Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 September 2025 – Friday 12 September 2025

Virtual Hearing

Name of Registrant:	**Emma Bilsborough**
NMC PIN:	10B2090E
Part(s) of the register:	Registered Nurse – Adult (26 March 2011)
Relevant Location:	Oldham
Type of case:	Misconduct
Panel members:	Nilla Varsani (Chair, Lay member) Angela Horsley (Registrant member) Joanne Morgan (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Sara Glen
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Mrs Bilsborough:	Not present and unrepresented
Facts proved:	Charges 1a,1b, 2, 3, 4a, 4d, 5
Facts not proved:	Charges 4b, 4c,
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 Mrs Bilsborough was not in attendance and that the Notice of Hearing letter had been sent to Mrs Bilsborough's registered email address by secure email on 1 August 2025 and registered address by recorded delivery and by first class post on 15 August 2025.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Bilsborough's registered address on 16 August 2025. It was signed for against the printed name of 'Bilbourogh' (sic).

Mr Hoskins 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, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Bilsborough's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Bilsborough 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 Mrs Bilsborough

The panel next considered whether it should proceed in the absence of Mrs Bilsborough. It had regard to Rule 21 and heard the submissions of Mr Hoskins who invited the panel to

continue in the absence of Mrs Bilsborough. He submitted that Mrs Bilsborough had voluntarily absented herself.

Mr Hoskins submitted that proceeding in the absence of Mrs Bilsborough is a discretionary decision to be made by the panel. He referred the panel to the relevant case law *R v Hayward & Ors* [2001] 3 WLR 125 and *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5. He submitted that there is a duty for Mrs Bilsborough to engage with her regulator and these hearing proceedings.

Mr Hoskins submitted that there had been numerous attempts by the NMC to make contact with Mrs Bilsborough in regard to these proceedings, by email and by telephone call. He referred the panel to emails dated 31 July 2025, and 1 August 2025 in which, several attempts were made by the NMC to discuss this case and her attendance with Mrs Bilsborough. Mr Hoskins further referred the panel to a telephone call attempt by the NMC on the 1 August 2025. Mrs Bilsborough answered her phone but then appeared to have signal issues and the call ended. Further attempts to make contact by telephone on 14 August 2025, 19 August 2025 went to Mrs Bilsborough's voicemail.

Ms Hoskins submitted that there had been very little to no engagement at all by Mrs Bilsborough with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Mr Hoskins submitted that due to Mrs Bilsborough's lack of engagement with the NMC, it is not known what her views are on the allegations against her, her current work situation, the extent of her insight and that proceeding in her absence is likely to be a disadvantage for Mrs Bilsborough. However, Mr Hoskins submitted that this must be weighed against the public interest and the expeditious disposal of this case. He further submitted that in choosing to not proceed in Mrs Bilsborough's absence, this may cause inconvenience to witnesses who have already given up their time to give evidence at this hearing. Further, there may be significant delay as to when this case may be listed again.

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Mrs Bilsborough. In reaching this decision, the panel has considered the submissions of Mr Hoskins and the advice of the legal assessor. It has 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:

- No application for an adjournment has been made by Mrs Bilsborough;
- Mrs Bilsborough has not engaged with the NMC and has not responded to any of the emails sent or telephone calls made to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness will attend today to give live evidence, and six others are due to attend later this week and next week;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Bilsborough in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations since her local investigation interview on 3 December 2021. The panel noted that Mrs Bilsborough gave an explanation

for some of her alleged conduct at an earlier stage. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Bilsborough'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 has decided that it is fair to proceed in the absence of Mrs Bilsborough. The panel will draw no adverse inference from Mrs Bilsborough's absence in its findings of fact.

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

At the outset of the hearing, Mr Hoskins made a request that this case be held partly in private on the basis that proper exploration of Mrs Bilsborough's case may involve reference to a personal event and her personal circumstances. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (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.

Having heard that there may be reference to Mrs Bilsborough's personal event and personal circumstances, the panel determined to go into private session as and when such issues are raised in order to protect Mrs Bilsborough's privacy.

Mr Hoskins submitted that prior to this hearing, Witness 1 had requested that she give her evidence on the telephone rather than by video link by reason of her specific personal circumstances. This will allow her to attend the hearing and give her best evidence.

Mr Hoskins further submitted that by allowing her to give her evidence by telephone, would not cause any prejudice. He also pointed out that Witness 1 would not be subject to cross examination and therefore that it was unnecessary to view Witness 1 on camera.

The panel accepted the advice of the legal assessor.

The panel accepted the application for Witness 1 to give their live evidence by telephone call. The panel was satisfied that this was necessary to enable Witness 1 to give their best evidence in these proceedings.

Background

The charges arose whilst Mrs Bilsborough was employed as a registered nurse by Northern Care Alliance NHS Foundation Trust ("the Trust").

Mrs Bilsborough commenced employment at the Trust on 13 March 2017. She was first promoted to a Band 7 in 2018 and was later seconded as Acting Lead Nurse (Band 8a) on 25 January 2021. Her secondment came to a natural end on 9 January 2022, and she returned to her substantive role as ward manager.

The nature of the concerns referred to the NMC on 4 March 2022 were that it is alleged that Mrs Bilsborough falsified clinical room daily checklists in the weeks commencing 26 July 2021 and 9 August 2021, and hypobox contents checklists on 8 August 2021 and

week commencing 9 August 2021 by inputting staff initials to show safety checks had been completed when they had not been.

It is further alleged that Mrs Bilsborough inappropriately closed an incident on the Datix system in August 2021, which related to the bruising of an elderly patient, by inputting incorrect clinical details and allegedly stating an investigation had been carried out when it had not.

Decision and reasons on application to amend the charge.

During the course of deliberations, the panel noted that the stem of Charge 4 made reference to dates 1 to 10 August 2021 and that Charge 4a) specifically referenced the investigation of a relative's complaint. When examining the evidence, the panel noted that the relative's complaint was received on 8 August 2021. The panel considered amending the wording of Charge 4 a) by removing the words 'relative's complaint' and replacing them with another form of words which did not refer to the relative's complaint. This would more accurately reflect the evidence.

