

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

Substantive Hearing

Monday, 29 September 2025 – Wednesday, 1 October 2025

Virtual Hearing

Name of Registrant:	Alison Linda Kerr
NMC PIN:	0711129S
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) 25 February 2011
Relevant Location:	East Ayrshire
Type of case:	Misconduct
Panel members:	Graham Gardner (Chair, Lay member) Karen Gardiner (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Michael Bell
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Lindsey McFarlane, Case Presenter
Mrs Kerr:	Present and represented by Jennifer McPhee, instructed by Anderson Strathern
Facts proved by admission:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension order with review (6 months)
Interim order:	Interim suspension order (18 months)

Details of charge (as read)

1. On 11 September 2020:
 - a. In respect of Patient A, recorded details of purported NEWS observations which did not take place:
 - i. At 12.45 pm;
 - ii. At 2.45 pm;
 - iii. At 4.45 pm.
 - b. In Respect of Patient B, Recorded details of purported NEWS observations which did not take place:
 - i. At 1.50 pm;
 - ii. At 3.50 pm.
2. Your actions as specified in charges 1a and/or 1b were dishonest in that:
 - a. You knew that you had not undertaken the NEWS observations set out in charges 1a and 1b .
 - b. You intended that anyone reading Patient A's records for 11 September 2020 would believe you had undertaken the NEWS observations in respect of Patient A as you had recorded.
 - c. You intended that anyone reading Patient B's records for 11 September 2020 would believe you had undertaken the NEWS observations in respect of Patient B as you had recorded.
3. On 11 September 2020, during a conversation with Colleague A, asserted that you had carried out the purported NEWS observations specified in charges 1a and 1b, and had recorded them retrospectively, when this was not the case.
4. On 16 September 2020, during an interview with Colleague B, asserted that you had carried out the purported NEWS observations specified in charges 1a and 1b, and had recorded them retrospectively, when this was not the case.
5. On 29 October 2020 and 18 November 2020, during an interview with Colleagues C and D, asserted that you had carried out the purported NEWS

observations specified in charges 1a and 1b, and had recorded them retrospectively, when this was not the case.

6. Your actions as specified in charges 3 and/or 4 and/or 5 were dishonest in that:
 - a. You knew that you had not undertaken the NEWS observations set out in charges 1a and 1b.
 - b. You intended that Colleague A and/or Colleague B and/or Colleague C and/or Colleague D would believe you had undertaken the NEWS observations specified in charges 1a and 1b as you had recorded.

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

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

At the outset of the hearing, Ms McPhee, on your behalf, made a request that this case be held in private on the basis that proper exploration of your case involves reference to your health and personal private matters. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms McFarlane, on behalf of the Nursing and Midwifery Council (NMC), submitted that she supports the application insofar as parts of the hearing that deal with your health and/or private life are held in private in order to maintain your privacy.

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

The panel determined to go into private session as and when your health and personal private matters issues are raised in order to keep those matters out of the public domain.

Decision and reasons for reasonable adjustments pertaining to your [PRIVATE]

The panel heard an application made by Ms McPhee under Rule 23 of the Rules and supported by Section 20 of the Equality Act 2010, for special measures to be allowed to assist you to give your best evidence as [PRIVATE].

Ms McPhee told the panel that you have currently been [PRIVATE].

Ms McPhee requested the following: [PRIVATE].

Ms McPhee referred the panel to NMC Guidance CMT-12 'Supporting people to give evidence in hearings'. She reminded the panel of its overriding objective to ensure fairness to allow you to participate fully in your own hearing.

Ms McPhee invited the panel to grant the application.

Ms McFarlane indicated that she supported the application.

The panel accepted the advice of the legal assessor which included reference to NMC guidance CMT-12 and *Council for the Regulation of Healthcare Professionals v General Medical Council and Ruscillo* [2005] 1 WLR 717.

The panel decided to grant the application on the basis of Rule 23.

Background

The charges arose whilst you were employed by NHS Ayrshire & Arran Trust (the Trust), working as a staff nurse at [PRIVATE] (the Hospital). You had been working there from 2013 until 5 May 2022. On 27 May 2022, the NMC received a referral from the Trust, raising concerns about your fitness to practise.

