Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 19 May – Wednesday, 28 May 2025
Friday 1 August 2025 (panel only day)
Tuesday, 25 November – Wednesday, 26 November 2025

Virtual Hearing

Name of Registrant:	**Samantha Souter**
NMC PIN	06I1873S
Part(s) of the register:	Nurses Part of the Register (Sub Part 1) RNA: Registered Nurse- Adult Nurse, Level 1 - (16 September 2009)
Relevant Location:	Dundee
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Helen Reddy (Registrant member) Jane Dalton (Lay member)
Legal Assessor:	Charles Apthorp (19 May – 28 May 2025 and 1 August 2025) Gelaga King (25 – 26 November 2025)
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter (19 May – 28 May 2025) Debbie Churaman, Case Presenter (25 – 26 November 2025)
Ms Souter:	Not present and not represented
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 3, 4, 5a, 5b, 6a, 6b, 7, 8 and 18 in parts.
Facts not proved:	Charges 9a, 9b, 9c, 10a, 10b, 10c, 11a, 11b, 11c, 12a, 12b, 12c, 13, 14, 15, 16, 17, 18 in parts, and 19

Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Souter was not in attendance and that the Notice of Hearing letter had been sent to her email address on 10 April 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and virtual hearing link of the hearing and, amongst other things, information about Ms Souter's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Souter

The panel next considered whether it should proceed in the absence of Ms Souter. It had regard to Rule 21 of the Rules and heard the submissions of Dr Joshi who invited the panel to continue in the absence of Ms Souter. Dr Joshi submitted that Ms Souter had voluntarily absented herself, that witnesses on standby to give evidence would be inconvenienced by the case not proceeding, and that it would be in the public interest to proceed with the hearing.

Dr Joshi referred the panel to the following email from Ms Souter dated 20 February 2025:

‘Hi there,
I am emailing to respond to your recent communication.
I have to [sic] intention on attending any hearings/meetings.
I do not wish to engage in any further/future meetings/hearings.
I do not have any information to provide you with.
I do bot [sic] have any representation.

The process off this has been ongoing for years [PRIVATE]*. I do not wish to hold onto my registration I also do not wish to return to any practice nor now nor the future, nor do I wish to be exposed to any hearings nor meetings.*
I want to be left alone.’

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *‘with the utmost care and caution’* as referred to in NMC guidance based on principles in the case of *R v Jones (Anthony William) (No.2)* [2002] UKHL 5.

The panel decided to proceed in the absence of Ms Souter. In reaching this decision, the panel considered the submissions of Dr Joshi, and the email sent by Ms Souter dated 20 February 2025.

The panel had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Souter had informed the NMC that she does not intend to attend the hearing;
- No application for an adjournment had been made by Ms Souter;
- Two witnesses were on standby to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer and, as they are involved in clinical practice, the patients who need their professional services; and
- There was a strong public interest in the expeditious disposal of the case.

In light of the above, the panel concluded that:

- Ms Souter had voluntarily absented herself; and
- There was no reason to suppose that adjourning would secure her attendance at some future date.

The panel noted that there would be some disadvantage to Ms Souter in proceeding in her absence. Although the evidence upon which the NMC relied will have been sent to Ms Souter at her registered email address, she would not be able to challenge the evidence relied upon by the NMC in person and would not be able to give evidence on her own behalf. However, in the panel's judgement, this could be mitigated. The panel could make allowance for the fact that the NMC's evidence would not be tested by cross examination and, of its own volition, could explore any inconsistencies in the evidence which it identified. Furthermore, the limited disadvantage was the consequence of Ms Souter's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it was fair, appropriate and proportionate to proceed in the absence of Ms Souter. The panel would draw no adverse inference from Ms Souter's absence in its findings of fact.

Decision and reasons on application to amend the charges

The panel heard an application made by Dr Joshi, on behalf of the NMC, to amend the wording of charges 4, 8, 17, the numbering of charges 16 and 17, and to insert a heading before the table.

The proposed amendments were to correct some typographical errors and minor numerical issues. It was submitted by Dr Joshi that the proposed amendments, as set out below, would provide clarity.

4. Your conduct ~~at~~ **in** one or more of Charges 2 to 3 was dishonest because ~~you~~ **your** actions were done to conceal your failure to make timely records of consultation and care.

8. Your conduct ~~at~~ **in one** or more of Charges 6 to 7 was dishonest because ~~you~~ **your** actions were done to conceal your failure to make timely records of consultation and care.

17. Your conduct at Charge ~~15~~ **16** was dishonest because the entry was made to conceal that you had failed to attend and conduct a consultation with Patient P.

~~16~~ **18**. Between 30 October 2019 and 6 December 2019 did not ensure that written patient records were secured safely in that you either did not return them to within 24 hours to the Royal Victoria Hospital or send them by internal mail in a timely manner following consultations with patients at external clinics or at their homes as set out in Schedule 1.

~~17~~ **19**. On or about 6 December 2019 having conducted a consultation with Patient C and Q failed to return written records of their consultations to the Royal Victoria Hospital in a timely manner.

Schedule 1 to be inserted before the table.

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

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Souter and no

injustice would be caused to either party by the proposed amendments being allowed. The panel determined that it was therefore appropriate to allow the amendments, as applied for, to ensure clarity.

Details of charges as amended

That you, a registered nurse:

1.On 30 October 2019 having conducted a consultation with Patient A:

(a) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation.
(b) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

2. On 15 November 2019

(a) made entries on EMIS of Patient A's consultation of 30 October 2019, dating the entries 30 October 2019.
(b) created a letter of referral to Patient A's GP on EMIS.
(c) signed and dated Patient A's referral letter 30 October 2019.

3. On 20 November 2019 amended Patient A's referral letter to their GP, created on 15 November 2019, and dated the letter 1 November 2019.

4. Your conduct in one or more of Charges 2 to 3 was dishonest because your actions were done to conceal your failure to make timely records of consultation and care.

5. On 5 November 2019 having conducted a consultation with Patient B:

(a) Failed to complete an electronic record on the Stroke Management System (SMS) of the consultation within 24 hours or as soon as possible after the consultation.

(b) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

6. On 5 December 2019 made entries on Patient B's electronic SMS records:

(a) by deleting a previous entry of 2 April 2019.
(b) by inserting an entry dated 5 November 2019 recording details of that consultation.

7. On 5 December 2019 created a letter of referral to Patient B's GP, dating it 5 November 2019

8. Your conduct in one or more of Charges 6 to 7 was dishonest because your actions were done to conceal your failure to make timely records of consultation and care.

9. On 1 November 2019 having conducted a consultation with Patient U:
(a) Failed to complete a written record of the consultation within 24 hours or as soon as possible after the consultation.
(b) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation.
(c) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

10. On 5 November 2019 having conducted a consultation with Patients K and L:
(a) Failed to complete written records of the consultations within 24 hours or as soon as possible after the consultations.
(b) Failed to complete an electronic records (EMIS) of the consultations within 24 hours or as soon as possible after the consultations.
(c) Failed to return written records of the consultations to the Royal Victoria Hospital in a timely manner.

