

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

**Substantive Hearing
Monday, 16 March 2026 to Tuesday, 24 March 2026**

Virtual Hearing

Name of Registrant: **Sifiso Ncube**

NMC PIN: 1711053S

Part(s) of the register: Nurses part of the register Sub part 1
RNA, Registered Nurse – Adult (23 November 2020)

Relevant Location: Scotland

Type of case: Misconduct

Panel members: Liz Dux (Chair, Lay member)
Dino Rovaretti (Lay member)
Jason Flannigan-Salmon (Registrant member)

Legal Assessor: Michael Bell

Hearings Coordinator: Ifeoma Okere

Nursing and Midwifery Council: Represented by Alex Radley, Case Presenter

Ms Ncube: Present and represented by Tom Docherty, from
Anderson Strathern Solicitors Edinburgh

Facts proved by admission: Charges 4, 6a and 6b(i) –(iii)

Facts proved: Charges 1a, 1b, 1c, 2, 6c, 7a, 7b, 7c, 8, 9, 10, 11,
12a, 12b and 12c

Facts not proved:	Charges 3a, 3b, 5a and 5b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Details of charge

That you, a registered nurse:

1. In/or around March 2022, when applying for a job with Cranford Care Home, did not disclose your employment with NHS Tayside in:
 - a. Your CV.
 - b. Your job application.
 - c. Your job interview.
2. After starting employment at Cranford Care Home on 27 April 2022, did not disclose your employment with NHS Tayside.
3. Your actions as set out in charges 1 and 2 were dishonest in that:
 - a. You knew you were required to disclose any secondary employment to Cranford Care Home.
 - b. You intended Cranford Care Home to believe that you did not have any other employment as a nurse.
4. Did not disclose starting employment with Cranford Care Home on 27 April 2022 to NHS Tayside.
5. Your actions as set out in charge 4 were dishonest in that:
 - a. You knew you were required to disclose any secondary employment to NHS Tayside.
 - b. You intended NHS Tayside to believe that you did not have any other employment as a nurse.
6. As director of Thurso Care Services Limited:

- a. In your application form to Cranford Care Home, dated 28 July 2022, stated that Thurso Care Services Limited was registered with the Care Inspectorate when this was not the case.
 - b. Published and/or were responsible for approving a company introduction document which stated:
 - i. All employees were Registered with the Scottish Social Services Council.
 - ii. All employees were under the Protecting Vulnerable Group Scheme.
 - iii. Thurso Care Services Limited would comply with all relevant legislation and regulatory bodies.
 - c. Prior to 13 October 2022, did not take appropriate steps to ensure staff had been through appropriate background checks.
7. Your actions as set out in charge 6a-c were dishonest in that:
 - a. You misrepresented Thurso Care Services Limited, and the services and staff provided.
 - b. You intended those using the services of Thurso Care Services Limited to believe you were registered with appropriate authorities when this was not the case.
 - c. You intended those using the services of Thurso Care Services Limited to believe staff had been appropriately vetted when this was not the case.
8. Your actions as set out in charge 6c did not provide appropriate safeguards for patients.
9. On one or more occasions, between 27 April 2022 and 13 September 2022, cancelled and/or arranged to be cancelled Cranford Care Home bookings for staff from another agency, and replaced those bookings with staff from Thurso Care Services Limited, without appropriate justification and/or following appropriate procedure.

10. On 5 October 2022, in your application for registration with the Care Inspectorate, incorrectly declared that you had not “*provided an agency supplying nurses to registered health or social care service*”.
11. On 5 October 2022, in an email to the Care Inspectorate, asserted that Thurso Care Services Limited had acted in accordance with relevant legislation when this was not the case.
12. Your actions in charges 10 and 11 were dishonest in that:
 - a. You knew Thurso Care Services Limited had supplied nurses without being registered with the Care Inspectorate.
 - b. You knew Thurso Care Services Limited was not entitled to supply nurses without registering with the Care Inspectorate.
 - c. You intended the Care inspectorate to believe that Thurso Care Services Limited, while unregistered, had not supplied nurses.

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

Background

The charges arose whilst you were employed as a registered nurse by NHS Tayside.

You commenced employment with NHS Tayside in October 2020 in a full-time role. Whilst still employed in that position, you applied for a further nursing role at Cranford Care Home in or around March 2022 and commenced employment there on 27 April 2022, which was also a full-time role.

It is alleged that, when applying for the role at Cranford Care Home, you did not disclose your existing employment with NHS Tayside in your CV, application form, or during your

interview. It is further alleged that, after commencing employment at Cranford Care Home, you did not disclose your continued employment with NHS Tayside.

It is also alleged that you did not disclose your employment at Cranford Care Home to NHS Tayside, despite there being a requirement to declare and obtain approval for any secondary employment.

In addition to your employment as a registered nurse, you were the sole director of Thurso Care Services Limited, a care service provider agency supplying staff including nurses, clinical support workers, and other personnel.

Concerns arise in relation to your management of that agency. It is alleged that Thurso Care Services Limited was not registered with the Care Inspectorate, Scottish Social Services Council, or Disclosure Scotland at the relevant time. Notwithstanding this, it is alleged that you represented that the agency and its staff were appropriately registered and vetted.

It is further alleged that you did not take appropriate steps to ensure that staff supplied by your agency had undergone the necessary background checks required for working with vulnerable individuals.

Additional concerns relate to your conduct whilst working at Cranford Care Home. It is alleged that, on one or more occasions between 27 April 2022 and 13 September 2022, you cancelled or arranged for the cancellation of bookings for staff from another agency and replaced those bookings with staff from your own agency without appropriate justification or following proper procedure.

It is further alleged that, on 5 October 2022, in your application for registration with the Care Inspectorate, you incorrectly declared that Thurso Care Services Limited had not supplied nurses to a registered health or social care service. It is also alleged that, in

correspondence with the Care Inspectorate on the same date, you asserted that the agency had acted in accordance with relevant legislation when this was not the case.

The NMC case is that your actions, as set out above, were dishonest and demonstrated a failure to act with integrity, a failure to ensure appropriate safeguards were in place, and a misuse of your position for the benefit of your agency.

Decision and Reasons on the Application to Admit a Document

Mr Docherty made an application on your behalf to admit a document which had been served late. This application was made pursuant to Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004.

Mr Docherty informed the panel that the document was a letter from you addressed to witness 1, which he stated had been sent following your dismissal in October 2022 from Cranford Care Home. He explained that the document had been provided to the NMC and the panel on the morning of the hearing and was therefore a late production.

Mr Docherty submitted that the document formed part of your defence. He explained that it set out your response to the allegations made against you at the time, including your position in relation to the allegation of dishonesty and your concerns regarding the accuracy of the minutes of the probationary review meeting.