The panel paused its deliberations and raised the matter with Mr Hoskins. He understood the panel's concern and raised no objections to the proposed amendments.

He submitted that the proposed amendments would be of no prejudice to Mrs Bilsborough as during the preparation for this hearing, Mrs Bilsborough did not respond to any of the charges or engage with the NMC. Mr Hoskins submitted that during proceedings, the NMC has referred to a safeguarding concern in relation to the investigation of Patient A and not the relative's concern specifically. Therefore, the wording of Charge 4 a) does not reflect the true position. Mr Hoskins further submitted that as Charge 5 (dishonesty) is based significantly on Charge 4 a), there is a public interest that the amendment is made. The proposed amendment would provide clarity and more accurately reflect the evidence.

The proposed amendments would read:

‘That you, a registered nurse:

4. Between 1 and 10 August 2021 in respect of Patient A:

a) Recorded false information in relation to the investigation ~~of a relative’s complaint~~ **of a concern in relation to Patient A** by inputting clinical details ~~in a Datix~~ **into a Datix system** which were incorrect

The panel accepted the advice of the legal assessor and had regard to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was fair and in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Bilsborough and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

‘That you, a registered nurse:

1. Falsified clinical room daily checklists by retrospectively inputting staff initials indicating safety checks had been completed without having checked whether they had been on:
a) Week commencing 26 July 2021
b) Week commencing 9 August 2021

2. On 8 and/or 9 August 2021, falsified hypobox checklists by retrospectively inputting staff initials indicating safety checks had been completed when they had not been.

3. Your actions in respect of charges 1 and/or 2 were dishonest in that you intended to create a misleading impression that safety checks had been completed when they had not been.

4. Between 1 and 10 August 2021 in respect of Patient A:
a) Recorded false information in relation to the investigation of a concern in relation to Patient A by inputting clinical details into the Datix system which were incorrect
b) Inappropriately closed the Datix noting that the investigation had been completed when it had not been
c) Failed to make a referral to safeguarding despite being told to do so by Colleague A
d) Failed to adequately undertake and/or oversee an investigation into a relative's complaint.

5. Your actions in respect of Charge 4 were dishonest in that you intended to create a misleading impression that you had completed an investigation when you had not.

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

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Bilsborough.

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: Band 6 Ward sister on the Acute Medical Unit (AMU) in the Royal Oldham Hospital ("the Hospital").

- Witness 2: The Macmillan Assistant Director of Nursing for Cancer, the Complex Medicines Directorate, Diabetes and Endocrine at the Royal Oldham Hospital ("the Hospital").

- Witness 3: Acting Assistant Divisional Director of Nursing for General and Specialist Medicine at the Royal Oldham Hospital ("the Hospital"). At the time of the allegations was the Lead Nurse on The Acute Medical Unit.

- Witness 4: Current Deputy Chief Nurse at East Cheshire NHS Trust. At the time of the allegations, was the Divisional Director of Nursing for the Division of Medicine at Oldham Care Organisation.

- Witness 5: Current Assistant Director of Nursing at the Royal Oldham Hospital (“the Hospital”) for urgent and emergency care. At the time of the allegations, was in the same role but covered trauma and vascular surgery.
- Witness 6: Current Domestic Abuse Specialist Nurse. At the time of the allegations was the Named Nurse for Safeguarding Adults at the Royal Oldham Hospital (“the Hospital”)
- Witness 7: Ward Sister on the respiratory ward at the Royal Oldham Hospital (“the Hospital”)

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 1

‘That you, a registered nurse:

1. Falsified clinical room daily checklists by retrospectively inputting staff initials indicating safety checks had been completed without having checked whether they had been on:

a) Week commencing 26 July 2021

b) Week commencing 9 August 2021

This charge is found proved in its entirety.

The panel considered each limb of this charge separately, but it has written its decision up together as they arise out of a similar set of circumstances.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 1, the documentary and oral evidence of Witness 3, the documentary and oral evidence of Witness 7 and Mrs Bilsborough's documentary evidence.

In reference to a discussion with Ms Bilborough, Witness 7 in her witness statement dated 24 January 2023 said;

> *'On 12 August 2021, Mrs Bilsborough was in the Sisters' office on T3. I was about to go for my lunch break, so I went to the Sisters' office to get my handbag. When I walked into the office, Mrs Bilsborough asked me if I knew which shifts I had worked over the last few weeks. Mrs Bilsborough did not ask for specific dates…Mrs Bilsborough told me they were filling in the checks for the fridge temperature, which had not been previously signed for…I glimpsed at what Mrs Bilsborough was doing and I noticed that they were doing the fridge checks and that they were writing my initials…I confirm that I had not completed the checks that Mrs Bilsborough had signed for. Mrs Bilsborough did not ask me to confirm whether I had done the checks.'*

This is further corroborated in Witness 7's earlier witness statement dated 17 September 2021 where she said;

‘On the 18 August 2021, I approached ADNs [Witness 2] for support as I was upset…I disclosed an incident that had happened several days previously and had left me feeling uncomfortable…Emma told me that she was filling in the gaps on the signing sheets for the checks that had not been done and was signing for [Witness 1] and myself on the days we had both been in.’

In their witness statement dated 12 February 2023, Witness 1 said;

‘ I first became aware of this incident on 9 August 2021 date when one of the other Ward Sisters on T3, [Witness 7], rang me and told me that they had gone into the ward office and Mrs Bilsborough had the checklists for the treatment room, fridge checks and the cleaning of the treatment room out in front of them…[Witness 7] said Mrs Bilsborough was signing the checklists with my initials and [Witness 7’s] initials…I saw the checklist that Mrs Bilsborough had signed on my behalf when I next came onto the ward for my shift… There were a lot of signatures that I did not personally sign, going back months… these signatures were of my initials, and [Witness 7’s].

