered whether or not there was a plausible alternative explanation. In the investigatory interviews dated 11 and 12 May 2021, Miss Curran maintained that she '*did attend'* to Patient A between 09:30 and 16:30. However, in both the witness statement of Person B and Witness 3's notes from their meeting with Person B, it is alleged that Miss Curran attended to Patient A around 16:30 and apologised to Person B, saying '*"when the GP is here, it is so busy and that "she forgot".*' It is also alleged that, when Person B asked Miss Curran if Patient A had been given his feed at 10:00, '*she said "I don't remember".'*

The panel considered the possibility that Miss Curran could have mixed up her patients, however, it did not hear or have sight of any evidence which suggested that this may have occurred.

Moreover, if Miss Curran did mistakenly record that she had provided Patient A with care when she had not, the panel heard oral evidence from Witness 3 that there were ways to correct this. For example, Witness 3 stated that it was normal practice at the Home to make a note on the back of care sheets, or to make a log on the Nourish system; Miss Curran did neither. The panel also noted that Miss Curran had the opportunity to tell Witness 3, or Person B, if she had made a mistake, which she did not do either.

The panel took note of the inconsistencies in Miss Curran's explanations and determined that, given the reliability and credibility of Person B's evidence, Person B's account of events undermined any alternative explanations.

On the balance of probabilities, the panel concluded that it is more likely than not that the reason Miss Curran recorded that she had administered medication and nutrition to Patient A when she had not was because she intended to cover up her failure

The panel therefore found this charge proved.

Charge 3

> "About 6 May 2021 failed to suction Patient A following a request from Person B, Patient A's relative."

This charge is found proved.

In reaching this decision, the panel took into account Miss Curran's job description outlining key responsibilities for the Nurse role, Patient A's care plan, the written statements and oral evidence of Person B, and the investigatory interview notes dated 12 May 2021.

The panel noted that the charge reads '*about 6 May*'. In oral evidence, Person B said this incident happened around early May, days before 6 May 2021. The panel directed its attention to Miss Curran's rota on 3 – 30 May 2021 and noted that she was on duty on 3 and 4 May 2021. Having carefully this evidence, the panel was of the view that the wording '*about*' is sufficiently proximate to 3 or 4 May 2021.

Carebase set out the key responsibilities for nurses in their employment, one of which was:

> '*To formulate, implement and regularly maintain nursing care plans, providing the highest level of personal care and attention to residents, following individual care plans carefully and ensuring that all contact is polite, friendly, warm and supportive.*'

The panel had regard to Patient A's care plan which stated, '*Patient A is very productive in secretions, he requires suctioning frequently…Suction him when necessary.*' Taking into account the above, the panel determined that Miss Curran was under a duty to suction Patient A in keeping with his care plan.

In Witness 3's meeting notes for Person B, Person B alleged that '*Patient A couldn't open mouth I washed the mouth, Patient A had secretion stuck in mouth, I asked for suction the nurse refused the suction – AMC* [sic].' In their oral evidence, Person B stated that her requests for Patient A to be suctioned were generally accepted by the other nurses at the Home, and Witness 3 said that there was rarely any reason for a nurse at the Home to not suction a patient if it was requested.

In the investigatory meeting notes, Miss Curran stated that she would suction Patient A '*maybe once'* a day because he wore *'a hyoscine patch'*. However, in light of Patient A's care plan; Miss Curran's duty to adhere to it, and the evidence of Person B and Witness 3, the panel determined that Miss Curran had more reasons to suction Patient A than to not.

The panel gave more weight to Person B's evidence which was consistent and, in particular, consistent when answering panel questions. In addition, Person B had witnessed and assisted with Patient A's care when he was in hospital for a prolonged period of time. Thereafter, when he was admitted into the Home, she visited him on a daily basis and was therefore highly familiar with his care needs and provision. The panel considered it unlikely that Person B would have requested such an invasive and potentially distressing procedure for Patient A if it was not needed.

The panel heard from Witness 3 the procedure for suctioning Patient A. It would take 10 – 15 minutes and involved noisy equipment. The panel considered it highly unlikely that Patient A could be suctioned without Person B's knowledge given that she was in the room the majority of the time.

The panel was satisfied that Miss Curran did not accede to Person B's request for her to suction Patient A at, or near, the time that Person B made the request and in line with his care plan.