Mr Docherty acknowledged that the document had not been served in advance and accepted that this was an omission. However, he submitted that, following further instructions from you, it had become apparent that the document was significant to your case. He therefore invited the panel to admit the document in the interests of fairness.

Mr Docherty referred the panel to Rule 31 and submitted that the panel had the discretion to admit documentary evidence where it was relevant and fair to do so, even if such evidence would not be admissible in civil proceedings.

On behalf of the NMC, Mr Radley did not oppose the application. However, he submitted that it was unfortunate that the document had been produced at such a late stage. He further indicated that the NMC would make submissions as to the weight to be attached to the document, noting in particular that it appeared to be undated.

The panel accepted the advice of the legal assessor.

The panel considered the application made by Mr Docherty to admit the late defence document.

The panel took into account the submissions of Mr Docherty, who submitted that the document was relevant to your defence, in particular to the allegation of dishonesty and to your account of the events following your dismissal. The panel also took into account that Mr Docherty accepted the document had been served late but submitted that it had only recently become apparent, following further instructions, that it was significant to your case.

The panel noted that Mr Radley, on behalf of the NMC, did not oppose the application, although he raised concern as to the lateness of the document and indicated that the NMC would make submissions as to the weight to be attached to it.

The panel had regard to Rule 31(1) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 and reminded itself that it may admit any evidence, whether or not it would be admissible in civil proceedings, provided that it is fair and relevant to do so. The panel considered the relevance of the document. The panel noted that the document appears to set out your contemporaneous response to the allegations made against you and includes matters which may be relevant to the issues of dishonesty and credibility.

The panel then considered fairness. The panel took into account that the document was served late and that this was not in accordance with proper case management. However, the panel noted that the NMC did not oppose the application and that any potential

prejudice could be addressed by allowing sufficient time for the NMC and the witness to consider the document.

The panel also took into account its overarching duty to ensure that all relevant evidence is considered in order to reach a fair determination.

In all the circumstances, the panel determined that it would be fair and appropriate to admit the document.

The panel therefore granted the application and admitted the document into evidence. The panel will determine what weight, if any, to attach to this document at a later stage.

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

During the course of your evidence, the legal assessor drew the panel's attention to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 and advised that parts of your evidence may engage your right to a private life.

This arose when you referred to sensitive aspects of your personal circumstances, including matters relating to your background, family history, and your health .

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.

Mr Docherty and Mr Radley did not oppose the application.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel took into account the principle of open justice, namely that hearings should be held in public, save where it is necessary to depart from that principle.

The panel considered that the evidence relating to your personal circumstances and health was private and sensitive in nature and not central to the factual issues it was required to determine. The panel determined that it would be disproportionate for such matters to be heard in public, and that your right to a private life under Article 8 outweighed the public interest in those limited aspects being heard in public.

Accordingly, the panel determined that those parts of the hearing concerning your personal and private life, including your health, would be heard in private, with the remainder of the hearing continuing in public.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Docherty, who informed the panel that you made full admissions to Charge 6a and Charge 6b(i) –(iii).

During the course of hearing the evidence of Witness 4, Mr Docherty informed the panel that you admitted to Charge 4.

The panel therefore finds Charges 4, 6a and 6b(i) –(iii) proved in their entirety, by way of your admissions.

The panel noted that the remaining charges were disputed and required determination.

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 Radley on behalf of the NMC and Mr Docherty on your behalf.

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 the 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: Regional Director for the Care Home
- Witness 2: Inspector / Regulatory Officer
- Witness 3: Data Protection Practitioner
- Witness 4: Senior Charge Nurse at the Trust

The panel also heard evidence from you under oath.

Charge 1a

“In/or around March 2022, when applying for a job with Cranford Care Home, did not disclose your employment with NHS Tayside in:

- a. Your CV”

This charge is found proved

In reaching this decision, the panel took into account your explanation that the CV you provided to the Home was a draft document. However, it determined that the relevant issue was not whether the document had been finalised, but whether it contained any reference to your employment with NHS Tayside.

The panel carefully reviewed the CV and noted that there was no reference whatsoever to your employment with NHS Tayside.

In these circumstances, the panel determined that, irrespective of whether the document was a draft, it did not disclose your employment with NHS Tayside.

Accordingly, this charge is found proved.

Charge 1b

“In/or around March 2022, when applying for a job with Cranford Care Home, did not disclose your employment with NHS Tayside in:

- b. Your job application”

This charge is found proved

In reaching this decision, the panel considered the job application form completed by you as part of the recruitment process.

The panel noted that there was no reference within the application to your employment with NHS Tayside. It determined that, as a formal document, the application form provided a clear opportunity for you to disclose your employment history.

In these circumstances, the panel concluded that the absence of any reference to your employment with NHS Tayside meant that no disclosure had been made.

Accordingly, this charge is found proved.

Charge 1c

“In/or around March 2022, when applying for a job with Cranford Care Home, did not disclose your employment with NHS Tayside in:

- c. Your job interview”

This charge is found proved

In reaching this decision, the panel considered the minutes of the job interview and also took into account your evidence that no interview had taken place.

However, upon careful review of the interview notes, the panel noted that they contained detailed references, including matters such as notice periods and pre-arranged holidays. The panel determined that the level of detail within the minutes made it wholly implausible that they could have been created without an interview having taken place.

In these circumstances, the panel rejected your evidence that no interview occurred and determined that an interview did take place, with the minutes representing a fair and accurate record of that discussion.

The panel further noted that there was no reference within the interview notes to your employment with NHS Tayside. It therefore concluded that you did not disclose this employment at interview.

Accordingly, this charge is found proved.

Charge 2)

“After starting employment at Cranford Care Home on 27 April 2022, did not disclose your employment with NHS Tayside.”

This charge is found proved

In reaching this decision, the panel took into account the evidence of Witness 1, who stated that there was no record of you disclosing your employment with NHS Tayside. The panel also noted her evidence that she was not aware of any such disclosure having been made.

The panel then considered your account that your employment with NHS Tayside was widely known within Cranford Care Home, and in particular that it was known to the registered manager. It therefore considered whether there was any evidence to support this assertion.

The panel noted that there was no contemporaneous documentary or other supporting evidence to demonstrate that any such disclosure had been made. It also took into account that you were under a contractual obligation to disclose secondary employment on an ongoing basis, and determined that, had such disclosure been made, it would have been recorded in contemporaneous records.

In these circumstances, the panel concluded that the absence of any documentary evidence of disclosure undermined your account. It found your explanation to be wholly implausible and further determined that there was nothing before it to undermine the evidence of Witness 1. The panel therefore preferred the evidence of Witness 1.

Accordingly, the panel concluded that you did not disclose your employment with NHS Tayside after commencing employment at Cranford Care Home.

This charge is therefore found proved.

