Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 21 July 2026 – Thursday, 30 July 2026

Virtual Hearing

Name of Registrant:	**Gillian Graham**
NMC PIN:	87Y0052S
Part(s) of the register:	Registered Nurse, Sub Part 1 RN1: Adult nurse, level 1 (16 March 1990) Specialist Community Public Health Nurse RHV: Health visitor (27 June 2003) Registered Midwife (26 November 1992) V100: Community Practitioner Nurse Prescriber (27 June 2003)
Relevant Location:	Fife
Type of case:	Misconduct
Panel members:	Oluwasola Falola (Chair, registrant member) Juliana Thompson (Registrant member) Norah Christie (Lay member)
Legal Assessor:	Tracy Ayling KC
Hearings Coordinator:	Clara Federizo
Nursing and Midwifery Council:	Represented by Nawazish Choudhury, Case Presenter
Ms Graham:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7.1, 8, 9 and 10
Facts not proved:	Charge 7.2
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Graham was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 9 June 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Graham'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 Ms Graham has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Graham

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

Mr Choudhury referred the panel to the email from Ms Graham dated 9 June 2026, which stated:

> *"…I shall not be attending this. I have already stressed I won't be attending any conferences etc. I have not worked for the NHS for 7 years and certainly don't wish to do so again."*

Mr Choudhury submitted that Ms Graham had clearly communicated that she does not wish to engage 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. He also submitted that there is a public interest in proceeding as these matters go back to incidents back in 2017 through to 2020. He noted there are two witnesses due to give evidence who had scheduled time off work, and if the matter were adjourned, their ability to recall events may fade with time. He submitted that in these circumstances, Ms Graham had voluntarily absented herself from these proceedings and it is in the interest of justice for this hearing to go ahead.

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 (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Graham. In reaching this decision, the panel has considered the submissions of Mr Choudhury, the email from Ms Graham, 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 Ms Graham;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Ms Graham is aware that this hearing is taking place as she replied to the Notice of Hearing and has informed the NMC that she does not wish to attend;

- The panel noted Ms Graham has expressed on multiple occasions that she does not wish to engage with these proceedings or work as a nurse in the future;
- Two witnesses are due to attend to give live evidence, and not proceeding may inconvenience the witnesses and any employer;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- The charges relate to events that occurred in 2017; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Graham in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, 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 allowances 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 Ms Graham's decision to absent herself from the hearing, waive her right to attend, and/or be represented, and not to 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 Ms Graham. The panel will draw no adverse inference from Ms Graham's absence in its findings of fact.

Decision and reasons on application to amend the charges

The panel heard an application made by Mr Choudhury, on behalf of the NMC, to amend the wording of charges 6.2.1, 8.1.1, 8.1.9, 8.2.3 and 9.1.1.

Mr Choudhury submitted that the proposed amendments were simply stylistic and were to correct typographical errors within the charges. He submitted that the amendments do not change the substance of the charges and would not cause any prejudice to Ms Graham.

"That you a registered nurse:

[…]

6 In relation to family 5:

[…]

6.2 Knowing that the child of the family was vulnerable / living in vulnerable circumstances:

6.2.1 Failed to **complete** ~~be completed~~ a wellbeing assessment with an analysis of risk ~~had~~ until June 2019.

[…]

[…]

8 In relation to family 13:

8.1 Failed to store / file the following documentation in a manner that was accessible:

8.1.1 ~~Integral~~ **Interagency** referral discussion dated 11.6.2018.

[…]

8.1.9 ~~Ack~~ **Acknowledgement** for referral letter dated 12.8.2019.

[…]

8.2.3 Failed to ~~updated~~ **update** the children's chronologies.

[…]

9 In relation to family 22:

9.1 Knowing that the child was vulnerable:

9.1.1 Failed to attend a nursery meeting, or file the ~~minute~~ **minutes** of that meeting in the Child Health Record.

[…]

And in light of the above your fitness to practise is impaired by reason of your misconduct."

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

The panel was of the view that such amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Graham and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments to ensure clarity and accuracy.

Details of charge (as amended)

That you a registered nurse:

1. On one or more occasions from 1 January 2017 to 31 March 2018, declared inaccurate mileage when submitting your travel expenses.

2. Your actions in charge 1 were dishonest because:

   2.1 By claiming inaccurate mileage you were aware that you could be overpaid for such expenses claimed, and/or

   2.2 By claiming inaccurate mileage you knew that there was a possibility that those assessing your expenses could be misled into believing that you had claimed the correct mileage when you knew that you had not.

3. On a date unknown when Colleague A enquired about your visit to the Nursery/Nurseries, incorrectly declared, *'everything was fine, It went well',* or words to that effect.

4. Your declaration in charge 3 was dishonest because you were attempting to mislead Colleague A into believing that you had attended the visit/s when you knew that you had not.