The Trust informed the NMC that on 11 September 2020 you failed to document patient

observations for two patients in your care and retrospectively falsified National Early Warning Score (NEWS) documentation.

The patients in your care were on a high dependency stroke ward and had significant related illnesses, one of whom was in recovery from a craniotomy. You were required to conduct and record observations on a two-hourly basis in light of the acuity of said patients.

Concerns were escalated by colleagues to the nurse in charge on the afternoon of 11 September 2020 that observations may not have been conducted and recorded as they should. You were first approached by the Band 3 health care assistant who was concerned Patient B was not being monitored correctly. Thereafter, you were approached by the senior nurse ward co-ordinator who raised the same concern and offered help. Such was the prevailing concern that a third nurse, the Thrombolysis Assessment nurse, again spoke with you and asked if you had conducted and recorded the observations as you should. You insisted to all who asked, that the observations had been taken correctly and declined all offers of help.

In a further conversation with the Thrombolysis Assessment nurse that evening, you insisted you had necessarily recorded them at a later time after having memorised the readings throughout the afternoon. Therefore, the risks to Patients A and B were not immediately recognised and could not be remedied.

During the first local investigation meeting by the Trust on 16 September 2020, you stated that you had undertaken the observations as documented on the NEWS charts at the times but had simply failed to record them immediately.

At a reconvened investigation meeting on 18 November 2020, you initially maintained the same explanation, that you had conducted the observations at the correct times, memorising the results and recording them on NEWS when you were less busy later in the day. When interviewers challenged your account and presented you with evidence of simultaneous technical recordings, which exposed a disparity in both times and recording figures, you asked for a break in proceedings to discuss issues with your Royal College of Nursing (RCN) representative. On returning to the hearing, you admitted to falsifying observations and deceiving colleagues. You later explained you

had expected a nurse colleague working on the same ward to be conducting the required observations on your behalf. When you discovered she had not, you panicked and falsified and back dated the observations on NEWS. Thereafter you maintained your initial lies despite opportunities to make amends and to reduce the risk posed to patients.

You returned the Regulatory Concern Response Form, via your representative, and noted that you accept all three concerns. You have also provided a reflective piece.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms McPhee that you made full admissions to all of the charges.

The panel therefore finds charges 1a(i); 1a(ii); 1a(iii); 1b(i); 1b(ii); 2a; 2b; 2c; 3; 4; 5; 6a; and 6b proved in their entirety by way of your admissions.

Fitness to practise

Having announced its finding on all of the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your 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 determined whether the facts found proved amounted to misconduct. Secondly, the panel considered whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

The panel considered all of the documentary evidence before it. It heard submissions from Ms McFarlane on behalf of the NMC, and those made by Ms McPhee on your behalf.

The panel also heard oral evidence from you under affirmation.

Ms McPhee asked you a series of questions about the background leading up to the events and in relation to each of the charges found proved, on what you would do differently now and your reflection on the impact your actions had on the patients concerned, their families, the Trust, your colleagues and the wider nursing profession, as well as a summary of your nursing qualifications and career history in the healthcare sector to date.

Charges 1a(i), 1a(ii), 1a(iii), 1b(i), 1(b)ii

Ms McPhee took time with you to help the panel understand the context in which this allegation occurred. You told the panel that it was important for them to understand the negative impact a previous clinical incident investigation; involving a Naso-gastric tube insertion, had caused. That investigation occurred in 2019 and you told the panel that since then you were prone to feeling overwhelmed and lacking confidence in your clinical abilities at times. You said although you had informed your manager you had not addressed it and were struggling at times with [PRIVATE]. In addition you cited the increased challenges of the workload during the COVID-19 restrictions and that you were on a busy shift on that day. You said no one brought it to your attention that the observations were not getting done and that there was also a newly qualified junior colleague in the same bay on duty who you assumed would undertake your patient's observations whilst you were out of the bay dealing with social services and a planned discharge.

You were asked what it was that made you document observations that never took place. You said that when the Band 3 health care assistant highlighted the missing observations, you *"froze and panicked"* and were fearful of repercussions. Therefore, in

a moment of panic, you documented observations similar to the ones from earlier in the day. Both your representative and the panel enquired about the potential impact of such an action to which you responded that if the *“observations were not accurate colleagues on later shifts could not know if a deterioration had happened”*. You added that if drugs needed to be changed, for example, those for blood pressure management, inaccurate readings could mislead doctors in their prescribing.