Charge 3

“Your actions as set out in charges 1 and 2 were dishonest in that:

- a. You knew you were required to disclose any secondary employment to Cranford Care Home
- b. You intended Cranford Care Home to believe that you did not have any other employment as a nurse.”

This charge is found NOT proved

In reaching this decision, the panel considered the issue of dishonesty by applying the two-stage test, namely whether you held the relevant knowledge or belief as to the facts, and whether, in light of that knowledge or belief, your actions would be considered dishonest by the standards of ordinary, decent people.

The panel first considered limb (a), namely whether you knew you were required to disclose any secondary employment to Cranford Care Home.

The panel took into account the contractual documentation, which included a requirement to disclose secondary employment. The panel also took into account the evidence of Witness 1, who indicated that such disclosure would ordinarily be expected and that it formed part of standard practice within the care home.

However, the panel considered your evidence that you did not read the contract in detail before signing it and were therefore unaware of the requirement to disclose secondary employment.

The panel noted that there was no direct evidence before it that you had read or understood the specific contractual provision relating to disclosure of secondary employment.

The panel was careful not to make assumptions based on your background or level of education. The panel determined that it could not properly infer that you must have read or understood the relevant contractual terms.

The panel therefore considered that your explanation was plausible and that there was no evidence before it to undermine your account.

Accordingly, the panel concluded that it had not been proved, on the balance of probabilities, that you knew you were required to disclose your secondary employment.

The panel then considered limb (b), namely whether you intended Cranford Care Home to believe that you did not have any other employment as a nurse.

The panel determined that, in the absence of proof that you knew of the requirement to disclose, it could not safely conclude that you formed an intention to mislead.

The panel found that there was insufficient evidence before it to establish that you deliberately sought to create a false impression regarding your employment status.

The panel therefore concluded that the NMC had not proved that you intended Cranford Care Home to believe that you did not have any other employment.

The panel then considered the objective limb of the test.

In light of its findings that your knowledge and intention had not been established, the panel determined that it could not properly conclude that your actions would be regarded as dishonest by the standards of ordinary, decent people.

Accordingly, the panel determined that the allegation of dishonesty is not made out.

This charge is therefore found not proved.

Charge 5a

“Your actions as set out in charge 4 were dishonest in that:

- a. You knew you were required to disclose any secondary employment to NHS

Tayside”

This charge is found NOT proved

In reaching this decision, the panel considered whether you knew that you were required to disclose any secondary employment to NHS Tayside.

In doing so, the panel took into account the evidence of Witness 4, who indicated that there were policies in place requiring staff to disclose secondary employment. However, the panel noted that no written policy had been provided and that there was no documentary evidence to demonstrate that you had received, read, or been made aware of such a requirement.

The panel then considered your evidence that you commenced employment during a period of disruption and that no formal induction had taken place. You stated that you were not made aware of any requirement to disclose secondary employment.

The panel also took into account the passage of time and the possibility that such policies may have been communicated informally during the course of your employment. However, it determined that there was insufficient evidence to establish that you had been made aware of any such requirement. In particular, there was no record of any such discussions and no evidence that the requirement had been specifically brought to your attention.

The panel considered your explanation and determined that it was plausible.

In these circumstances, the panel concluded that there was insufficient evidence to establish, on the balance of probabilities, that you knew you were required to disclose any secondary employment to NHS Tayside.

Accordingly, this charge is found not proved.

Charge 5b

“Your actions as set out in charge 4 were dishonest in that:

- b. You intended NHS Tayside to believe that you did not have any other employment as a nurse”

This charge is found NOT proved

In reaching this decision, the panel considered whether you intended NHS Tayside to believe that you did not have any other employment as a nurse.

In doing so, the panel determined that, in the absence of proof that you knew you were required to disclose your secondary employment, it could not safely conclude that you formed an intention to mislead.

The panel further found that there was insufficient evidence to establish that you deliberately sought to create a false impression regarding your employment status.

In these circumstances, the panel concluded that the NMC had not proved that you intended NHS Tayside to believe that you did not have any other employment.

The panel then considered the objective limb of the test. In light of its findings that your knowledge and intention had not been established, the panel determined that it could not properly conclude that your actions would be regarded as dishonest by the standards of ordinary, decent people.

Accordingly, this charge is found not proved.

Charge 6c

“As director of Thurso Care Services Limited:

- c. Prior to 13 October 2022, did not take appropriate steps to ensure staff had been through appropriate background checks”

This charge is found proved

In reaching this decision, the panel heard evidence from Witness 3 in relation to what constituted appropriate background checks prior to 13 October 2022.

The panel determined that Witness 3 had sufficient background knowledge, experience and skill set to be able to give evidence on this matter. The panel further determined that there was nothing before it to undermine the evidence of Witness 3 as to the relevant appropriate steps to be taken.

The panel therefore considered the evidence of Witness 3, in particular paragraphs 5 and 6 of their witness statement, which state:

“Disclosure Scotland is a government body who checks and shares information about individuals criminal records. Disclosure Scotland manages the Protection of Vulnerable Groups (“PVG”) Scheme, which is a membership scheme for individuals who work with children or protected adults. It helps ensure that people who are unsuitable to work with these groups cannot do this type of work.

In order for an organisation to be able to ensure their employees are suitable to do regulated work, they must complete PVG applications that have been signed by an active counters-signatory registered with Disclosure Scotland. They can do this by using the services of an Umbrella Body who will counter-sign applications on their behalf, or by registering with Disclosure Scotland by completing a registration application form which names a lead counter-signatory and up to four counter-signatories. During this registration process, these counter-signatories are suitability assessed, that is, our compliance department checks police databases, and if they’re satisfied that the counter-signatory is suitable, they are issued a notice of acceptance. This completes the registration process, allowing the counter-signatory to begin counter-signing and submitting applications on behalf of employees.”

The panel determined that the above evidence sets out what constituted appropriate background checks.

The panel then took into account your evidence that you had relied on files held at Cranford Care Home and had looked at the historic documentation available in those files.

The panel determined that checking historic documentation held by another organisation did not amount to appropriate background checks as described by Witness 3.

The panel noted that there was no evidence before it that you had carried out PVG applications, registered with Disclosure Scotland, used an umbrella body, or taken any steps to independently verify the suitability of staff.

The panel determined that simply reviewing existing files, without carrying out the processes described above, was not appropriate.

The panel therefore concluded that prior to 13 October 2022 you had not taken appropriate steps to ensure that staff had been through appropriate background checks.

Accordingly, this charge is found proved.

Charge 7a

“Your actions as set out in charge 6a-c were dishonest in that:

- a. You misrepresented Thurso Care Services Limited, and the services and staff provided.”