5. In relation to family 4:

   5.1 Failed to store / file the following documentation in a manner that was accessible:

      5.1.1 A&E Discharge Summary dated 27.9.2018.

      5.1.2 IRD Request Form dated 12.6.2018.

      5.1.3 Interagency referral discussion dated 25.09.2018.

      5.1.4 Interagency referral document 25/09/2018.

      5.1.5 De-registration core group meeting invite letter dated 2.10.2018.

      5.1.6 Child Protection Message confirmation dated 1.10.2018.

      5.1.7 Interagency referral discussion dated 21.12.2018.

      5.1.8 Letter from Education and Children's Services dated 4.10.2019.

   5.2 Knowing that the child of the family was vulnerable / living in vulnerable circumstances:

      5.2.1 Failed to document a wellbeing assessment using SHANARRI indicators providing an analysis of risk.

5.2.2 Failed to maintain contact with the family knowing the history of risks associated with the family.

5.2.3 Failed to follow up with Leven Colleagues leaving the child at risk.

5.2.4 Failed to follow the pathway for the child / family.

6. In relation to family 5:

6.1 Failed to store / file the following documentation in a manner that was accessible:

6.1.1 Discharge summary dated 4.11.2018.

6.1.2 Email from Team Leader undated.

6.1.3 Medical Report dated 5.11.2018.

6.1.4 Initial child protection case conference dated 12.12.2018.

6.1.5 Invite letter to child wellbeing meeting dated 13.6.2019.

6.1.6 Review meeting minutes dated 11.2.2019.

6.1.7 Child's plan dated 12.12.2018.

6.2 Knowing that the child of the family was vulnerable / living in vulnerable circumstances:

6.2.1 Failed to complete a wellbeing assessment with an analysis of risk until June 2019.

6.2.2 Failed to document information within the chronology since August 2019, and

6.2.3 Failed to document any visits that took place between February 2019 and May 2019.

7. In relation to family 6:

7.1 Failed to store / file the following documentation in a manner that was accessible:

7.1.1 Concern report police dated 8.7.2018.

7.1.2 Concern report police dated 1.1.2019.

7.2 Knowing that the children of the family were vulnerable / living in vulnerable circumstances:

7.2.1 Failed to assess the impact of an incident outlined in the police report on the children.

7.2.2 Failed to record one or more visits on the family.

7.2.3 Failed to keep the Child Health record updated.

8. In relation to family 13:

8.1 Failed to store / file the following documentation in a manner that was accessible:

8.1.1 Interagency referral discussion dated 11.6.2018.

8.1.2 IRD information request form dated 29.5.2019.

8.1.3 Childs plan undated.

8.1.4 IRD request form dated 11.6.2018.

8.1.5 IRD Summary dated 11.6.2018.

8.1.6 IRD info request from dated 29.5.2019.

8.1.7 Childs plan undated.

8.1.8 Letter from Pre-school community teams dated 12.8.2019.

8.1.9 Acknowledgement for referral letter dated 12.8.2019.

8.1.10 IRD information request dated 11.6.2018.

8.1.11 IRD Summary dated 11.5.2018.

8.1.12 IRD information request dated 29.5.2019

8.2 Knowing that the children of the family were vulnerable / living in vulnerable circumstances:

8.2.1 Failed to document a wellbeing assessment using SHANARRI indicators providing an analysis of risk with any of the children.

8.2.2 Failed to action to IRD's appropriately.

8.2.3 Failed to update the children's chronologies.

8.2.4 Having undertaken a visit to the home only recorded findings within Child B's record.

8.2.5 Failed to complete the 13 – 15 month check on Child B.

8.2.6 Failed complete the 27 – 30 month development check on either Child C, or Child D.

9. In relation to family 22:

9.1 Knowing that the child was vulnerable:

9.1.1 Failed to attend a nursery meeting, or file the minutes of that meeting in the Child Health Record.

9.1.2 Failed to undertake monthly visits in line with the agreed care plan.

9.1.3 Failed to document or evidence that the CWP was being followed.

9.1.4 Failed to document or evidence that a wellbeing assessment had been carried out using the SHANARRI indictors.

10. In relation to family 48:

10.1 Knowing that the child was vulnerable:

10.1.1 Failed to update the child's chronology.

10.1.2 Failed to document two home visits to the child in the Child Health Record.

10.1.3 Failed to document or evidence that a wellbeing assessment had been carried out using the SHANARRI indictors.

And in light of the above your fitness to practise is impaired by reason of your misconduct

Background

The charges arose whilst Ms Graham was working as a Health Visitor for NHS Fife.

The NMC received a referral on 27 November 2019 from NHS Fife raising concerns regarding Ms Graham's practice. It was alleged that Ms Graham fraudulently claimed travel mileage for a total sum of £768.43 (£1059.15 after removing the frequent unnecessary and unusual return journeys back to the office (base) rather than travelling directly from one call visit to another, especially when the visits were in the same area).

During the course of the NMC investigation into the above allegation, NHS Fife informed the NMC of further concerns relating to Ms Graham's clinical practice. It was alleged that whilst on suspension, NHS Fife found documents relating to children of families assigned to Ms Graham in her desk drawer. Six of these children were identified as being left at considerable risk of harm by the unfiled or non-actioned documents. The children were also on stage 2 child wellbeing pathways and required contemporaneous input from all agencies involved to fully risk assess and plan for their wellbeing:

• Family 4 – Ms Graham allegedly reported in the child health record a significant incident where this child was subject to harm and a plan to visit the family, but no record that this visit or further visits took place.

• Family 5 – The multi-agency child plan included minimum of monthly visits by named person Ms Graham to have a good understanding of the home life and to report areas of concern to the other agencies involved. This was allegedly not recorded on the chronology and no record of any visits between February and May 2019 were recorded.

• Family 6 – A police concern report that children were present during a violent incident in the home was found in the desk drawer, however, Ms Graham allegedly failed to note this in the child health record.

• Family 13 – Number of significant concerns relating to each child in this family, but there was no evidence of wellbeing assessments to inform a full analysis of risk with any of the children. Despite being aware of a catalogue of violent incidents in the home, there were few records of visits to the family and findings were consistently positive with no identification of areas of concern.

• Family 22 – Allegedly failed to carry out planned monthly visits as per care plan despite levels of concern and neglect identified. No wellbeing assessment to inform analysis of risk, plan, assess and identify needs, risks, strengths and protective factors.

• Family 48 – No evidence of wellbeing assessment to inform analysis of risk, plan, assess and identify needs, risks, strengths and protective factors. This child was at significant risk of abuse and neglect living in a household with evidence of frequent incidents of violence, parental alcohol and substance abuse. Police concerns identify an unsafe high risk home environment which Ms Graham allegedly failed to assess or monitor the impact on the child.

Ms Graham was dismissed from employment with the Trust in March 2020 and has not worked in a clinical role since. Ms Graham informed the NMC that she has no intention to work as a Nurse or Health Visitor again.

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

Mr Choudhury made a request that this case be held partly in private on the basis that proper exploration of Ms Graham's case involves reference to Ms Graham's [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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

The panel determined to go into private session in connection with Ms Graham's [PRIVATE], as and when such issues are raised, in order to protect her privacy and confidentiality in these proceedings.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Choudhury under Rule 31 to allow the two local interview records to be admitted as hearsay evidence, namely, the interview of Ms Lynn Reid dated 6 January 2020, and the interview of Ms Judith Gemmell dated 3 January 2020. He submitted that both interviews were relevant as these provided a background and contextual evidence regarding the training and claiming of expenses, and that these were not sole or decisive evidence to charges in which they relate, namely Charges 1 and 2.

Mr Choudhury referred the panel to the principles set out in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). He submitted that the interviews were not the sole or decisive evidence in support of the charges as the panel also had before it, Ms Sally O'Brien's detailed investigation report, together with extensive appendices and spreadsheets. He further submitted that, to his knowledge, Ms Graham had not specifically challenged the contents of either local interview, despite having received them prior to this hearing.

Mr Choudhury also submitted that there was no suggestion either Ms Reid or Ms Gemmell had any reason to fabricate their evidence. While Ms Graham had alleged that another individual, Mrs Sandra Patterson, had bullied her, no similar allegation had been made against Ms Reid or Ms Gemmell, whose interviews appeared to have been conducted as part of a routine local investigation.

Mr Choudhury accepted that the allegations were serious, involving alleged dishonesty of a financial nature. He also acknowledged that he could provide no explanation for Ms Reid and Ms Gemmell's absence, could not say whether the NMC had taken reasonable steps to secure their attendance, and had no information to suggest that Ms Graham had prior notice that a hearsay application would be made to adduce the interviews as hearsay evidence.

Despite those concessions, Mr Choudhury submitted that admitting the documents would not be unfair or prejudicial to Ms Graham. He emphasised that the interviews were brief and limited to background matters. He submitted that these should therefore be admitted, and that the weight the panel gives to such evidence is ultimately a matter for it at a later stage.

