

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Wednesday, 29 October 2025 – Friday, 31 October 2025
Monday, 3 November 2025**

Virtual Meeting

Name of Registrant:	Liza Marie Hawes
NMC PIN:	92I4012E
Part(s) of the register:	Registered Nurse – Adult, RNA (23 September 1995)
Relevant Location:	Milton Keynes/Northamptonshire
Type of case:	Misconduct
Panel members:	James Carr (Chair, Lay member) Michelle Wells-Braithwaite (Registrant member) Sam Wade (Lay member)
Legal Assessor:	Tracy Ayling KC
Hearings Coordinator:	Eleanor Wills
Facts proved:	Charges 7a, 7b, 8, 9a, 9b, 10, 14, 15, 16, 20, 22, and 24
Facts not proved:	Charges 1a, 2, 3a, 3b, 3c, 4, 5a, 5b, 6, 11a, 11b, 12, 13, 17, 18, 19, 21a, 21b and 23
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Ms Hawes's registered email address by secure email and registered address by recorded delivery on 1 October 2025.

The panel noted that the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered email/address.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the date from which the hearing was to be held, and the fact that this meeting was heard to be virtually.

In the light of all of the information available, the panel was satisfied that Ms Hawes has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34.

Decision and reasons on application to amend the charge

Having had regard to the documentation, the panel, in advance of the hearing, raised a query regarding the wording of charge 23.

Having reviewed the charges, the NMC proposed the following amendments to the charges.

"2) Your actions in charge 1 was dishonest in that you were intending to mislead others into believing that Colleague A or another nurse staff member had signed the "Witnessed by (signature)" box in the Controlled Drug book in relation to Resident A when you knew they had not.

...

4) Your actions in charge 3 ~~was~~ **were** dishonest in that you were Intending to mislead others into believing that Colleague C or another nurse staff member had signed the “Witnessed by (signature)” box in the Controlled Drug book in relation to Resident A when you knew they had not.

...

6) Your actions in charge 5 was dishonest in that you were intending to mislead others into believing that Colleague C had signed the “Witness signature” boxes in the “Destroyed or Returned Medication” book in relation to Resident A when you knew they had not.

...

14) You failed to have **the** administration of controlled drugs to Residents countersigned by another nurse on one or more occasions in September 2021.

15) You **improperly** signed the Controlled Drug book prior to giving medication to residents;

16) On 31 August 2021, **improperly** made an entry on the “Destroyed or Returned Medication” record with “unknown” in the “Service Username” box and the name of the “medication”.

...

19) On 29 September 2021, did not complete the “progress evaluation form” for Resident C to evidence **the** reason for administering Morphine Sulphate to Resident C.

20) On 22 September 2021, did not complete the “progress evaluation form” for Resident D to evidence **the** reason for administering Morphine Sulphate to Resident D.

...

23) Your conduct in Charge 22 showed a lack of integrity in that you **failed to ascertain the outcome of an interim order hearing on 6 October 2022 during which an interim suspension order was imposed upon you.** ~~received emails from the Nursing and Midwifery Council notifying you of the interim order hearing on 6 October 2022 as well as the outcome to impose an interim suspension order but you did not inform yourself of the hearing or the outcome.~~

In the alternative

24) Your conduct in Charge 22 ~~is~~ **was** dishonest in that you practised as a registered nurse when you knew that an interim suspension order was imposed on your practice on 6 October 2022.”

The NMC considered that the amendments do not result in any unfairness, as they concern matters of form rather than substance.

The NMC notified Ms Hawes of the proposed amendments via recorded delivery on 28 October 2025.

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

The panel was of the view that the amendments to charges 2, 4, 6, 14, 19, 20 and 24 were to correct grammatical errors. The panel determined that the proposed amendments to charges 15 and 16, which involved the addition of the word ‘*improperly*’, provided more clarity and more accurately reflected the evidence.

The panel was of the view that the amendments to charges 2, 4, 6, 14, 15, 16, 19, 20 and 24 were in the interests of justice.

The panel was satisfied that there would be no prejudice to Ms Hawes, and 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 ensure clarity and accuracy.

The panel determined that the proposed amendment to charge 23 did not provide clarity but in fact led to more ambiguity. The panel took into account that the proposed amendment would be a material change to the charge, as originally drafted. The panel noted that Ms Hawes was only notified of the proposed amendment to charge 23 on 28 October 2025. The panel determined that the amendment to charge 23 would cause prejudice to Ms Hawes and it would be unfair and inappropriate to allow such an amendment. Therefore, the panel did not allow the proposed amendment in respect of charge 23.

In respect of charging charge 24 in the alternative, the panel determined that charge 23 and charge 24 relate to the same mischief, in that they relate to Ms Hawes's state of knowledge of the interim suspension order imposed on her practice on 6 October 2022. Charge 23 relates to whether Ms Hawes lacked integrity, having not made herself aware of the interim order hearing and the subsequent decision to impose an interim suspension order. Charge 24 relates to whether Ms Hawes was dishonest, in that she knew that she had an interim suspension order imposed on her practice and yet continued to practice as a Registered Nurse. The panel was of the view that charge 23 is the lesser charge, in that if found proved, it would imply that Ms Hawes was not aware of the interim suspension order when she ought to have been; whereas charge 24, if found proved, would result in Ms Hawes having been aware of the interim suspension order and deliberately breaching the order. The panel therefore determined that charging charge 24 in the alternative is in the interests of justice, it is not prejudicial, and it would not cause any unfairness to either party. It was therefore appropriate to allow the amendment, as applied for, in respect of charging charge 24 *"in the alternative"*.

Details of charges as amended

That you, a registered nurse,

Resident A

1) Incorrectly entered the signature of Colleague A or another nurse staff member in the “Witnessed by (signature)” box in the Controlled Drug Book in relation to Resident A on the;

a) 21 September 2021 **[Found NOT proved]**

2) Your action in charge 1 was dishonest in that you were intending to mislead others into believing that Colleague A or another nurse staff member had signed the “Witnessed by (signature)” box in the Controlled Drug book in relation to Resident A when you knew they had not. **[Found NOT proved]**

3) Incorrectly entered the signature of Colleague C or another nurse staff member in the “Witnessed by (signature)” box in the Controlled Drug Book in relation to Resident A on the;

a) 11 September 2021 **[Found NOT proved]**

b) 12 September 2021 **[Found NOT proved]**

c) 13 September 2021 **[Found NOT proved]**

4) Your actions in charge 3 were dishonest in that you were Intending to mislead others into believing that Colleague C or another nurse staff member had signed the “Witnessed by (signature)” box in the Controlled Drug book in relation to Resident A when you knew they had not. **[Found NOT proved]**

5) On 31 August 2021, incorrectly entered the signature of Colleague C in the “Witness signature” box in the “Destroyed or Returned Medication” book in relation to Resident A with regards to the following medication;

a) Lactulose **[Found NOT proved]**

b) Lorazepam **[Found NOT proved]**

6) Your action in charge 5 was dishonest in that you were intending to mislead others into believing that Colleague C had signed the “Witness signature” boxes in the “Destroyed or Returned Medication” book in relation to Resident A when you knew they had not. **[Found NOT proved]**

Resident C

7) Incorrectly entered a signature in the MAR chart for Morphine Sulphate in relation to Resident C on the;

- a) 27 September 2021 **[Found proved]**
- b) 29 September 2021 **[Found proved]**

8) Your conduct in charge 7 was dishonest in that you were intending to mislead others into believing that another nurse staff member at the Home had signed the MAR chart in relation Resident C when you knew that they had not. **[Found proved]**

9) Incorrectly entered a signature in the “Witnessed by (signature)” box in the Controlled Drug Book for Morphine Sulphate in relation to Resident C on the;

- a) 27 September 2021 **[Found proved]**
- b) 29 September 2021 **[Found proved]**

10) Your conduct in charge 9 was dishonest in that you were intending to mislead others into believing that another nurse staff member had signed the Controlled Drug book for Resident C when you knew they had not. **[Found proved]**

Resident D

11) Incorrectly entered a signature in the “Witnessed by (signature)” box in the Controlled Drug Book for Morphine Sulphate in relation to Resident D on the;

- a) 22 September 2021 **[Found NOT proved]**
- b) 23 September 2021 **[Found NOT proved]**

12) Your conduct in charge 11 was dishonest in that you were intending to mislead others into believing that another nurse staff member had signed the Controlled Drug

book entry in relation to Resident D when you knew they had not. **[Found NOT proved]**

Other charges

13) You failed to destroy unused medications in the presence of another nurse on one or more occasions in September 2021. **[Found NOT proved]**

14) You failed to have the administration of controlled drugs to Residents countersigned by another nurse on one or more occasions in September 2021. **[Found proved]**

15) You improperly signed the Controlled Drug book prior to giving medication to residents; **[Found proved]**

16) On 31 August 2021, improperly made an entry on the “Destroyed or Returned Medication” record with “unknown” in the “Service Username” box and the name of the “medication”. **[Found proved]**

17) On 12 September 2021, did not complete the “progress evaluation form” for Resident A to evidence the reason for administering Morphine Sulphate to Resident A. **[Found NOT proved]**

18) On 13 September 2021, did not complete the “progress evaluation form” for Resident A to evidence the reason for administering Morphine Sulphate to Resident A. **[Found NOT proved]**

19) On 29 September 2021, did not complete the “progress evaluation form” for Resident C to evidence the reason for administering Morphine Sulphate to Resident C. **[Found NOT proved]**

20) On 22 September 2021, did not complete the “progress evaluation form” for Resident D to evidence the reason for administering Morphine Sulphate to Resident D. **[Found proved]**

- 21) In October 2020, attended work whilst unfit in that you
- a) appeared dazed and/or **[Found NOT proved]**
 - b) demonstrated erratic behaviour. **[Found NOT proved]**

Additional charges

22) Worked as a registered nurse in breach of an interim suspension order between 6 October 2022 and 28 September 2023. **[Found proved]**

23) Your conduct in Charge 22 showed a lack of integrity in that you received emails from the Nursing and Midwifery Council notifying you of the interim order hearing on 6 October 2022 as well as the outcome to impose an interim suspension order but you did not inform yourself of the hearing or the outcome. **[Found NOT proved]**

In the alternative

24) Your conduct in Charge 22 was dishonest in that you practised as a registered nurse when you knew that an interim suspension order was imposed on your practice on 6 October 2022. **[Found proved]**

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

Background

Ms Hawes was referred to the NMC on 7 September 2022 by Barchester Healthcare. Ms Hawes was employed by Barchester Healthcare from 24 July 2015 to 16 June 2022.