This charge is found proved

In reaching this decision, the panel took into account its findings in Charge 6a–c, which it had found proved and/or admitted. In particular, the panel noted that you had stated in your approved recruitment agencies application form to Cranford Care Home, which you completed and signed yourself, that Thurso Care Services Limited was registered with the Care Inspectorate when this was not the case. The panel had regard to Witness 1 and Witness 2’s evidence, that Thurso care services was not registered at this time following both witnesses investigating this issue.

The panel also considered the company introduction document which you had published and/or approved. This document stated:

“...All staff are SSSC registered and are under the Protecting Vulnerable Groups (PVG) Scheme.”

In light of its findings in Charge 6c, the panel determined that Thurso Care Services Limited was not registered with the relevant regulatory bodies and that appropriate background checks were not being carried out. The panel therefore concluded that the representations contained within these documents were false.

The panel considered your explanations in relation to these matters but found them to be inconsistent, unsupported by evidence, and lacking in credibility. The panel was satisfied that the representations made were not accidental or inadvertent, but formed part of a deliberate presentation of the company's status and services.

The panel therefore concluded that you had misrepresented Thurso Care Services Limited and the services and staff provided.

The panel then considered whether this conduct was dishonest. It determined that you knew that these representations were false, or at the very least that you had no reasonable basis for making them. Applying the objective test, the panel concluded that ordinary, decent people would consider such conduct to be dishonest.

Accordingly, this charge is found proved.

Charge 7b

“Your actions as set out in charge 6a-c were dishonest in that:

b. You intended those using the services of Thurso Care Services Limited to believe you were registered with appropriate authorities when this was not the case.”

This charge is found proved

In reaching this decision, the panel again relied on its findings in Charge 6a–c. It noted that you had expressly stated in your approved recruitment agencies application form that Thurso Care Services Limited was registered with the Care Inspectorate, when in fact it was not.

The panel considered the context in which this representation was made, namely in the course of seeking to provide services to a care home. It determined that the purpose of

such a statement was to give assurance that the company was properly regulated and compliant with relevant statutory requirements.

In these circumstances, the panel concluded that the only reasonable inference was that you intended those using the services of Thurso Care Services Limited to believe that it was registered with the appropriate authorities. The panel was satisfied that you knew this was not the case and that your actions were intended to create a false impression.

Applying the objective test, the panel determined that ordinary, decent people would consider such conduct to be dishonest.

Accordingly, this charge is found proved.

Charge 7c

“Your actions as set out in charge 6a-c were dishonest in that:

c. You intended those using the services of Thurso Care Services Limited to believe staff had been appropriately vetted when this was not the case.”

This charge is found proved

In reaching this decision, the panel took into account its findings in Charge 6c, namely that you had not taken appropriate steps to ensure that staff had been through appropriate background checks.

The panel also considered the statements made in the company documentation which indicated that staff were appropriately vetted and registered.

The panel determined that this representation was false, as the evidence demonstrated that Thurso Care Services Limited was not registered with Disclosure Scotland and that appropriate PVG checks were not being carried out and that without this registration, Thurso Care services were unable to carry out the appropriate checks.

The panel considered the purpose of including such a statement in company documentation and concluded that it was intended to provide reassurance regarding the safety, suitability and compliance of staff supplied.

The panel was therefore satisfied that you intended those using the services to believe that staff had been appropriately vetted, when this was not the case. The panel further determined that you knew this to be untrue.

Applying the objective test, the panel concluded that ordinary, decent people would consider such conduct to be dishonest.

Accordingly, this charge is found proved.

Charge 8)

“Your actions as set out in charge 6c did not provide appropriate safeguards for patients..”

This charge is found proved

In reaching this decision, the panel took into account its finding in Charge 6c, namely that prior to 13 October 2022 you did not take appropriate steps to ensure that staff had been through appropriate background checks.

In considering what constituted appropriate safeguards for patients, the panel placed significant weight on the evidence of Witness 3. In his witness statement, he explained:

“Disclosure Scotland is a government body who checks and shares information about individuals’ criminal records. Disclosure Scotland manages the Protection of Vulnerable Groups (“PVG”) Scheme, which is a membership scheme for individuals who work with children or protected adults. It helps ensure that people who are unsuitable to work with these groups cannot do this type of work.

In order for an organisation to be able to ensure their employees are suitable to do regulated work, they must complete PVG applications that have been signed by an active counter signatory registered with Disclosure Scotland. They can do this by using the services of an Umbrella Body who will countersign applications on their behalf, or by registering with Disclosure Scotland by completing a registration application form which names a lead counter signatory and up to four counter signatories. During this registration process, these counter signatories are suitability assessed, that is, our compliance department checks police databases, and if they are satisfied that the counter signatory is suitable, they are issued a notice of acceptance. This completes the registration process, allowing the counter signatory to begin countersigning and submitting applications on behalf of employees.”

The panel determined that this evidence clearly set out the safeguarding framework designed to protect vulnerable patients. It noted that the purpose of the PVG scheme is to prevent individuals who are unsuitable from working with vulnerable groups and concluded that compliance with these processes is a fundamental safeguarding requirement.

The panel then considered your actions. In light of its finding in Charge 6c, the panel determined that you had not taken the necessary steps to ensure that staff had been subject to appropriate background checks. In the absence of such checks, there was no assurance that the staff supplied were suitable to work with vulnerable patients.

The panel therefore concluded that this amounted to a failure to put in place appropriate safeguards.

Accordingly, this charge is found proved.

Charge 9

“On one or more occasions, between 27 April 2022 and 13 September 2022, cancelled and/or arranged to be cancelled Cranford Care Home bookings for staff from another agency, and replaced those bookings with staff from Thurso Care

Services Limited, without appropriate justification and/or following appropriate procedure.”

This charge is found proved

In reaching this decision, the panel heard oral evidence from Witness 1, which it found to be credible and reliable. It also relied on the contemporaneous documentary evidence, namely the minutes of the probationary review meeting, in particular the entry relating to 10 and 11 September, in which the following conversation is recorded:

“Witness 1: On the 10th and 11th September we had RGN agency shifts, and we covered them with UVIP and Initial you spoke to CR and Admin and told them to cancel them as Thurso will cover these shifts.

You: I covered these shifts as Initial are expensive and we are half the price.

Witness 1: So, you did cancel them?

You: I asked admin to cancel them

Witness 1: So, you did cancel without getting my authorisation.

You: Yes”

The panel determined that this was clear evidence that bookings for staff from another agency were cancelled and replaced with staff from Thurso Care Services Limited.

The panel then considered whether there was appropriate justification for your actions. It took into account your explanation that the other agency was expensive but determined that this did not amount to appropriate justification.

The panel placed significant weight on the evidence of Witness 1, who explained that there was a clear procedure for arranging and approving agency staff, and that such decisions required authorisation from a manager or other authorised individual. The panel determined that you did not have the authority to cancel or replace bookings.