The panel heard and accepted the advice of the legal assessor, who referred it to the relevant case law including: *Ogbonna v Nursing and Midwifery Council* [2010] EWCA Civ 1216, *Bonhoeffer v General Medical Council* [2011] EWHC 1585 (Admin), *R v Horncastle* [2009] UKSC and *Thorneycroft.*

In reaching its decision, the panel considered the factors identified in *Thorneycroft*:

> "*i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
> *(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.*"

The panel accepted the submissions of Mr Choudhury and determined that the two local interview records were not the sole or decisive evidence in support of the allegations. It noted that the allegations were supported by extensive contemporaneous records, including investigation reports, interview notes, expense claim records, payroll and mileage records, chronologies, clinical records and child protection documentation.

The panel also noted that there was no challenge from Ms Graham as to the contents of the interview statements. It noted that Ms Graham had not engaged with the NMC proceedings despite having been provided with the hearing bundle prior to this hearing. The panel was satisfied that she therefore had the opportunity to review and challenge the documents.

The panel also found no basis for concluding that either Ms Reid or Ms Gemmell had any motive to fabricate their evidence. It noted that, whilst Ms Graham had previously alleged bullying by other managers, she had made no such allegations against Ms Reid or Ms Gemmell.

The panel accepted that the allegations were serious, particularly as these include dishonesty, but it concluded that admitting the local interview records as hearsay would not cause unfairness or prejudice because they were limited to background matters and were not relied upon as the principal evidence against Ms Graham.

The panel further acknowledged that the NMC had provided no explanation for the witnesses' absence and no evidence of steps taken to secure their attendance. However, it considered that these factors carried less weight given the nature of the evidence.

Further, the panel also considered the documentary nature of the NMC's case. It considered that the majority of the allegations concerned documentary processes, record keeping and expense claims, which could largely be assessed by reference to the underlying records themselves rather than the oral recollection of witnesses.

Having had regard to each of the above factors, the panel was satisfied that the two local interviews were relevant to the charges, specifically Charges 1 and 2, because they provided background and contextual information about the processes for claiming mileage and expenses.

The panel then considered whether Ms Graham would be disadvantaged by allowing the hearsay evidence of Ms Reid and Ms Gemmell, who were not attending the hearing to give oral evidence before the panel.

The panel considered that as Ms Graham had been provided with a copy of the two local interviews of Ms Reid and Ms Gemmell held in January 2020 prior to this hearing. As the panel had already determined that Ms Graham had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel also considered that there was a strong public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be fair and relevant to accept the local interview of Ms Reid dated 6 January 2020 and the local interview of Ms Gemmell dated 3 January 2020 into evidence, but the panel would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it. Accordingly, the panel granted the hearsay application.

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 Choudhury on behalf of the NMC.

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

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:

- Ms Sally O'Brien: At the time of the concerns, was employed by NHS Fife Trust as the Lead Nurse for the Family Nurse Partnership and as the Deputy Senior Manager for Community Children's Services;

- Mrs Sandra Paterson: At the time of the concerns, was employed by NHS Fife Trust as a Band 7 Team Leader for the Health Visiting Service.

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 both the NMC and Ms Graham.

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

Charge 1

1. "On one or more occasions from 1 January 2017 to 31 March 2018, declared inaccurate mileage when submitting your travel expenses."

This charge is found proved.

In reaching its decision, the panel relied on all the documentary evidence before it, the written and oral evidence of Ms O'Brien, and Ms Graham's own admissions. The panel had regard to Ms O'Brien's witness statement dated 13 May 2025 and the exhibits relating to milage claims and calculations, which explained the methodology used in the mileage claim investigation.

The panel accepted that the investigation into the mileage claims was thorough and reliable. In Ms O'Brien's oral evidence before the panel, she confirmed that the mileage claims had been checked against Ms Graham's diary entries, clinical records, and child files to identify visit locations, with distances recalculated using Google Maps. She confirmed to the panel that the 'E-expenses claims recalculated for actual mileage' document *"showed that Gillian had incorrectly calculated the mileage for most of the journeys she made and claimed for."* The panel considered this to be a robust methodology for verifying the accuracy of the claims.

The panel noted evidence that some claimed journeys could not be corroborated because there were no corresponding diary or clinical record entries. It also accepted evidence that Ms Graham had regularly claimed unnecessary return-to-base mileage which was not supported by her working practices.

The panel found Ms O'Brien to be a credible witness with no reason to fabricate her evidence and noted that her testimony was supported by contemporaneous documentation rather than recollection alone. The panel found that this was a robust investigation.

The panel placed significant weight on Ms Graham's own admissions. During the Trust's investigation, she accepted that her mileage claims were *"not always accurate"*, explaining that she guessed street names, addresses and mileage estimates. In her written response, she further admitted that she had developed *"a habit of estimating mileage"* and entering incorrect addresses for convenience because she struggled to submit her claims on time, routinely entering up to three months' worth of claims at the same time.

The panel had regard to Ms Graham's statement dated 18 October 2023, which stated:

> *"I want to explain that I certainly did not intend to exaggerate any work mileage between 2018 and 2019. At this time I was under intense pressure at work due to my workload and staff shortage…As I struggled to submit my monthly mileage on time I stupidly got into the habit of estimating my mileage and putting*

in wrong addresses for quickness. [PRIVATE] I did manage to visit many but then forgot to write up my records. Many families were seen but it appeared they weren't. I actually underestimated my mileage at times."

Taking the documentary evidence, the investigation findings and Ms Graham's admissions together, the panel was satisfied, on the balance of probabilities, that Ms Graham had more likely than not submitted inaccurate mileage claims between 1 January 2017 and 31 March 2018.

Accordingly, the panel found Charge 1 proved.

Charge 2

2. "Your actions in charge 1 were dishonest because:

   2.1 By claiming inaccurate mileage you were aware that you could be overpaid for such expenses claimed, and/or

   2.2 By claiming inaccurate mileage you knew that there was a possibility that those assessing your expenses could be misled into believing that you had claimed the correct mileage when you knew that you had not."

This charge is found proved in its entirety.

The panel considered the charges together because the evidence relevant to both charges was the same. The panel had regard to documentary evidence before it, the written and oral evidence of Ms O'Brien and Ms Patterson, and Ms Graham's own admissions.

In relation to Charge 2.1, the panel was satisfied that Ms Graham was aware that submitting inaccurate mileage claims could result in her being overpaid. Having found Charge 1 proved, the panel was satisfied that the inaccuracies were not isolated errors but formed part of a repeated pattern of overclaiming. The panel concluded that Ms

Graham was aware that submitting inaccurate mileage claims created the possibility that she would receive payment to which she was not entitled.

The panel attached significant weight to the electronic declaration completed with every expense claim:

> *"I declare that the information I have given is correct and complete…*
>
> *I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings."*

The panel was satisfied that the above declaration required employees to confirm that the information provided was accurate. It considered that Ms Graham could not have submitted her claims without acknowledging this declaration and therefore understood the consequences of providing inaccurate information.