In relation to the risks in not conducting observations in a timely manner, you told the panel that stroke patients can deteriorate very quickly and the medical and nursing teams would not have picked up an increase or decrease in the patients' blood pressure or a deterioration in neurological readings; furthermore the patients could have gone on to have a more serious stroke. When asked by Ms McPhee if you had any comments on the fact that there was no serious harm, but there could have been. You said *“I've been lucky they never deteriorated”*.

In relation to what the risks would have been to your colleagues and others you were working with during that shift, you said that if the patients had deteriorated and it was not being picked up until later on, colleagues would be upset that you had let them down and would not be able to trust you.

In relation to the risks associated with the reputational aspects to both yourself and the profession, you said it would affect your reputation as people might struggle to work with you because of what you had done. You said the reputation of the nursing profession could be damaged if the public thought a nurse had not done what they should have on a shift.

Charge 2a, 2b, 2c, 6a, 6b

In relation to the dishonesty charges you were asked what you would do differently if you were faced with those same circumstances again. You said you would never assume that things were getting done and liaise with your team members throughout the day to make sure everything has been done. You would keep clear and accurate records and update them when required. You told the panel with the benefit of hindsight

you should have alerted your manager that you had not managed to do the sets of observations. In future you would put in an incident report about it and also speak to the patients explaining the omission.

Dishonesty

In relation to how you thought your colleagues were affected by your dishonesty, you said they would lose the trust and respect they previously had for you as a nurse and a loss of confidence in your abilities to do things properly; they would be second guessing if you had done things correctly.

When asked what your reflection is now in terms of your prolonged dishonesty, you said you would ask for help if you were struggling with your workload and never be dishonest again by trying to cover things up. You said you should have confessed right at the beginning and not wait until the fourth time of being asked about what really happened.

When asked why you misrepresented the facts, you said you felt overwhelmed and in a state of panic and made a bad decision. You had never been subject to a hearing before and just did not know how to sort it all out at the time; you had made a bad situation worse by documenting readings when you should not have.

Ms McPhee asked what you would do differently if the same situation arose to which you responded you would tell the nurse in charge and report a clinical incident. You added that when you look back you *“don’t like the person [I was] in 2020”* and after lots of counselling and reflection have realised you had failed to deal with the impact of the incident in 2019 and had become defensive. In particular, you told the panel you were angry that colleagues had been talking about your practice behind your back and that made you more entrenched in the untruths you continued to tell.

When asked how you would avoid such a situation arising again, you said that you did not anticipate working in an acute hospital again which you may find too stressful.

Ms McPhee highlighted that both your managers at [PRIVATE] have described you as honest, reliable and competent and asked you how do you feel that you have earned their trust after these incidents. You said by being honest and upfront with them and informing them of the charges against you; they have both put their trust in you. You said that you are grateful for them giving you the chance and to continue and to show them that you are an honest person and no longer need to be dishonest.

You were asked and answered a set of questions from the panel.

In relation to your [PRIVATE] levels now compared with before, you said you are less [PRIVATE]. You said that you are currently working in a nursing home environment which you said was [PRIVATE]. You said you feel you are now a better person, helpful and honest and do not let yourself get [PRIVATE] as much as you did when working at the Hospital.

When asked at what point you decided to tell the truth, you advised this was after speaking to your RCN representative at the last disciplinary meeting. You added you could not continue not being truthful about the incident of falsifying the documentation because it was eating away at you that you were telling lies and it was affecting your [PRIVATE] and had been [PRIVATE] who was getting you to open up and talk about things. The panel asked a supplementary question and noted it appeared from the transcripts that when the investigator had pressed you regarding discrepancies in your recollections of the event it was then that you conceded as the lies seemed to be unravelling. You agreed there came a point where it was simply impossible to continue with your version of events as you started to become aware of the seriousness of the situation and were fearful of referral to the NMC.

You were asked what your personal responsibility was to those four patients on your shift. You said to help them through their stroke journey and to see them get better, to see them either walk out the ward or go to for some rehabilitation and back out in the community themselves and enjoying life. In relation to what the fundamentals would be for those patients in a hyperacute stroke unit, in particular one patient who had

craniotomy, you said to make sure that observations are documented in a timely manner there and then on the NEWS chart for any member of staff coming after you to see the observations you had taken and plan the care accordingly.

