

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

**Substantive Hearing  
Monday, 28 July 2025 – Friday, 1 August 2025  
Monday 17 November 2025 (in camera)  
Monday, 27 April 2026 – Wednesday, 29 April 2026  
Wednesday, 13 May 2026**

Nursing and Midwifery Council  
2 Stratford Place, Montfichet Road, London, E20 1EJ

Virtual Hearing

**Name of Registrant:** Lusina Dirorimwe

**NMC PIN:** 03E03580

**Part(s) of the register:** Nurses' part of the register – Sub part 1  
RN1: Adult nurse, level 1 – 16 May 2003

**Relevant Location:** Aylesbury

**Type of case:** Misconduct

**Panel members:** Lucy Watson (Chair, Registrant member)  
Diane Gow (Registrant member)  
Margaret Jolley (Lay member)

**Legal Assessor:** Natalie Byrne (28 July 2025 – 1 August 2025, 27-  
29 April 2026)  
Graeme Sampson (17 November 2025 only)

**Hearings Coordinator:** Aisha Charway (28 July – 1 August 2025, 17  
November 2025)  
Khatra Ibrahim (27-29 April 2026)  
Hamizah Sukiman (13 May 2026 only)

**Nursing and Midwifery Council:** Represented by Naa-Adjeley Barnor, Case  
Presenter

<b>Ms Dirorimwe:</b>	Present and represented by Jon Trussler Counsel instructed by the Royal College of Nursing (RCN)
<b>Facts proved by way of admission:</b>	Charges 4, 5a, 5b, 5c and 7
<b>Facts proved:</b>	Charges 6 (in respect of charge 5) and 8
<b>Facts not proved:</b>	Charges 1a, 1b, 2, 3a, 3b, 3c, 3d and charge 6 (in respect of charge 3)
<b>Fitness to practise:</b>	<b>Impaired</b>
<b>Sanction:</b>	<b>Suspension order (12 months)</b>
<b>Interim order:</b>	<b>Interim suspension order (18 months)</b>

## Decisions and reasons on application to amend the charges

The panel heard an application made by Ms Barnor, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of the charges, namely the stem of charges 1a, 1b and 2. She referred the panel to Rule 28 of the NMC Fitness to Practise Rules [2004] (the Rules).

Ms Barnor submitted that she was applying to amend the charges by inserting the following into the stem of charges 1 and 2.

Ms Barnor submitted that that proposed amendment was to insert: '*o an unknown date / November 2019*' into the stem of charge 1 and 2. She submitted that proposed amendment would accurately reflect the events accurately to allow fair justice.

That you, a registered nurse:

1. **In relation to a night shift which was due to commence on the evening on 4 November 2019 or an unknown date in November 2019:**

1b. Claimed hours you had not worked ~~on 4 November 2019~~ by submitting an inaccurate timesheet

2. Your conduct at charge 1b above was dishonest in that you sought to create an impression that you had worked the shift **which was due to commence on the evening on 4 November 2019 or an unknown date in November 2019.**

Ms Barnor submitted that the proposed amendment would accurately reflect the evidence, specifically in respect of what you stated during the local interview. She submitted that the proposed amendments requested would more accurately reflect the events as detailed in the charges. She submitted that there would be no prejudice or injustice caused to you, as

the proposed amendments do not materially alter the substance of the allegations. She referred the panel to case of *The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi* [2015] EWHC 764 (Admin).

Following Ms Barnor's submissions, the panel suggested, for clarity, Charges 1 and 2 should be further amended to state: '*a night shift which commenced on the evening of 4 November through to the morning 5 November*'. It also suggested that the amendments proposed by Ms Barnor should also be reflected in Charge 3, which also refers to the events of 4 November 2019.

In response, Ms Barnor agreed that the date of the incidents referred to in the charges should read as: '*on a night shift commencing on 4 November through to the morning of 5 November 2019*'.