The panel relied on Ms Graham's admissions that she knowingly entered estimated mileage. Whilst the panel noted there was evidence that Ms Graham occasionally underclaimed mileage, it concluded that this did not undermine the evidence of repeated and significant overclaiming. The panel also noted that Ms Graham's mileage claims became accurate during the period in which she was subject to enhanced monitoring, which showed that she was capable of submitting accurate claims when she chose to do so. Therefore, taken together, Ms Graham's actions appeared to be indicative that the inaccurate claims were, more likely than not, deliberate and that she was aware that she could be overpaid for such expenses claimed.

In relation to Charge 2.2, the panel considered that the same evidence established that Ms Graham knew there was a possibility that those assessing her expenses would be misled into believing the claims were accurate. The panel found it difficult to reconcile the deliberate use of false addresses and estimated mileage with an innocent explanation. It concluded that, by certifying the accuracy of her claims while knowingly submitting incorrect information, Ms Graham intended those processing the claims to accept them as genuine.

Taking the evidence as a whole and on the balance of probabilities, the panel found that it was more likely than not that Ms Graham knowingly submitted inaccurate mileage claims, understood that this could lead to overpayment, and knew that those authorising the claims could be misled.

Accordingly, the panel found Charge 2 proved in its entirety.

Charge 3

3. "On a date unknown when Colleague A enquired about your visit to the Nursery/Nurseries, incorrectly declared, *'everything was fine, It went well',* or words to that effect."

This charge is found proved.

The panel considered the statement of Ms Patterson (Colleague A), dated 8 May 2025:

> *"22. I am unable to recall the date but there was also one morning when Gillian informed me that she was leaving base to go visit a Nursery then onto home visit…*
>
> *23. A while after Gillian left to visit the Nursery, I was alerted that something was not right after a parent had telephoned the Surgery and asked whether Gillian was still visiting the child for their appointment because she had not turned up at the scheduled time. I cannot recall the name of the patient, but I believe that their appointment was due to take place after Gillian's visit to the Nursery…*
>
> *24. When I tried to telephone Gillian, the calls went straight through to voicemail. This then became a safeguarding issue, and our policy is to look at the last known whereabouts of the staff member to ensure their safety. In this instance, I contacted the two local Nurseries that Gillian could have visited to determine whether she was still there and possibly running late with her*

appointments. However, both Nurseries confirmed that Gillian did not have any appointments scheduled to take place that day.

25. When Gillian finally returned to base, I spoke to her in a private room away from the other staff and asked her how the meeting with the Nursery went. Gillian indicated that the meeting had gone well…I am unable to recall specifics of the conversation, but I believe that Gillian said words to the effect of "everything was fine. It went well". Gillian said that she managed to visit the parent who had telephoned earlier that day querying her whereabouts…

26. I waited for the meeting to finish before I had a further private conversation with Gillian regarding the events that had happened. I informed Gillian that I had contacted the Nurseries, and they told me that there were no meetings scheduled to take place that day. It was at this point that Gillian admitted she'd been dishonest. When I asked Gillian where she had been all morning, she was unable to offer any explanation…"

During her oral evidence, Ms Patterson was asked what she meant by *"Gillian admitted she was being dishonest"*. She told the panel words to the effect of *"she didn't go to the nurseries at all, she didn't have anything scheduled".*

The panel also had regard to Ms Graham's account of the events. However, it was not persuaded by her later explanation that she had attended on the wrong day, as this did not accord with her initial response when specifically asked how the visit had gone and there was no documentary evidence of a visit logged in her diary.

The panel preferred the evidence of Ms Patterson, which it found to be consistent in her oral evidence, credible and supported by contemporaneous documentation. The panel accepted Ms Patterson's evidence that Ms Graham declared *"everything was fine, it went well"* or words to that effect. The panel was satisfied, on the balance of probabilities, that it was more likely than not that Ms Graham's statement was incorrect as she had not attended the visit.

Accordingly, the panel found Charge 3 proved.

Charge 4

4. “Your declaration in charge 3 was dishonest because you were attempting to mislead Colleague A into believing that you had attended the visit/s when you knew that you had not.”

This charge is found proved.

In considering dishonesty, the panel had regard to the NMC Guidance on *‘Making decisions on dishonesty charges and the professional duty of candour’* (Reference: DMA-8, Last Updated 06/05/2025) and the relevant caselaw it was referred to.

The panel had regard to the evidence it considered in Charge 3. In particular, it considered Ms Patterson’s evidence that Ms Graham had later admitted being dishonest:

> “*I informed Gillian that I had contacted the Nurseries, and they told me that there were no meetings scheduled to take place that day. It was at this point that Gillian admitted she’d been dishonest. When I asked Gillian where she had been all morning, she was unable to offer any explanation…”*

The panel was satisfied that Ms Graham knew she had not attended the nursery visit yet initially deliberately gave the impression that she had. The panel concluded that she intended to mislead her colleague and that ordinary, reasonable members of the public would regard such conduct as dishonest.

Accordingly, the panel found Charge 4 proved.

Charges 5.1 (5.1.1 to 5.1.8)

5. “In relation to family 4:

5.1 Failed to store / file the following documentation in a manner that was accessible:

5.1.1 A&E Discharge Summary dated 27.9.2018.

5.1.2 IRD Request Form dated 12.6.2018.

5.1.3 Interagency referral discussion dated 25.09.2018.

5.1.4 Interagency referral document 25/09/2018.

5.1.5 De-registration core group meeting invite letter dated 2.10.2018.

5.1.6 Child Protection Message confirmation dated 1.10.2018.

5.1.7 Interagency referral discussion dated 21.12.2018.

5.1.8 Letter from Education and Children's Services dated 4.10.2019."

This charge is found proved.

The panel first considered Charge 5.1 and the relevant particulars. In reaching its decision, the panel had regard to the documentary evidence before it, including the list of documents found in drawer, Ms Graham's interview notes on 31 December 2019, Records of care, Child Wellbeing Pathway, GIRFEC Framework and Document Review in relation to Family 4, as well as Ms O'Brien's written and oral evidence.

The panel accepted Ms O'Brien's evidence regarding the in-depth review of Ms Graham's case records and the documents discovered in her desk drawer. It considered that Ms O'Brien's Document Review included a detailed table for each document type, outlining whether this was found in Ms Graham's desk drawer, what the concern was and how Ms Graham dealt with it, what Ms Graham should have done and whether there was any harm or risk of harm caused to the family due to Ms

Graham's lack of appropriate action in line with her role as the named Health Visitor for the families.

The panel was satisfied that the documents listed in Charges 5.1.1 to 5.1.8 should have been stored within the relevant child health records so that they were accessible to those involved in the child's care. It accepted that the documents had remained unfiled for significant periods, in some instances many months. It therefore concluded that Ms Graham had failed to store or file the documentation in an accessible manner.