When asked further about the reasons for your dishonesty, you said it was driven by you being concerned about losing the respect of your colleagues and nothing else *“my colleagues had been behind my back talking to each other, I was angry and went into defensive mode...”*.

In relation to duty of candour, you were asked to give a summary, if you were teaching a student, about what duty of candour is. You said we have to be honest and truthful. with our patients and give them the care and support that they need, no matter if it is a bad incident.

Submission 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 McFarlane invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015’ (the Code) and identified the specific sections, where your actions were in breach of the Code and amounted to misconduct, as follows: 8.2, 8.5, 8.6, 10.2, 10.3, 14.1, 14.2, 14.3, 17.1, 19.1, 19.4, 20.1, 20.2 and 20.8.

Ms McFarlane submitted that nurses are obliged under the Code to act honestly and with integrity. However, you dishonestly documented five sets of false NEWS observations for two separate patients. Your reason for doing so is that you panicked, but what you did was cover up the fact that you did not undertake the required observations at the relevant times.

Ms McFarlane submitted that it is highly important that the observations for those patients were recorded accurately as they were at high risk, with one being at high risk of deterioration of a further stroke and the other having undergone emergency surgery, namely a right frontal craniotomy.

Ms McFarlane submitted that to have entered false observation into the patients' records meant that they were placed at serious risk of harm due to other professionals being involved in their care and treatment, not having access to accurate information. She submitted that you would or at least should have known the risks and thought that false entries could have posed further risk to the patients.

Ms McFarlane submitted that you then lied at the end of that shift on the 11 September 2020, when questioned during the local investigation whether the entries in the documentation were made retrospectively. You stated at the time that you were unable to document the observations contemporaneously due to workload pressures and therefore memorised the observations and added them into the NEWS charts later. You then repeated the lie that as that you carried out the NEWS scores and documented them retrospectively on several further occasions.

Ms McFarlane submitted that as a registered nurse, you are also obliged to cooperate with all investigations. You did eventually make admissions at the end of the second interview on the 18 November and subsequently at the first disciplinary hearing on the 5 May 2022 and during the NMC's fitness to practice process, however it does not erase the course of dishonest conduct that you took place prior to making admissions.

Ms McFarlane submitted that it is acknowledged not every breach of the Code will result in a finding of misconduct. However, the conduct and above-mentioned breaches by you are a serious departure from the professional standards and behaviour expected of a registered nurse. She submitted that your actions and resulting breaches of the Code clearly amount to serious misconduct.

Ms McPhee submitted by way of context that the misconduct was in a clinical setting of a hyper-acute stroke unit not a routine medical bay. On that day, you were working with

a newly qualified nurse and had three patients in a six-bedded bay and a fourth in a side room. The shift itself was busy in the way that only such units can be.

Ms McPhee submitted that you entered observations that had not been taken. By late afternoon, confronted by gaps and handover approaching, you panicked. Instead of escalating, you wrote plausible figures that were close to the previous readings and reassured colleagues who had asked you that those observations had been done.

Ms McPhee submitted that your conduct was not financially driven or a persistent pattern of behaviour. It was a one-off episode on one day by a nurse who otherwise has had an unblemished career.

Turning to the NMC Guidance on impairment DMA-1 in reference to dishonesty, Ms McPhee submitted that the guidance requires you to calibrate dishonesty on a sliding scale. At the top end is calculated deception and at the bottom end isolated panic driven incidents that are subsequently owned and remediated. She submitted that your dishonesty falls firmly at the bottom of this scale.

Ms McPhee submitted that context is never an excuse for dishonesty, however it does inform one's prospective judgment. Dishonesty in a nurse is always serious, but it is not always the same in terms of the drivers, insight and remediation, weighing future risk with the clinical reality of that day, real patients, real pressures and real human errors under pressure.

Ms McPhee submitted that when looking further at the context of the misconduct, you were working with a newly qualified nurse which would have had an impact on the allocation of work and that this was not an equal burden across the department, but that there was a significant burden placed on you.

Ms McPhee submitted that you do not hide behind the fact that Patient A and Patient B did not deteriorate. What you called "*lucky*" was that the absence of harm was by chance, not a protection built into your actions, and you own the risk that you created.