In response to Ms Barnor's proposed amendments, Mr Trussler, on your behalf, submitted that in relation to the night shifts on 4 November 2019 and 31 December 2019, you are aware of the dates, and that as a result the night shift of the two dates in question should be reflected in the charge. He submitted that there is no objection to that aspect of the amendment being sought by Ms Barnor. However, in regard to the amendment '*on an unknown date in November 2019*', Mr Trussler submitted that to allow such an amendment would be unjust as you do not have access to all of the records held for the period November 2019, and referred the panel to Dr Wickramarachchi's statement, namely paragraphs 7-10. He submitted that Dr Wickramarachchi made reference to a number of documents being unobtainable, and that '*due to the passage of time since I made the referral the whole records and files referred to are not currently accessible*'. He submitted that it is reasonable and understandable that you do not have access to records, and so cannot answer to the charge.

Mr Trussler invited the panel not to grant Ms Barnor's application to include '*on an unknown date in November 2019*', and submitted that the charges put to you are serious,

and in the event they are found proved, could have serious implications on you and your career. He submitted that this case has been ongoing since 2020, and as such you would not be in a position to fairly test the charges as set out in these proposed amendments.

In response, Ms Barbor informed the panel that the Royal College of Nursing (RCN) were placed on notice by the NMC on 22 July 2025 that it would be seeking to amend the charges as applied for today. She submitted that it is detailed in the meeting minutes exhibited by Dr Wickramarachchi that you were present at that meeting and the amendment is being sought to reflect what you are purported to have said.

Mr Trussler submitted that you have not been provided with a copy of the meeting minutes, as exhibited by Dr Wickramarachchi. He submitted that this document has only just been brought to your attention, and that you do not have the means to responding to the evidence, as you have no access to the records at the material time.

Mr Trussler submitted that if the panel felt clarity was required in relation to charges 1 and 2, it may also consider adopting a similar stance in relation to charges 4 and 5.

In response to panel questions, Ms Barnor confirmed she also wished to amend charge 3:

3. Completed one or more of the following documents indicating that you had provided care to Patient A on **the evening of 4 November 2019 through to the morning of 5 November 2019** when you had not .

Mr Trussler did not object to the above proposed amendment.

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

In reaching its decision, the panel considered the submissions of both Mr Trussler and Ms Barnor. The panel decided to partially amend charges 1 and 2. It also decided to amend charges 4 and 5 of its own volition. The amended charges accepted are as follows:

That you, a registered nurse:

1. In relation to a night shift which was due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019:
  - a. Failed to attend your shift at Patient A's home.
  - b. Claimed hours you had not worked on 4 November 2019 by submitting an inaccurate timesheet
2. Your conduct at charge 1(b) above was dishonest, in that you sought to create an impression that you had worked the night shift due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019.
3. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019 when you had not:
  - a. Night Clinical Checklist for 4 November 2019
  - b. Fluid Balance Chart for 4 November 2019
  - c. Night Shift Evaluation Sheet for 4 November 2019
  - d. MAR Chart for 4 November 2019
4. On 31 December 2019, failed to attend your night shift at Patient A's home

5. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift commencing on 31 December 2019 when you had not:

- a. Night Clinical Checklist for 31 December 2019
- b. Fluid Balance Chart for 31 December 2019
- c. Night Shift Evaluation Sheet for 31 December 2019

Having considered the submissions of Mr Trussler and Ms Barnor, the panel was of the view that the amendments, to charges 1, 1b, 2 and 3 to include '*on an night shift commencing on 4 November 2019 through to the morning of 5 November 2019*' as applied for, would clarify the detail of the charges, and are relevant and fair. Further, the panel was satisfied that by accepting these amendments, there would be no prejudice to you, and no injustice caused to either party. Therefore, the panel accepted the application to amend charges 1, 1b, 2 and 3 in this respect.

In addition, the panel of its own volition, decided to amend charges 4 and 5 for the same reasons as above to state: '*failed to attend your night shift*' and '*the night shift commencing on 31 December 2019*' respectively. It determined that these amendments would accurately reflect the details of the charges without causing prejudice or injustice to you or either party.