In these circumstances, the panel concluded that your actions were carried out without appropriate authorisation and outside of the established procedure. The absence of authorisation meant that the proper procedure had not been followed.

The panel also found that your explanation lacked credibility, particularly in light of the evidence that the agency in question was trusted and routinely used.

The panel therefore concluded that, on one or more occasions within the relevant period, you cancelled and/or arranged to cancel bookings for staff from another agency and replaced them with staff from Thurso Care Services Limited, without appropriate justification and without following appropriate procedure.

Accordingly, this charge is found proved.

Charge 10

“On 5 October 2022, in your application for registration with the Care Inspectorate, incorrectly declared that you had not ‘provided an agency supplying nurses to registered health or social care service’.”

This charge is found proved

In reaching its decision, the panel took into account the documentary evidence relating to your application for registration with the Care Inspectorate dated 5 October 2022.

The panel noted that within that application you declared that you had not:

“provided an agency supplying nurses to registered health or social care service.”

The panel then considered whether that declaration was correct.

The panel heard clear evidence that Colleague A (registered nurse) had worked a nursing shift on the 25th of March 2022 within Cranford Care Home. The panel had sight of an invoice for Colleague A’s nursing service which had been submitted by Thurso Care

Services Limited on the 28th of April 2022. The panel determined that this demonstrated that your agency had provided a nurse to a registered health or social care service on 25th of March 2022.

The panel took into account your explanation that this fee was for introducing Colleague A to Cranford Care Home. There was nothing before the panel to support this explanation and therefore the panel rejected it.

The panel also took into account its findings in earlier charges, in particular Charge 9, where it found that you had arranged for staff from your agency to be supplied to Cranford Care Home.

In addition, the panel took into account the wider documentary evidence, including records examined during Witness 2's investigation on behalf of the Care Inspectorate which referred to:

“dates from March to September 2022 when Larchwood Group alleged they were provided by nurses by Thurso Services to cover shifts at Cranford Care Home.”

The panel further took into account the evidence of Witness 2, which relied on information provided by Witness 1 from Cranford Care Home's internal records identifying additional nurses supplied by your agency. The panel noted that your explanation that these nurses were not supplied by you was not supported by any evidence and did not undermine the evidence of Witness 2 and Witness 1.

The panel determined that this evidence was consistent and mutually supportive, and that there was nothing before it to undermine that evidence. It also determined that this evidence demonstrated that your agency had provided nursing services to a registered care home prior to 5 October 2022.

The panel therefore concluded that the declaration made by you in your application was an incorrect declaration.

Accordingly, this charge is found proved.

Charge 11

“On 5 October 2022, in an email to the Care Inspectorate, asserted that Thurso Care Services Limited had acted in accordance with relevant legislation when this was not the case.”

This charge is found proved

The panel took into account the documentary evidence of your email to the Care Inspectorate dated 5 October 2022.

The panel also paid significant regard to the letter from Witness 2, in which the regulatory obligations applicable to your agency were clearly set out. The panel noted that this letter explained that it is an offence to provide a care service without being registered with the Care Inspectorate and advised that you should cease doing so and seek independent advice.

The panel determined that this correspondence set out the regulatory position in clear and unambiguous terms.

Given the gravity of the matters outlined in that correspondence, the panel considered that a reasonable response would have been either to explain why you believed you were not in breach of the legislation or to seek further advice as recommended.

The panel noted that, in your email dated 5 October 2022, you asserted:

“Thurso Services is not partaking in any illegal activities.”

The panel also noted that within the same email you stated that your application had been submitted and was awaiting consideration.

The panel then considered whether that assertion was correct. In doing so, it took into account its findings in earlier charges. In particular, the panel noted that:

- In Charge 6a–c, it found that Thurso Care Services Limited was not registered with the appropriate regulatory bodies and that incorrect representations had been made
- In Charge 6c, it found that appropriate background checks were not being carried out
- In Charge 8, it found that appropriate safeguards for patients were not in place

The panel also took into account the evidence that Thurso Care Services Limited was not registered with the Care Inspectorate as required for supplying nurses.

In light of these findings, the panel determined that the assertion that the company had acted in accordance with relevant legislation was incorrect.

The panel further determined that, in light of the clear information provided to you prior to your email, your assertion was not credible.

The panel further determined that your email was misleading in that it suggested that an application had already been submitted and was under consideration, whereas in fact the application was submitted on the same date as the email.

The panel determined that this added to the overall misleading nature of your communication.

The panel therefore concluded that your statement in the email was false.

Accordingly, this charge is found proved.

Charge 12a

“Your actions in charges 10 and 11 were dishonest in that:

a. You knew Thurso Care Services Limited had supplied nurses without being registered with the Care Inspectorate.”

This charge is found proved

The panel took into account its findings in Charges 9, 10 and 11 above, in which it had determined that Thurso Care Services Limited had supplied nurses to a registered care home prior to 5 October 2022.

The panel then considered whether you knew that this had occurred. In doing so, it noted that you were the Director of Thurso Care Services Limited and were directly involved in the provision of staff to care homes.

The panel also relied on the contemporaneous evidence in the documentary evidence, which included your admission:

“Witness 1: On the 10th and 11th September we had RGN agency shifts, and we covered them with UVIP and Initial you spoke to CR and Admin and told them to cancel them as Thurso will cover these shifts.

You: I covered these shifts as Initial are expensive and we are half the price.

Witness 1: So, you did cancel them?

You: I asked admin to cancel them

Witness 1: So, you did cancel without getting my authorisation.

You: Yes”

The panel determined that this further demonstrated your direct involvement in arranging and supplying staff, including nurses.

In light of this, and its finding that Thurso Care Services Limited was not registered with the Care Inspectorate at the relevant time, the panel concluded that you knew that nurses had been supplied without the required registration.

Accordingly, this charge is found proved.

Charge 12b

“Your actions in charges 10 and 11 were dishonest in that:

b. You knew Thurso Care Services Limited was not entitled to supply nurses without registering with the Care Inspectorate.”

This charge is found proved

In reaching this decision, the panel took into account its findings in Charges 10 and 11 above and considered whether you knew that Thurso Care Services Limited was not entitled to supply nurses without registration.

In doing so, the panel had regard to your role as director of the company and the regulatory framework governing the provision of nurses to care homes in Scotland, as set out in the evidence. It noted that registration with the Care Inspectorate is a fundamental requirement for the lawful provision of such services.

The panel further took into account that you had made an application to the Care Inspectorate for registration. It determined that the act of applying for registration demonstrated that you were aware that registration was required in order to lawfully supply nurses.

In these circumstances, the panel concluded that you knew that Thurso Care Services Limited was not entitled to supply nurses without being registered with the Care Inspectorate.