As such, the panel found this charge proved.

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 Curran's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 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 Curran's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Davies directed the panel to specific sections within 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and identified where, in the NMC's view, your actions amounted to a breach of the Code:

'***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.'

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

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records

To achieve this, you must:

10.1 complete 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 not kept to these requirements.'

*'**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...'

Ms Davies highlighted that Miss Curran did not provide fundamental care to a very vulnerable patient and was dishonest about not providing that care. She reminded the panel that Patient A relied on the medication to ensure that he had adequate nutrition as his condition meant that he was unable to eat food or take oral medication, therefore missing doses would have inevitably meant that he was hungry and potentially distressed. She stated that, by Miss Curran falsifying the records and documenting that medication and nutrition had been given to Patient A when she knew it had not, that other staff would have been under the impression that Patient A had received his care.

Ms Davies therefore submitted that the facts found proved amount to misconduct and should be considered serious.

Submissions on impairment

Ms Davies 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. She also made reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Davies submitted that all four limbs of *Grant* are engaged in this case. She went on to submit that:

1. Miss Curran has in the past put a patient, namely Patient A, at risk of unwarranted harm by neglecting to follow the clear, unambiguous process of giving Patient A his feed and medication, and suctioning him in line with his care plan;

2. Miss Curran has in the past breached the fundamental tenants of nursing, particularly practising effectively and promoting professionalism; in that

3. Miss Curran has in the past brought the nursing profession into disrepute; and

4. Miss Curran has acted dishonestly in the past by falsifying records

Ms Davies submitted that the conduct in this case is such that it cannot be addressed due to the underlying attitudinal concerns which stem from the dishonesty. However, in any event, Miss Curran has disengaged from this Fitness to Practise process and not provided any evidence of insight, remediation or strengthened practice. She submitted that the

concerns have not been addressed and there is a high risk of repetition. She therefore invited the panel to find that Miss Curran is currently impaired on the ground of public protection.

Ms Davies further submitted that public confidence in the profession would be undermined if a finding of impairment was not made in this case, and therefore invited the panel to find that Miss Curran's fitness to practise is also impaired on the ground of public interest.

Decision and reasons on misconduct

The panel heard and accepted the advice of the legal assessor.

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

The panel bore in mind that breaches of the Code do not automatically result in a finding of misconduct. It was of the view that Miss Curran's actions breached the following sections of the Code:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion.

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.'

1.5 respect and uphold people's human rights.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively.

2.6 recognise when people are anxious or in distress and respond compassionately and politely.

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages.

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records

To achieve this, you must:

10.1 complete 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 not kept to these requirements.'

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code.

20.2 act with honesty and integrity at all times…'

The panel considered that Miss Curran's did not comply with established policy and procedure and Patient A's care plan, and her falsification of Patient A's MAR chart with regard to the administration of his medication and nutrition to be very serious. The panel was of the view that the seriousness is heightened when taking into account that Patient A was vulnerable and highly dependent on nursing staff for care, and that she had the option to record the non-administration rather than falsifying his records.

The panel found that Miss Curran falsified Patient A's MAR chart to cover up her omissions and deliberately misrepresent that she provided care that she had not. The panel was mindful that dishonesty, in any circumstance, but particularly when linked directly to patient care, is very serious as it undermines patient safety.

Miss Curran also showed a lack of regard for Patient A's care plan, failing to show kindness or compassionate for Patient A and Person B when she refused to suction him. The panel heard from Witness 3 and Person B that this was dangerous and could have resulted in Patient A choking on his secretions.

For the above reasons, the panel found that Miss Curran's actions fell seriously short of the conduct and standards expected of a nurse.

Accordingly, the panel determined that, both separately and cumulatively, the charges found proved amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance 'DMA-1: Impairment', (last updated: 3 March 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 *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 was satisfied that the four limbs of the Shipman test in *Grant* were engaged in this case in relation to Miss Curran's past conduct.

Miss Curran put Patient A, who was highly vulnerable, at unwarranted risk of harm by not administering prescribed medication and nutrition which could have caused weight loss and other health complications, as well as not suctioning him upon Person B's request which was necessary to ensure he did not choke on his secretions.