Accordingly, Charge 5.1 (5.1.1 to 5.1.8) was found proved.

Charge 5.2 (5.2.1 to 5.2.4)

5. "In relation to family 4:

    5.2 Knowing that the child of the family was vulnerable / living in vulnerable circumstances:

        5.2.1 Failed to document a wellbeing assessment using SHANARRI indicators providing an analysis of risk.

        5.2.2 Failed to maintain contact with the family knowing the history of risks associated with the family.

        5.2.3 Failed to follow up with Leven Colleagues leaving the child at risk.

        5.2.4 Failed to follow the pathway for the child / family."

This charge is found proved.

In relation to Charge 5.2, the panel was satisfied that Ms Graham knew the child was vulnerable, given that she was the named Health Visitor for the family and responsible for assessing and coordinating their health and care needs. As such, she was aware

of the significant safeguarding concerns, police involvement and multi-agency referrals recorded within the case.

The panel had regard to the documentary evidence before it, including the chronology, care plans and safeguarding records. The panel accepted the evidence of Ms O'Brien, who had undertaken an in-depth document review of each of the families. The panel found that there was no documented SHANARRI wellbeing assessment or recorded analysis of risk, despite the expectation that one should have been completed. It further found that Ms Graham failed to maintain appropriate contact with the family, failed to follow up concerns with colleagues and failed to follow the agreed pathway for the child and family.

Accordingly, Charge 5.2 (5.2.1 to 5.2.4) was found proved.

Charge 6

6. "In relation to family 5:

    6.1 Failed to store / file the following documentation in a manner that was accessible:

        6.1.1 Discharge summary dated 4.11.2018.

        6.1.2 Email from Team Leader undated.

        6.1.3 Medical Report dated 5.11.2018.

        6.1.4 Initial child protection case conference dated 12.12.2018.

        6.1.5 Invite letter to child wellbeing meeting dated 13.6.2019.

        6.1.6 Review meeting minutes dated 11.2.2019.

        6.1.7 Child's plan dated 12.12.2018.

6.2 Knowing that the child of the family was vulnerable / living in vulnerable circumstances:

6.2.1 Failed to complete a wellbeing assessment with an analysis of risk until June 2019.

6.2.2 Failed to document information within the chronology since August 2019, and

6.2.3 Failed to document any visits that took place between February 2019 and May 2019."

This charge is found proved in its entirety.

For the reasons already given in relation to Charge 5.1, the panel found Charge 6.1 proved in its entirety. It had regard to the documentary evidence before it, including the Document Review in relation to Family 5, as well as Ms O'Brien's written and oral evidence. The panel determined that, on the balance of probabilities, the documents identified in the charge had not been appropriately stored within the child's health records and remained inaccessible to those requiring them.

In relation to Charge 6.2, the panel was satisfied that Ms Graham knew the child was vulnerable given that she was the named Health Visitor for the family and responsible for assessing and coordinating their health and care needs. Ms O'Brien stated in her witness evidence dated 9 October 2023:

> *"25. Family 4 – Gillian reported in the child health record a significant incident where this child was subject to harm and a plan to visit the family but no record that this visit or further visits took place and when Gillian was suspended and the case was reallocated significant events such as violence witnessed by the child, had occurred in the intervening period."*

The panel had regard to the contemporaneous documentary evidence which supported this account. It accepted the evidence from Ms O'Brien that *"despite knowing the history of this child and significant risks associated with his welfare [Ms Graham] failed to maintain contact or follow up with Leven Colleagues which has left this child at risk",* there was *"no record of a wellbeing assessment using SHANARRI indicator to inform analysis of risk"* and *"documents not filled or followed up and not consistently recorded in chronology".*

The panel considered these omissions to be well supported by the documentary evidence reviewed by Ms O'Brien. Therefore, on the balance of probabilities, the panel found that it was more likely than not that Ms Graham failed to complete a wellbeing assessment with an appropriate analysis of risk, as there is no record of this until June 2019. It further found that Ms Graham failed to maintain an accurate chronology and failed to document visits undertaken between February and May 2019.

Accordingly, Charge 6 was found proved in its entirety.

Charge 7.1

7. "In relation to family 6:

    7.1 Failed to store / file the following documentation in a manner that was accessible:

        7.1.1 Concern report police dated 8.7.2018.

        7.1.2 Concern report police dated 1.1.2019."

This charge is found proved.

Following the same evidence and reasoning provided for Charge 5.1, the panel was satisfied that the police concern reports identified in the charge had not been stored appropriately. The panel determined that, on the balance of probabilities, Ms Graham failed in her duty to appropriately store the reports within the child's health records,

and therefore as they were in Ms Graham's desk drawer, they were more likely than not inaccessible to those requiring them.

Accordingly, the panel finds Charge 7.1 proved.

Charge 7.2

7. “In relation to family 6:

   7.2 Knowing that the children of the family were vulnerable / living in vulnerable circumstances:

      7.2.1 Failed to assess the impact of an incident outlined in the police report on the children.

      7.2.2 Failed to record one or more visits on the family.

      7.2.3 Failed to keep the Child Health record updated.”

This charge is found NOT proved.

Whilst the panel acknowledged that there was evidence of safeguarding concerns relating to Family 6, the panel was not satisfied, on the balance of probabilities, that Ms Graham was the named Health Visitor responsible for the family during the relevant period. It found that the documentary evidence did not clearly establish Ms Graham’s responsibility, and it noted that Ms O'Brien accepted during her oral evidence that she could not be certain on this point.

In the absence of sufficiently reliable evidence establishing Ms Graham's responsibility for the family at the relevant time, the panel could not be satisfied that the NMC had met the burden of proof in relation to this charge.

Accordingly, the panel found Charge 7.2 (7.2.1, 7.2.2 and 7.2.3) not proved.

Charge 8

8. “In relation to family 13:

8.1 Failed to store / file the following documentation in a manner that was accessible:

8.1.1 Interagency referral discussion dated 11.6.2018.

8.1.2 IRD information request form dated 29.5.2019.

8.1.3 Childs plan undated.

8.1.4 IRD request form dated 11.6.2018.

8.1.5 IRD Summary dated 11.6.2018.

8.1.6 IRD info request from dated 29.5.2019.

8.1.7 Childs plan undated.

8.1.8 Letter from Pre-school community teams dated 12.8.2019.

8.1.9 Acknowledgement for referral letter dated 12.8.2019.

8.1.10 IRD information request dated 11.6.2018.

8.1.11 IRD Summary dated 11.5.2018.

8.1.12 IRD information request dated 29.5.2019

8.2 Knowing that the children of the family were vulnerable / living in vulnerable circumstances:

8.2.1 Failed to document a wellbeing assessment using SHANARRI indicators providing an analysis of risk with any of the children.