In relation to your insight into the impact on your colleagues, Ms McPhee submitted that you accept that reassuring four colleagues that observations had been done when they had not was corrosive to teamwork. She submitted that you also recognise that declining offers of help was a pivotal error, however you have resolved never to repeat that. In terms of your insight into the profession, you accept without defensiveness that even one instance of dishonesty damages public trust in nurses. She submitted that you have mapped your conduct against the Code, prioritising people, practising effectively, preserving safety, promoting professionalism and trust.

Ms McPhee submitted that you accept that your gravest failing was not only the falsification, but the lack of candour. Telling one lie led to another and made everything worse. She submitted that you have described the dishonesty as eating you up inside and explained that once the lie existed you did not know how to get out of it.

Ms McPhee submitted that your insight has also been shaped painfully by this fitness to practise process itself. For five years you have lived with this referral. You [PRIVATE] in an area that you loved and in which you were already developing a specialism and taken through a local investigation process that lasted two years. She submitted that you have told the panel in your evidence that this whole process has taught you much more than anything that you never want to be here again. She submitted that your insight fits the legal framework that allows you to say that the risk is now negligible.

In relation to remediation, Ms McPhee submitted that you have not collected certificates for show. You have completed voluntary Continuing Professional Development (CPD) on candour, documentation, NEWS escalations, acute neural observations and making ethical decisions under pressure and after each you have written a short piece on what has changed in your practice. Ms McPhee also explained you had completed the duty of candour training on the previous Friday and were unable to download a certificate showing completion. You explained to the panel you found technical difficulties with the system which explained the lack of your name and date of completion.

In terms of the risk of repetition, Ms McPhee referred to the test in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011]

EWHC 927 (Admin). She submitted that the decisive question asks whether you are liable in the future to put patients at unwarranted risk. She submitted that the historic limbs are met by what happened in 2020. The prospective limbs are what matters now. She contextualised the misconduct as one day, one shift, one set of patients, no gains and no patterns. She submitted that your actions were at the lower end of dishonesty.

Ms McPhee submitted that you were trusted to lead shifts after full disclosure, there are positive testimonials without concern. She asked the panel to consider that your insight is detailed across patients, families, colleagues, profession, candour and self. Your remediation, retraining integrated into daily practice and in consideration of deterrence – you have experienced five years of scrutiny, stigma and consequences. She submitted that these are all protective factors. She submitted that the risk of repetition is highly unlikely.

Ms McPhee submitted that what matters to you are the multiple progressive deeper reflections and frank self-critical oral evidence which to you is a journey from defensiveness to candour. She submitted that you have studied candour and have produced learning notes.

Submissions on impairment

Ms McFarlane submitted that a finding of impairment is appropriate on public protection grounds. Your actions placed two vulnerable patients under your care at a real risk of serious harm. Your misconduct in this case is serious and your dishonesty in making several false entries to the patient records is linked to your clinical professional practice and related to your professional duty of candour. These patients were seriously ill at the material time and required two-hourly observations to assess the risk of deterioration given their medical conditions.

Ms McFarlane submitted that a finding of impairment is also in the wider public interest in this case to declare and uphold proper standards of conduct and behaviour. She submitted that the public expect registered nurses to act with the utmost honesty and integrity and to adhere to their professional duty to candour due to the position that they

hold caring for people at their most vulnerable and the trust is accordingly placed in them. She submitted that your actions clearly undermined public confidence in the nursing profession. She invited the panel to make a finding that your fitness to practise is currently impaired.

Ms McPhee submitted that in relation to the wider public interest and public confidence dishonesty by a nurse always attracts public concern and trust is the currency of nursing. Accurate records and candour are the bedrock, but the authorities are clear that public confidence is not maintained by reflective punishment.

Ms McPhee submitted that a fully informed member of the public would accept that this was a situation where a nurse five years ago made a single panic-driven mistake who falsified observations and then compounded it by not admitting it when first asked, who has admitted it since, repeatedly apologised, retrained voluntarily, changed her behaviours and practice and demonstrates candour under stress. She submitted that members of the public would see accountability, learning and rehabilitation, not impunity in these circumstances.