11. On 4 December 2019 having conducted a consultation with Patient M:

(a) Failed to complete a written record of the consultation within 24 hours or as soon as possible after the consultation.
(b) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation.
(c) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

12. On 6 December 2019 having conducted a consultation with Patients I and J:
a) Failed to complete written records of the consultations within 24 hours or as soon as possible after the consultations.
(b) Failed to complete an electronic records (EMIS) of the consultations within 24 hours or as soon as possible after the consultations.
(c) Failed to return written records of the consultations to the Royal Victoria Hospital in a timely manner.

13. On or about 6 November 2019 following Patients N and O failing to attend clinic on 6 November 2019, failed to send follow up letters to them.

14. On 6 November 2019 recorded in Patient O's medical records that you had sent Patient O a follow up letter following their failure to attend the clinic on 6 November 2019.

15. Your conduct at Charge 14 was dishonest because the entry was made to conceal your failure to send a follow up letter following Patient O's failure to attend clinic on 6 November 2019.

16. On 20 November 2019 recorded in Patient P's medical records that you had attended at Patient P's home address to undertake a consultation when you had not.

17. Your conduct at Charge 16 was dishonest because the entry was made to conceal that you had failed to attend and conduct a consultation with Patient P.

18. Between 30 October 2019 and 6 December 2019 did not ensure that written patient records were secured safely in that you either did not return them to within 24 hours to the Royal Victoria Hospital or send them by internal mail in a timely manner following consultations with patients at external clinics or at their homes as set out in Schedule 1.

19. On or about 6 December 2019 having conducted a consultation with Patient C and Q failed to return written records of their consultations to the Royal Victoria Hospital in a timely manner

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

Schedule 1

Patient	Date of Consultation
Patient A	30 October 2019
Patient B	5 November 2019
Patient C	6 December 2019
Patient Q	6 December 2019

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

Dr Joshi made an application that parts of this hearing may need to be held in private on the basis that proper exploration of Ms Souter's case may involve reference to her health. The application was made pursuant to Rule 19 of the Rules.

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

The panel decided to hold parts of the hearing which refer to Ms Souter's health in private because it concluded that this was justified by the need to protect her private health matters and that this outweighed any prejudice to the public interest in holding

those parts of the hearing in public. However, where there is no reference to Ms Souter's health matters, the hearing would be held in public.

Background

On 27 January 2023 Ms Souter was referred to the NMC by NHS Tayside. At the time, Ms Souter was a Stroke Liaison Nurse (SLN) at Royal Victoria Hospital (RVH) and had recently returned to work after an extended period of leave.

The allegations against Ms Souter arose following her return to work under a phased reintroduction. The charges are serious and primarily concern failures in record-keeping and patient care, with a clear risk of harm to patients. These concerns span from October to December 2019, during which time Ms Souter served as a stroke liaison nurse. Given the nature of her role, accurate and timely documentation, both physical and electronic, was essential, as any record she created would directly impact patient care and communication with other healthcare professionals.

At the time, there was a record keeping system in place. Notes were required to be completed and securely stored within 24 hours of any patient interaction, whether in clinics or home visits. A Standard Operating Procedure (SOP) provided guidance, and staff were trained on the EMIS electronic system that was being implemented during this period. Ms Souter had received both formal training and shadowed a colleague for three weeks. The procedures allowed for records to be returned to the RVH either physically or by internal mail. The procedure allows for safe temporary storage of notes at home in some circumstances, but in all cases, prompt completion and secure handling were mandatory. GP letters were also expected to be drafted and sent within 24 hours of each patient consultation, which was standard practice.

Specific concerns arose in relation to several patients. For example, with Patient A, who was seen on 30 October 2019. When a query was raised by Patient A's relative regarding this consultation, no notes could be found despite searches of the allocated notes cabinet conducted on 12 and 14 November. Ms Souter claimed the notes were in the cabinet but could not explain their absence. A dietitian later raised concerns that no

notes were found on the EMIS system either. Ms Souter stated that she had the physical notes and was tying up *"a few loose ends,"* but the EMIS entry and GP letter, both of which should have been completed shortly after the consultation, were only created on 15 November following reminders. Consequently, the GP did not receive the correspondence within the required timeframe.

In the case of Patient B, who had an appointment on 5 November 2019, no electronic records relating to this appointment could be found, following a search for them on 4 December. Patient B's written notes were later discovered by another nurse in a drawer on 5 December, a month after the consultation.

More seriously, there were instances where Ms Souter appeared to have falsified records. In one case, she said she had visited a patient's home and spoken to a neighbour, when in fact the patient was housebound. These actions potentially indicate not only poor performance but also deliberate attempts to mislead colleagues and cover up her failures. The core of the case against Ms Souter is her alleged repeated failure to fulfil her duties as a registered nurse, her responses when challenged, and her alleged efforts to retrospectively alter or fabricate records. If proven, these matters go beyond mere administrative lapses and raise serious concerns about her conduct and professional integrity.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Souter.

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

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

- Witness 1: Registered Nurse and Team Leader.

- Witness 2: Registered Nurse who completed the management investigation report.

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

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

Charge 1a

1. On 30 October 2019 having conducted a consultation with Patient A:

   (a) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation.

The panel considered whether a consultation between Ms Souter and Patient A had taken place on 30 October 2019. The panel relied on the evidence of Witness 1, along with EMIS entries confirming the appointment on 30 October 2019. As this was not disputed, the panel concluded that the consultation did, in fact, occur.

This charge is found proved.

The panel had to determine whether Ms Souter had a duty to complete an electronic record EMIS of the consultation with Patient A within 24 hours or as soon as possible after the consultation. In doing so, it referred to NHS Tayside's *'Policy for Records and Record Keeping for Nursing and Midwifery Staff'* (the Policy), giving particular attention to the following sections:

> 'The NMC Code (2015) states *'Records should be completed at the time or as soon as possible after an event.' It is therefore recommended that entries in records are not left to the end of a shift and are written as frequently as dictated by care delivery and changes in the patient's well-being…*
>
> *In community settings or in home settings, documentation entries should be on the day of contact. This may only be relaxed in exceptional circumstances where this is not practicable e.g. it is impossible for the Registrant to access an electronic system in order to update the patient's record. In such cases, the record must be completed at the earliest opportunity and in line with local Standard Operating Procedures which support a robust assessment of risk in each case…*
>
> *The best practice is where there is risk; the record is updated the same day regardless of constraints*; *however, some flexibility is acceptable for the recording of routine interventions/visits.'*

The panel also took into account the evidence of Witness 1, who confirmed in both her written statement and oral evidence that: *'As I had previously stated, SLT nurses are expected to take notes during patient observations. At the time of the events these notes were taken physically—not electronically—and were then copied into the electronic patient recordkeeping system. These notes included the patient observations, their condition and symptoms, and their blood pressure. Nurses were expected to update the electronic patient recordkeeping system within 24 hours of the observation and then store the physical notes inside the patient's folder.'*

Furthermore, the panel considered the written statement of Witness 2, confirmed in her oral evidence, that: *'The Stroke Liaison Team nurses were required to input the same information as was in their physical notes into the electronic recordkeeping system within 24 hours of the consultation.'*

Given the clear duty to complete the electronic record within 24 hours, the panel assessed whether Ms Souter had failed to do so. The evidence, particularly the audit report regarding Patient A, indicated that the consultation for Patient A, which took place on 30 October 2019, was not recorded on EMIS until 15 November 2019. This was well beyond the required 24-hour window.