8.2.2 Failed to action to IRD's appropriately.

8.2.3 Failed to update the children's chronologies.

8.2.4 Having undertaken a visit to the home only recorded findings within Child B's record.

8.2.5 Failed to complete the 13 – 15 month check on Child B.

8.2.6 Failed complete the 27 – 30 month development check on either Child C, or Child D."

This charge is found proved in its entirety.

The panel found Charge 8.1 proved in its entirety for the same reasons set out in relation to Charges 5.1 and 6.1. It accepted that the documents identified in the charge had not been stored appropriately within the child health records.

In relation to Charge 8.2, the panel was satisfied that Ms Graham knew that the child was vulnerable given that she was the named Health Visitor for the family and responsible for assessing and coordinating their health and care needs. The panel had regard to the statement of Ms O'Brien which outlined the concerns relating to this child:

> *"28. Family 13 – Number of significant concerns related to each child in this family, no evidence of wellbeing assessments to inform a full analysis of risk with any of the children. Despite being aware of a catalogue of violent incidents in the home there are few records of visits to the family her findings were consistently positive with no identification of areas of concern."*

The panel had regard to the documentary evidence before it which established the duties expected of Ms Graham in dealing with a vulnerable child. It had regard to the Child Wellbeing Pathway and GIRFEC Framework, as well as the Document Review completed by Ms O'Brien where she outlines what was expected of Ms Graham in that situation.

The panel accepted that there was no evidence that Ms Graham completed SHANARRI wellbeing assessments or documented analyses of risk for the children. The panel found that Ms O'Brien's account was supported by extensive documentary evidence, including safeguarding records, care plans and chronology entries. It was therefore satisfied, on the balance of probabilities, that Ms Graham failed to action interagency referral discussions appropriately, failed to maintain the children's chronologies, recorded findings only within one child's records despite undertaking a family visit, and failed to complete the required developmental reviews.

Accordingly, the panel found Charge 8 proved in its entirety.

Charge 9

9. "In relation to family 22:

    9.1 Knowing that the child was vulnerable:

        9.1.1 Failed to attend a nursery meeting or file the minutes of that meeting in the Child Health Record.

        9.1.2 Failed to undertake monthly visits in line with the agreed care plan.

        9.1.3 Failed to document or evidence that the CWP was being followed.

        9.1.4 Failed to document or evidence that a wellbeing assessment had been carried out using the SHANARRI indictors."

This charge is found proved.

In reaching this decision, the panel had regard to all the documentary evidence before it. The panel had regard to Ms O'Brien's concerns in relation to this child as outlined in her witness statement:

> *"Family 22 –Failed to carry out planned monthly visits as per care plan despite levels of concern and neglect identified. No wellbeing assessment to inform analysis of risk, plan assess and identify needs, risks, strengths and protective factors."*

The panel had regard to Ms Graham responses in her interviews in 2019 and was satisfied that Ms Graham knew the child was vulnerable.

The panel also considered Child Wellbeing Pathway and GIRFEC Framework which outline Ms Graham's duties. It also considered the Document Review with questions on Family 48, where Ms O'Brien details the concerns and what was expected of Ms Graham in that situation:

> *"a.GG management of this case as the named person, she did not provide support to the family by visiting monthly as agreed. She did not attend review meeting despite high level of concerns about risk of parental physical, emotional abuse and neglect identified. b. As named person attend meetings arrange to assess and review child wellbeing, record findings and plan in child health record."*

The panel accepted Ms O'Brien's evidence. It was satisfied that Ms Graham had a duty but failed to attend the nursery meeting or file the meeting minutes within the child health record, and that, on the balance of probabilities, Ms Graham failed to undertake monthly visits in accordance with the agreed care plan, failed to document or evidence compliance with the Child's Plan, and failed to document a wellbeing assessment using the SHANARRI indicators.

Accordingly, the panel found Charge 9 proved in its entirety.

Charge 10

10. "In relation to family 48:

10.1 Knowing that the child was vulnerable:

10.1.1 Failed to update the child's chronology.

10.1.2 Failed to document two home visits to the child in the Child Health Record.

10.1.3 Failed to document or evidence that a wellbeing assessment had been carried out using the SHANARRI indictors."

This charge is found proved.

In relation to Charge 10, the panel was satisfied that Ms Graham knew the child was vulnerable given that she was the named Health Visitor for the family and responsible for assessing and coordinating their health and care needs.

In reaching this decision, the panel had regard to all the documentary evidence before it, in particular Ms Graham's interview notes in 2019, the Document Review with questions on Family 48, Child Wellbeing Pathway and GIRFEC Framework. The panel also had regard to Ms O'Brien's statement in relation to this child:

> *"Family 48 – Raft of concerning documents found in desk drawer unfiled in child health record, report submitted by Gillian for case conference but no record of any visits to the family to inform the report. No evidence of wellbeing assessment to inform analysis of risk, plan assess and identify needs, risks, strengths and protective factors. This child was at significant risk of abuse and neglect living in a household with evidence of frequent incidents of violence, parental alcohol and substance abuse. Police concerns identify unsafe high risk home environment which Gillian failed to assess or monitor the impact on the child."*

The panel considered the documentary evidence to be compelling and accepted the explanations provided by Ms O'Brien regarding the chronology and missing records.

The panel accepted the evidence that Ms Graham failed to maintain the child's chronology, failed to document two home visits that were said to have informed a case conference report, and failed to record any SHANARRI wellbeing assessment despite the child being subject to significant safeguarding concerns.

Accordingly, the panel found Charge 10 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Graham'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 safely and effectively without restriction.

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 serious misconduct. Secondly, only if the facts found proved amount to serious misconduct, the panel must decide whether, in all the circumstances, Ms Graham's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Choudhury invited the panel to take the view that the facts found proved, whether considered individually or cumulatively, amounted to serious misconduct because

they represented significant departures from the standards set out in the NMC Code. He referred the panel to the terms of *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) and identified the specific, relevant standards where Ms Graham's actions amounted to misconduct.

In relation to the record-keeping allegations, Mr Choudhury submitted that although Ms Graham had some records, she failed to store them appropriately, escalate concerns, and follow them up correctly. He submitted that this engaged section 10 of the Code, particularly the requirements to keep clear and accurate records, identify and record risks and ensure records are securely stored. He submitted that her failings to store records in the designated filing system and properly document safeguarding concerns relating to vulnerable children, meant that her colleagues did not have the information they required to protect the vulnerable children.

Mr Choudhury further submitted that section 20 of the Code was also engaged. He submitted that Ms Graham failed to uphold the standards and values of the profession, act with honesty and integrity, and serve as a professional role model. He relied particularly on the panel's findings of financial dishonesty and the finding that she falsely informed her managers that she had attended a nursery visit when she had not. He submitted that these were not trivial matters but went to the heart of the professional standards expected of registered nurses.