The panel then applied the objective test and determined that ordinary, decent people would consider your conduct, in making the declarations set out in Charges 10 and 11 in those circumstances, to be dishonest.

Accordingly, this charge is found proved.

Charge 12c

“Your actions in charges 10 and 11 were dishonest in that:

c. You intended the Care Inspectorate to believe that Thurso Care Services Limited, while unregistered, had not supplied nurses.”

This charge is found proved.

The panel took into account its findings in Charges 9, 10 and 11 above. In particular, the panel had already determined that Thurso Care Services Limited had supplied nurses to a registered care home prior to 5 October 2022 and that your declaration to the Care Inspectorate that this had not occurred was incorrect.

The panel then considered whether you intended the Care Inspectorate to believe that Thurso Care Services Limited had not supplied nurses.

The panel noted that you expressly stated that Thurso Care Services Limited had not provided an agency supplying nurses to registered health or social care services. The panel also noted your assertion:

“Thurso Services is not partaking in any illegal activities.”

The panel determined that, in light of its findings, these statements were untrue.

The panel concluded that the only reasonable inference was that you intended the Care Inspectorate to believe that Thurso Care Services Limited had not supplied nurses while unregistered.

The panel determined that you knew this to be the case.

The panel then applied the objective test and determined that ordinary, decent people would consider such conduct to be dishonest.

Accordingly, this charge 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise 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 misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Radley, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. The panel 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.

Mr Radley identified the relevant provisions of the Code and submitted that your conduct involved dishonesty, a lack of candour, a lack of transparency, and failures in safeguarding and professional responsibility.

Mr Radley submitted that, given your background in business, law and nursing, you were well equipped to understand the importance of regulatory compliance, accurate documentation and contractual obligations. He submitted that you provided false information in formal documentation, including stating that you were a member of a registered body when you were not, in response to clear and straightforward questions.

Mr Radley submitted that your explanations, including that you were rushed or did not check documents, should be afforded limited weight in light of your experience and understanding of legal and regulatory processes.

Mr Radley further submitted that your failure to disclose your employment arrangements demonstrated a lack of openness and candour. He submitted that the issue was not the holding of more than one role, but the lack of transparency, which is essential for patient safety and workforce oversight.

Mr Radley submitted that you allowed or facilitated staff to work without appropriate checks, contrary to legal requirements and safeguarding expectations, giving rise to serious concerns.

Mr Radley invited the panel to consider your conduct cumulatively and submitted that it demonstrates serious regulatory failings, including dishonesty and safeguarding concerns, which go to the heart of the profession.

Mr Radley submitted that your actions breached the Code, in particular *paragraphs 10.3, 8.6, 11.1, 13.3, 16.2, 17.1, 19.1, 20.1, 20.2 and 21.3*, and fall seriously short of the standards expected of a registered nurse.

Mr Docherty submitted that misconduct is a matter for the panel's judgment and that not every breach of the Code will amount to misconduct. He submitted that the panel must consider whether the conduct is sufficiently serious and that mere negligence is not sufficient.

Mr Docherty referred the panel to the test for dishonesty set out in *Ivey v Genting Casinos [2017] UKSC 67* and submitted that the panel must assess your state of mind at the relevant time, including your knowledge and understanding of the circumstances.

Mr Docherty submitted that this is not a typical dishonesty case but one arising in a disorganised and informal environment, where processes were poorly structured and documentation was incomplete.

Mr Docherty submitted that you lacked a proper understanding of regulatory requirements at the relevant time and that your actions arose from confusion and lack of knowledge rather than deliberate dishonesty.

Mr Docherty submitted that the panel should consider whether your conduct is more appropriately characterised as negligence, lack of competence or poor practice rather than serious professional misconduct.

Submissions on impairment

Mr Radley addressed the panel on the issue of impairment and the need to have regard to the protection of the public and the wider public interest, including the need to uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He referred the panel to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)*.

Mr Radley submitted that the panel should consider whether your conduct:

- placed patients at risk of harm,
- breached fundamental tenets of the profession,
- brought the profession into disrepute, and
- involved dishonesty.

Mr Radley submitted that the misconduct found proved relates directly to patient safety, safeguarding, honesty and professional integrity, which are central to nursing practice.

Mr Radley submitted that your conduct involved failures in safeguarding, a lack of candour and dishonest behaviour, and that these are serious concerns going to the core of the profession.

Mr Radley submitted that, whilst the panel should consider your level of insight, remediation and risk of repetition, the seriousness of the misconduct requires a finding of impairment on both public protection and public interest grounds.

Mr Radley further submitted that public confidence in the profession would be undermined if a finding of impairment were not made.

Mr Docherty submitted that impairment must be assessed as at today's date and not at the time of the events. He submitted that the panel should consider whether the conduct is remediable, whether it has been remedied, and whether it is unlikely to be repeated.

Mr Docherty submitted that the matters are historical and arose in a specific business context which no longer exists.

Mr Docherty referred the panel to your reflective statement and submitted that you have demonstrated developing insight, including acknowledging that you should have taken more time to understand regulatory processes and seek advice.

Mr Docherty submitted that there is no evidence of repetition and that the conduct arose in a unique context which is no longer continuing.

Mr Docherty submitted that the panel should be cautious about treating a rejected account as evidence of lack of insight.

Mr Docherty submitted that your conduct is remediable, has been reflected upon, is unlikely to be repeated, and does not require a finding of current impairment.

The panel accepted the advice of the legal assessor, which included reference to the relevant legal principles in respect of misconduct and impairment. These included:

- *Roylance v General Medical Council (No. 2) [2000] 1 AC 311*
- *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)*
- *Ivey v Genting Casinos [2017] UKSC 67*
- *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)*

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to breaches of the Code. Specifically:

'8 Work co-operatively

To achieve this, you must:

8.6 share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

17.3 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.

21 Uphold your position as a registered nurse

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore considered each group of charges carefully, both individually and cumulatively.

The panel first considered charges 1, 2 and 4. The panel noted that these matters demonstrated failings in your professional practice and judgment. However, the panel determined that, whilst concerning, these matters did not reach the threshold of serious professional misconduct when considered in isolation.

The panel then turned to charges 6 to 12.

The panel noted that these charges involved the provision of false information and misrepresentation in formal and professional contexts. The panel considered that these were not minor inaccuracies or administrative errors. The panel determined that these were clear and deliberate misstatements made in response to straightforward questions.

The panel carefully considered whether this conduct could be explained by confusion, disorganisation or lack of knowledge, as you had suggested. The panel rejected that explanation. The panel determined that the information in question required accurate and truthful responses and did not involve complex or ambiguous matters. The panel further noted that, given your background in business, law and nursing, you would have understood the importance of accuracy, honesty and regulatory compliance in such documentation.