This is also corroborated in their earlier witness statement dated 19 September 2021 where Witness 1 stated;

‘Roughly around the 9 August I received a telephone call from [Witness 7]. She informed me Emma Bilsborough (lead nurse) was filling in gaps on the signing sheets for checks that had not been done within the clinical room, and was signing my initials and [Witness 7’s] initials on them for the days which we had been in. [Witness 7] informed me Emma had asked [Witness 7] for what shifts me and she had previously worked and [Witness 7] gave her this information. I previously have come into work and checked these checklists. The checklists have been signed with my

initial and [Witness 7's] initial. I did not complete these checks and neither did [Witness 7].'

In his witness statement dated 28 February 2023, Witness 3 stated;

'I met with Mrs Bilsborough on Friday 27 August 2022 and showed them the treatment room checklists, which staff alleged had been falsified… Mrs Bilsborough admitted they had signed as the other nurses' initials retrospectively and apologised for doing so. They provided mitigative circumstances following completion of a reflective practise.'

Further Witness 3 stated;

'Mrs Bilsborough explained that they had asked the nurses whether they were on duty on specific dates and if they said yes, they signed the nurses' initials on the checklists in front of them…It was clear from my review of the checklists that it was Mrs Bilsborough's handwriting.'

This is corroborated in a letter detailing a discussion between Witness 3 and Mrs Bilsborough about the concerns raised regarding the signing of checklists to Witness 2 by Witness 7. In this letter Witness 3 states;

'You disclosed that this had happened and apologised and promised it would not happen again…Exploration into this concern has identified that there may be more than 1 full week of checks had been backdated…You agreed and identified the 2 full weeks of backdated checks.'

In her reflective statement dated 10 September 2021, Mrs Bilsborough stated;

'On the week commencing 16 August I returned from a week annual leave and attended T3 in the morning. Throughout the course of that morning, I

went to check that the checks had been done in my absence by the staff and band 6s on shift and found that there were blank spaces where the staff should have signed. I asked if they had completed the checks and they stated yes, we discussed remembering to sign for them in real time and then I put their initials on the checks, backdating them.'

'I know that this was not the right thing to do, it was unprofessional and did not set a good example for my more junior staff…I regret making a rash decision to complete the forms retrospectively and after discussion with my manager I realised there where (sic) greater implications than what I considered at the time.'

'I now realise that I should have spoken to the band 6s individually to see what reason they had for checking the checks but not signing for them at the time, and then managing this separately. As a manager I have carried this out before so knew that this was an option but instead took a short cut and backdated.'

The panel took into consideration the consistent evidence provided by Witness 1 and Witness 7 in both their documentary and oral evidence. The panel also found Witness 3's evidence to be credible and consistent in both their documentary and oral evidence. Witness 3, as her line manager, confirmed to the panel that it was Mrs Bilsborough's handwriting on the checklists. The panel took into account this evidence, together with Mrs Bilsborough's acceptance that she had retrospectively added signatures to the checklists, without noting that she had done so, and found on the balance of probabilities Charge 1a) and Charge 1b) are proved.

Charge 2

'That you, a registered nurse:

2. On 8 and/or 9 August 2021, falsified hypobox checklists by retrospectively inputting staff initials indicating safety checks had been completed when they had not been.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 3 and Mrs Bilsborough's documentary evidence.

In their witness statement dated 28 February 2023, Witness 3 said;

> *"I collated the physical evidence and also requested statements from [Witness 1] and [Witness 7]. I reviewed the checklists and noticed that 8 August 2021 and week commencing 9 August 2021, Mrs Bilsborough has also falsified the hypobox checklists.'*

This is further corroborated in a letter detailing a discussion between Witness 3 and Mrs Bilsborough about the concerns raised regarding the signing of checklists to Witness 2 by Witness 7. In this letter Witness 3 states;

> *'You disclosed that this had happened and apologised and promised it would not happen again…Exploration into this concern has identified that there may be more than 1 full week of checks had been backdated…You agreed and identified the 2 full weeks of backdated checks.'*

In her reflective statement dated 10 September 2021, Mrs Bilsborough stated;

> *'On the week commencing 16 August I returned from a week annual leave and attended T3 in the morning. Throughout the course of that morning, I went to check that the checks had been done in my absence by the staff and band 6s on shift and found that there were blank spaces where the*

staff should have signed. I asked if they had completed the checks and they stated yes, we discussed remembering to sign for them in real time and then I put their initials on the checks, backdating them.'

'I know that this was not the right thing to do, it was unprofessional and did not set a good example for my more junior staff…I regret making a rash decision to complete the forms retrospectively and after discussion with my manager I realised there where (sic) greater implications than what I considered at the time.'

'I now realise that I should have spoken to the band 6s individually to see what reason they had for checking the checks but not signing for them at the time, and then managing this separately. As a manager I have carried this out before so knew that this was an option but instead took a short cut and backdated.'

The panel found Witness 3's evidence to be credible and consistent in both their documentary and oral evidence. During their oral evidence, Witness 3 confirmed to the panel that it was Mrs Bilsborough's handwriting on the checklists and that as her line manager he had a familiarity with her handwriting. The panel determined that with Mrs Bilsborough's acceptance that she retrospectively added signatures to the checklists and with Witness 3's oral and documentary evidence, on the balance of probabilities, Charge 2 is proved.

Charge 3

'That you, a registered nurse:

3. Your actions in respect of charges 1 and/or 2 were dishonest in that you intended to create a misleading impression that safety checks had been completed when they had not been.

This charge is found proved in respect of Charge 1a), Charge 1b) and Charge 2.

The panel considered each of the three allegations of dishonesty separately and came to three separate decisions but have written them up together as they arise from a similar set of circumstances.

In reaching this decision, the panel took into account Mrs Bilsborough's documentary evidence, the oral evidence of Witness 3, the documentary and oral evidence of Witness 4, the documentary and oral evidence of Witness 1 and the documentary and oral evidence of Witness 7.