Submissions on impairment

Mr Choudhury then moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Choudhury reminded the panel that impairment should be assessed as at the date of the hearing, so is a current and forward-looking exercise. He submitted that Ms Graham could not currently practise safely because of the seriousness of the

breaches of the Code, which he submitted also breached fundamental tenets of the nursing profession.

Mr Choudhury submitted that all four limbs in the case of *Grant* were engaged. Although no child had suffered actual harm, he submitted that Ms Graham's failings had exposed vulnerable children to a significant risk of harm. He further submitted that Ms Graham's engagement with the proceedings were limited, and she had not provided any meaningful insight or reflection, no evidence of strengthened practice, and no references or testimonials. For these reasons, he submitted that there remained a high risk of repetition. Although Ms Graham stated that she no longer intended to practise as a nurse, Mr Choudhury submitted there was still a possibility she could change her mind, but there was no evidence before the panel in relation to her current circumstances or how she would respond differently if she were to face similar circumstances in the future.

Finally, Mr Choudhury submitted that a finding of impairment was also required in the public interest. He submitted that, having regard to the NMC's overarching objectives of protecting the public, public confidence in the profession and the regulatory process, these would be seriously undermined if the panel did not make a finding of current impairment in the circumstances of this case.

The panel accepted the advice of the legal assessor which included reference to the relevant judgments including: *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, and the case of *Grant.* The panel were also referred to the NMC Guidance on *'Misconduct'* (Reference: FtP-2a, Last Updated: 20/05/2026), *'Making decisions on dishonesty charges and the professional duty of candour'* (Reference: DMA-8, Last Updated: 06/05/2025) and *'Impairment'* (Reference: DMA-1, Last Updated: 28/01/2026).

Decision and reasons on misconduct

In coming to its decision, 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 had regard to the NMC guidance referred to and the terms of the Code.

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

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

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.5 respect and uphold people's human rights

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

To achieve this, you must:

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

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

8 Work cooperatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.4 take account of your own personal safety as well as the safety of people in your care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it concluded that Ms Graham's failings were sufficiently serious to amount to misconduct.

The panel found that Ms Graham knowingly submitted inaccurate mileage claims to make false expense claims. It considered that this conduct was not a mere administrative error but involved the deliberate submission of information she had known to be inaccurate for the purpose of financial/personal gain. The panel considered that honesty in financial matters is a fundamental professional obligation. It emphasised that public confidence in the nursing profession depends upon nurses acting with honesty and integrity at all times, including when making claims for expenses. Therefore, in knowingly submitting inaccurate mileage claims, Ms Graham breached the fundamental tenets of honesty and integrity and undermined public confidence in the professions. The panel concluded that Ms Graham's actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Further, the panel found that Ms Graham's repeated safeguarding and record-keeping failures were also a serious departure from the standards expected of a registered nurse. It noted that these failures occurred over a significant period and involved a number of families with vulnerable children entrusted to Ms Graham's care.

The panel found that Ms Graham failed to maintain chronologies and records that accurately reflected her professional involvement, failed to undertake or record wellbeing assessments, failed to complete or document agreed visits, failed to act upon multi-agency safeguarding information, and failed to store safeguarding records in an appropriate and accessible manner so that other professionals could readily obtain information necessary to safeguard the children concerned. The panel concluded that these repeated failures represented serious breaches of her professional duties and fell significantly below the standards expected of a registered nurse.

The panel concluded that these were not isolated or minor record-keeping errors. It was of the view that accurate records are fundamental to safeguarding practice because they ensure continuity of care, facilitate communication between colleagues and other health professionals and enable risks to be identified and managed appropriately. Ms Graham's repeated failures exposed vulnerable children, who were already known to safeguarding and child protection services, to an increased risk of harm and undermined safeguarding arrangements.

Accordingly, the panel found that Ms Graham's conduct represented serious departures from the standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *‘Impairment’* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to act professionally, honestly and with integrity. 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 found all four limbs in *Grant,* as set out above, were engaged in this case. The panel determined that Ms Graham had placed vulnerable children at an unwarranted risk of harm through her repeated safeguarding failures, inadequate record keeping and failure to appropriately follow safeguarding procedures.

The panel further concluded that Ms Graham had brought the nursing profession into disrepute by acting dishonestly in relation to mileage claims and by repeatedly failing to discharge her safeguarding responsibilities. Her conduct breached fundamental tenets of the profession, including honesty, integrity, safeguarding vulnerable patients and maintaining accurate clinical records. The panel was also satisfied that public confidence in the profession would be seriously undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel accepted that Ms Graham had apologised and demonstrated some understanding that her actions were wrong. However, it considered that her insight was limited. Whilst it noted that she attributed her failures to depression, anxiety, panic disorder, bullying and excessive workload, the panel found that her explanations focused largely upon external factors rather than a reflection on her actions. It concluded that she had not demonstrated a sufficient understanding of the impact of her misconduct upon vulnerable children, their families, her colleagues or public confidence in the profession.

The panel was satisfied that some of the misconduct in this case was capable of remediation. However, it found no evidence that Ms Graham had taken any

meaningful steps to strengthen her practice. There was no evidence before the panel of any reflection on the incidents, relevant safeguarding training, professional development, testimonials or any other evidence demonstrating remediation.

The panel was therefore of the view that there remains a significant risk of repetition. It considered that the absence of meaningful insight and remediation, together with the repeated nature of the safeguarding failures and dishonesty, meant there remained a real risk that similar conduct could occur again should Ms Graham decide to return to practise in the future. The panel therefore decided that a finding of impairment was necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC: to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing profession and upholding proper professional standards.

The panel determined that a finding of impairment on public interest grounds was also required. It considered that members of the public would be seriously concerned if a registered nurse who had repeatedly failed in safeguarding responsibilities involving vulnerable children, maintained inadequate records and acted dishonestly in relation to expense claims were found not to be impaired. A finding of impairment was therefore necessary to maintain confidence in the profession and uphold proper professional standards.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Graham off the register. The effect of this order is that the NMC register will show that Ms Graham 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 regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

Submissions on sanction

In light of the panel's decision on impairment, Mr Choudhury submitted that the appropriate and proportionate sanction was a striking-off order. Whilst he acknowledged Ms Graham's mitigating circumstances related [PRIVATE], as well as the admissions she made during the local investigation, he submitted that these were outweighed by the seriousness of her misconduct.

Mr Choudhury submitted that the aggravating features included Ms Graham's seniority as an experienced nurse, a breach of trust and lack of integrity, prolonged financial dishonesty, safeguarding failures that exposed vulnerable children to a significant risk of harm, limited insight, and a failure to adequately address the concerns.

Mr Choudhury noted that although there was no evidence of actual patient harm, he submitted that Ms Graham's inadequate assessments and poor record-keeping created a real risk of harm in that children's wellbeing needs would not be identified or appropriately managed. He further submitted that the dishonest mileage claims and other dishonest conduct were sustained over a significant period and were directly linked to Ms Graham's clinical practice.