Ms McPhee submitted that your fitness to practise is not currently impaired, however if the panel is minded to the contrary and a public marker is required, she referred to her earlier submission that you are a nurse who on one pressured day, falsified records and misled colleagues. You accept that this was dishonest, serious and damaging. You have reflected with depth and specificity, retrained voluntarily and integrated that learning into daily practice. You have embedded practical coping strategies that directly interrupt the chain that failed in 2020. You have fully demonstrated candour under pressure and since then, you have been trusted by your current employer after full disclosure and have practised safely. She submitted that you have lived through five years of scrutiny that has reshaped you both professionally and personally. She submitted that your dishonesty is at the lower end of the scale and the risk of repetition is negligible.

Ms McPhee invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included *Cohen v GMC* and *Roylance v General Medical Council*.

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 determined that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'1.2 make sure you deliver the fundamentals of care effectively

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

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

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

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

11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard*

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence'*

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*

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*

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

20.2 *act with honesty and integrity at all times, [...]*

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

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

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The panel was aware of the guidance given in FTP-2a that not all breaches of the Code or issues with practice will be a matter of regulatory concern.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

‘The question that will help decide whether a professional’s fitness to practise is impaired is:

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”

If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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 determined that parts a), b), c) and d) of the above test to be engaged.

The panel finds that patients were put at risk of serious harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel was of the view that this was not a one-off error. The panel considered there were multiple omissions of fundamental elements of clinical care when recognised these were covered up. The panel was of the view that you failed to do the required observations for two patients a number of times over a period of four hours. These two patients were on an acute ward where observations are of crucial importance. One patient was recovering from serious craniotomy surgery. This was significant and you were not able to prioritise this patient effectively. The panel determined that both these patients were fragile and at risk of deteriorating at any moment.

The panel considered that you fabricated a cover up of your failings and declined the offer of help. The panel determined that this was a protracted deception in that you made an error and thought how to get out of it. In so doing, you decided to make up figures and enter them into the documentation having claimed to have memorised them. You declined the chance to avert the risk to patients by immediately telling the truth.

Later, when asked during the interview, you said that you did not press the button hard enough on the machine and persisted with the deception. The panel noted the language you used in your oral evidence in relation to the impact on the risk of harm to the patients, you said *"I was lucky..."* and *"I never want to be here again..."*. The panel determined that you made self-interested decisions with no regard for patients or colleagues. You had ample opportunity to not continue with your lie given the series of meetings which took place with colleagues about this incident over

months. When you recognised that you had made a mistake you failed in your duty of candour and continued for the next two months with a continuing series of breaches, only admitting the dishonesty when you were challenged with hard evidence which meant that the lie could not be sustained.

The panel determined that you created a very serious risk of harm to patients. While your written reflective piece shows some evidence of insight, the panel concluded that this was not well supported by your oral testimony. The panel considered that there is a risk to patients in the future as there remains limited evidence of insight and you continue to minimise your actions and blame others, including a newly qualified nurse (who you had not worked with before), and the context and personal circumstances for what happened on that day. During your oral evidence, you provided the panel with a detailed description of the multiple competing demands during this shift upon your time/concentration. You stated that this shift was particularly busy and this was the reason you had failed to undertake vital observations. The panel determined what you were describing was not unusual for the type of clinical environment in which you were practising and should not constitute a reason for your failure to undertake vital observations. In fact, the panel found this demonstrated a failure to effectively prioritise clinically. The panel was therefore not satisfied that you have sufficiently remediated in order for it to be assured you could practise kindly, safely and professionally.

The panel acknowledged that you have admitted to dishonesty. However, the panel considered your dishonesty to be at the upper end of the scale. It was of the view that you made conscious active decisions to be dishonest on repeated occasions. You had multiple opportunities over a period of two months to be honest in a number of ways in a number of different settings. The panel determined that the only reason you were eventually honest was that you were confronted with hard evidence which meant that the lie could not be sustained. The panel was of the view that although you may have initially panicked, there was time thereafter to retract the lie and as you did not do so, it found that you had been deceitful on multiple occasions.

The panel acknowledged that the misconduct in this case, given that it involves dishonesty, is not easily remediable. Furthermore, it had concerns that the deceit in question, having continued over a period of months was indicative of deep-seated attitudinal issues which are difficult to remedy. The panel was of the view that even during your oral testimony in this hearing, it was your intention to have it believed that you had ultimately confessed during your second interview out of remorse, as opposed to the incontrovertible evidence that was presented to you.