Ms Hawes was working as a senior Registered Nurse at Ashby House Care Home (the Home) in August and September 2021. Ms Hawes was dismissed from the Home on 16 June 2022.

The following alleged concerns were raised by the Home:

- Falsification of colleagues' signatures in residents', Controlled Drug (CD) books, Medication and Administration Records (MAR) charts, and destroyed or returned medication book;
- Poor medication practice in that Ms Hawes did not follow the procedures in relation to controlled drugs on more than one occasion;
- Destroyed and administered controlled drugs without a second nurse present and did not complete the destroyed or returned medication record properly;
- Did not record the reason for administering controlled drugs to one or more patients;
- Attended work whilst unfit and appeared to be dazed and/or showed erratic behaviour.

On 28 September 2023, the NMC received another referral from Northamptonshire Healthcare NHS Foundation Trust (the Trust). Ms Hawes commenced employment at the Trust on 5 July 2022 and worked there until 17 October 2023. During the pre-employment checks, it was highlighted that Ms Hawes was under investigation by the Home however this was not looked into further by the Trust and Ms Hawes's employment was approved.

When Ms Hawes's NMC registration was due for renewal in September 2023, the Trust identified that she was subject to an interim suspension order which was imposed by the NMC on 6 October 2022. Ms Hawes had allegedly not declared to the Trust that she was subject to an interim suspension order and when questioned, Ms Hawes claimed she was unaware of the interim suspension order.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Deputy Home Manager at the Home at the relevant time, Home Manager at the Home from March 2022.
- Witness 2: Colleague A, Registered Nurse at the Home at the relevant time
- Witness 3: Colleague C, Senior Nurse at the Home at the relevant time
- Witness 4: Service Manager for Adult Community Health Services at the Trust since September 2023

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

The panel first had regard to the composition and allocation of the staff at the Home as outlined by Witness 1 in their witness statement dated 5 March 2024. The panel took into account that there were three Registered Nurses per day shift, and they were supported by nine Healthcare Assistants (HCA). None of the HCA's complete medication rounds. Medication is the responsibility of the Registered Nurses. The panel took into account that there were eight Registered Nurses at the Home who could administer medication excluding Ms Hawes. The panel took into account that the time at which the concerns arose was during the COVID-19 pandemic.

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

Charge 1

“1) Incorrectly entered the signature of Colleague A or another nurse staff member in the “Witnessed by (signature)” box in the Controlled Drug Book in relation to Resident A on the;

a) 21 September 2021”

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the CD book for Resident A. The panel noted that there was an entry in the CD book, dated either 21 or 22 September 2021. The panel was of the view that the exact date of the entry was unclear in that it appeared to have been altered. The panel considered that, there was no evidence before it, to determine when the entry had been altered, by whom and why.

The panel took into account that Witness 1, in relation to the CD book for Resident A, referred to *“The entry dated 21 September 2021 where Liza has confirmed “checked and destroyed” and provided her initials.”*

However, the panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: LH, can you confirm the date please? (showed the CD book)

LH: Either 21st or 22nd by the look of it

[Witness 1]: You need to be specific

LH: I would say 21st

[Witness 1]: You were not working on the 21st

LH: It must be the 22nd then.”

The panel therefore determined that it was more likely than not that the entry on Resident A's CD book was dated 22 September 2021 and therefore charge 1a referred to the incorrect date.

In any event, the panel still considered the evidence in respect of the stem of charge 1.

The panel took into account that the entry dated 22 September 2021 stated "*checked + destroyed*" and contained a signature in the column "*Witnessed by*".

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

"[Mr 5]: On 22nd after Resident A passed did you destroy the rest of his medication and who witnessed you?

LH: Yes, it may have been [Colleague A] or who I was working with."

The panel took into account Witness 1's witness statement signed and dated 5 March 2024.

"When looking at the initials made by the witness, this should be the initials of [Colleague A], I can confirm these are not the initials of [Colleague A]."

The panel took into consideration Colleague A's witness statement dated 22 April 2024.

"I reviewed [the CD book for Resident A] I can confirm that this is not my initials on the 'witnessed by' section of the controlled drug book."

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

"None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other

staff were spoken to and provided statements confirming they did not administer, or witness control drug medication being given or destroyed by Liza during the dates of concern.”

The panel had regard to the staff's local statements and noted that there were no staff statements in respect of this charge. Therefore, there was no direct evidence from staff, excluding Colleague A, to confirm that they had not signed the CD book for Resident A on 22 September 2021.

The panel therefore determined that the signature in the column “*Witnessed by*”, in the entry dated 22 September 2021, in Resident A's CD book, was not, on the balance of probabilities, Colleague A's signature. However, the panel determined that there was no direct evidence to prove that another member of staff had not witnessed Ms Hawes administering the controlled drug to Resident A and had accordingly signed the column “*Witnessed by*” in Resident A's CD book. The panel took into account that no rota had been provided evidencing which Registered Nurses were on duty on the day in question. The panel noted that Ms Hawes, during the investigation meeting, could not give a definitive answer as to who had witnessed her. The panel was of the view that this was plausible given that ten days had passed and Ms Hawes, during the local investigation meeting, did not appear to have been provided with any rota or time sheet to show who was on duty with her at the relevant time.

The panel therefore determined that the NMC has not discharged its burden of proof. Firstly, in respect of the incorrect date having been charged and secondly in that there was insufficient evidence to satisfy the panel that another member of staff had not signed the column “*Witnessed by*” in Resident A's CD book on 22 September 2021.

Accordingly, the panel found charge 1 NOT proved.

Charge 2

“2) Your action in charge 1 was dishonest in that you were intending to mislead others into believing that Colleague A or another nurse staff member had signed the

“Witnessed by (signature)” box in the Controlled Drug book in relation to Resident A when you knew they had not.”

This charge is found NOT proved.

Having found charge 1 not proved the panel found charge 2 not proved.

Charge 3

“3) Incorrectly entered the signature of Colleague C or another nurse staff member in the “Witnessed by (signature)” box in the Controlled Drug Book in relation to Resident A on the;

- a) 11 September 2021*
- b) 12 September 2021*
- c) 13 September 2021”*

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the CD book for Resident A. The panel noted that there were three entries in the CD book dated 11 September 2021, 12 September 2021 and 13 September 2021 which contained a signature in the column *“Witnessed by”*.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: Page 100 reference Resident A for Morphine Sulphate, do you recognise the signature on the 11th?

LH: It looks like mine

...

[Witness 1]: Are they your signatures on 11th, 12th and 13th?

LH: Yes

[Witness 1]: Who was the witness and who administered? On 11th 12th and 13th?

LH: on 11th mine is the second signature, on 12th mine is the second signature and on 13th mine is the first signature.

...

[Witness 1]: ...Can you tell us please who was dispensing the medication with you on these dates, and who's signatures are there?

LH: ... I don't recognise the signature on 13th, 11th of 12th"

The panel took into account Witness 1's response to the entries dated 11, 12 and 13 in the CD book for Resident A, contained in their witness statement signed and dated 5 March 2024.

"This signature is not assignable to any of the nurses employed at [the Home]"

The panel took into consideration Colleague C's supplementary witness statement dated 19 August 2025.

"[CD book for Resident A], relates to me and the signatures on 11 September 2021 and 13 September 2021. I can confirm that the signature does not belong to me. And I do not know who signed the controlled drug book... as this is not my signature."

The panel had regard to Colleague C's witness statement dated 17 May 2023.

"One of my colleagues(cannot recall who) [sic] showed me the CD book to show that CD- Morphine or Midazolam had been administered to Resident A on 12 September 2021... One of the signatures on page 100 of the CD book looked very

different. There is an entry on this page at 2010 with two signatures: given by and witnessed by. I was unable to recognise both the signatures.”

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

“None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other staff were spoken to and provided statements confirming they did not administer, or witness control drug medication being given or destroyed by Liza during the dates of concern.”

The panel had regard to the staff’s local statements and noted the following:

- Colleague C stated that they did not sign the CD book for Resident A on 12 September 2021, signed and dated 1 October 2021;
- Colleague D stated that they did not sign the CD book for Resident A on 12 September 2021, signed and dated 2 October 2021.