The panel therefore concluded that your actions were not inadvertent but were deliberate. The panel further considered that these actions were premeditated rather than arising spontaneously or through oversight.

The panel determined that your conduct demonstrated an intention to mislead. The panel considered that this was not an isolated incident but a series of dishonest acts which, when taken together, demonstrated sustained dishonest behaviour.

The panel also considered the safeguarding aspects of your conduct. The panel noted that you allowed or facilitated individuals to work without appropriate checks being carried out. The panel determined that this was contrary to legal and regulatory requirements and created a risk that vulnerable individuals could be exposed to harm.

The panel considered that this conduct engaged core professional responsibilities relating to patient safety and safeguarding.

The panel therefore concluded that the dishonest conduct, combined with the safeguarding failings and lack of transparency, represented serious departures from the standards expected of a registered nurse.

The panel determined that these matters, both individually and cumulatively, amounted to serious breaches of fundamental tenets of the profession, in particular honesty, integrity and the duty to protect the public.

Accordingly, the panel found that your actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

The panel heard and accepted the advice of the legal assessor. The legal assessor provided detailed advice to the panel on the relevance of *Sawati v General Medical Council (2022) EWHC 283 (Admin)*. He explained that the case addresses the extent to which a rejected defence may be relevant when assessing impairment, and in particular whether a disingenuous defence can aggravate findings of dishonesty. He advised that this must be carefully balanced against the registrant's right to a fair hearing.

The legal assessor emphasised that each case is fact-specific. He directed the panel to consider a range of relevant factors, including whether you were denying primary or secondary facts, whether there was evidence of a lack of insight beyond the rejected defence, whether the defence amounted to a blatant untruth, whether it involved attributing blame to others, or whether it was instead an attempt to present events in a more favourable light. He cautioned that this requires a careful and measured balancing exercise.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on 'Impairment' (*Reference: DMA-1, last updated 28 January 2026*), which states:

'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.'

The panel also had regard to the need to consider both public protection and the wider public interest.

The panel considered the judgment in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)*.

In considering the issue of current and future impairment, the panel took into account the guidance of the legal Assessor, including the principles set out in *Sawati v General Medical Council (2022) EWHC 283 (Admin)*, when evaluating your rejected defence. The panel accepted that you were entitled to advance a defence and to challenge the allegations, and that an unsuccessful defence should not automatically be held against you. However, the panel considered that the dishonesty found proved related to primary allegations involving deliberate deceit and proactive attempts to mislead.

The panel determined that the account you advanced as to your state of mind was unrealistic and implausible.

In considering your insight, the panel noted that your reflections did not demonstrate an understanding of the potential impact of your actions on patients, vulnerable individuals, or public confidence in the profession. The panel further determined that your account went beyond presenting events in a more favourable light than eventually proved warranted.

The panel took these matters into account when assessing your level of insight and the risk of repetition.

The panel bore in mind that nurses occupy a position of privilege and trust in society and are expected at all times to act with honesty, integrity and professionalism. 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* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel also considered the questions posed in paragraph 76 of Grant.

The panel determined that your misconduct engages all four limbs of the Grant test

The panel found that your conduct had the potential to place patients and service users at unwarranted risk of harm. This arose from the safeguarding failures identified, particularly allowing individuals to work without appropriate checks.

The panel determined that your conduct breached fundamental tenets of the profession, namely honesty, integrity, candour and safeguarding responsibilities.

The panel was satisfied that your actions brought the profession into disrepute. The panel considered that members of the public would be concerned to learn that a registered nurse had provided false information and acted without transparency in professional matters.

The panel also found that your misconduct involved dishonesty.

The panel then considered your level of insight.

The panel noted that you provided a reflective statement and acknowledged that you should have taken more time to understand regulatory requirements. However, the panel determined that your insight is limited.

The panel considered that your reflections focused on confusion, lack of knowledge and disorganisation, rather than a full acceptance of the dishonest nature of your conduct.

The panel noted that your account of events had been rejected. The panel determined that your continued reliance on that account indicated that you had not fully accepted the panel's findings. The panel was concerned that this demonstrated that the underlying concerns identified remain unaddressed and ongoing.

The panel therefore concluded that you have not demonstrated sufficient insight into the seriousness of your misconduct or its impact on patient safety, public confidence and professional standards.

The panel considered whether your misconduct is capable of remediation. The panel determined that aspects of your conduct, such as improving your understanding of regulatory requirements, are capable of remediation.

However, the panel identified that the central concern in this case is attitudinal, namely dishonesty and a lack of candour. The panel considered that attitudinal concerns are inherently more difficult to remediate, particularly in the absence of full insight. The panel noted that there was limited evidence of meaningful remediation addressing the dishonesty identified. The panel was not satisfied that you have demonstrated sufficient remediation to address the attitudinal concerns identified. The panel therefore concluded that remediation remains incomplete.

The panel then considered whether there is a risk of repetition.

The panel determined that your misconduct did not arise from a lack of clinical competence but from attitudinal concerns, including dishonesty and lack of transparency. The panel considered that, in the absence of full insight and remediation, there remains a real risk of repetition. The panel further determined that your continued reliance on an account which had been rejected demonstrates that the concerns identified remain ongoing.

The panel therefore determined that there is a real risk of repetition.

Accordingly, the panel concluded that a finding of impairment is necessary on the grounds of public protection.

The panel then considered the wider public interest. The panel bore in mind the need to uphold proper professional standards and maintain public confidence in the profession and in the NMC as a regulator.

The panel determined that the misconduct in this case involved serious dishonesty and safeguarding failings, which go to the heart of the profession, particularly in relation to honesty and integrity.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made. The panel also determined that a finding of impairment is required to declare and uphold proper professional standards.

Having regard to all of the above, the panel was satisfied that your 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 you off the register. The effect of this order is that the NMC register will show that you have 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 Radley reminded the panel that the overarching objective is the protection of the public, which includes the protection of patients, the maintenance of public confidence in the profession, and the upholding of proper professional standards.

Mr Radley submitted that the panel should impose a sanction that is proportionate, but which adequately reflects the seriousness of the case. He invited the panel to consider the available sanctions in ascending order of seriousness.

In relation to aggravating features, Mr Radley submitted that:

- You occupied a position of trust as a registered nurse and were required to maintain professional standards at all times.
- Your actions occurred over a period of time, including during the application, interview, and employment process.
- There is a lack of understanding and insight into your failings, with your reflections maintaining the account previously given.
- Your actions have had an impact on the reputation of the profession and public confidence in nurses.
- The conduct engaged all four limbs of the test in *Grant*.
- There was a breach of fundamental tenets of the profession.
- The public interest is clearly engaged.
- There were detrimental effects on service provision, including the displacement of an established provider.