In his witness statement dated 28 February 2023, Witness 3 described the Nursing and Accreditation Assessment System (NAAS) that the Trust uses. He said;

> '*Within the accreditation it sets out that nurses must review daily checks and box contents (Standard 5) to ensure the environment is safe for patients. The NAAS assessments carried out during Mrs Bilsborough's time as Ward Manager on F8/CCU indicated an overall score of 'green'. This is the highest standard, indicating Mrs Bilsborough was aware of the standards and what was required to achieve them*.'

Witness 4 corroborates this in his witness statement dated 11 June 2025 by stating;

> '*Mrs Bilsborough was responsible for the delivery of action plans associated with the NAAS ward accreditation programme.*'

In their witness statement dated 12 February 2023, Witness 1 said;

> *' I first became aware of this incident on 9 August 2021 date when one of the other Ward Sisters on T3, [Witness 7], rang me and told me that they*

had gone into the ward office and Mrs Bilsborough had the checklists for the treatment room, fridge checks and the cleaning of the treatment room out in front of them…[Witness 7] said Mrs Bilsborough was signing the checklists with my initials and [Witness 7's] initials…I saw the checklist that Mrs Bilsborough had signed on my behalf when I next came onto the ward for my shift… There were a lot of signatures that I did not personally sign, going back months… these signatures were of my initials, and [Witness 7's].

When Mrs Bilsborough was asked in the local investigation meeting dated 23 February 2022, if there would have been any repercussions for her as a senior manager if she had left the checklists unsigned, Mrs Bilsborough said;

'There could have been as there were a lot of issues at that time of T3, high workload, understaffed.'

The panel noted at the time that Mrs Bilsborough, in respect of Charge 1a) and Charge 1b) said that she was being accurate with the signatures as she stated that Witness's 1 and 7 had previously confirmed to her that the safety checks had been carried out. In their oral evidence to this panel, Witness's 1 and 7 denied that they were ever asked about the checks by Mrs Bilsborough. The panel determined that the accounts of both Witness 1 and Witness 7 were consistent and credible and preferred this evidence to that of Mrs Bilsborough. In addition, in relation to Charge 2 Mrs Bilsborough never suggested that she had conferred with others before adding signatures to the hypobox checklists.

The panel determined that as a registered professional and Lead Nurse and also having achieved 'green' status in the NAAS, Mrs Bilsborough would have been aware of how to complete checklists and the potential repercussions if they were not filled in accurately. The panel found that Mrs Bilsborough's actions, by retrospectively inputting the checklists with other people's initials was a deliberate

attempt to mislead. This would give the impression to anybody reviewing the document that safety checks had been completed when they had not. The panel determined that Mrs Bilsborough knew that by doing so, her actions would mislead and that this would be seen as dishonest by the standards of ordinary decent people.

Therefore, on balance of probabilities, Charge 3 in relation to Charge 1a), Charge 1b) and Charge 2 is found proved.

Charge 4a)

'That you, a registered nurse:

"Between 1 and 10 August 2021 in respect of Patient A:

a) *Recorded false information in relation to the investigation of a concern in relation to Patient A by inputting clinical details into the Datix system which were incorrect*

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 3, the documentary evidence of Mrs Bilsborough and a complaint letter written by the daughter of Patient A dated 8 August 2021.

In the complaint letter dated 8 August 2021, the daughter of Patient A said;

'*On Sun 26/7 I found her to have a severe black eye. I assume she must have had a fall but neither the day staff or night staff had logged such an event. I therefore asked for an incident to be raised as to how this could have happened, I have heard nothing*.'

In the local investigation meeting dated 3 December 2021, when asked if she had met Patient A, Mrs Bilsborough said, 'I *previously met her as part of her journey but I didn't see her following the bruise/datix.*'

The panel had sight of the Datix history report, which are timestamped with Mrs Bilsborough attributed to the entries. In an entry on 1 August 2021 Mrs Bilsborough said;

> *'Seeing Patient A for first time, while I was taking over patient from nightstaff. HCA…Informed me that they had been taken care of Patient A yesterday and has not seen any mark or bruises over her face, however noticed bruises over her right inner cantus and around, asked night staff nurse who was unsure about the reason of bruise… informed to daughter*'

Further entries stated;

> *"The patient was known to be on apixaban and bruises very easily, the bruising upon inspection was small."*

However, information summarised in an email dated 28 August 2021 by Witness 3 borne from an investigation states that, '*There were no discussions with staff; only one staff member had been approached*…*There was no inspection of the bruise , which was not small*…*The patient was not on Apixiban*…*There was no conversation or apology to the family with lead nurse and ward sister*.'

The panel found that the Datix was completed incorrectly including;

- There were no discussions with staff;
- There was no inspection of the bruise, which was not small;
- The patient was not on Apixiban;
- There was no conversation or apology to the family with lead nurse and ward sister;

- There was no evidence of discussion with staff surrounding good communication and escalation.

This is corroborated by the letter from Patient A's daughter stating that no contact had been made. Therefore, on balance of probabilities, the panel found Charge 4a) is proved.

Charge 4b)

'That you, a registered nurse:

Between 1 and 10 August 2021 in respect of Patient A:

b) Inappropriately closed the Datix noting that the investigation had been completed when it had not been.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 3, the documentary and oral evidence of Witness 5 and Mrs Bilsborough's documentary evidence.

In regard to the closing of the Datix report, Witness 5, in her witness statement dated 27 March 2023 stated;

> *'Mrs Bilsborough stated that [Ms 1], Divisional Governance Manager, closed the Datix. This is not accurate as the electronic system showed the Datix was closed by Mrs Bilsborough.'*

Further, in his witness statement dated 28 February 2023, Witness 3 stated;

> *'Mrs Bilsborough closed the incident on the Datix system in August 2021, stating that an appropriate investigation had been carried out.'*

However, the panel heard oral evidence from both Witness 3 and Witness 5, who on examination of the Datix history report confirmed that it appeared that Ms 1 closed the Datix on or around 16 August 2021.