The panel took into account that, in respect of the entries for 11 and 13 September 2021, there was no direct evidence from staff, excluding Colleague C, to confirm that they had not signed the CD book for Resident A. The panel took into consideration that, in respect of the entry for 12 September 2021, there was no direct evidence from staff, excluding Colleagues C and D, to confirm that they had not signed the CD book for Resident A. The panel noted that there are eight Registered Nurses at the Home who could administer medication excluding Ms Hawes.

The panel therefore determined that the signatures in the column *“Witnessed by”*, in the entries dated 11 and 13 September 2021, in Resident A’s CD book, were not, on the balance of probabilities, Colleague C’s signature and the signatures in the column *“Witnessed by”*, in the entry dated 12 September 2021, in Resident A’s CD book, was not, on the balance of probabilities, Colleagues C or D’s signature.

However, the panel determined that there was no direct evidence to prove that another member of staff had not witnessed Ms Hawes administering the controlled drug to Resident A and had accordingly signed the column *“Witnessed by”* in Resident A’s CD book. The panel took into account that no rota had been provided evidencing which Registered Nurses were on duty on the day in question. The panel noted that Ms Hawes, during the investigation meeting, could not recognise the signatures in the entries dated 11,12 and 13 September 2021 and could not remember who she was with. The panel was of the view that this was plausible given that at least 19 days had passed and Ms Hawes, during the local investigation meeting, did not appear to have been provided with any rota or time sheet to show who was on duty with her at the relevant time.

The panel therefore determined that the NMC has not discharged its burden of proof, in that there was insufficient evidence to satisfy the panel that another member of staff had not signed the column *“Witnessed by”* in Resident A’s CD book on 11, 12 and 13 September 2021.

Accordingly, the panel found charge 3 NOT proved.

Charge 4

“4) Your actions in charge 3 were dishonest in that you were Intending to mislead others into believing that Colleague C or another nurse staff member had signed the “Witnessed by (signature)” box in the Controlled Drug book in relation to Resident A when you knew they had not.”

This charge is found NOT proved.

Having found charge 3 not proved the panel found charge 4 not proved.

Charge 5

“5) On 31 August 2021, incorrectly entered the signature of Colleague C in the “Witness signature” box in the “Destroyed or Returned Medication” book in relation to Resident A with regards to the following medication;

- a) Lactulose
- b) Lorazepam”

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the “*Destroyed or Returned Medication*” book for Resident A. The panel noted the entries dated 31 August 2021 for Resident A in relation to Lactulose and lorazepam, and the corresponding signatures in the column “*Witness signature*”.

The panel took into account the minutes from the investigatory meeting dated 31 May 2022.

[Witness 1]: (showing the evidence) Liza do you recognise the hand writing in the Returns Mediation Book for entries on 31.08.21?

LH: 31st, lactose...lorazepam...

[Witness 1]: 3 entries is it your writing

LH: Yes

[Witness 1]: You have written Resident A refused his medication, whose signature is it? [Colleague C] and you?

LH: This is mine and this is most likely to be [Colleague C] (pointing to the entry)

[Witness 1]: Larazepam [sic]...says stopped by GP, you signed and who else signed?

LH: Yes, must be [Colleague C] I can't remember long time ago.”

The panel took into consideration Witness 1's witness statement signed and dated 5 March 2024.

"...I conducted an interview with [Ms Hawes] to discuss my findings in the Returns Medication book, specifically the last three entries made by Liza dated 31 August 2021. Liza confirmed in interview these were her signatures."

The panel had regard to Colleague C's witness statement dated 17 May 2023, in relation to 31 August 2021.

"I was not working on this day however I had come into the home to do a PCR Covid-19 test. I believe Liza was due to be working a night shift on this day. A nurse by the name of [Colleague G] approached me as she saw me. She asked me if I had got Lorazepam destroyed for Resident A. I told her that I had not destroyed it... [Colleague G] showed me the destroying book page, which had my second signature and a note stating Resident A's GP had stopped Lorazepam for him. I told her that the second signature was not mine and it looked like it had been falsified. I made it clear that I was not at work on this day..."

The panel also took into account Colleague C's statement dated 26 May 2022 in which she stated that she came to work when she was "off" to do a PCR test. Colleague G asked if she destroyed Lorazepam for Resident A to which she confirmed that she had not. Colleague C stated she was not on shift on 31 August 2021, she checked the "Destroyed and Returned Medication" book and noticed somebody had tried to imitate her signature.

The panel therefore concluded that it was more likely than not that Colleague C did not sign the "Destroyed and Returned Medication" book for Resident A on 31 August 2021.

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

"None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other staff were spoken to and provided statements confirming they did not administer, or

witness control drug medication being given or destroyed by Liza during the dates of concern.”

The panel had regard to the staff's local statements and noted that there were no staff statements in respect of this charge. Therefore, there was no direct evidence from staff, excluding Colleague C, to confirm that they had not signed the *“Destroyed and Returned Medication”* book for Resident A on 31 August 2021.

The panel therefore determined that there was no direct evidence to prove that another member of staff had not witnessed Ms Hawes destroying the Lactulose and Lorazepam for Resident A and had accordingly signed the column *“Witnessed by”* in Resident A's *“Destroyed and Returned Medication”* book on 31 August 2021. The panel took into account that no rota had been provided evidencing which Registered Nurses were on duty on the day in question. The panel noted that Ms Hawes, during the investigation meeting, could not definitively say whether Colleague C had been the witness. The panel was of the view that this was plausible given that approximately nine months had passed and Ms Hawes, during the local investigation meeting, did not appear to have been provided with any rota or time sheet to show who was on duty with her at the relevant time.

The panel therefore determined that the NMC has not discharged its burden of proof, in that there was insufficient evidence to satisfy the panel that another member of staff had not signed the column *“Witnessed by”* in Resident A's *“Destroyed and Returned Medication”* book on 31 August 2021.

Accordingly, the panel found charge 5 NOT proved.

Charge 6

“6) Your action in charge 5 was dishonest in that you were intending to mislead others into believing that Colleague C had signed the “Witness signature” boxes in the “Destroyed or Returned Medication” book in relation to Resident A when you knew they had not.”

This charge is found NOT proved.

Having found charge 5 not proved the panel found charge 6 not proved.

Charge 7

“7) Incorrectly entered a signature in the MAR chart for Morphine Sulphate in relation to Resident C on the;

a) 27 September 2021

b) 29 September 2021”

This charge is found proved.

In reaching this decision, the panel first had regard to the MAR chart for Resident C for Morphine Sulphate and noted that there were two signatures for both 27 September 2021 and 29 September 2021.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: 27th, Monday at 20:10 who is the 1st signature?

LH: Can't remember

[Witness 1]: [Colleague D] was on the night

LH: I don't know without checking who was on

[Witness 1]: [Colleague A] was on days

LH: It must have been [Colleague A] then

...

[Mr 5]: The most recent one is Resident C why did he need it twice on 27th ...

LH: It was my assessment, unfortunately he was in pain and looked in distress

...

[Witness 1]: You and [Colleague A] went to assess him, who administered the Morphine?

LH: Me

...

LH: I went and got [Colleague A]

...

[Witness 1]: On Wednesday 29.09.2021 were you here with [Colleague F]?

LH: I think so

[Witness 1]: You were...at 02:00 you state they [sic] you found [Resident C] in discomfort, did you call [Colleague F], did she come to witness you do the Controlled Drug, who drew it up and who administered it?

LH: I gave it I don't remember who drew it up."

The panel took into consideration Witness 1's witness statement signed and dated 5 March 2024.

"I produce the [MAR chart entry for Resident C for Morphine Sulphate dated 27 and 29 September 2021] which I believe is a falsified signature in the chart for resident C for the entries dated 27 and 29 September 2021On review there are no nurses with signatures that closely resemble the witness signatures in the MAR chart."

The panel took into account Colleague A's witness statement dated 22 April 2024.

"I completed 'staff statements'... confirming that I did not sign the MAR chart for Resident C on 29 September 2021..."

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

"None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other staff were spoken to and provided statements confirming they did not administer, or witness control drug medication being given or destroyed by Liza during the dates of concern."

The panel had regard to the staff's local statements and noted the following:

- Colleague C stated that they did not sign the MAR for Resident C on 27 or 29 September 2021 signed and dated 1 October 2021;
- Colleague A stated that they did not sign the MAR for Resident C on 27 or 29 September 2021, signed and dated 1 October 2021;
- Colleague D stated that they did not sign the MAR for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021;
- Colleague E stated that they did not sign the MAR for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021;
- Colleague F stated that they did not sign the MAR for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021, nor have they at any other time given Resident C morphine sulphate;
- Colleague G stated that they did not sign the MAR for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021, nor have they administered any subcutaneous injection for this resident.

The panel noted that there are eight Registered Nurses at the Home who could have administered medication excluding Ms Hawes. Having had regard to the staff's local statements and taking into account that Witness 1 is one of the individuals who could

administer medication, the panel noted that seven out of the eight potential Registered Nurses who could administer medication did not witness Ms Hawes administering Morphine Sulphate to Resident C and accordingly did not sign the MAR chart for Resident C.