The panel found that the first EMIS entry was made on 15 November 2019, which was inconsistent with the expected timeline and not within 24 hours of the consultation. Witness 1's statement supported this, as she explained: *'The dietitian claimed that she could not find any patient notes entered into EMIS, and requested them to be completed. I then called and sent an email to Ms Souter to her about the situation.'*

In her email response on 15 November 2019, Ms Souter stated: *'I have her notes on me as I still have a few loose ends to tie up. I'm not sure why they are not on EMIS as I have her print out of assessment letter."* Witness 1 responded: *"I am concerned that you have the casefile on your person. Please see attached the SOP regarding case notes within the service…'*

The panel also took into account the investigation meeting notes, in which Ms Souter was asked: *"…are you confident in the Perth Clinic you had written the paper notes and then next day on EMIS? Can you explain why there is nothing documented until 15 November?"* Ms Souter replied: *"It was identified that the mistakes I think have been because I have printed and closed it and it hasn't saved."*

The panel did not consider that Ms Souter's explanation that the electronic notes had been entered but not saved was plausible. The panel considered the IT audit report to be an independent source of information and was likely to reflect a true and accurate record of data entry timings. The report clearly detailed that the notes were not entered

electronically until 15 November 2019. This was significantly beyond the required 24-hour window and the panel found that the delay of over two weeks could not be regarded as *'as soon as possible'* after the consultation.

For these reasons the panel determined that it was more likely than not that Ms Souter, having conducted a consultation with Patient A on 30 October 2019, had failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation.

The panel therefore found this charge proved.

Charge 1b

> (b) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

This charge is found proved.

The panel considered whether Ms Souter had a duty to return the written records of the consultation to the RVH in a timely manner. Based on the available evidence, the panel concluded that such a duty did exist.

In reaching this conclusion, the panel referred to *'the Policy'* which states:

> *'When visiting patients at home or in a community setting, patient records should not be left unattended ……records must be returned within 24 hours and staff must ensure that whilst away from the work base that patient records are stored safely and securely in their own home.'*

The panel also reviewed the NHS Tayside SOP which specifies:

> *'When case files are removed from the office for the purpose of attending clinics or visiting patient's (sic) in their own homes the Stroke Liaison Nurse will ensure*

that these records are not left unattended…..and are returned to the office-work base within 24 hours.'

These documents, taken together, clearly impose a responsibility on staff to ensure that patient records are returned promptly.

In addition, the panel considered the evidence of Witness 1. In her written statement, confirmed during her oral testimony, she explained the procedure that should be followed when nurses are unable to return files directly to the Stroke Liaison Nurse Service (SLNS) base:

'If a Nurse had patient files on herself but would not return to SLNS based on the next shift, she was expected to place the files within an envelope addressed to SLNS base office at RVH and then placed into the NHS Tayside Internal Mail. The Internal mail system will collect the internal mail from clinical ward areas and normally the reception areas based within outpatient clinic areas. The mail then goes to the central mail room at Ninewells before then being sent out to the clinical/internal areas, including SLNS office at RVH. The files would consistently be delivered in two working days from the day they were placed in the internal mail.'

Based on the Policy, the SOP and Witness 1's evidence, the panel was satisfied that Ms Souter was under a clear duty to return the written records in a timely manner.

The panel then considered whether Ms Souter had failed to return the written records in a timely manner.

The panel relied on Witness 1's account regarding the missing records. In her written statement, Witness 1 stated:

'An email was sent to Ms. Souter by fellow SLNS Nurse […] asking her about the whereabouts of patient A's files as she had searched for them in the filing cabinets and was unable to find them, but the email went unanswered. On the

12th of November I personally searched for the patient files on the cabinets, and was unable to find them. Two days later on the 14th I had a one-to-one supervision with Ms. Souter regarding her phased return to work plan, and I enquired about the missing files. She confirmed that the files were in the cabinet, and did not know why they could not be found inside.'

The panel noted Ms Souter's response, in which she stated that the notes were in the cabinet and claimed not to know why they could not be located. The panel noted that two people had reportedly conducted an independent search for the same records. Additionally, having heard and considered Witness 1's evidence, which the panel found to be consistent, credible, and supported by both written and oral testimony, it was satisfied that a thorough search had been carried out and that the notes were, in fact, not in the cabinet on or prior to 14 November 2019.

The panel determined that the delay of over two weeks did not constitute returning the documents in a timely manner.

Accordingly, on the balance of probabilities, the panel determined that this charge was found proved.

Charge 2a

On 15 November 2019

(a) made entries on EMIS of Patient A's consultation of 30 October 2019, dating the entries 30 October 2019.

This charge is found proved.

In considering whether Ms Souter made entries on EMIS of Patient A's consultation dated 30 October 2019 and recorded those entries as if made on 30 October 2019, the panel carefully reviewed the available evidence. It relied on the audit report regarding

Patient A, which confirmed that while the consultation did take place on 30 October 2019, the corresponding EMIS entry was not created until 15 November 2019.

The panel also considered the EMIS record itself, which included an entry labelled *'Face to face consultation (Clinic)'* dated 30 October 2019. However, when this was cross-referenced with the audit report, it was evident that the entry was in fact inputted on 15 November 2019, despite appearing to have been made on the date of the consultation.

In light of this evidence and having concluded that the record was retrospectively entered but dated as though it had been made on 30 October 2019, the panel determined that this charge is found proved.

Charge 2b

(b) created a letter of referral to Patient A's GP on EMIS

This charge is found proved.

In relation to the charge that Ms Souter created a letter of referral to Patient A's GP on EMIS, the panel relied on the documentary evidence provided in the audit report for Patient A. The audit report contains an entry dated 15 November 2019 titled *'Stroke Liaison Assessment Letter,'* which was entered by Ms Souter. This entry is also supported by the EMIS records for Patient A, covering the period from 30 October to 5 December 2019, where the same letter is recorded on 15 November 2019 as *'Stroke monitoring (01-Nov-2019) Stroke Liaison Assessment Letter.'*

Based on this consistent evidence, the panel was satisfied that Ms Souter did create a letter of referral to Patient A's GP on EMIS on 15 November 2019, and therefore found this charge proved.

Charge 2c

(c) signed and dated Patient A's referral letter 30 October 2019

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence of Witness 1 alongside the documentary records, including a printout of Patient A's referral letter. The panel noted that the referral letter is hand-dated and signed by Ms Souter as if completed on 30 October 2019. For the reasons set out in the panel's findings in Charge 2b, the EMIS audit confirmed that the document was actually produced on 15 November 2019. This indicates that the document could only have been signed on or after 15 November 2019.

Having considered the above, the panel determined that this charge is found proved.

Charge 3

On 20 November 2019 amended Patient A's referral letter to their GP, created on 15 November 2019, and dated the letter 1 November 2019;

This charge is found proved.

In reaching this decision, the panel carefully considered the evidence of Witness 1, the audit report, and Patient A's referral letter.

In her written statement, Witness 1 stated that on 21 November 2019, she checked Patient A's physical files and observed that the GP referral letter, dated 30 October 2019, had been replaced with a revised version. Although the revised version was largely the same, it included additional information in the summary box and was now dated 1 November 2019.