By way of dishonesty and failing to undertake basic care responsibilities she should have been adhering to, Miss Curran brought the nursing profession into disrepute. Public confidence in the profession would be undermined if the public were aware that a nurse responsible for vulnerable patients in a care home was dishonest and did not fulfil their basic duties.

The panel was satisfied that Miss Curran had breached several sections of the Code and failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust.

The panel found that Miss Curran acted dishonestly when she intentionally recorded that she had administered medication and nutrition to Patient A when she had not.

Having found all four limbs of the Shipman test engaged at to the past, the panel considered whether Miss Curran's fitness to practise is currently impaired in the sense of looking at her practice today and going forward.

The panel had regard to the factors set out in NMC guidance 'FTP-15: Insight and strengthened practice', in particular:

> '*When assessing evidence of the nurse, midwife or nursing associate's insight and the steps they have taken to strengthen their practice, decision makers will need to take into account the following questions:*
>
> - *Can the concern be addressed?*
> - *Has the concern been addressed?*
> - *Is it highly unlikely that the conduct will be repeated?*'

The panel was of the view that the misconduct in this case is not easily remediable as it relates to a deliberate act of dishonesty which raises attitudinal concerns. The panel was

also mindful that Miss Curran did not give any reasons for why she did not carry out her duties.

Miss Curran has not engaged with this hearing. The panel did not have sight of any evidence to suggest that Miss Curran had taken steps to strengthen her practice, reflect on her actions. Nor has she shown any insight into the seriousness of her failures and the potential consequences on Patient A. Instead, the only evidence before the panel was her responses in the investigatory meetings on 11 and 12 May 2021 in which she deflected and minimised impact of her misconduct.

The panel bore in mind that Miss Curran acted dishonestly in that she made multiple false entries on Patient A's MAR chart. Given the difficulty to remediate dishonest behaviour, and in absence of any evidence to the contrary, the panel determined that Miss Curran is liable to repeat her actions.

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.

The panel considered that public confidence in the nursing profession and the NMC as a regulatory body would be undermined if a finding of impairment were not made in this case. The panel therefore determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Miss Curran's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

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

Submissions on sanction

Ms Davies submitted that the following were aggravating features in this case:

- Miss Curran's lack of insight as noted within the panel's determination on impairment.
- That this was dishonest conduct which put a Patient A at risk of harm.
- That Patient A was a highly vulnerable patient
- That the misconduct was repeated

Ms Davies did not set out any mitigating features.

Ms Davies directed the panel to NMC sanctions guidance on cases involving dishonesty ('SAN-2: Sanctions for particularly serious cases', last updated: 6 May 2025)

Ms Davies submitted that the charges in this case are too serious to be dealt with by way of taking no further action or imposing a caution order. She added that both sanctions would be inappropriate to deal with the concerns surrounding public protection and the wider public interest in this case.

Ms Davies further submitted that a conditions of practice order would not a suitable sanction because the panel made a finding of dishonesty which would indicate attitudinal issues beyond just clinical practice failures.

Ms Davies highlighted that Miss Curran has not engaged with this hearing, nor has the panel had sight of any evidence to suggest that she has taken any steps to strengthen her practice, reflect or demonstrate insight. For these reasons, Ms Davies submitted that a suspension order would not suitable due to the lack of insight shown by Miss Curran and therefore the risk of repetition.

Ms Davies went on to submit that Miss Curran's misconduct is fundamentally incompatible with remaining on the register. She added that the facts found proved by the panel raise fundamental questions about Miss Curran's professionalism and public confidence would not be maintained if she were not struck off from the register. Ms Davies invited the panel to impose a striking-off order and submitted that it is the only sanction which would be sufficient to protect the public and maintain professional standards.

Decision and reasons on sanction

The panel heard and accepted the advice of the legal assessor.

Having found Miss Curran's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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. In reaching its decision, the panel had regard to all the evidence that has been adduced in this case and had careful regard to the sanctions guidance published by the NMC. The decision on sanction is a matter for the panel independently exercising its own professional judgement.

The panel decided that the following aggravating features should be taken into account:

- Miss Curran has demonstrated a lack of insight into her failings, the potential consequences for Patient A and the wider public interest
- Miss Curran deliberately acted to cover up her omissions

- Miss Curran's misconduct, although during the course of one shift, was not an isolated instance in that it was repeated falsification of a number of records
- Miss Curran's misconduct put a vulnerable patient at risk of suffering significant harm.