The panel took into account Witness 1's evidence is hearsay evidence and the statements provided by the staff are "*pro forma*" statements with no declaration of truth. However, the panel noted that Ms Hawes, during the investigation meeting, stated that, in respect of 27 September 2021, Colleague A had witnessed the medication administration for Resident C. Furthermore, in respect of 29 September 2021, Ms Hawes stated the nurse on duty, namely Colleague F, had witnessed the medication administration for Resident C. The panel noted that the investigation meeting took place four to six days after the alleged incorrect entries. The panel was therefore of the view that Ms Hawes was, more likely than not, able to accurately recall the events and noted that she had in fact identified the nurses who had apparently witnessed her on 27 and 29 September 2021.

The panel therefore determined, in light of Ms Hawes responses and given that all the staff, bar one, confirmed they did not witness Ms Hawes, that it was more likely than not that Ms Hawes incorrectly entered a signature in the MAR chart for Morphine Sulphate in relation to Resident C on the 27 and 29 September 2021.

Accordingly, the panel found charge 7 proved.

Charge 8

"8) Your conduct in charge 7 was dishonest in that you were intending to mislead others into believing that another nurse staff member at the Home had signed the MAR chart in relation Resident C when you knew that they had not."

This charge is found proved.

The panel had regard to the principles established in the case of *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67.

'What was the defendant's actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?'

The panel referred to the NMC guidance *'Making decisions on dishonesty charges and the professional duty of candour'* reference *'DMA-8'*, last updated 6 May 2025.

The panel had regard to the minutes from the investigation meeting dated 2 October 2021.

"[Mr 5]: ...What is the procedure regarding Controlled Drugs

LH: We check the dose, the person, the time.

[Mr 5]: Should there always be two people?

LH: No

[Mr 5]: Should there be two people for Controlled Drugs?

LH: Yes

[Mr 5]: What is the principal for the 2nd person?

LH: To double check

[Mr 5]: To clarify both of the senior Staff (here Nurses) would check the medication, take to the person, dispense – making sure the person takes the medication and then you return to sign the chart in CD book and MAR-chart both sign the CD book and MAR chart?

LH: mmmmm

[Mr 5]: Is that correct?

LH: Yes"

Having had regard to the investigation meeting minutes the panel determined that Ms Hawes knew that when administering controlled drugs, two Registered Nurses need to be present, and both nurses would subsequently sign the MAR chart for the relevant resident, having administered the medication.

The panel determined that there was no alternative explanation, in incorrectly entering a signature in the MAR chart for Morphine Sulphate in relation to Resident C on 27 and 29 September 2021 Ms Hawes intended to mislead others into believing that another nurse staff member at the Home had signed the MAR chart for Resident C when she knew that they had not. The panel determined that Ms Hawes's actions would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel found charge 8 proved.

Charge 9

"9) Incorrectly entered a signature in the "Witnessed by (signature)" box in the Controlled Drug Book for Morphine Sulphate in relation to Resident C on the;

a) 27 September 2021

b) 29 September 2021"

This charge is found proved.

In reaching this decision, the panel first had regard to the CD book for Resident C for Morphine Sulphate and noted that there were two signatures for both 27 September 2021 and 29 September 2021.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

"[Witness 1]: 27th, Monday at 20:10 who is the 1st signature?

LH: Can't remember

[Witness 1]: [Colleague D] was on the night

LH: I don't know without checking who was on

[Witness 1]: [Colleague A] was on days

LH: It must have been [Colleague A] then

...

[Witness 1]: According to the CD book you did the writing, did you draw up the medication and did you administer and did [Colleague A] witness the whole process?

LH: Yes.

...

[Witness 1]: On Wednesday 29.09.2021 were you here with [Colleague F]?

LH: I think so

[Witness 1]: You were...at 02:00 you state they [sic] you found [Resident C] in discomfort, did you call [Colleague F], did she come to witness you do the Controlled Drug, who drew it up and who administered it?

LH: I gave it I don't remember who drew it up."

The panel took into consideration Colleague C's witness statement signed and dated 17 May 2023.

"I refer to the CD page 107, the entry dated 27 September. The first signatures given by, looks like Liza's signature. However, the witnessed by signature for that entry does not match any staff member's signature, and appears falsified. The signatures for the entry on 29 September 2021 also not recognisable."

The panel took into account Colleague A's witness statement dated 22 April 2024.

"I completed 'staff statements'... confirming that I did not sign... Nor did I sign the controlled drug book on 29 September 2021 for Resident C, p107."

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

"None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other staff were spoken to and provided statements confirming they did not administer, or witness control drug medication being given or destroyed by Liza during the dates of concern."

The panel had regard to the staff's local statements and noted the following:

- Colleague C stated that they did not sign the CD book for Resident C on 27 or 29 September 2021 signed and dated 1 October 2021;
- Colleague A stated that they did not sign the CD book for Resident C on 27 or 29 September 2021, signed and dated 1 October 2021;
- Colleague D stated that they did not sign the CD book for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021;
- Colleague E stated that they did not sign the CD book for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021;
- Colleague F stated that they did not sign the CD book for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021;
- Colleague G stated that they did not sign the CD book for Resident C on 27 or 29 September 2021, signed and dated 2 October 2021, nor have they witnessed any subcutaneous injection for this resident.

The panel noted that there are eight Registered Nurses at the Home who could have administered medication excluding Ms Hawes. Having had regard to the staff's local statements and taking into account that Witness 1 is one of the individuals who could administer medication, the panel noted that seven out of the eight potential Registered Nurses who could administer medication did not witness Ms Hawes administering Morphine Sulphate to Resident C and accordingly did not sign the CD book for Resident C.

The panel took into account Witness 1's evidence is hearsay evidence and the statements provided by the staff are "*pro forma*" statements with no declaration of truth. However, the panel noted that Ms Hawes, during the investigation meeting, stated that, in respect of 27 September 2021, Colleague A had witnessed the medication administration for Resident C. Furthermore, in respect of 29 September 2021, Ms Hawes stated the nurse on duty, namely Colleague F, had witnessed the medication administration for Resident C. The panel noted that the investigation meeting took place four to six days after the alleged incorrect entries. The panel was therefore of the view that Ms Hawes was, more likely than not, able to accurately recall the events and noted that she had in fact identified the nurses who had witnessed her on 27 and 29 September 2021.

The panel therefore determined, in light of Ms Hawes responses and given that all the staff, bar one, confirmed they did not witness Ms Hawes, that it was more likely than not that Ms Hawes incorrectly entered a signature in the CD book for Morphine Sulphate in relation to Resident C on the 27 and 29 September 2021.

Accordingly, the panel found charge 9 proved.

Charge 10

"10) Your conduct in charge 9 was dishonest in that you were intending to mislead others into believing that another nurse staff member had signed the Controlled Drug book for Resident C when you knew they had not."

This charge is found proved.

The panel had regard to the principles established in the case of *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67.

‘What was the defendant’s actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?’

The panel referred to the NMC guidance *‘Making decisions on dishonesty charges and the professional duty of candour’* reference *‘DMA-8’*, last updated 6 May 2025.

The panel had regard to the minutes from the investigation meeting dated 2 October 2021.

“[Mr 5]: ...What is the procedure regarding Controlled Drugs

LH: We check the dose, the person, the time.

[Mr 5]: Should there always be two people?

LH: No

[Mr 5]: Should there be two people for Controlled Drugs?

LH: Yes

[Mr 5]: What is the principal for the 2nd person?

LH: To double check

[Mr 5]: To clarify both of the senior Staff (here Nurses) would check the medication, take to the person, dispense – making sure the person takes the medication and then you return to sign the chart in CD book and MAR-chart both sign the CD book and MAR chart?

LH: mmmmm

[Mr 5]: Is that correct?

LH: Yes”

Having had regard to the investigation meeting minutes the panel determined that Ms Hawes knew that when administering controlled drugs, two Registered Nurses need to be present, and both nurses would subsequently sign the CD book for the relevant resident, having administered the medication.

The panel determined that there was no alternative explanation, in incorrectly entering a signature in the CD book for Morphine Sulphate in relation to Resident C on 27 and 29 September 2021 Ms Hawes intended to mislead others into believing that another nurse staff member at the Home had signed the CD Book for Resident C when she knew that they had not. The panel determined that Ms Hawes’s actions would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel found charge 10 proved.

Charge 11

“11) Incorrectly entered a signature in the “Witnessed by (signature)” box in the Controlled Drug Book for Morphine Sulphate in relation to Resident D on the;

a) 22 September 2021

b) 23 September 2021”

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the CD book for Resident D for Morphine Sulphate. The panel noted that there was an entry in the CD book, dated either 21 or 22 September 2021 and another entry in the CD book dated either 23, 26 or 28 September 2021. The panel was of the view that the exact date of these entries was unclear in that they appeared to have been altered.

In any event the panel considered the evidence in respect of the stem of charge 11.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: Page 86 re Resident D is that your writing and signature?”

LH: Yes

[Witness 1]: Is it for Morphine Sulphate?

LH: Yes

[Witness 1]: Who is the witness?

LH: I don't know I can't remember.”

The panel took into consideration Witness 1's witness statement signed and dated 5 March 2024.

“I produce [CD book entry for Resident D dated 22 September 2021] showing Liza administered 0.25mls of morphine sulphate to resident D on 22 September 2021.”

The panel took into account Colleague C's witness statement signed and dated 17 May 2023.

“Resident D - 23 September 2021

...

I refer to the CD page for...Resident D. We do weekly stock checks for Controlled Drugs, and we did one on this day. However I do not recognise the signatures for that entry. There is another entry above this as 22 September 2021...The

signatures both look like Liza's. Therefore, this entry also seems falsified and incorrect."