The panel also examined the GP referral letter itself, which was signed and dated by Ms Souter. The letter is clearly dated 1 November 2019.

Additionally, the EMIS audit report confirmed that on 20 November, Ms Souter amended a letter that was originally created on 15 November, altering the date to 1 November 2019.

Based on the evidence the panel concluded that the amendments to the letter were indeed made by Ms Souter. Accordingly, the panel determined that this charge is found proved.

Charge 4

Your conduct in one or more of Charges 2 to 3 was dishonest because your actions were done to conceal your failure to make timely records of consultation and care.

This charge is found proved.

In reaching its decision, the panel carefully considered the questions set out in the NMC's Fitness to Practise Guidance: *'Making Decisions on Dishonesty Charges and the Professional Duty of Candour'* - Reference: DMA-8.

The panel heard evidence from Witness 1 and Witness 2 regarding the context in which the concerns arose. At the relevant time, the Trust was in the process of transitioning from paper and legacy electronic systems to a new electronic record-keeping system, EMIS. During this transitional period, nursing staff, including Ms Souter, were required to maintain both handwritten and electronic records. Training on EMIS was provided to staff, and further support was available through ad hoc queries to the trainer. Ms Souter attended this training and was aware of the availability of additional support, which was discussed during team meetings and regular one-to-one meetings with her manager (Witness 1), all of which she attended.

Ms Souter had access to, and was aware of, the Trust's policies on record-keeping, which were readily available to staff. Her job description also clearly set out the expectations for maintaining accurate and timely patient records. As a registered nurse,

Ms Souter would have also been fully aware of the importance of accurate documentation as a core requirement under the NMC Code of Conduct.

The panel considered whether there was any credible alternative explanation for Ms Souter's actions. It was noted that Ms Souter had been absent from work [PRIVATE] and annual leave from June 2018 to July 2019. [PRIVATE]

Upon returning to work, Ms Souter followed a phased return in a part-time capacity [PRIVATE]. She had weekly formal meetings with Witness 1, which were signed and dated by both parties.

The panel considered whether Ms Souter's [PRIVATE]. However, no medical evidence or occupational health reports were presented to support this as a contributing factor.

Although Ms Souter had told Witness 1 that she felt slower with IT and administrative tasks following her absence, during the internal investigation she demonstrated a competent understanding of the electronic systems. Witness 1 confirmed that Ms Souter was managing her workload, using appointment blocks for administrative time and support when required.

The panel also considered whether workload pressures, insufficient training, or a misunderstanding of the record-keeping procedures might have contributed to the conduct. However, there was no evidence to support these as alternative explanations. While Ms Souter stated during the investigation that the work environment was hostile, the panel received no evidence to corroborate this. There was no record of any formal concerns raised by Ms Souter prior to the investigation. Although she was moved to a different role during the investigation, allegedly for safeguarding reasons, no details were provided.

The panel noted that Witness 1 confirmed that Ms Souter was keen to return to work and take on responsibilities, and there were no concerns raised about her clinical competence.

The panel considered whether Ms Souter's actions amounted to dishonesty in the context of charges 2a), 2c), and 3.

For charge 2(a) the panel found that Ms Souter made EMIS entries on 15 November 2019 but deliberately dated them as 30 October 2019. This was done to give the false impression that the entries had been made contemporaneously. Ms Souter did not annotate the entries as retrospective or inform colleagues or her manager of the delay. The panel concluded that this was a conscious decision to conceal her failure to make timely records, and that this conduct was dishonest.

For charge 2(c), the panel found that Ms Souter signed and dated a letter as 30 October 2019, although it was created on 15 November 2019. This too was found to be an intentional attempt to misrepresent the timing of the document's creation and was deemed dishonest for the same reasons as charge 2(a).

For charge 3, on 20 November 2019, Ms Souter amended the letter created on 15 November, changing the date to 1 November 2019. The audit trail confirms this change. The panel concluded that this amendment was also made with the intent to create the impression the letter had been written earlier than it was, again constituting dishonest behaviour.

The panel did not find dishonesty in the creation of the document itself in charge 2(b). It determined that merely creating a document, without more, did not in itself demonstrate dishonest intent.

For charges 2(a), 2(c), and 3, the panel is satisfied that Ms Souter's actions were taken with the purpose of concealing her failure to make timely records of consultations and care and this conduct amounted to dishonesty.

The panel has found that Ms Souter acted dishonestly in relation to charges 2(a), 2(c), and 3. The actions were not a result of misunderstanding, workload pressure, lack of training, [PRIVATE]. Instead, the conduct was a deliberate attempt to mislead others by

concealing failures in record-keeping obligations, in breach of the professional duty of candour.

Charge 5a

On 5 November 2019 having conducted a consultation with Patient B:

(a) Failed to complete an electronic record on the Stroke Management System (SMS) of the consultation within 24 hours or as soon as possible after the consultation.

The panel first considered whether Ms Souter conducted the consultation with Patient B on 5 November 2019.

Having reviewed the available evidence, the panel was satisfied that there is clear and undisputed documentation within the TrakCare system confirming that Ms Souter saw Patient B on that date. This is supported by the patient record and is not disputed.

The panel therefore concluded that Ms Souter had conducted a consultation with Patient B on 5 November 2019.

In line with its findings in relation to Charge 1(a), the panel determined that Ms Souter had a duty to complete the electronic record within 24 hours or as soon as possible after the consultation.

This charge is found proved.

In reaching its decision, the panel carefully considered the evidence of Witness 1, the documentary evidence, and the notes from the investigation meeting.

Witness 1 stated that she had checked the SMS on 4 December 2019 and seen that there were no notes of the consultation with Patient B on 5 November 2019 and that the last entry had been made in April 2019. Witness 1 emailed Ms Souter on 4 December

2019 asking her to explain where the notes were for Patient B. On 5 December 2019, Ms Souter replied she had entered the notes into SMS. Witness 1 stated that:

> *"This struck me as odd, given that I had not seen any entries made by Ms Souter on SMS the day prior."*

Further, the panel reviewed the investigation meeting notes in which Ms Souter stated:

> *'To be honest, in Stracathro the computer systems crash. Emailed and telephoned* [Witness 1]. *I came back to Dundee that day. Not sure if I have forgotten or the system was down. It was still an open case, he was on SMS...'*

While the panel considered Ms Souter's explanation, it preferred the evidence of Witness 1, which it found to be credible and reliable. Witness 1 confirmed, both in her written and oral evidence, that there was no SMS entry made by Ms Souter regarding Patient B's consultations by 4 December 2019, when she checked the system.

On the basis of the documentary evidence and the panel's assessment of the credibility of the witnesses, it concluded that Ms Souter failed to make the required record of the consultation.

The panel determined that this charge is found proved.

Charge 5b

> (b) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner.

The panel first considered whether there was a duty to return the written record to RVH. The panel determined that Ms Souter did have a duty to return the written records to RVH as it was found in Charge 1b.

This charge is found proved.