In his oral evidence, Witness 3 said;

> *"I didn't realise Emma had been asked to attach the statements. When you entered everything into it, there's a drop-down box to close or leave as pending. I don't think this history pulls exactly who pressed the button to say Datix can be closed."*

Further, during her oral evidence, Witness 5 said *"[Ms 1]'s closed it knowing we still need statements, it's very much administrative."* This is corroborated by Mrs Bilsborough in the initial investigation meeting notes dated 3 December 2021. When asked by Witness 5 who closed the Datix? Mrs Bilsborough replied "[Ms 1]".

The panel found it was clear from the documentary evidence presented that the Datix system was "closed" on or around 16 August 2021 by Ms 1. When Mrs Bilsborough was interviewed in the initial investigation, her understanding was also that Ms 1 had closed the Datix report. Both Witness 3 and Witness 5 in their oral evidence confirmed that it appeared that Ms 1 closed the Datix investigation.

The panel considered whether the definition of "closed" could be widened to encompass something more than Ms 1's administrative function of closing the Datix form, pending the addition of statements. The panel rejected this and concluded that the Datix system clearly shows that it was closed by Ms 1.

Therefore, Charge 4b) is found not proved.

Charge 4c)

‘That you, a registered nurse:

Between 1 and 10 August 2021 in respect of Patient A:

c) Failed to make a referral to safeguarding despite being told to do so by Colleague A

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 6, the documentary and oral evidence of Witness 4, Mrs Bilsborough’s documentary evidence.

In her witness statement dated 29 April 2025, Witness 6 said;

> *‘I was unable to find any evidence that a safeguarding referral had been made in respect of this patient.’*

When asked in the initial local investigation dated 3 December 2021 if she had contacted safeguarding, Mrs Bilsborough said that ‘They *were already aware as there were emails going around.’*

In an email dated 2 August 2021 from Witness 4 to Mrs Bilsborough, Witness 4 asked;

> *‘Please could you confirm what advice has been sought from and provided by the safeguarding team in relation to this?’*

In his oral evidence, Witness 4 clarified to the panel that he was asking for a discussion around the issue of the unexplained bruising on Patient A and was not asking about a referral to safeguarding.

Taking into the account the evidence of Witness 4, the panel concluded that Witness 4 never told Mrs Bilsborough that a referral to safeguarding was required and at most she was told to have a discussion with the safeguarding team.

Therefore, Charge 4c) is found not proved.

Charge 4d)

'That you, a registered nurse:

Between 1 and 10 August 2021 in respect of Patient A:

d) Failed to adequately undertake and/or oversee an investigation into a relative's complaint.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Witness 3, the documentary and oral evidence of Witness 4, the documentary and oral evidence of Witness 1 and the documentary evidence of Mrs Bilsborough.

In a Datix feedback message dated 1 August 2021, Mrs Bilsborough said;

'*This incident is under investigation, I am awaiting staff statements. I will update further when I have more information.'*

In the local investigation meeting notes dated 18 November 2021, Witness 3 told Witness 5;

'I had been assured at the time of the datix, that the investigation was in hand…EB had closed the datix investigation stating that the Lead Nurse had apologise (sic) to the family about the bruising, however the complaint

indicated this was not the case and appeared when I asked EB about this she never actually met the patient of the family.'

In the local investigation meeting dated 3 December 2021, Mrs Bilsborough stated that she had got mixed up regarding the different patients and investigations. She said;

'[*Witness 3] came up to speak to relatives. They were both so close together. What I remember, [Witness 3] had spoken to the family which I thought was Patient A, but he spoke to other relative. There was crossed wires about who spoke to who.'*

The panel had sight of Exhibit AT1 which documents the Lead Nurse job description, it states that responsibilities include "*Monitor the delivery of the service whilst promptly identifying and investigating any issues."* The panel also had sight of Exhibit AT6 which shows that Mrs Bilsborough attended investigating officer training on 15 June 2021.

The panel determined that as Lead Nurse it was Mrs Bilsborough's responsibility and duty to undertake and/or oversee an investigation into the relative's complaint, but she failed to do so. Therefore, on the balance of probabilities Charge 4d) is found proved.

Charge 5

'That you, a registered nurse:

Your actions in respect of Charge 4 were dishonest in that you intended to create a misleading impression that you had completed an investigation when you had not.

This charge is found proved in relation to Charge 4a).

In reaching this decision, the panel took into account Mrs Bilsborough's documentary evidence, the documentary and oral evidence of Witness 3 and the documentary and oral evidence of Witness 1.

During the investigation, Mrs Bilsborough made reference to the fact that she had got mixed up between Patient A and another patient. In the local investigation meeting dated 3 December 2021, when asked if she could recall the other safeguarding Datix that was submitted, Mrs Bilsborough said;

> *"It wasn't the same week. It was the week after. That was in relation to a patient who had a scratch on the chest."*

The panel considered Mrs Bilsborough's explanation that she got confused over two different incidents but did not find that this was likely in the circumstances. The panel noted that both the circumstances of the two concerns and the dates of the incidents were different.

The panel found that Mrs Bilsborough's actions, by recording false information in relation to the investigation of a concern in relation to Patient A into the Datix system was a deliberate attempt to mislead. This would give the impression to anybody reviewing the Datix system that there had been discussions with staff and the family, that she had inspected the bruise and the patient was on Apixiban. The panel determined that Mrs Bilsborough knew that her actions would create a misleading impression and that this would be seen as dishonest by the standards of ordinary decent people.

On the balance of probabilities, Charge 5 in relation to Charge 4a) is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs

Bilsborough'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, Mrs Bilsborough's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Hoskins invited the panel to take the view that the facts found proved amount to misconduct. He directed the panel to the cases of *Roylance v GMC (2) [2000] 1 AC 311, Nandi v General Medical* Council [2004] EWHC 2317 (Admin) and *Shaw* v *General Osteopathic Council* [2015] EWHC. 2721 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin). He further referred the panel to NMC guidance.