The panel took into account that Witness 1 in their witness statement signed and dated 5 March 2024 confirmed that:

"None of the signature are recognised by the staff who were in shift with Liza at the time the controlled drug medication was given to the residents involved. All other staff were spoken to and provided statements confirming they did not administer, or witness control drug medication being given or destroyed by Liza during the dates of concern."

The panel had regard to the staff's local statements and noted the following:

- Colleague C stated that they did not sign the CD book for Resident D on 23 September 2021 signed and dated 1 October 2021;
- Colleague A stated that they did not sign the CD book for Resident D on 22 or 23 September 2021, signed and dated 1 October 2021;
- Colleague D stated that they did not sign the CD book for Resident D on 22 or 23 September 2021, signed and dated 2 October 2021;
- Colleague E stated that they did not sign the CD book for Resident D on 22 or 23 September 2021, signed and dated 2 October 2021;
- Colleague F stated that they did not sign the CD book for Resident D on 21 or 23 September 2021, signed and dated 2 October 2021, nor have they administered any morphine to this resident;
- Colleague G stated that they did not sign the CD book for Resident D on 21, 22 or 23 September 2021, signed and dated 2 October 2021, nor have they ever administered Morphine Sulphate to this resident.

The panel noted that there are eight Registered Nurses at the Home who could have administered medication excluding Ms Hawes. Having had regard to the staff's local statements and taking into account that Witness 1 is one of the individuals who could administer medication. The panel noted that five out of the eight potential Registered Nurses who could administer medication did not witness Ms Hawes administering

Morphine Sulphate to Resident D on 22 September 2021 and accordingly did not sign the CD book for Resident D. Seven out of the eight potential Registered Nurses who could administer medication did not witness Ms Hawes administering Morphine Sulphate to Resident D on 23 September 2021 and accordingly did not sign the CD book for Resident D.

However, the panel took into account Witness 1's evidence is hearsay evidence and the statements provided by the staff are "*pro forma*" statements with no declaration of truth. The panel also noted that that no rota had been provided evidencing which Registered Nurses were on duty on the day in question. The panel noted that Ms Hawes, during the investigation meeting, could not remember who had witnessed her administer the medication to Resident D on the days in question. The panel was of the view that this was plausible given that at least nine days had passed and Ms Hawes, during the local investigation meeting, did not appear to have been provided with any rota or time sheet to show who was on duty with her at the relevant time.

The panel therefore determined that the NMC has not discharged its burden of proof. Firstly, in respect of the lack of clarity around the dates of the entries in the CD book and secondly in that there was insufficient evidence to satisfy the panel that another member of staff had not signed the column "*Witnessed by*" in Resident D's CD book on 22 or 23 September 2021.

Accordingly, the panel found charge 11 NOT proved.

Charge 12

"12) Your conduct in charge 11 was dishonest in that you were intending to mislead others into believing that another nurse staff member had signed the Controlled Drug book entry in relation to Resident D when you knew they had not."

This charge is found NOT proved.

Having found charge 11 not proved the panel found charge 12 not proved.

Charge 13

“13) You failed to destroy unused medications in the presence of another nurse on one or more occasions in September 2021.”

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the wording of the charge in that it relates to one or more occasions in September 2021, however the panel noted that the evidence the NMC was seeking to rely on in support of this charge related to 31 August 2021.

The panel therefore determined that there was no evidence before it, to support that Ms Hawes failed to destroy unused medication in the presence of another nurse on one or more occasions in September 2021.

However, in any event, the panel still considered whether Ms Hawes failed to destroy unused medication in the presence of another nurse on one or more occasions in respect of 31 August 2021, acknowledging that the charge appeared to refer to the wrong month.

The panel first considered whether Ms Hawes had a duty to destroy unused medications in the presence of another nurse. The panel took into account that Witness 1 in their witness statement dated 5 March 2024 stated, *“Whenever medication is disposed of, this is recorded, however the medications must not be destroyed without another nurse present, as two nurses are required to sign confirming the medication has been destroyed.”*

The panel noted the three entries in the *“Destroyed or Returned Medication”* book for Resident A, dated 31 August 2021, in relation to the medications *“Lactulose, lorazepam and unknown”* and the corresponding signatures in the column *“Witness signature”*.

The panel took into account the minutes from the investigatory meeting dated 31 May 2022.

“[Witness 1]: (showing the evidence) Liza do you recognise the hand writing in the Returns Mediation Book for entries on 31.08.21?”

LH: 31st, lactose...lorazepam...

[Witness 1]: 3 entries is it your writing

LH: Yes”

The panel took into consideration Witness 1’s witness statement dated 5 March 2024

“The first two entries have not been countersigned by [Colleague C], despite the initials to look like [Colleague C] has signed this. In addition, it is unacceptable for a nurse to make an entry with “unknown” against the resident name and the name of the medication. There is also no witness signature that Liza destroyed this medication.”

The panel had regard to its previous finding at charge 5 in that Ms Hawes did NOT incorrectly enter the signatures in the column *“Witness signature”* in the *“Destroyed or Returned Medication”* book for Resident A on 31 August 2021 in relation to Lactulose and Lorazepam. The panel therefore determined that it was more likely than not that someone did witness Ms Hawes destroy the Lactulose and Lorazepam.

The panel took into account that there was a *“Witness signature”* in the *“Destroyed or Returned Medication”* book for the entry dated 31 August 2021 for the *“unknown”* medication. Furthermore, the panel noted that there was no suggestion that Ms Hawes incorrectly entered this signature. The panel therefore determined that it was more likely than not that someone did witness Ms Hawes destroy the *“unknown”* medication.

The panel therefore determined that in light of the fact that that all three entries in the *“Destroyed or Returned Medication”* book, dated 31 August 2021 have a signature in the column *“Witness signature”* and there is insufficient evidence to support that these signatures are incorrect, it is more likely than not, that Ms Hawes destroyed the unused medications in the presence of another nurse.

The panel therefore determined that the NMC has not discharged its burden of proof. Firstly, in that there is no evidence to support the Ms Hawes failed to destroy any used medication in the presence of another nurse on one or more occasions in September 2021. Secondly, in that there is evidence in the *“Destroyed or Returned Medication”* book, that the entries dated 31 August 2021 contained a *“Witness signature”* and there is insufficient evidence to prove that these entries are incorrect.

Accordingly, the panel found charge 13 NOT proved.

Charge 14

“14) You failed to have the administration of controlled drugs to Residents countersigned by another nurse on one or more occasions in September 2021.”

This charge is found proved.

In reaching its decision, the panel had regard to its previous findings at charges 1, 3, 7, 9 and 11. The panel took into account that having found charges 7 and 9 proved it has determined that Ms Hawes did incorrectly enter a signature in the MAR chart and CD Book for Morphine Sulphate in relation to Resident C on 27 and 29 September 2021

The panel having had regard to its previous findings at charges 8 and 10 was satisfied that Ms Hawes had a duty to have the administration of controlled drugs to residents countersigned by another nurse and she was aware of this policy. The panel therefore determined that Ms Hawes failed in her duty to have the administration of controlled drugs to Resident C countersigned by another nurse on 27 and 29 September 2021.

Accordingly, the panel found that charge 14 proved.

Charge 15

“15) You improperly signed the Controlled Drug book prior to giving medication to residents;”

This charge is found proved.

In reaching this decision, the panel took into account the minutes from the investigatory meeting dated 2 October 2021.

“[Mr 5]: Do you sign the CD book prior to giving the medication?”

LH: I sign before giving.

[Mr 5]: You sign CD book prior to giving the medication?

LH: Yes.

[Mr 5]: Do you know this is completely against the policy?

LH: Well, I guess sometimes it happens.”

Having had regard to the minutes from the investigatory meeting on 2 October 2021 the panel determined that Ms Hawes admitted to having signed the CD book prior to giving medication. Further she also admitted to knowing that her actions were against policy.

The panel therefore concluded that Ms Hawes improperly signed the CD book prior to giving medication to residents.

Accordingly, the panel found charge 15 proved.

Charge 16

“16) On 31 August 2021, improperly made an entry on the “Destroyed or Returned Medication” record with “unknown” in the “Service Username” box and the name of the “medication”.”

This charge is found proved.

In reaching this decision, the panel noted the entry in the *“Destroyed or Returned Medication”* book, dated 31 August 2021, in relation to the *“unknown”* medication. The panel determined that the medication was written as *“unknown”*. The panel could not determine whether or not the resident’s name was written as *“unknown”*, due to the fact that it had been redacted.

The panel had regard to the fact that in the investigatory meeting on 31 May 2022 Ms Hawes acknowledged that this entry was written by her.

The panel took into consideration Witness 1’s witness statement dated 5 March 2024.

“The final entry made by Liza stated “unknown” resident and “unknown” medication. When I questioned Liza about this during interview, she said this must be for resident A also.

...In addition it is unacceptable for a nurse to make as entry with “unknown” against the resident name and the name of the medication.”

The panel had regard to the minutes of the investigatory meeting on 31 May 2022.

“[Witness 1]: It is a serious error; you have recorded service user unknown and medication unknown?”

LH: I couldn’t identify it he spat it out

[Witness 1]: He could not have spat out 3 and you destroyed 3, reason given was stopped by GP?

LH: I see what you saying.”

The panel took into account that in the *“Destroyed or Returned Medication”* book the *“reason for disposal”* for the *“unknown”* medication was *“stopped by GP”* rather than medication refused.