In reaching its decision, the panel carefully considered the evidence of Witness 1. In her written statement, which she confirmed during her oral evidence, she stated:

> *'I emailed Ms. Souter and enquired about patient B's file. I also looked for the files thoroughly once more in the cabinets, but was unable to locate them. She responded the next day (December 5th 2019), stating that the physical files were stored in the cabinets and was unsure why I was unable to find them.'*

She also stated:

> *'*[Medical Secretary] *—the SLNS's administrative officer—was printing files for new patients that had been referred to the service that day and noticed that patient B already had an open file.*'

The Medical Secretary later produced a formal, signed document as part of the management investigation, confirming the following:

> *'On Wednesday 4th December 2019. I was going through referral emails for when a patient gets discharged I take their EDD referral and pass it onto the nurse who then gives me appointment day and clinic and then I appoint them, sending letters out to patient and then add them onto EMIS etc…*
>
> *'I looked through* [Ms Souter's] *drawer due to being her patient, there were no notes in the drawer regarding patient B. I checked other nurses' drawers to see if it had been misplaced. Not in any other nurses' drawers. I checked the discharge drawer. Not in there. I then checked* [Ms Souter's] *drawer another 2 times (3 times altogether). These notes were not in this drawer at all.'*

Witness 1 confirmed this in her oral evidence and stated emphatically that *"there was no way the folder was there."*

Based on the written statement of Witness 1, corroborated by her oral testimony, and the evidence provided by the Medical Secretary, the panel determined, on the balance of probabilities, that the written records had not been returned in a timely manner, as they could not be found in the drawer on 4 December 2019, despite the appointment having been carried out on 5 November 2019.

Having considered all of the above, the panel determined that this charge is found proved.

Charge 6a

On 5 December 2019 made entries on Patient B's electronic SMS records:

(a) by deleting a previous entry of 2 April 2019.

The panel first considered whether Ms Souter made the entries. It took into account the email dated 9 January 2020 with the IT department regarding the audit of Patient B's SMS entries, as requested by Witness 1, which states:

'There is a Visit that has a "DateOfVisit" of 05/11/2019, which was "CREATED" on 02/04/2019 14:33:08, and which was "LAST AMMENDED" on 05/12/2019 10:15:31… the "ActionTakenBy" on this record is recorded as ssouter. [sic]'

Based on this evidence, the panel accepted that this audit referred to Patient B and determined that Ms Souter had made the entries on those dates.

This charge is found proved.

The panel noted that in Patient B's SMS notes, there is an entry made on 2 April 2019, which clearly relates to Patient B. A later version of Patient B's SMS record, current up to 5 November 2019, no longer includes the 2 April 2019 entry. The panel found that the entry for 2 April 2019 had been deleted.

Taking into account the IT audit report, which confirms that Ms Souter accessed and amended the records on 5 December 2019, the panel found that the deletion was carried out by her. The SMS report shows that an entry for 2 April 2019 existed, and a subsequent version shows it had been removed. The IT evidence confirms that it was Ms Souter who accessed the record and made the amendment on 5 December 2019.

Having considered all of the above, the panel determined that this charge is found proved.

Charge 6b

(b) by inserting an entry dated 5 November 2019 recording details of that consultation.

This charge is found proved.

The panel considered whether Ms Souter inserted the entry dated 5 November 2019 into Patient B's SMS records. It reviewed the SMS entries available up to 5 November 2019 and noted that the record bearing the date 5 November 2019 had in fact been added at a later time.

The panel took into account the IT audit report provided by the IT department regarding Patient B's SMS records. This report confirmed that the entry dated 5 November 2019 was added on 5 December 2019 and that the action was recorded as having been carried out by Ms Souter.

Having reviewed the IT documentation, the panel was satisfied that the entry was made by Ms Souter on 5 December 2019, although it was dated 5 November 2019.

The panel determined that this charge is found proved.

Charge 7

On 5 December 2019 created a letter of referral to Patient B's GP, dating it 5 November 2019.

This charge is found proved.

The panel considered whether Ms Souter created the referral letter on 5 December 2019 and intentionally dated it 5 November 2019. In reaching its decision, the panel took into account the evidence of Witness 1, including her written statement, the screenshot of the Gmail file, and her inquiry to the IT department regarding the creation date of the document stored in the G-drive.

Witness 1 stated in her written statement:

> *'First, it determined that the GP letter for patient B was created, saved and printed on December 5th 2019. Thus, the GP letter was in fact backdated to November 5th. Second, it was determined that the notes on patient B's visit were created on April 2nd 2019 and last modified on December 5th 2019. Thus, the November 5th entry was in fact the April entry made* [SLN charge nurse] *that had been modified and redated to December 5th 2019.'*

The panel also had sight of the letter addressed to a doctor and dated 5 November 2019. It was satisfied that this letter was intended for Patient B's GP and was sent by Ms Souter.

The panel noted the IT department's response to Witness 1's query, confirming that the document in question was authored, and created by another member of staff, but printed on 5 December 2019 by Ms Souter. It noted that the audit trail identified Ms Souter as the individual who saved the document.

The panel relied on the independent audit trail and IT documentation, which confirmed that although the letter was dated 5 November 2019, it was in fact created on 5 December 2019. Therefore, the panel concluded that the document was backdated.

Having considered all of the above, the panel determined that this charge is found proved.

Charge 8

Your conduct in or more of Charges 6 to 7 was dishonest because your actions were done to conceal your failure to make timely records of consultation and care.

This charge is found proved.

In reaching its decision on charge 4, the panel considered the questions set out in the NMC's Fitness to Practise guidance, *'Making decisions on dishonesty charges and the professional duty of candour'*– Reference:DMA-8. These questions were equally applied in the panel's assessment of Charges 6(a), 6(b), and 7.

The panel first considered the background circumstances, and what Ms Souter knew or believed at the relevant time. It also considered whether there was any evidence of an alternative explanation, and whether such an explanation was more likely. The panel concluded that there was no plausible alternative explanation, and that Ms Souter's actions were deliberate.

In respect of charges 6(a) and 6(b), the panel found that Ms Souter had deleted and created entries on the SMS system in order to create the false impression that the entries were made on 5 November 2019, when in fact they were made on 5 December 2019. The panel determined that Ms Souter was aware this would mislead anyone accessing the records, leading them to believe the documentation had been made earlier than it actually had. Ms Souter made no attempt to clarify in the records that the entries were being completed retrospectively, nor did she inform colleagues or her manager about this.

While the panel could not determine the reason why Ms Souter failed to make the records in accordance with the required policies, it concluded that she was aware of her

professional duty to maintain accurate and timely records, and that her conduct was intended to conceal her failure to meet that duty.

Regarding Charge 7, the panel found that by creating a letter of referral on 5 December 2019 and dating it 5 November 2019, Ms Souter intended to give the impression that the letter had been completed earlier than it was. The panel determined that she did this because she knew she had a duty to complete documentation related to care and consultations in a timely manner and had failed in that obligation.

Accordingly, the panel finds that in relation to Charges 6(a), 6(b), and 7, Ms Souter's conduct was dishonest. Her actions were intended to conceal her failure to create timely and accurate records of consultations and patient care.