Mr Choudhury submitted that Ms Graham's alternative explanation [PRIVATE] did not excuse her conduct, particularly as she had not properly reported those issues at the relevant time. He also emphasised that there was no evidence of remediation, strengthened practice, reflective work, training, testimonials or positive references that demonstrate that the concerns had been addressed. He noted that while Ms Graham previously indicated that she no longer wished to practise and was content to be struck off, the panel should be mindful that she was not present at this hearing to confirm her future intentions.

Mr Choudhury submitted that taking no action, imposing a caution order or a conditions of practice order would be insufficient. He submitted that although some clinical concerns, such as record-keeping, might be capable of remediation, the dishonest conduct reflected attitudinal issues that could not easily be addressed by workable or measurable conditions. He further submitted that a suspension order would not adequately reflect the seriousness of the case because the misconduct was fundamentally incompatible with remaining on the register, given its repeated nature over a sustained period, attitudinal concerns and insufficient evidence of insight or remediation.

Accordingly, Mr Choudhury submitted that only a striking-off order would adequately protect the public, maintain public confidence in the profession, uphold proper professional standards, and reflect the fundamental incompatibility of Ms Graham's conduct with continued registration.

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

Decision and reasons on sanction

Having found Ms Graham's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust, as an experienced and senior nurse;
- Conduct which deliberately or recklessly put vulnerable children and their families at risk of suffering harm through repeated safeguarding failures;
- A pattern of misconduct over a sustained period of time;
- Prolonged and deliberate dishonesty for personal financial gain;

- Premeditated behaviour in that Ms Graham returned to submitting inaccurate mileage claims after a period of enhanced monitoring (during which she was capable of making accurate claims);
- Failure to engage meaningfully with the Fitness to Practise process; and
- Absence of insight, remediation or strengthened practice.

The panel also took into account the following mitigating features:

- Ms Graham's admissions regarding the inaccurate expenses claims during her employer's investigation;
- [PRIVATE].

The panel considered that, while Ms Graham's admissions and personal difficulties offer some mitigation, they do not diminish the seriousness, persistence, or impact of her actions, nor do they counter the ongoing risk posed by her absence of reflection or evidence of strengthened practice.

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 next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b, Last Updated: 28/01/2026), which states:

> *"A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again."*

The panel considered that Ms Graham's misconduct was not at the lower end of the spectrum. This involved sustained dishonesty, repeated safeguarding failures pertaining to vulnerable children, and a finding of current impairment. The panel

found that there is an ongoing real risk to patients, and therefore determined that a sanction that does not restrict Ms Graham's practise would not protect patients nor the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to impose a conditions of practice order. In considering whether conditions of practice were appropriate, the panel had regard to the factors set out in the NMC Guidance on '*Conditions of practice order'* (Reference: SAN-2c, Last Updated: 28/01/2026).

The panel concluded that a conditions of practice order would not be appropriate. Whilst some aspects of Ms Graham's misconduct were clinical concerns that may, in isolation, have been capable of remediation, the dishonesty found proved reflected attitudinal concerns which could not be adequately addressed through conditions. Furthermore, Ms Graham had repeatedly stated that she did not intend to return to nursing and had not meaningfully engaged with these proceedings or demonstrated any willingness to remediate her practice. The panel therefore concluded that there were no relevant, proportionate, workable or measurable conditions that could be formulated to protect the public or uphold professional standards.

The panel then considered whether a suspension order would be appropriate. It had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d, Last Updated: 28/01/ 2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional.*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

Whilst the panel recognised that suspension would temporarily remove Ms Graham from practice, it concluded that such an order would not sufficiently address the seriousness of the misconduct. The panel found that the misconduct involved

prolonged dishonesty for financial gain, repeated safeguarding failures affecting highly vulnerable children and indicated significant attitudinal concerns. The panel considered that there was no evidence before it from Ms Graham which demonstrated any meaningful insight, evidence of remediation, reflection, relevant training or strengthened practice. It also noted that she has not worked as a nurse in the last 7 years and previously made clear that she has no intention of returning to nursing. In those circumstances, the panel concluded that there was no realistic prospect that a period of suspension would result in Ms Graham developing the necessary insight or addressing the concerns so as to permit a safe return to practice.

Accordingly, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering whether a striking-off order was appropriate, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference: SAN-4, Last Updated: 28/01/2026). The panel concluded that this case fell within the category of a 'highest risk' case due to the combination of sustained dishonesty, serious safeguarding failures and the continuing absence of insight or remediation.

The panel also had regard to the NMC Guidance on *'Striking-off order'* (Reference: SAN-2e, Last Updated: 28/01/2026), which set out the following considerations:

- *'Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?'*

The panel concluded that the charges found proved raised fundamental questions about Ms Graham's professionalism and integrity. It was of the view that her sustained financial dishonesty, together with repeated failures to safeguard vulnerable children and maintain appropriate records, represented serious departures from the standards expected of a registered nurse. The panel considered that these failings undermined the trust placed in Ms Graham by children, families, colleagues and the wider public.

The panel found that there was no evidence demonstrating a realistic prospect that, following a period of suspension, Ms Graham would develop sufficient insight or strengthen her practice so that the risk she posed would be reduced.

The panel also considered that public confidence in the profession would be seriously undermined if a registrant who had engaged in prolonged dishonesty and repeatedly failed to safeguard vulnerable children remained on the register. It found that Ms Graham's actions were fundamentally incompatible with remaining on the register. The panel was satisfied that allowing her to continue practising would not protect the public and would undermine public confidence in both the nursing profession and the NMC as its regulator.

Balancing all of these factors, and after taking into account all of the evidence before it, the panel determined that the only appropriate and proportionate sanction is a striking-off order. Having regard to the effect of Ms Graham's misconduct in bringing the profession into disrepute and undermining public confidence, the panel concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this order is necessary to protect the public, maintain public confidence in the profession, and uphold proper professional standards and conduct by sending a clear message about the standards expected of a registered nurse.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Choudhury. He invited the panel to consider an interim suspension order for 18 months to account for the possibility that an appeal may be lodged during the interim period. In light of the panel's earlier findings, he submitted that an interim order is necessary under the grounds of public protection and otherwise in the public interest.

The panel accepted the advice of the legal assessor and referred the panel to the NMC Guidance on Interim Orders (Reference: INT-2 to INT-4, Last Updated 25/03/2026).

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 concerns, 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 striking-off order.

The panel determined that an interim suspension order was necessary to protect the public as it identified an ongoing risk of harm and risk of repetition, given Ms Graham's absence of insight and remediation. It also determined that an interim order was necessary to uphold public confidence in the nursing profession and concluded that to do otherwise would be incompatible with its earlier findings. The panel determined that the period of this order is for 18 months, to allow for the possibility of an appeal to be made and concluded.

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

That concludes this determination.