The panel noted that the relevant resident's name was redacted in the *"Destroyed or Returned Medication"* book, however in light of the fact that Witness 1 stated that it was written as *"unknown"* and this was put to Ms Hawes during the investigatory meeting and was not disputed, the panel was satisfied that *"unknown"* was written in the *"Service Username"* box.

The panel had regard to Ms Hawes's explanation in that she could not identify the medication due to Resident A having spat it out. The panel determined that this explanation was inherently implausible in that the alternative explanation documented by Ms Hawes was that the medication had been stopped by the GP. This was agreed by Ms Hawes and she in fact wrote in the *"Destroyed or Returned Medication"* book that the *"unknown"* medication had been stopped by the GP.

The panel had regard to the fact that it was considered unacceptable by Witness 1 for a nurse to make an entry with *"unknown"* against the resident's name and the name of the medication. The panel determined, given the implausibility of Ms Hawes's explanation and her tacit admission to the fact that she had written *"unknown"* for both the resident's name and the medication, it was more likely than not on 31 August 2021 she made an improper entry in the *"Destroyed or Returned Medication"* record with *"unknown"* in the *"Service Username"* box and the name of the *"medication"*.

Accordingly, the panel found charge 16 proved.

Charge 17

"17) On 12 September 2021, did not complete the "progress evaluation form" for Resident A to evidence the reason for administering Morphine Sulphate to Resident A."

This charge is found NOT proved.

In reaching this decision the panel had regard to the progress and evaluation records for Resident A in respect of 12 September 2021. The panel noted that the first entry for 12 September 2021 was at 02:00 and the last entry at 18:15.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: Page 100 reference Resident A for Morphine Sulphate, do you recognise the signature on the 11th?”

LH: It looks like mine

...

[Witness 1]: Are they your signatures on 11th, 12th and 13th?

LH: Yes.

...

[Witness 1]: On the 12th medication was given at 20:10 who were you with?

LH: It could be the nurse from days.”

The panel took into account Colleague C’s witness statement dated 17 May 2023.

“A day shift at the home usually has two nurses on shift and runs from 0745-2000. and a night shift has two nurse [sic] in charge and runs from 2000-0745.

...

12 September 2021

I was working a day shift on this. Liza had taken over from me for the night shift at the end of the day.”

The panel therefore concluded that there was insufficient evidence to determine whether Ms Hawes did not complete the *“progress evaluation form” for Resident A* on 12 September 2021, in light of the fact that she started her shift at 20:00, the medication was apparently administered at 20:10, however the panel did not have before it the progress and evaluation records for Resident A after 18:15 on 12 September 2021.

The panel therefore determined that the NMC had not discharged its burden of proof.

Accordingly, the panel found charge 17 NOT proved.

Charge 18

“18) On 13 September 2021, did not complete the “progress evaluation form” for Resident A to evidence the reason for administering Morphine Sulphate to Resident A.”

This charge is found NOT proved.

In reaching this decision the panel had regard to Witness 1’s witness statement dated 5 March 2024.

“Liza also administered Morphine Sulphate on 13 September 2021, however we are unable to produce the progress evaluation for this date.”

The panel determined that there was insufficient evidence to find this charge proved in that it did not have before it the progress and evaluation records for Resident A for 13 September 2021.

The panel therefore concluded that the NMC has not discharged its burden of proof.

Accordingly, the panel found charge 18 NOT proved.

Charge 19

“19) On 29 September 2021, did not complete the “progress evaluation form” for Resident C to evidence the reason for administering Morphine Sulphate to Resident C.”

This charge is found NOT proved.

In reaching this decision the panel took into consideration the MAR chart for Resident C and noted that they were administered Morphine Sulphate on 29 September 2021, but no time was given.

The panel took into consideration the minutes of the investigatory meeting dated 2 October 2021.

“[Witness 1]: On Wednesday 29.09.2021 were you here with [Colleague F]?”

LH: I think so

[Witness 1]: You were...at 02:00 you state they [sic] you found [Resident C] in discomfort, did you call [Colleague F], did she come to witness you do the Controlled Drug, who drew it up and who administered it?

LH: I gave it I don't remember who drew it up.”

The panel had regard to the progress and evaluation records for Resident C. The panel took into account that there was a note which stated, *“Difficult start of night – Resident C did not pee and was clearly in discomfort. Analgesia given – settled down very well”*, dated 30 September 2021 with no time given. The panel noted the next entry is dated 30 September 2021, 14:15.

The panel having had regard to the minutes of the investigatory meeting noted that Ms Hawes was apparently working a night shift on 29 September 2021, having found Resident C at 02:00.

The panel therefore determined that, it was more likely than not, the note in the progress and evaluation records for Resident C dated 30 September 2021 with no time provided, related to the interaction with Resident C at 02:00 when they were administered Morphine Sulphate.

The panel therefore concluded that Ms Hawes had provided a reason in the progress and evaluation records for Resident C to evidence the reason for administering Morphine Sulphate for 29 September 2021, in that she stated *“Difficult start of night – Resident C did not pee and was clearly in discomfort. Analgesia given – settled down very well”*. The panel decided that the NMC had not proved, on the balance of probabilities, that *“analgesia”* did not refer to Morphine Sulphate.

Accordingly, the panel found charge 19 NOT proved.

Charge 20

“20) On 22 September 2021, did not complete the “progress evaluation form” for Resident D to evidence the reason for administering Morphine Sulphate to Resident D.”

This charge is found proved.

In reaching this decision, the panel took into account the CD book for Resident D for Morphine Sulphate. The panel noted that there was an entry in the CD book, dated either 21 or 22 September 2021. The panel was of the view that the exact date of these entries was unclear in that they appeared to have been altered.

The panel had regard to the progress and evaluation records for Resident D dated 22 September 2021. The panel noted that there was no mention of having administered any Morphine Sulphate or the reason for administering it. The panel took into account that the notes in respect 22 September 2021 for Resident D at 03:45 stated *“No concerns reported to me by care staff over night...Slept well all night”*.

The panel therefore concluded that that Ms Hawes did not complete the “progress evaluation form” for Resident D to evidence the reason for administering Morphine Sulphate to Resident D on 22 September 2021.

Accordingly, the panel found charge 20 proved.

Charge 21

“21) In October 2020, attended work whilst unfit in that you

a) appeared dazed and/or

b) demonstrated erratic behaviour.”

This charge is found NOT proved.

In reaching this decision the panel had regard to the minutes of the investigatory meeting dated 14 October 2020.

“[Witness 1]: The nurses are concerned about your erratic behaviour did you know you were being erratic?

LH: ‘No’

[Witness 1]: Carers and nurses have said you are looking dazed and you do, are you ok

LH: ‘not 100% after bashing my head’

[Witness 1]: Do you realise it is impacting how you are presenting

LH: ‘I feel nauseous and not 100%’”

The panel took into account Witness 1’s witness statement dated 5 March 2024.

“Whilst I was in my position Deputy Home Manager it was reported to me some concerns in regard to Liza’s behaviour, it was also reported to me that on one occasion Liza attended the home appearing dazed and demonstrating erratic behaviour.”

The panel took into consideration that Witness 1’s evidence is anonymous hearsay, in that she did not witness Ms Hawes appearing dazed or demonstrating erratic behaviour, it was reported to her by unidentified nurses. The panel noted that there was no direct evidence in respect of Ms Hawes appearing dazed or demonstrating erratic behaviour. The panel took into account that there was no specification as to the date on which the alleged behaviour occurred, it was simply stated *“on one occasion”* in October 2020.

The panel concluded that there was insufficient evidence to determine that Ms Hawes attended work whilst unfit in that she appeared dazed and/or demonstrated erratic behaviour.

The panel therefore concluded that the NMC has not discharged its burden of proof.

Accordingly, the panel found charge 21 NOT proved.

Charge 22

“22) Worked as a registered nurse in breach of an interim suspension order between 6 October 2022 and 28 September 2023.”

This charge is found proved.

In reaching this decision the panel first had regard to the decision outcome letter from the NMC to Ms Hawes sent to her registered email address on 7 October 2022, which confirmed the outcome of the interim order hearing held on 6 October 2022. The panel took into account that an interim suspension order was imposed on Ms Hawes’s practice on 6 October 2022.

The panel had regard to Witness 4's witness statement dated 7 March 2025.

"Liza was employed as a registered nurse within the Community District nursing Central team of the [Trust] from 5 July 2022 until 17 October 2023.

...

The [Trust] workforce team found out that an ISO was imposed on Liza's practice on 25 September 2023, when Liza's registration was due for renewal. An email regarding this discovery was picked up by Liza's line manager...on 26 September 2023.

...

Regarding the ongoing investigation related to the concerns raised at Barchester Healthcare and the ISO that was imposed on 6 October 2022, Liza did not declare the ongoing investigation or that the ISO was imposed on 6 October 2022 to the [Trust]."

The panel took into account that Ms Hawes was suspended by the Trust pending investigation on 27 September 2023 and an NMC referral was made on 28 September 2023.

The panel took into consideration the investigation meeting notes dated 4 October 2023 from Ms Hawes's interview with the Trust, which confirmed that she had been working as a Registered Nurse, in breach of the interim suspension order.

Accordingly, the panel found charge 22 proved.