Charges 9, 10, 11 and 12

9. On 1 November 2019 having conducted a consultation with Patient U:

(a) Failed to complete a written record of the consultation within 24 hours or as soon as possible after the consultation
(b) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation
(c) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner

10. On 5 November 2019 having conducted a consultation with Patients K and L:

(a) Failed to complete written records of the consultations within 24 hours or as soon as possible after the consultations
(b) Failed to complete an electronic records (EMIS) of the consultations within 24 hours or as soon as possible after the consultations
(c) Failed to return written records of the consultations to the Royal Victoria Hospital in a timely manner

11. On 4 December 2019 having conducted a consultation with Patient M:

(a) Failed to complete a written record of the consultation within 24 hours or as soon as possible after the consultation
(b) Failed to complete an electronic record (EMIS) of the consultation within 24 hours or as soon as possible after the consultation
(c) Failed to return written records of the consultation to the Royal Victoria Hospital in a timely manner

12. On 6 December 2019 having conducted a consultation with Patients I and J:

a) Failed to complete written records of the consultations within 24 hours or as soon as possible after the consultations
(b) Failed to complete an electronic records (EMIS) of the consultations within 24 hours or as soon as possible after the consultations
(c) Failed to return written records of the consultations to the Royal Victoria Hospital in a timely manner

These charges are found NOT proved.

The panel considered Charges 9, 10, 11, and 12 together, as they concerned similar allegations and relied on the same underlying evidence.

In reaching its decision, the panel took into account the written statement of Witness 1, who stated that Ms Souter was responsible for the care of Patient U, Patient K, Patient L, Patient M, Patient I, and Patient J.

The panel reviewed a document which contained the list of patients involved in the 2019 concerns, which included the relevant patients. This document contained handwritten notes indicating that Ms Souter had worked on 6 November and 5 December 2019, although none of the charges related to those specific dates. The notes appeared inconsistent, on one side indicating that the clinics took place on 1 November, 5

November, 4 December, and 6 December 2019, while on the other side, the reported dates of her work attendance did not match the clinic dates.

The panel also considered the investigation meeting notes, which recorded the following exchange between Witness 2 and Ms Souter:

Witness 2:

> *'…Do you have an explanation for the 6 sets of notes that are still missing from 4 clinics that ran in Arbroath on the 1st and 6th December 2019, Stracathero on 5th November 2019 and Perth on 4th December 2019… and Arbroath clinic x3 sets of notes, Stracathero clinic x2 and Perth clinic x1?'*

Ms Souter:

> *'… I can't explain. If don't have big envelopes have to split into envelopes and band together. I just know I put then in envelope and send back to the office. I wasn't aware they were missing until I was told they were.'*

The panel gave careful consideration to this evidence but noted a number of inconsistencies and ambiguities. In particular, there was uncertainty around Ms Souter's working days, the dates of the relevant clinics, and the handling of the consultation records. The panel found the documentary evidence to be unclear and, in some places, contradictory.

Given these inconsistencies and the lack of reliable evidence demonstrating that Ms Souter definitively failed in the ways alleged, the panel was not persuaded that the charges were proved on the balance of probabilities.

The panel determined that these charges are found not proved.

Charge 13

On or about 6 November 2019 following Patients N and O failing to attend clinic on 6 November 2019, failed to send follow up letters to them.

This charge is found NOT proved.

In reaching this decision, the panel carefully considered the evidence. It took into account the evidence of Witness 1. In her written statement she stated:

> *'Ms Souter was scheduled to see Patient N and O on 6 November 2019 at the Perth Royal Infirmary, however they did not attend. Normal practice would be to either contact the patient via telephone to discuss if they wished a further appointment, to reappoint them or to send them a Did Not Attend (DNA) letter with a four-week period in which to respond if they wished to arrange a further appointment. I am unable to provide a copy of the patient records for Patient N prior to 13 December 2019, as they would have been on the Stroke Management System that has since been decommissioned.*
>
> *'Ms Souter recorded on Patient O's Trakcare record that she had discharged them from the clinic on 6 November 2019, however when I contacted the Patient on 12 December 2019, they confirmed they had not received a DNA letter from Ms Souter.'*

The panel concluded that the evidence provided is in the form of hearsay and the charge is not supported by sufficient evidence, for example an IT audit trail.

Taking into consideration all of the above, the panel determined that this charge is found not proved.

Charge 14

On 6 November 2019 recorded in Patient O's medical records that you had sent Patient O a follow up letter following their failure to attend the clinic on 6 November 2019.

This charge is found NOT proved.

After thoroughly reviewing all the evidence presented, the panel did not find sufficient evidence to find this charge proved.

Charge 15

Your conduct at Charge 14 was dishonest because the entry was made to conceal your failure to send a follow up letter following Patient O's failure to attend clinic on 6 November 2019.

This charge is found NOT proved.

Having found that Charge 14 is not proved, the panel determined that this charge is not proved.

Charge 16

On 20 November 2019 recorded in Patient P's medical records that you had attended at Patient P's home address to undertake a consultation when you had not.

This charge is found NOT proved.

In reaching this decision, the panel noted that the sole evidence in support of the allegation was hearsay. The panel considered the EMIS notes for Patient P, which indicated that Ms Souter had attended Patient P's home on 20 November 2019. According to the records, there was no response at the property, and Ms Souter left a note through the front door to inform the patient that she had attended.

The panel also reviewed the written witness statement of Witness 1, who stated:

> *'Regarding Patient P in particular, Ms Souter had written in the patient notes that she had gone to the patient's home but found nobody inside. She claims to have spoken to a neighbour who advised that Patient P was not home. She then claims to have placed a note through the letter box of Patient P's front door,*

letting them know that she had gone for their visit. On the call made to Patient P on December 12th, they stated that they were home on November 6th, as they are housebound, and that they had not received any notes through their letter box, front door.'

The panel attached limited weight to the evidence of Witness 1's phone call with Patient P. Further, there was no explanation provided for why Patient P was unable to give direct evidence, nor was there any information regarding their capacity to do so. Additionally, no supporting evidence was presented to substantiate the charge.

Taking into consideration all of the above, the panel determined that this charge is found not proved.

Charge 17

Your conduct at Charge 16 was dishonest because the entry was made to conceal that you had failed to attend and conduct a consultation with Patient P.

This charge is found NOT proved.

The panel determined that this charge is not proved, in light of its earlier finding that Charge 16 was not proved.

Charge 18

Between 30 October 2019 and 6 December 2019 did not ensure that written patient records were secured safely in that you either did not return them to within 24 hours to the Royal Victoria Hospital or send them by internal mail in a timely manner following consultations with patients at external clinics or at their homes as set out in Schedule 1.

Schedule 1

Patient	Date of Consultation
Patient A	30 October 2019

Patient B	5 November 2019
Patient C	6 December 2019
Patient Q	6 December 2019

This charge is partially found proved.

Having found Charges 1b and 5b proved, the panel determined that the written patient records for Patient A and Patient B were not returned to the RVH within 24 hours, nor were they sent via internal mail in a timely manner. While there was no evidence before the panel to suggest that the records were not securely maintained by Ms Souter immediately following the consultations and for a short period thereafter, the panel found that she retained the records and failed to return them as soon as practicable.

The panel was of the view that Ms Souter's conduct in this charge contravenes the Trust's Standard Operating Procedure effective from 31 October 2017, which states:

> *'If notes are to be maintained by Stroke Liaison Nurse overnight (normally following home visits or due to outlying clinics) – these MUST be stored safely and securely within the Stroke Liaison Nurse's home and should be returned to base as soon as practicable (either via internal mail or in person).'*

The panel noted that this SOP is derived from the Tayside NHS Trust's policy on record keeping for nursing and midwifery staff, originally established in July 2011 and most recently updated in October 2019.