Mr Radley further submitted that the misconduct involved serious and repeated dishonesty. He stated that the conduct was premeditated, systematic, and carried out over a period of time, rather than being a single or isolated incident.

Mr Radley submitted that there was potential for personal financial gain, noting that although profit was not ultimately realised, this was due to the conduct being identified rather than any absence of intent.

In relation to mitigating factors, Mr Radley submitted that:

- There were limited admissions to part of the case.
- You have previous good character reference.

Mr Radley submitted that these mitigating factors carry limited weight in light of the seriousness of the dishonesty.

Turning to sanction, Mr Radley submitted:

- No action would be wholly inappropriate given the seriousness of the case.

- A caution order would be insufficient and would fail to mark the gravity of the misconduct.
- Conditions of practice would not be workable or appropriate, as the concerns relate to attitudinal issues and dishonesty rather than remediable clinical deficiencies.

In relation to suspension, Mr Radley submitted that this sanction would not be appropriate because:

- The misconduct was not a single instance but involved repeated acts of dishonesty.
- There are deep-seated attitudinal concerns.
- There is insufficient evidence of insight.
- The behaviour is inconsistent with remaining on the register.

Mr Radley submitted that the appropriate and proportionate sanction in this case is a striking-off order, on the basis that:

- The misconduct raises fundamental concerns about your professionalism.
- Public confidence in the profession would be undermined if you were permitted to remain on the register.
- A striking-off order is the only sanction sufficient to maintain professional standards and protect the public.

Mr Docherty invited the panel to consider carefully the mitigation available and to adopt a proportionate approach when determining sanction. He further stated that the consequences of being struck off the register would be tragic and will have a huge effect on your family. Mr Docherty reminded the panel that the overriding objective was to maintain public confidence and proper standards.

Mr Docherty submitted that there are limited but relevant mitigating features in this case. In particular, he referred to:

- Your admissions to part of the case;
- Your previous good character, with no prior regulatory findings;

Mr Docherty submitted that these factors demonstrate that your conduct should not be viewed as wholly representative of your professional character.

Mr Docherty further submitted that there is no evidence to suggest that the dishonesty identified extends into your clinical practice. He also stated that these events were historical occurring four years ago in an environment which was removed from the hospital. Mr Docherty emphasised that:

- There are no concerns regarding your clinical competence;
- There are no issues identified in relation to your record keeping;
- There is no evidence to suggest that your relationships with colleagues or patients in a clinical context were unsafe;

Mr Docherty submitted that the concerns identified by the panel are non-clinical in nature, and therefore do not directly translate into a risk to patient safety in day-to-day nursing practice.

Mr Docherty invited the panel to consider that your conduct arose in a specific context, and that it would be disproportionate to conclude that you are incapable of safe and effective practice as a nurse more broadly.

Mr Docherty submitted that the panel should take into account that:

- The dishonesty, whilst serious, does not form part of a wider pattern affecting your clinical work;
- There is no evidence that patients were harmed as a direct result of your actions in a clinical setting;

Mr Docherty submitted that the panel should be cautious about imposing the most restrictive sanction where there remains scope for remediation.

Turning to the available sanctions, Mr Docherty submitted:

- That a sanction at the lower end, such as no action or a caution order, may not sufficiently reflect the seriousness of the findings;

However, he invited the panel to consider whether a suspension order would be sufficient and proportionate in the circumstances.

Mr Docherty submitted that a suspension order would:

- Mark the seriousness of the misconduct;
- Provide you with an opportunity to reflect on your actions;
- Allow you to develop insight and take steps to address the concerns identified by the panel;

Mr Docherty submitted that such an approach would strike an appropriate balance between the public interest and fairness to you.

Mr Docherty therefore invited the panel not to impose a striking-off order, and instead to consider whether a lesser sanction, in particular a suspension order, would be sufficient to meet the regulatory objectives.

Decision and reasons on sanction

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

The panel identified the following aggravating features:

- A continued attempt to deceive
- A potential for financial gain
- The conduct was not opportunistic or spontaneous

- Detrimental effects on service providers

The panel considered that these factors demonstrated the seriousness of the conduct and were of particular concern.

The panel identified limited mitigating features:

- Part admissions
- Good character

The panel did not identify any further mitigating features.

The panel first considered whether to take no action or impose a caution order. It determined that these would not reflect the severity of the charges found proved and would therefore be inappropriate.

The panel next considered whether a conditions of practice order would be appropriate. The panel found that workable conditions of practice could not reasonably be drafted to address the concerns found proved.

The panel determined that your dishonesty, together with your deep-seated attitudinal issues, could not properly be addressed by a conditions of practice order.

The panel then considered whether a suspension order would be an appropriate sanction.

The panel found that your behaviour was incompatible with your remaining on the register, as a suspension order would not address the concerns about public protection or maintaining public confidence in the profession.

The panel determined that:

- The incidents involved repeated acts of dishonesty
- Your conduct demonstrated deep-seated attitudinal concerns
- These were compounded by the representations you made during the hearing

The panel further determined that you had failed to demonstrate meaningful insight, which evidenced a lack of a realistic prospect that you would develop insight, address the concerns identified, or return to safe practice.

In these circumstances, the panel concluded that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel finally considered a striking-off order. In looking at a striking-off order, the panel took note of the following paragraphs of the SG:

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

The panel determined that the charges found proved raise fundamental questions about your professionalism.

The panel considered that your conduct, which involved multiple acts of dishonesty including misrepresentations to the professional regulator, was serious and represented significant departures from the standards expected of a registered nurse. It determined that your actions were incompatible with continued registration.

The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should

conduct themselves, the panel has concluded that no lesser sanction would be sufficient in this case.

The panel concluded that public protection and public confidence necessitate removal from the register.

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 you 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 your 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 into account the submissions made by Mr Radley, who submitted that an interim suspension order for a period of 18 months is necessary on the grounds of public protection and the public interest. He reminded the panel of its findings at the facts, misconduct, impairment and sanction stages, and submitted that those findings reflect the seriousness of the case.

Mr Radley submitted that, in the event of an appeal, an interim order is necessary to cover the appeal period. He further submitted that an interim suspension order for 18 months

would allow sufficient time for any appeal to be determined. He noted that if no appeal is made, the interim order would fall away once the substantive striking-off order takes effect.

Mr Docherty did not oppose the application.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, for the reasons already identified in its determination when imposing the substantive order.

The panel therefore decided to impose an interim suspension order for a period of 18 months. In reaching this decision, the panel took into account the submissions of Mr Radley and noted that the application was not opposed by your representative.

The panel had regard to the relevant guidance, including SAN-6. It determined that an interim suspension order for a period of 18 months is necessary on the grounds of public protection and the public interest.

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

That concludes this determination.