Mr Hoskins identified the specific, relevant standards from 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) where Mrs Bilsborough's actions amounted to misconduct, namely; 10, 10.1, 10.2, 10.3, 10.4, 10.6, 14,14.1,14.2, 14.3, 20, 20.1, 20.2, 20.3, 20.8.

Mr Hoskins submitted that Mrs Bilsborough's actions amounted to serious misconduct. He submitted the actions that amount to Mrs Bilsborough's dishonesty occur on more than one instance and over a short period of time. He submitted that in her role as a Band 8a

Nurse, Mrs Bilsborough was not without support and that she was not left with any option but to take shortcuts as she has stated. Mr Hoskins directed the panel to Witness 3 and Witness 4's evidence, which he states, is indicative of an open and supportive workplace. Mr Hoskins submitted that in regard to the fact that Mrs Bilsborough was relatively new to her working role and the ward was relatively new to being set up, these are not sufficient reasons to mitigate her dishonest actions.

Mr Hoskins submitted that Ms Bilborough's actions to input other's initials on incomplete checklists were dishonest and had a potential to cause serious harm to patients. He referred the panel to Witness 3's oral evidence. Witness 3 told the panel that the checklists formed part of the NAAS accreditation and were expected to be completed. In terms of patient safety, if items were missing, out of date or incomplete on the hypobox checklists, then this could cause a real risk to patient life. Further, in regard to the daily checklists, Mr Hoskins submitted that these form part of infection control monitoring and if fridge temperatures are not monitored and completed correctly, or if potassium solutions are mixed with water solutions, then this may also cause a serious risk to patient safety. Mr Hoskins referred the panel to Witness 3's evidence where he stated that it would have been easier to escalate any concerns and seek help if one was not able to complete the checklists rather than acting dishonestly.

Mr Hoskins submitted that there is a tangible effect on colleagues as a result of Mrs Bilsborough's dishonest actions. He submitted that it is not fair for Mrs Bilsborough to have written two of her colleague's initials, who were more junior and for them to be placed in a situation where they felt they could possibly not challenge those actions. He also submitted that Mrs Bilsborough's actions further put her colleagues' professional careers into question.

Mr Hoskins submitted that the issue of dishonesty is of significant importance as those in senior positions, those in the nursing profession need to be trusted, often with people's most sensitive information at a time where they are at their most vulnerable. He submitted that this includes staff as well as patients. Mr Hoskins submitted that for all of the reasons

above, that trust cannot be correctly bestowed on Mrs Bilsborough. He submitted that this is a case that a finding for misconduct should be found.

Submissions on impairment

Mr Hoskins 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 Cheatle v General Medical Council* [2009] EWHC 645, *Cohen v General Medical Council [2008]* EWHC 581 (Admin), *Grant* [2011] EWHC 927 (Admin) and *Yeong v General Medical Council* [*2009*] EWHC 1923 (Admin); [*2009*] WLR (D) 268.

Mr Hoskins submitted that in regard to the facts of this case and in reference to the case of *Grant*, all four limbs of Dame Janet Smith's "test" are engaged.

Mr Hoskins submitted that Mrs Bilsborough has shown a lack of insight into her failings. He referred the panel to Witness 3's evidence where in his witness statement dated 28 February 2023 he states, "I *feel that Mrs Bilsborough has shown very little insight into the concerns raised regarding this patient*." Witness 3 also stated in relation to the Datix incident;

> "*Mrs Bilsborough was unable to articulate why they had falsified the Datix entry and has shown little insight into the management of this concern."*

Mr Hoskins directed the panel to the reflective account provided by Mrs Bilsborough to Witness 3 on 10 September 2021. He submitted that contained within this reflective statement are matters that have been found in the course of this hearing to not be factually correct. He submitted that Mrs Bilsborough's reflective statement is not demonstrative of significant insight and instead shows Mrs Bilsborough's attempts to deflect blame.

Mr Hoskins directed the panel to Witness 5's witness statement dated 27 February 2023 where it was stated that Mrs Bilsborough did give some insight but Witness 5 stated, "*I do not feel there was any concern for the welfare for the patient or acknowledgement of the risk to the patient*." Further, Mr Hoskins directed the panel to the disciplinary meeting minutes dated 23 February 2022 where he submits that even although it appears that Mrs Bilsborough was being represented at the time, there is very little insight into her failings at the time or apology.

Mr Hoskins submitted that Mrs Bilsborough has not engaged with NMC proceedings or this hearing process even though as a Registered Nurse she has an obligation to comply with the NMC code of conduct and attend investigations. He submitted that there has been no evidence of Ms Bilborough's current mindset or attempt to remediate her failings. There has also been no evidence of whether Mrs Bilsborough has practised nursing since the incident and whether when faced with similar situations if she has taken an alternative course of action.

Mr Hoskins submitted that in the context of this case, Mrs Bilsborough's dishonesty is not easily remediable and in the absence of any further information or insight, is likely to be repeated in the future. He submitted that Mrs Bilsborough has breached the fundamental tenets of the nursing profession and has brought the profession into disrepute. He submitted that as Mrs Bilsborough was in a senior nursing position, she is required to set an example and that there is a need to uphold the professional standards of the nursing profession in order to maintain public confidence. He submitted that Mrs Bilsborough's actions fell short of the standards expected of a Registered Nurse and that a finding of current impairment should be found on public interest and public protection grounds.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

The panel had regard to the case of *Roylance* 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'.*

When determining whether the facts found proved amount to misconduct, the panel also had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

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

> *'**10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> ***10.1** complete 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*
> ***10.6** collect, treat and store all data and research findings appropriately*
>
> ***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*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

The panel also had regard to the relevant Trusts policies provided by Witness 3 and Witness 5.