Charges 23

"23) Your conduct in Charge 22 showed a lack of integrity in that you received emails from the Nursing and Midwifery Council notifying you of the interim order hearing on 6 October 2022 as well as the outcome to impose an interim suspension order but you did not inform yourself of the hearing or the outcome."

This charge is found NOT proved.

In reaching this decision, the panel first had regard to the notice of the interim order hearing sent on 29 September 2022 to Ms Hawes's registered email address. The panel also took into account that the NMC stated that the notice was also sent to Ms Hawes's registered address by recorded delivery.

The panel took into account that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered email/address.

The panel took into consideration that the decision outcome letter from the NMC to Ms Hawes was sent to her registered email address on 7 October 2022, which confirmed the outcome of the interim order hearing held on 6 October 2022. Ms Hawes was informed in this letter that an Investigating Committee panel had imposed an interim suspension order on her practice.

The panel had regard to the fact that Ms Hawes has a duty to engage with her regulator, the NMC. The panel considered the definition of the phrase "*lack of integrity*", meaning the absence of honesty and strong moral principles.

However, the panel determined that on the balance of probabilities, Ms Hawes was aware of the interim order hearing and the subsequent outcome. It determined that Ms Hawes had been aware of the concerns raised by Barchester Healthcare. Ms Hawes had been suspended by Barchester Healthcare then subsequently dismissed. The panel therefore went on to consider charge 24, in the alternative.

Accordingly, the panel found charge 23 NOT proved.

Charge 24

"In the alternative

24) Your conduct in Charge 22 was dishonest in that you practised as a registered nurse when you knew that an interim suspension order was imposed on your practice on 6 October 2022”

This charge is found proved.

The panel had regard to the principles established in the case of *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67.

‘What was the defendant’s actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?’

The panel referred to the NMC guidance *‘Making decisions on dishonesty charges and the professional duty of candour’* reference *‘DMA-8’*, last updated 6 May 2025.

The panel considered the background of the case and had regard to Witness 1’s witness statement dated 5 March 2024, and the minutes of the investigatory meeting dated 31 May 2022. The panel noted that concerns were raised regarding Ms Hawes practice, by Barchester Healthcare. She was suspended by her employer at the time, as a result of the concerns and was subsequently dismissed on 16 June 2022. However, the panel took into account that during the investigation meeting with the Trust on 4 October 2023 Ms Hawes stated she resigned from Barchester Healthcare.

The panel took into consideration the statement regarding Ms Hawes provided by the Trust, in which it is stated that Ms Hawes did not know of anything regarding the NMC, she sounded shocked on the phone regarding the interim suspension order and stated she was aware of previous issues in another role, but she thought they were supporting her.

The panel took into account the investigation meeting notes dated 4 October 2023 from Ms Hawes’s interview with the Trust in which it is clear that Ms Hawes did not inform the Trust about the investigation undertaken by Barchester Healthcare. The panel noted that at the time of applying to the Trust, a reference was requested from Barchester healthcare, who disclosed that they were not aware that Ms Hawes was leaving and that there was an

ongoing investigation regarding Ms Hawes due to allegations regarding her conduct at work.

The panel determined that Ms Hawes's accounts were inconsistent and inherently contradictory, in that she was aware of the concerns and the ongoing investigation by Barchester Healthcare at the time of applying to the Trust. She knew that she had been dismissed from her employment with Barchester Healthcare due to the concerns. However, she stated that she was unaware of the NMC's investigation, the interim order hearing and the subsequent interim suspension order imposed on her practice.

The panel had regard to the fact that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered email/address. The notice of the interim order hearing was sent on 29 September 2022 to Ms Hawes's registered email address. The decision outcome letter from the NMC to Ms Hawes was sent to her registered email address on 7 October 2022, which confirmed the outcome of the interim order hearing held on 6 October 2022. The panel took into account that Ms Hawes has a duty to engage with her regulator.

The panel determined that on the balance of probabilities it is more likely than not that Ms Hawes knew that there was an interim suspension order imposed on her practice but deliberately did not disclose it to the Trust as she was seeking to conceal the concerns previously raised by Barchester Healthcare and the fact that she had been dismissed because she wanted to continue practising as a Registered Nurse.

Having had regard to its previous finding at charge 22 the panel determined that Ms Hawes practised as a Registered Nurse between 6 October 2022 and 28 September 2023, when she knew that her practice was subject to an interim suspension order. The panel determined that Ms Hawes's conduct was dishonest by the standards of ordinary decent people.

Accordingly, the panel found charge 24 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 Ms Hawes'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, Ms Hawes's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC referred the panel to the case of *Roylance v GMC (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 and the cases of *Calheam v GMC* [2007] EWHC 2606 (Admin) and *Nandi v GMC* [2004] EWHC 2317 (Admin).

The NMC identified the provisions of the '*The NMC code of professional conduct: standards for conduct, performance and ethics (2015)*' (the Code) which it considers Ms Hawes to have breached.

The NMC submitted that Ms Hawes actions involve multiple incidents of dishonest behaviour and can therefore properly be described as serious professional misconduct and deplorable. The NMC submitted that Ms Hawes's conduct was directly linked to her practice and was both clinical and attitudinal in nature.

Furthermore, the NMC submitted that Ms Hawes failed to follow the Home's procedures when administering controlled drugs in the presence of another nurse on one or more occasions. She admitted to signing the controlled drug book prior to giving medication to residents and on multiple occasions she improperly completed residents' records. These actions demonstrate a disregard for delivering the fundamentals of care effectively and preserving the safety of those receiving care.

The NMC submitted that Ms Hawes worked as a Registered Nurse in breach of her interim suspension order between 6 October 2022 and 28 September 2023. The NMC submitted that Ms Hawes was informed about the interim order hearings however she continued to work at the Trust until September 2023. Both incidents demonstrate a disregard to resident care and any risk she could impose on residents and therefore amount to serious misconduct. The NMC submitted that Ms Hawes acted dishonestly when practicing as a Registered Nurse when she knew that an interim suspension order was imposed.

The NMC submitted that Ms Hawes's conduct fell far below the standards to be expected of a Registered Nurse.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC submitted that all four limbs of the *Grant* test can be answered in the affirmative.

The NMC submitted that Ms Hawes in the past has acted so as to put residents at unwarranted risk of harm by falsifying colleagues' signatures, failing to follow procedures in relation to administering controlled drugs, failing to record information in relation to medication administration on residents' records and completing resident records inaccurately.

The NMC submitted that Ms Hawes worked as a Registered Nurse in breach of her interim suspension order between 6 October 2022 and 28 September 2023. These actions demonstrate a disregard to any risk of unwarranted resident harm and preservation of safe care. Further Ms Hawes in practising whilst her under an interim suspension order, showed that she lacked honesty and integrity and demonstrated a complete disregard for the steps the NMC has put in place to keep the public safe or uphold confidence in the professions.

The NMC submitted that such actions as highlighted above have brought the nursing profession into disrepute. The public, quite rightly, expects registrants to be individuals of unimpeachable probity and the NMC is tasked by statute to promote and maintain public confidence in the profession and promote and maintain proper professional standards and conduct. The NMC submitted the Ms Hawes has clearly breached fundamental tenets of the nursing profession. Furthermore, the NMC submitted that Ms Hawes has acted dishonestly on multiple occasions.

The NMC submitted that the concerns are difficult to address as Ms Hawes has acted dishonestly multiple times. The dishonesty is serious as it was premeditated, sustained over a period of time and directly linked to Ms Hawes professional practice. Furthermore, Ms Hawes practiced as a Registered Nurse whilst an interim suspension order was imposed on her practice which the NMC submitted demonstrated a lack of integrity and honesty.

The NMC submitted the Ms Hawes has not engaged with NMC proceedings at all and has not provided any insight or reflection into her actions. During the local investigation interviews, she appeared to acknowledge that she signed controlled drug books before administering medication. However, with regards to falsification of signatures Ms Hawes maintained that she had not done it, although she agreed that there was no reason why other colleagues would say that it was not their signature.

The NMC informed the panel that Ms Hawes received the notice of interim order hearing on 29 September 2022, and the interim suspension order was imposed on 6 October 2022. Ms Hawes did not respond to NMC correspondence and subsequently did not engage with interim order review meetings.

The NMC submitted that Ms Hawes's actions display attitudinal concerns which are not easily remediable and have not been remedied. She has not provided any information into her personal circumstances and/or reflections in relation to the incidents.

The NMC submitted that in the absence of any insight, remorse, reflection and strengthening of practice/remediation there is a risk that Ms Hawes will repeat such behaviour in the future.

Additionally, the NMC submitted that the concerns are so serious in this case, involving multiple instances of dishonesty that a finding of current impairment is required in order to maintain public confidence in the profession.

The panel took into account that no written representations or documentation were provided by Ms Hawes.

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

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 Ms Hawes's actions did fall significantly short of the standards expected of a Registered Nurse, and that Ms Hawes's actions amounted to a breach of the Code. Specifically:

“8 Work co-operatively

To achieve this, you must

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

8.2 maintain effective communication with colleagues

8.3 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

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

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

23 Cooperate with all investigations and audits *This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.*

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body"

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

The panel therefore considered whether each charge individually amounted to serious misconduct.