Having considered all of the above, the panel determined that this charge is partially proved, i.e., only in relation to Patient A and Patient B.

In relation to Patient C and Patient Q, the panel determined that there was insufficient evidence to substantiate this charge.

In reaching this decision, the panel considered the written evidence provided by Witness 1, who stated:

‘Patient C: the patient had their appointment changed from November 1st to December 6th 2019, and no notes were taken regarding the change on EMIS. The physical notes were not found on December 4th 2019. No patient notes were found on EMIS either. The physical notes then arrived through the internal post on December 19th 2019.’

‘Patient Q: was seen by Ms Souter on December 6th 2019 at the Arbroath location. No physical notes were found on December 10th 2019. The notes later arrived through the delivery system on December 19th 2019.’

The panel was not satisfied that there was independent or corroborative evidence confirming if, or when, Ms Souter conducted consultations with these patients.

Accordingly, and for the same reasons outlined in relation to Charges 9, 10, 11, and 12, the panel determined that this charge is found not proved.

Charge 19

On or about 6 December 2019 having conducted a consultation with Patient C and Q failed to return written records of their consultations to the Royal Victoria Hospital in a timely manner.

This charge is found NOT proved.

For the reasons set out under Charge 18 in relation to Patient C and Patient Q, the panel found that there was no independent evidence confirming if or when Ms Souter conducted consultations with these patients. Accordingly, in the absence of such evidence, the panel could not establish that Ms Souter failed to return the patient records in a timely manner.

The panel determined that this charge is found not proved.

The hearing resumed on 25 November 2025

Decision and reasons on service of Notice of Hearing

Ms Souter was not in attendance and Ms Churaman informed the panel that the Notice of Hearing letter had been sent to Ms Souter's registered email address by secure email on 10 June 2025.

Ms Churaman submitted that the NMC had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Ms Souter

The panel next considered whether it should proceed in the absence of Ms Souter. It had regard to Rules 21 and 34 and heard the submissions of Ms Churaman who invited the panel to continue in the absence of Ms Souter.

Ms Churaman submitted that the panel should proceed in the absence of Ms Souter. She submitted that the legal framework guiding the panel's discretion is clear. She referred to the case of *R v Jones*, in which the House of Lords stressed that the

discretion to commence a hearing in a defendant's absence must be exercised with the utmost care and caution. She reminded the panel that the fact stage had been heard in May 2025 and that Ms Souter had not attended at that stage; today is the start of the resuming hearing.

She also referred to the decision of *GMC v Adeogba*, where it was held that although caution is required before proceeding in the absence of a registrant, the regulatory process must not be frustrated by wilful disengagement or a deliberate attempt to evade proper inquiry. While a registrant has the right to attend a hearing concerning their fitness to practise, that right is not absolute and must be balanced against the regulator's duty to ensure a timely and effective process in the public interest.

The panel also heard from the Hearings Coordinator that he had emailed Ms Souter on 24 November 2025 with a reminder that the hearing was resuming today and that he had provided her with the details of how and when to join the meeting.

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

The panel decided to proceed in the absence of Ms Souter. In reaching this decision, the panel considered the submissions of Ms Churaman, the email sent by Ms Souter dated 20 February 2025, and the additional reminder email sent to Ms Souter on 24 November 2025.

The panel had particular regard to the factors set out in the decision of *R v Jones* and *GMC v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Souter had informed the NMC that she does not intend to attend the hearing;
- No application for an adjournment had been made by Ms Souter;
- There was a strong public interest in the expeditious disposal of the case.

In light of the above, the panel concluded that:

- Ms Souter had voluntarily absented herself; and
- There was no reason to suppose that adjourning would secure her attendance at some future date.

In these circumstances, the panel decided that it was fair, appropriate and proportionate to proceed in the absence of Ms Souter.

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

Submissions on misconduct

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

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

Ms Churaman submitted that the legal test for misconduct is established. She referred to *Roylance v GMC* [1999] UKPC 16, where Lord Clyde explained that 'misconduct' involves an act or omission that falls seriously short of the standards expected of a professional. She also relied on *Culverhouse v GMC* [2007] EWHC 2606 (Admin) and *Nandi v GMC* [2004] EWHC 2317 (Admin*)*, where the courts emphasised that misconduct must be serious and often involves conduct that fellow practitioners would view as *'deplorable'*.

Ms Churaman submitted that the panel's findings meet that threshold. As a stroke liaison nurse, Ms Souter was required to make, store, and return accurate clinical records promptly, and to ensure that information was accessible to colleagues providing care. The panel found that Ms Souter deliberately deleted entries, backdated letters, altered electronic records, and overwrote existing entries. Ms Churaman submitted that these actions represent serious, dishonest conduct falling far below the standards expected.

Ms Churaman referred the panel to the Code, highlighting duties to treat people with dignity (1 and 1.2), work cooperatively (8, including paragraphs 8.2, 8.3, 8.5 and 8.6), keep clear and accurate records (10 and 10.1 to 10.5), be open and honest (14 and 14.1 to 14.3), and uphold the reputation of the profession (20 and 20.1 to 20.3, 20.5). She stated that Ms Souter's conduct represents a serious breach of these professional standards and clearly amounts to misconduct.

Submissions on impairment

Ms Churaman moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in

the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Churaman submitted that impairment is a forward-looking assessment, guided by the NMC's published framework at DMA-1. The key question is whether Ms Souter can practise safely, kindly, and professionally in the future. In answering that question, a panel must consider both the nature and seriousness of the concerns and the wider public interest.

She referred to the approach in *Cohen* which asks whether the concerns are easily remediable, whether they have been remedied, and whether they are likely to be repeated. She also relied on the tests from Dame Janet Smith's formulation in the Fifth *Shipman* Report, as adopted in *Grant*. She said all four limbs are engaged. This is because Ms Souter placed patients at unwarranted risk of harm, brought the profession into disrepute, breached fundamental tenets of nursing, and acted dishonestly, behaviour that is liable to be repeated.

Ms Churaman submitted that the dishonesty in this case is particularly serious. Ms Souter falsified clinical records, deleted or altered entries, and made false statements about the whereabouts of notes. These actions created a real risk of harm to vulnerable, seriously ill stroke patients whose care depended on timely and accurate information. She submitted that such behaviour damages public trust, breaches core tenets of honesty and integrity, and, given its repeated nature, is likely to recur. In her view, both patient safety and the wider public interest require a finding of current impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v GMC*, and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

8 Work cooperatively

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk,

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

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

10.5 take all steps to make sure that all records are kept securely,

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

To achieve this, you must:

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered the charges found proved collectively, and whether the conduct alleged amounts to misconduct.

The panel referred to the NMC's guidance, which highlights the seriousness of such breaches, particularly where a nurse is required to act with transparency and integrity. In this case, Ms Souter failed to meet those fundamental professional expectations.

The panel found that the dishonesty proved constituted a serious departure from the standards expected of a registered nurse. In reaching this conclusion, the panel took into account the submissions presented, as well as the NMC's Fitness to Practise guidance (FTP-2a), which states that dishonesty can amount to serious misconduct.