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 Mrs Bilsborough's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct. The panel determined that acting with integrity and honesty is a fundamental tenet of nursing and Mrs Bilsborough's dishonest conduct was intentional and occurred on more than one occasion albeit over a short period of time. The panel considered that Mrs Bilsborough's conduct would be considered deplorable by other practitioners in the nursing profession.

In respect of Charge 1 falsifying clinical daily room checklists will give the impression to a reader of the list that safety checks have been completed, drugs were in date and stored in fridges of the correct temperature. Also, there were infection prevention and control measures in place. By falsifying these checklists, there is a real risk for example, that medicine that had not been stored correctly, or in date, could be administered to a patient and compromise their safety. Such actions amount to serious misconduct.

In respect of Charge 2, falsifying hypobox checklists will give the impression to a reader of the list that safety checks have been completed. If items were missing from the hypobox and there was a patient who required care for a hypoglycaemic episode, their treatment may be delayed and there would be a real risk that their safety could be compromised. Such actions amount to serious misconduct.

In respect of Charges 4a) and 4d), by recording false information in relation to an investigation and failing to adequately investigate a relative's complaint, this is likely to have adverse consequences for Patient A and her care. It is also undermined Patient A's family's trust in the hospital and the care that she may have received. Such actions amount to serious misconduct.

The panel noted that Mrs Bilsborough was an experienced senior nurse with a longstanding career in the nursing profession. As a Registered Nurse, Mrs Bilsborough occupied a position of trust and privilege and as such, is expected to act professionally and with integrity at all times. The panel has made several findings of dishonesty which could have caused significant patient harm and seriously undermined confidence in the nursing profession, both for her colleagues and for the public. Such dishonesty amounts to serious misconduct.

Further, the panel considered the impact that Mrs Bilsborough's dishonesty and failing to investigate concerns around Patient A had on Patient A and their family. In his oral evidence, Witness 3 told the panel that Patient A had unexplained bruising which upon her return home for palliative care caused her family considerable concern. Mrs Bilsborough

had assured Witness 3 that an investigation was taking place and said that she had spoken to the family of Patient A. The panel heard evidence at this hearing, that this did not take place and that Patient A's family were not contacted. The panel recognised the emotional distress this would have caused Patient A and their family at a time that is already emotionally difficult.

Further, the panel recognised that there was significant investment in Mrs Bilsborough succeeding in her role as a Band 8a Nurse and that she received regular support from senior management. In his oral evidence, Witness 3 stated "I *would not benefit if my lead nurses do not succeed*." The panel felt that there appeared to be an open and supportive culture in the workplace and that there were alternative actions that Mrs Bilsborough could have taken but chose not to. The panel determined that Mrs Bilsborough's limited explanation for her failings did not mitigate her dishonesty.

For the reasons above, the panel concluded that Mrs Bilsborough's actions amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Bilsborough'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.'*

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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 concluded that limbs a), b), c) and d) of *Grant* apply in this case both as to the past and to the future.

The panel found that patients, patient families and colleagues were put at risk of harm and were caused physical and emotional harm as a result of Mrs Bilsborough's misconduct. Mrs Bilsborough's 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 such conduct extremely serious.

The panel went on to consider in respect of Charges 1, 2, 4a) and 4d) and determined that completing documents incorrectly is potentially remediable. However, the panel has no evidence whatsoever that it has been remedied and therefore in the circumstances the panel determined the conduct is likely to be repeated.

In respect of Charges 3 and 5 which involve dishonesty, the panel determined that such behaviour is more difficult to remediate, and in this case there no evidence of remediation and therefore Mrs Bilsborough's conduct is likely to be repeated.

The panel next considered Mrs Bilsborough's insight. The panel noted that there is no new information before it in the form of reflections, testimonials or training certificates to demonstrate any insight or strengthened practise other than what was provided to the Trust as part of their investigation. It considered that Mrs Bilsborough, has not

demonstrated an understanding of how her actions put patients at risk of harm, nor demonstrated any remorse or understanding at the time of the incident or since, as to why what she did was wrong. Also there has been an inability for her to reflect on her own performance and the seriousness of her actions on both patients, colleagues and the nursing profession. Furthermore, the panel has no information as to what Mrs Bilsborough is currently doing and therefore is unable to say how she might handle the situation differently in the future.

In all the circumstances, the panel determined that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that given its findings including dishonesty and the lack of insight, a member of the public would be concerned about Mrs Bilsborough's conduct. Public confidence in the profession would be undermined if a finding of impairment were not made. Therefore, the panel also finds Mrs Bilsborough's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Bilsborough's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Bilsborough off the register. The effect of this

order is that the NMC register will show that Mrs Bilsborough has been struck off the register.

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

Submissions on sanction

Mr Hoskins submitted that the NMC's position on sanction is for a strike-off order to be made. It was his submission that this would be the most appropriate and proportionate sanction.

Mr Hoskins referred the panel to NMC Guidance San-1 'Factors to consider before deciding on sanctions' last updated 2 December 2024.

Mr Hoskins took the panel through what he submitted were the aggravating factors of this case. He submitted that Mrs Bilsborough has demonstrated very little insight into her failings, and that there is evidence of a lack of remorse and limited remediation. Mr Hoskins submitted that Mrs Bilsborough was in a senior position of trust in her role as a Lead Nurse. Further, Mr Hoskins submitted that with the panel's findings of a pattern of misconduct, though over a relatively short time period, Mrs Bilsborough's offer of explanation by way of her circumstances offer no mitigation or explanation as to why she was dishonest in her failings. Mr Hoskins also submitted that Mrs Bilsborough's misconduct put patients and colleagues at risk of suffering physical and emotional harm and as such, her actions fell far short of what is expected of a Registered Nurse.

Mr Hoskins submitted that there were some mitigating factors in this case. He submitted that Mrs Bilsborough has had a long-standing career as a Registered Nurse with no previous complaints about her conduct. He also submitted that Mrs Bilsborough in her role as Lead Nurse helped the ward achieve 'green' status in NAAS accreditation. Further, he

submitted that Mrs Bilsborough's disclosure of a significant personal event around the time of the allegations that formed Charges 1, 2 and 3 should be given some consideration, however, this has not had the opportunity to be tested.