Charges 7 and 9

The panel had regard to the fact that countersigning MAR charts and CD books is a safety measure put in place to ensure that medication is being dispensed and administered correctly. The panel determined that Ms Hawes; by incorrectly entering signatures in Resident C's MAR chart and CD book, put Resident C at risk of harm. The panel took into account that Ms Hawes failed to have two different documents countersigned on two different occasions. The panel had regard to the fact that Ms Hawes was aware of the Home's policy and procedure in relation to countersigning documentation. The panel therefore concluded that Ms Hawes's conduct at charges 7 and 9 fell significantly short of the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charges 8 and 10

The panel had regard to its previous findings, in that Ms Hawes was aware of the Home's policy and procedures regarding countersigning documentation and deliberately breached it. She incorrectly entered a signature in the MAR chart and CD book for Resident C on more than one occasion, in order to mislead colleagues into believing that the document had been correctly countersigned when it had not. The panel took into account that it had determined that Ms Hawes's conduct at charges 8 and 10 was dishonest. The panel had regard to the fact that Ms Hawes, in acting dishonestly, breached one of the fundamental tenets of the nursing profession by failing to promote professionalism and trust. The panel therefore concluded that Ms Hawes's conduct at charges 8 and 10 fell significantly short of the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charges 14, 15, 16 and 20

The panel had regard to the fact that Ms Hawes was aware of the Home's policy and procedures in relation to resident documentation. The panel took into account that Ms Hawes failed to adhere to these policies by not completing resident's records accurately or at all, on four separate occasions with three different residents. The panel took into account that record keeping is a fundamental skill of the nursing profession. The panel determined that failing to complete resident's records accurately or at all undermines continuity of care and results in a risk of harm to residents. The panel therefore concluded that Ms Hawes's conduct at charges 14, 15, 16 and 20 fell significantly short of the standards expected of a Registered Nurse and therefore amounted to misconduct.

Charges 22 and 24

The panel had regard to the fact that Ms Hawes knowingly practised as a Registered Nurse in breach of an interim suspension order for a period of approximately 11 months. The panel took into account that it had determined that Ms Hawes's conduct at charge 24 was dishonest. The panel had regard to the fact that Ms Hawes, in acting dishonestly, breached one of the fundamental tenets of the nursing profession by failing to promote professionalism and trust. The panel concluded that Ms Hawes's conduct at charges 22 and 24 fell significantly short of the standards expected of a Registered Nurse and therefore amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Hawes'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 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 and to maintain professional boundaries. 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/their fitness to practise is impaired in the sense that S/He/They:

- 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 determined that residents were put at risk of harm as a result of Ms Hawes's misconduct. Ms Hawes's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel having had regard to its findings at charges 8, 10 and 24 was satisfied that Ms Hawes has in the past acted dishonestly.

The panel had regard to the case of *Cohen v General Medical Council* [2008] EWHC 581.

"It must be highly relevant in determining if a [registrant's] fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

The panel considered whether the misconduct is easily remediable. The panel noted that Ms Hawes's clinical failings did not occur due to a lack of knowledge or understanding regarding the Home's policy and procedure. The panel took into account that Ms Hawes's clinical failings were deliberate acts to cover up her wrongdoing and to mislead colleagues. The panel therefore concluded that there are repeated instances of dishonesty which demonstrate a disregard for resident's welfare and is indicative of deep-seated attitudinal concerns. The panel took into account that attitudinal concerns are inherently difficult to remediate.

The panel was therefore of the view that the misconduct in this case would be very difficult to address.

The panel considered whether the misconduct has been remedied. The panel took into account that due to Ms Hawes's lack of engagement there is no evidence of any insight, remorse, remediation or testimonials.

The panel therefore determined that there is a risk of repetition given the serious nature of the facts found proved and in the absence of any insight and remediation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. The panel concluded that the public's trust and confidence in the profession would be severely undermined if a finding of impairment were not made in this case given the serious nature of the facts found proved, involving dishonesty, and in absence of any insight and remediation.

In all the circumstances the panel conclude that Ms Hawes is not currently able to practice *"kindly, safely and professionally"*.

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

Representations on sanction

The panel noted that the NMC had advised Ms Hawes that it would seek the imposition of a striking-off order if it found Ms Hawes's fitness to practise currently impaired.

The NMC identified the aggravating features of the case.

The NMC submitted that given the public protection issues identified in this case taking no further action of imposing a cation order would not be appropriate. It would not protect the public nor address the public interest given that this case is serious involving premeditated dishonesty which was sustained over a period of time.

The NMC submitted that whilst a conditions of practice order could deal with the issues around Miss Hawes's clinical practice, such a sanction is not appropriate to address the attitudinal concerns, namely dishonesty, nor would it mark the seriousness of the matters concerned. The NMC submitted that it is not possible to formulate conditions to fully manager the risks in this case.

The NMC submitted that a suspension order would not be appropriate given that this case involves repeated dishonest behaviour over a period of time which is indicative of attitudinal concerns. Furthermore, Ms Hawes has not demonstrated any insight, remorse or reflection into her actions.

The NMC submitted that a suspension order would not be sufficient to send a message to the profession that such behaviour is wholly unacceptable for a Registered Nurse. A suspension order would not address the public interest in the particular circumstances of this case. The NMC submitted that Ms Hawes's behaviour is fundamentally incompatible with remaining on the register.

The NMC submitted that a striking-off order is the proportionate and necessary sanction to maintain public confidence. Ms Hawes's behaviour is fundamentally incompatible with being a registered profession. The concerns raise fundamental questions about her professionalism and a striking off order is the only sanction that will protect the public, maintain professional standards and public confidence in the profession.

Decision and reasons on sanction

Having found Ms Hawes'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:

- Previous regulatory findings, in that Ms Hawes has a previous finding of dishonesty
- Abuse of a position of trust
- Lack of insight into failings
- A pattern of misconduct, namely dishonesty, over a period of time
- Conduct which put vulnerable residents at risk of suffering harm

The panel, having had regard to all the evidence before it and determined that there were no identifiable mitigating features in this case.

The panel had regard to the NMC guidance titled '*Sanctions for particularly serious cases*', reference 'SAN-2', last updated 6 May 2025, which states that not all dishonesty is equally serious. The panel therefore considered the seriousness of Ms Hawes's dishonest conduct.

The panel determined that Ms Hawes's dishonest conduct was not a one-off incident, there were the following five separate instances of dishonesty:

- Ms Hawes incorrectly entered a signature on Resident C's MAR chart on two separate dates, intending to mislead others into believing that another Registered Nurse had signed the MAR chart for Resident C when she knew they had not.
- Ms Hawes incorrectly entered a signature on Resident C's CD book on two separate dates, intending to mislead others into believing that another Registered Nurse had signed the CD book for Resident C when she knew they had not.
- Ms Hawes knowingly practised as a Registered Nurse in breach of an interim suspension order for a period of approximately 11 months.

The panel determined that Ms Hawes misused her power and deliberately breached her duty of candour. Her dishonest conduct was directly linked to her clinical practice and put vulnerable residents at direct risk of harm. The panel concluded that Ms Hawes's dishonesty was premeditated and involved longstanding dishonesty. The panel determined that Ms Hawes, in practising as a Registered Nurse in breach of her interim suspension order, sought to benefit personally and financially from her dishonesty.

The panel therefore determined that Ms Hawes's dishonest conduct was at the high end of the spectrum of seriousness.

The panel next considered what sanction, if any, to impose.

The panel concluded that to take no action would not be appropriate or proportionate in view of the seriousness of the case. The panel decided that taking no further action would not sufficiently protect the public or adequately address the public interest.

The panel 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 Ms Hawes'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 Ms Hawes's misconduct was not at the lower end of the spectrum and that a caution order would not be proportionate or appropriate in view of the issues identified. The panel

decided that a caution order would not sufficiently protect the public or adequately address the public interest concerns previously identified.

The panel next considered whether placing conditions of practice on Ms Hawes's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved. The panel concluded that in light of the repeated instances of dishonesty, the premeditated and longstanding deception involved in practising in breach of an interim suspension order, and the previous fitness to practice finding of dishonesty in 2013, there is evidence of deep-seated attitudinal concerns. The panel therefore determined that the misconduct identified in this case was not something that can be addressed through retraining. Additionally, due to Ms Hawes's lack of engagement the panel took into account that there was no evidence of any insight, remediation. The panel concluded that a conditions of practice order, would not adequately protect the public or satisfy the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel had regard to the fact that this was not a single instance of misconduct. There is evidence of deep-seated attitudinal concerns, namely dishonesty. There is evidence of repetition in that Ms Hawes's has a previous finding of dishonesty in respect of her conduct in 2013. The panel also noted that Ms Hawes was subject to an interim suspension order, having acted dishonestly on more than one occasion in 2021, and yet she deliberately breached the interim suspension order having practised as a Registered Nurse for a period of approximately 11 months in 2023. The panel took into account that

due to Ms Hawes's lack of engagement there was no evidence of any insight and/or remediation and therefore the panel concluded that she does pose a significant risk of repeating the behaviour.

The 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 Ms Hawes's actions is fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel determined that Ms Hawes'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 determined that the facts found proved raise fundamental questions about Ms Hawes's professionalism. The panel was of the view that the findings in this particular case demonstrate that Ms Hawes's actions 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 concluded that a striking off order is the only sanction which would be sufficient to maintain public confidence and professional standards.

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 matters it identified, in particular the effect of Ms Hawes'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 Ms Hawes in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Hawes's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC. The NMC invited the panel to impose an interim suspension order on the grounds of public protection and public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to protect the public and address the public interest concerns previously identified for the period of any appeal.

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

That concludes this determination.