Accordingly, the panel found that Ms Souter's conduct fell significantly short of the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

The panel noted that Ms Souter had provided nothing to show strengthened practice, no evidence of any reflection or remediation, and had fully disengaged from the process.

Nurses occupy a position of privilege and trust in society and are expected at all times to be capable of being safe, kind and professional. Patients and their families must be able to trust nurses and midwives with their lives and the lives of their loved ones. To

justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel was satisfied that all four limbs (a, b, c and d) were engaged. It found that patients had been put at risk of harm through Ms Souter's false records, delays in record keeping and failures to correctly follow up vulnerable patients; that Ms Souter had brought the profession into disrepute by potentially undermining patient confidence in the service; that she had breached fundamental tenets of nursing, including providing safe care and prioritising patients; and that her actions involved repeated dishonesty.

The panel went on to consider remediation. It accepted that record-keeping concerns can, in principle, be remedied, including through training, supervision and support. However, it found no evidence that Ms Souter had taken any steps to remediate her failings. The misconduct had been repeated over a period of time despite circumstances where she had opportunities to correct her behaviour through support in the workplace. Ms Souter had not engaged with the NMC process and has provided nothing to demonstrate any changes to her practice. Therefore, the panel had no evidence of insight, remorse or strengthened practice. The panel concluded that given there had been no evidence to demonstrate that Ms Souter had changed her record keeping practice, she is highly likely to repeat the same concerns in the future and that this would pose a risk of harm to patients.

The panel further considered that dishonesty is attitudinal, and it is significantly more difficult to demonstrate changes in attitude and genuine remediation. Given the lack of engagement and the repetition of dishonest acts, the panel considered there to be a high likelihood of repetition of similar dishonest behaviour. It therefore concluded that Ms Souter continues to pose a risk to patients, through the falsification of records and dishonest behaviour, requiring a finding of impairment for public protection.

The panel also considered contextual factors with reference to guidance DMA-1. It had examined these at the fact-finding stage and concluded there was nothing in the surrounding circumstances that explained or mitigated the misconduct. In light of Ms Souter's non-engagement, the panel had no further information.

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. Given the repeated and serious nature of Ms Souter's actions which were found proved, including dishonesty, and the potential damage to public confidence, the panel determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Ms Souter's fitness to practise is currently impaired on the grounds of public protection and in the wider public interest.

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 Souter off the register. The effect of this order is that the NMC register will show that Ms Souter has been struck off the register.

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

Submissions on sanction

Ms Churaman invited the panel to consider the appropriate sanction in light of the seriousness of the misconduct. She referred the panel to the SG, specifically SAN-1, which outlines the overarching purpose of sanction: to apply the right degree of regulatory force in order to protect the public, uphold the wider public interest, and send a clear message that registered nurses must maintain the standards of the profession.

Ms Churaman submitted that the only appropriate outcome in this case is a striking-off order. She explained that neither no further action nor a caution order is suitable because the panel has already found that Ms Souter poses a risk to the public and to the wider public interest. Where a nurse undermines public trust, breaches fundamental standards, and presents an ongoing risk to patients, such lower-level sanctions cannot be justified.

Ms Churaman further submitted that conditions of practice and suspension are also inappropriate. Conditions of practice would not address the problem, as Ms Souter has already been trained and the finding of dishonesty shows a deep-seated attitudinal concern. Suspension is not suitable either, as it is only meant for single incidents of misconduct where there is no harmful attitude. In this case, there are multiple failings and a serious attitudinal issue.

Ms Churaman concluded that a striking-off order is the only sanction that can protect patients and maintain public confidence. She referred to the guidance on dishonesty in SAN-2, which includes covering up mistakes, misuse of power, risks to vulnerable patients, and long-term or deliberate deception, all of which she says are present here. For those reasons, she submitted that Ms Souter should be removed from the register.

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

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings

- The repeated nature of the dishonesty, and
- Put vulnerable patients at risk of serious harm.

The panel could not identify any mitigating features. While it noted that Ms Souter had returned to work following a period of sick leave, the panel did not consider this to be a mitigating factor.

The panel referred to SG SAN-2 Sanctions for particularly serious cases. It noted in particular the following:

> *'Some concerns that come before a panel are particularly serious and are likely to attract the most serious sanctions…'*
>
> *'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register. However, in every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct that has taken place. Not all dishonesty is equally serious.'*

The panel found that the dishonesty in this case lay at the higher end of seriousness. It involved repeated conduct, risks to vulnerable individuals, direct risks of harm, and no evidence of attempts by Ms Souter to correct or report her actions. It also noted that she had not engaged with the hearing, and no evidence of insight was submitted to the panel. The panel further took into account Ms Souter's communication stating that she no longer wished to remain on the register.

The panel considered the nature of the misconduct in detail. It noted that Ms Souter had gone back into patient records, altered them, changed dates, and added information. There were concerns that some records were not kept in a secure environment in line with the Trust's policy, despite her stating otherwise. The panel considered this behaviour to be more than poor practice; it demonstrated a concerning attitudinal issue.

The dishonesty was premeditated and directed at concealing her failure to maintain accurate, timely records. It took place in a clinical setting, involved falsification of patient records, and created a risk of harm both to patients and to colleagues who relied on accurate records for safe care. The panel found that Ms Souter breached the duty of candour and attempted to cover up her failures rather than address them.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Souter'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 Souter's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Souter's registration would be a sufficient and appropriate response. The panel is of the view that there are no workable or measurable conditions that could be formulated, given the nature of the concerns in this case, which are attitudinal. The misconduct relating to dishonesty identified in this case was not something that can be addressed through retraining. Additionally, due to the fact that Ms Souter has stated that she no longer wishes to remain on the register and she has not engaged with the hearing, there is no evidence to suggest she would comply with conditions. Furthermore, the panel concluded that the placing of conditions on Ms Souter's registration would not adequately address the seriousness of this case and would not protect the public nor address the wider 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; and*
- *The panel is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.'*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Souter's actions is fundamentally incompatible with Ms Souter remaining on the register.

It noted that suspension may be appropriate where there has been a single incident, where there is no risk of repetition, and where the registrant shows insight. None of these features applied. The panel considered the misconduct fundamentally incompatible with remaining on the register. It was repeated, serious, and involved deep-seated attitudinal issues. Suspension would not address the wider public interest and would not be sufficient or proportionate.

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 all of these factors were relevant in this case.

The panel concluded that the misconduct represented a significant departure from the standards expected of a registered nurse and was fundamentally incompatible with Ms Souter remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Souter'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.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Souter'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 for the protection of the public, to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Interim order

As the substantive 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 is in Ms Souter's own interests until the striking-off order takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Churaman. She submitted that an interim suspension order is necessary to cover the period until the substantive striking-off order comes into effect having regard to the panel's findings. She submitted that if Ms Souter appeals the decision of the panel, then she would be able to practise without restrictions until the appeal process is finished, and this can take up to 18 months. She therefore invited the panel to impose an order for a period of 18 months to cover the whole of the appeal period.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be an interim suspension order, as to do otherwise would be incompatible with its earlier findings. The interim suspension order will be for a period of 18 months to cover the appeal period and 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 Souter is sent the decision of this hearing in writing.

This decision will be confirmed to Ms Souter in writing.

That concludes this determination.