The panel noted that Miss Curran raised in the investigatory meeting on 11 May 2021 that she had experienced a recent bereavement but that this occurred after the incident on 6 May 2021. It also took note that when asked if she felt '*that the Clinical lead might be a bit too much*' for her, Miss Curran responded '*no, I'm just struggling today*'. Miss Curran, at the time of the meeting, did not seek to rely on any mitigating circumstances for her actions.

Further, whilst Miss Curran did respond to the NMC's case in the limited form of seeking removal, she did not provide any further information in relation to the above two matters, or any other matter, after the investigatory meetings.

The panel therefore determined that there were no mitigating features in this case.

The panel considered that, whilst the dishonesty charge relates to one shift and appears to not have been premediated, Miss Curran falsified multiple records and her misconduct relates directly to her clinical practice and the breach of duty of candour. The panel took into account that a very vulnerable patient was involved who was put at unwarranted risk of harm due to Miss Curran's acts and omissions. Therefore, the panel deemed this case to be at the higher end of the scale of seriousness.

The panel then went on to consider which sanction, if any, would be appropriate and proportionate in the circumstances of this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case and the public protection issues identified, an order that does not restrict Miss Curran's practice would not be appropriate in the circumstances. The sanction guidance 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 Curran'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 Curran'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 attitudinal nature of the dishonesty charge in this case. There is no evidence of a general lack of clinical competence identified in this case, the panel was not satisfied that the misconduct was such that it could be addressed through training and supervision. Furthermore, the panel did not have any evidence from Miss Curran demonstrating a willingness to engage with the NMC to suggest that she would comply with conditions. The panel therefore concluded that imposing a conditions of practice order would not adequately protect the public, or address the seriousness of this case and public interest concerns.

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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse and a serious breach of the fundamental tenets of the nursing profession.

In its findings, the panel noted that, although Miss Curran's falsification of Patient A's MAR chart occurred on one shift, it was repeated multiple times. The panel identified attitudinal concerns in that Miss Curran was dishonest. The panel also considered that Miss Curran has not demonstrated insight into the impact of her behaviour but rather chose to deflect and minimise, which the panel found made her liable to repeat such behaviour in the future. For these reasons, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in this particular case.

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

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

Miss Curran's actions were directly responsible for putting Patient A, an extremely vulnerable patient, at unwarranted risk of harm. The panel considered Miss Curran's misconduct to be a serious breach of duty of candour which raises fundamental questions about her professionalism. The panel found previously that Miss Curran's misconduct was

a significant departures from the standards expected of a registered nurse, and it determined that her misconduct is fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Curran's actions and omissions were 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 took into account that Miss Curran has been a registered nurse since September 1999 with no regulatory finding against her. However, the panel has determined that the nature and extent of the dishonesty is especially serious so as to obviate consideration of her previously unblemished career. In coming to this conclusion, the panel took into account the NMC guidance 'SAN-1: Factors to consider before deciding on sanctions' which states as follows:

> '*Sometimes, the nurse, midwife or nursing associate's conduct may be so serious that it is fundamentally incompatible with continuing to be a registered professional. If this is the case, the fact that the nurse, midwife or nursing associate does not have any fitness to practise history cannot change the fact that what they have done cannot sit with them remaining on our register.*
>
> *For these reasons, panels should bear in mind there will usually be only limited circumstances where the concept of a 'previously unblemished career' will be a relevant consideration when they are deciding which sanction is needed, or in giving their reasons.*'

Balancing all of these factors, and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Curran'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 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 Curran in writing.

Interim order

As a striking-off order cannot take effect until the end of the 28-day appeal period, the panel 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 Curran's own interests until the striking-off sanction takes effect.

Submissions on interim order

Ms Davies submitted that an interim order is necessary to protect the public and is otherwise in the public interest. She invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period, bearing in mind the nature and the seriousness of the concerns and the associated risks. She submitted that an interim suspension order is appropriate and proportionate in all the circumstances.

Decision and reasons on interim order

The panel heard and accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary to protect the public and otherwise in the public interest. The panel had regard to the seriousness of the misconduct. The panel also directed its attention to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order, in particular its conclusion that a conditions of practice order would not adequately protect the public, or address the seriousness and public interest concerns in this case. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to Miss Curran in writing.

That concludes this determination.