The panel carefully considered the evidence before it in terms of remediation to determine whether or not you have taken steps to strengthen your practice. The panel took into account your recent duty of candour training. However, it noted that this training was only carried out shortly before the hearing and that no validated certificate for it was available. Further when probed by the panel about it during your evidence, it became clear that you lacked an understanding of the value and importance of candour within your professional practice. Further, much of the training you have undertaken is mandatory for any practising nurse. The panel was of the view that the crux of this case is about falsifying records and dishonesty and that you have taken limited steps over the course of five years to address this.

The panel was of the view that there is a risk of repetition. On the basis of the evidence before it, there is emerging insight however it is limited as there continues to be evidence of attitudinal issues as demonstrated by some of your responses to questions and aspects of your reflective piece. The panel took account that when questioned, you focussed on the impact on yourself, not on the risk to patients, colleagues and public perception of nursing. While you have worked since the incident and have testimonials in support. The panel was aware that this work has been in a lower pressure environment in a nursing home and that you yourself conceded that you would not wish to work in a hospital again. However, it was mindful that nurses are registered to work without restriction in all environments and as such it did not have sufficient evidence before it to be satisfied that you could cope with a similar stressful situation again without repeating the conduct displayed in this incident. The testimonials provided, while positive, are limited in number, do not cover the full duration of the past five years, and do not show how you would cope under similar stressful circumstances in future and

whether you have been able to change any deep-seated attitudinal issues which may have affected your conduct. The panel therefore concluded that there is a risk of repetition.

In light of the above, the panel therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind 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 had regard to the serious nature of your misconduct and determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case which give rise to the public interest in this case.

The panel took into consideration your reflective piece provided as part of your documentation. However, on day one of the hearing, the panel heard your oral evidence and came to the assessment that you do not fully acknowledge the impact of the risk of death that could have resulted by your actions to Patient A and Patient B. The panel was of the view that these are deep-seated issues that are attitudinal in nature.

The panel was of the view that a fully informed member of the public knowing the seriousness of this case would be concerned if you were permitted to practise as a registered nurse without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds is also required. It determined that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

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. It took account of all the submissions of Ms McFarlane and those of Ms McPhee. Aside from your updated reflective statement provided dated today 1 October 2025, the panel received no further evidence from anyone at this stage.

Submissions on sanction

The panel was aware that in the Notice of Hearing dated 18 August 2025, the NMC had advised you that it would seek the imposition of a suspension order for period of three months with review if it found your fitness to practise currently impaired.

Ms McFarlane submitted that the following aggravating factors are applicable in this case:

- Your dishonesty which could have directly resulted in patient harm
- Your continuing dishonesty; you maintained a course of dishonest conduct when questioned about the matter on three occasions

With respect to the mitigating factors, Ms McFarlane submitted:

- You have shown some insight
- You have demonstrated some remediation through positive testimonials and training and practice since the referral

Ms McFarlane submitted that taking no action or imposing a caution order would not be the appropriate and proportionate order in this case. She referred to NMC Guidance SAN-2 and submitted that due to the serious nature and your deliberate breach of your professional duty of candour, this type of dishonesty is considered to be of a type which may call into question whether a professional should remain on the register.

Ms McFarlane submitted that a conditions of practice order is not an appropriate and proportionate sanction given the concerns raised in this case relate wholly to dishonesty. She submitted that a conditions of practice order would fail to address the public interest concerns raised, nor mark the seriousness of the misconduct in the circumstances of this case.

Ms McFarlane submitted that any sanction less than a suspension order would not be appropriate to satisfy the public interest concerns in this case, to mark the seriousness of your misconduct and to uphold professional standards given all of the circumstances. She submitted that a suspension order is the appropriate proportionate sanction. She referred to guidance SAN-2 and submitted that cases involving dishonesty will always be serious.

Ms McFarlane referred the panel to your most recent reflection submitted after the panel's finding on misconduct and impairment. She submitted that dishonesty in record keeping is gravely serious because records are the backbone of safe care. She submitted that you accept that you falsified the NEWS observations creating the risk of missed deterioration of vulnerable patients and betraying the trust of families and colleagues.