Mr Hoskins referred the panel to NMC sanction guidance SAN-2 'Sanctions for particularly serious cases' last updated 6 May 2025. Mr Hoskins submitted that dishonesty in this case is at the higher end of the spectrum given its repetitive nature and that Mrs Bilsborough's action caused physical and emotional harm to Patient A, who was vulnerable. Her actions further caused emotional harm to her colleagues, Witness 1 and Witness 7, who were put into a vulnerable position due to their job role and the fact that they told the panel that they felt that they could not challenge Mrs Bilsborough on her misconduct.

Mr Hoskins submitted that due to the nature of Mrs Bilsborough's misconduct, the continuing risk to patients and the findings of this case, taking no further action or imposing a caution order would not sufficiently protect the public and would undermine the public confidence in the profession and the NMC as its regulator. He further submitted that a caution order may be appropriate where the misconduct is at the lower end of the spectrum, but it is not appropriate in this case.

Mr Hoskins noted the panel's findings that the misconduct of Charges 1, 2, 4a) and 4d) was potentially remediable, but that Charges 3 and 5 were difficult to remediate. He submitted that a conditions of practice order would not be appropriate in this case and given the nature of the misconduct there are no practicable or workable conditions that could be formulated due to the evidence of deep-seated attitudinal problems. He submitted that placing conditions on Mrs Bilsborough's registration would not adequately address the seriousness of the case and given Mrs Bilsborough's lack of engagement with the NMC there is no confidence that any conditions would be complied with by Mrs Bilsborough.

Mr Hoskins submitted that a suspension order would not be appropriate in this case. He submitted that given the panel's findings of an ongoing risk, lack of insight and remediation

that one could not be satisfied that a period of suspension would sufficiently protect the public. He submitted that whilst there is no evidence of remediation before the panel, this has also not had the opportunity to be tested. He submitted that given the passage of time since the allegations against Mrs Bilsborough, the lack of evidence of insight and remediation should be considered significant. He told the panel that this is not a single instance of misconduct and that there is evidence of deep-seated personality or attitudinal problems. Mr Hoskins submitted that Mrs Bilsborough's lack of engagement with the NMC is indicative of someone that is unable to entirely reflect on their practice and that this is concerning as it is attitudinal in nature.

Mr Hoskins told the panel that Mrs Bilsborough's actions were a significant departure of the standards expected of Registered Nurse and that she has breached the fundamental tenets of the nursing profession. He submitted that her actions are fundamentally incompatible with continued registration and that a suspension order would not be a sufficient, appropriate or proportionate sanction in this case.

Mr Hoskins submitted that honesty and integrity are fundamental tenets of the nursing profession. He submitted that Mrs Bilsborough's misconduct and repeated dishonesty was serious and that to allow her to continue to practise would undermine public confidence in the profession and the NMC as a regulator.

Mr Hoskins submitted that a striking off order is necessary and proportionate in this case and that it is the only sanction which is sufficient to maintain professional standards to protect the public.

The panel heard and accepted the advice of the legal assessor who referred the panel to NMC guidance on sanctions and a number of authorities including *Atkinson v General Medical Council* [2009] EWHC 3636.

Decision and reasons on sanction

Having found Mrs Bilsborough'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 engagement with the NMC
- In a senior position of trust
- Lack of insight into seriousness of failings
- A pattern of misconduct over a period of time
- Conduct which put patients and colleagues at risk of suffering harm.

The panel also took into account the following mitigating features:

- Limited apology
- Previous good character
- Personal mitigation

As the panel has already determined Mrs Bilsborough's misconduct was serious and included dishonesty over a period of time. Falsifying checklists in order to give a misleading impression that safety checks had been carried out posed a real risk of serious harm to patients. The dates on the drugs and the temperature of the fridges had not been checked, but Mrs Bilsborough's actions led staff to believe that they had.

Patient A's family were entitled to a thorough investigation as to the circumstances of her bruising. To fail to undertake an appropriate investigation was a serious dereliction of duty and brings the nursing profession into disrepute.

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 Mrs Bilsborough'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 Mrs Bilsborough'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 Mrs Bilsborough's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and her lack of engagement. The panel considered that the serious dishonest nature of the matters found proved and attitudinal concerns were difficult to remedy. The panel therefore determined that given the pattern of Mrs Bilsborough's misconduct, her limited insight and potential to cause real harm to patients and the public, there were no relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition, which poses a risk of harm to patient safety and the reputation of the nursing profession. The panel concluded that the placing of conditions on Mrs Bilsborough's 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;*

The panel determined that Mrs Bilsborough's misconduct did not reflect a single instance of misconduct. As a result of Mrs Bilsborough's lack of insight into her failings, lack of evidence of remediation and lack of engagement with the NMC, the panel were not satisfied that she did not pose a significant risk of repeating her past conduct. Furthermore, the panel has no information as to what Mrs Bilsborough is currently doing despite there being a responsibility on her to engage with her regulator. This raises questions about her professionalism. The panel noted that Mrs Bilsborough's misconduct 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 Mrs Bilsborough's actions is fundamentally incompatible with Mrs Bilsborough remaining on the register.

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

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Bilsborough's actions were significant departures from the standards expected of a Registered Nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Bilsborough'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. Mrs Bilsborough's actions jeopardised patients' safety as did her dishonesty. This brings the profession into disrepute by adversely affecting the public's view of how a Registered Nurse should conduct herself and the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a Registered Nurse.

This will be confirmed to Mrs Bilsborough in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Bilsborough's own interests until the striking-off 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 Mr Hoskins. He submitted that an interim order was necessary for a period of 18 months. He submitted that this is necessary to protect the public and the wider public interest until the substantive order takes effect and to cover the period of any prospective appeal.

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. Not to impose an interim suspension order would be inconsistent with the panel's earlier findings and determination.

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

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

That concludes this determination.