Ms McPhee submitted that the primary submission is for a conditions of practice order

for a period of 12 months with review. She submitted that conditions can be put in place to directly address risks identified and suggested that these could include:

- Mentor or supervisor that would work with you to carry out reviews on monthly basis on candour, record keeping and coping under pressure strategies
- Restrict your practice to one substantive employer unless otherwise agreed at the NMC
- You must not be the sole nurse in charge and not act as the sole nurse in charge for 12 months unless endorsed by a mentor or employer
- Notify the NMC of a validated CPD completed accreditation within 12 weeks on: candour, record keeping including NEWS, ethical decision making, coping with pressure
- Submit certificates and reflective pieces with the NMC quarterly reports
- Your mentor to submit quarterly reports covering matters of candour, documentation, accuracy, escalation under pressure, professional attitude, record keeping audits of random samples of notes to make sure the observations were being documented contemporaneously
- Incident disclosure, immediate disclosure of any record keeping or escalation incidents, complete incident form and a reflective log, maintaining a structured log with two entries per month, evidence in candour, escalation, documentation reviewed by a mentor and filed for review.

Ms McPhee submitted that these suggested conditions are robust, tangible and enforceable and directly address the risk of falsification and ensure candour, honesty and integrity are evidenced in practice to the NMC as regulator.

Ms McPhee submitted that if the panel conclude that dishonesty cannot be marked by conditions of practice alone, then a short reviewable suspension of three months would suffice to mark the seriousness, allow the CPD to be completed and enable a reviewing panel to test your progress.

Ms McPhee submitted that a strike off would be disproportionate. It would ignore five

years of safe practice, dismiss two positive employer testimonials, [PRIVATE] and deprive the profession of an experienced nurse who has demonstrably changed.

Ms McPhee reiterated that the proportionate sanction is either a conditions of practice order which would be targeted, reviewable and protective or in the alternative, a short suspension that would mark the public discourse and the dishonesty.

Decision and reasons on sanction

Having found your 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:

- Your serious dishonesty
- Your limited insight into failings
- Your failure to be a role model to a junior colleague
- You posing a serious risk to highly vulnerable patients by falsifying records and maintaining dishonesty

The panel also took into account the following mitigating features:

- Your attempts to address the issues of dishonesty including through training and reflection
- You admitted all of the charges
- Your previous good character

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.

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 your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel was of the view that the misconduct identified in this case was not something that can be addressed through retraining. Whilst the panel noted Ms McPhee's recommended conditions of practice, it was cognisant of SAN-2 regarding misconduct and impairment. The panel agreed that it was very difficult to remediate what it had observed as attitudinal issues, through conditions of practice. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered these factors carefully and acknowledged that not all the factors listed above fit squarely in that there is some evidence of deep-seated or attitudinal problems and limited insight. The panel determined that there remains a risk of repetition.

The panel determined that the following factors applied to this case:

- The dishonesty while protracted stems from one single occasion where omissions were made in making observations followed by efforts to cover up the omission
- There is no evidence of repetition

Furthermore, the panel took into account proportionality, the efforts made to remediate in terms of reflection and training, the emerging insight, your previous good character and your engagement with the NMC.

The panel therefore determined that a suspension order would be the most appropriate sanction which would mark the seriousness of the dishonesty. Your dishonesty continued to put patients at risk and it is therefore necessary to protect the public for a period of time while you continue to strengthen your practice and develop further insight in relation to your duty of candour and dealing with stressful events in clinical practice.

The panel determined that the public interest in this case would be significant not least because of the increased risk to highly vulnerable patients. The panel decided that only a significant period of suspension would be appropriate to mark the gravity of the misconduct.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it and of the mitigation provided, it concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of six months with review was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion of courses related to duty of candour
- Testimonials from a line manager or supervisor that detail your current work practices in the area of duty of candour
- Evidence of you working with a mentor
- References / testimonials from colleagues who you work with

- Your attendance at a hearing

This will be confirmed to you in writing.

Interim order

As the suspension 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 your own interests until the suspension order sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms McFarlane. She submitted that an 18-month interim suspension order is appropriate and proportionate in this case given the panel's determination on sanction.

Ms McPhee did not oppose the application.

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 as to do otherwise would be inconsistent with its earlier findings.

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

That concludes this determination.