The panel did not accept the amendment to include '*On an unknown date in 2019*' for charges 1a and 1b, and did not accept the amendment to remove '*4 November 2019*' in charge 2. The panel noted that this amendment had only recently been put to you, and the allegation in relation to this date took place over five years ago. The panel also acknowledged that it was not possible for either yourself or Dr Wickramarachchi – as stated in her supplementary statement – to provide evidence for this period. The panel

therefore concluded that it would not be appropriate, fair or just to accept the aforementioned amendments.

### **Decision and reasons on application to further amend the charges**

When the hearing resumed, on day 4, the panel heard an application made by Ms Barnor to amend the charges pursuant to Rule 28 Nursing & Midwifery Council's Fitness to Practice Rules 2004.

The proposed amendment was to insert the following charges;

**7. In relation to a night shift which was due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020, claimed hours that you had not worked**

**8. Your conduct at charge 7 above was dishonest, in that you sought to create an impression that you had worked the night shift due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020**

Ms Barnor explained that the additional charges relate to the claiming of hours, not worked, during a night shift due to commence on the evening of 31 December 2019 through to the morning of 1 January 2020. Ms Barnor submitted that during your oral evidence yesterday, you had acknowledged more than once, that you did submit a time sheet for 31 December 2019 when you did not work that night. Ms Barnor submitted that this evidence was further supported by the audio recording, exhibit CW/01, in which a representative of Pheonix Health Care identified that a time sheet had been submitted for 31 December 2019.

Ms Barnor acknowledged that proposed charges 7 and 8 were not included in the initial schedule of charges and stated that this had been a regrettable oversight on the part of the NMC. However, she explained that the submission of the timesheet and the associated alleged dishonesty had always been heralded as part of the NMC's case, and without these amendments, the NMC would be failing to bring the full gravity of the allegations before the Panel. Ms Barnor submitted that the situation was similar to that which had arisen in the case of *The Professional Standards Authority for Health and*

*Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi [2015] EWHC 764 (Admin).*

Ms Barnor submitted that any prejudice to you was mitigated by the fact you had admitted the facts and had always been aware that the circumstances giving rise to the charges were part of the NMC's case.

Ms Barnor submitted that by failing to include these charges the NMC would be failing in its duty to protect the public and that in accordance with Rule 28, the Panel do have a power to amend charges at any point before making its finding of fact.

In response to panel questions, Ms Barnor accepted that your reflective statement (in which you make reference to submitting a timesheet on 31 December 2019) was before the NMC at the point the charges were drafted, and the case was being prepared. She stated that the only information she could provide the panel with, was that this had been a regrettable oversight and again, she offered apologies on behalf of the NMC. Ms Barnor explained that once a case had been referred to a panel by the Case Examiners, the NMC have to bring the case. Given that the Case Examiners, in this case, made a referral relating to the timesheet, the NMC must bring that charge; a failure to do so is potentially a procedural irregularity and an appeal point. Addressing the panel in relation to seriousness, Ms Barnor submitted that if the charge was not brought, the NMC would not be placing the full scale of your alleged misconduct before the Panel.

Mr Trussler, on your behalf submitted that to allow the application would be an abuse. He noted that the application had been raised at the conclusion of your oral evidence but in fact, it had always been being considered in the background.

Mr Trussler invited the panel to carefully consider the wording of Rule 28 which he stated allowed for "amendments." He submitted that these are not amendments but rather further allegations. He submitted that it was not acceptable to raise these at the conclusion of your oral evidence; further allegations should mean that you have the opportunity to see

the evidence in support, to provide instructions to the RCN in good time, to provide further evidence and have a further hearing.

Mr Trussler further submitted that the latter part of Rule 28 requires the panel to have regard to the merits of the case – and he submitted that this was a glaring example of “overkill” on the part of the NMC. He submitted that there are already a number of allegations before the panel, in relation to the recording of false information which have been admitted. Dishonesty has been, and is, denied. He further submitted that in terms of the overall gravity of the case, the additional allegations add nothing further and there is enough material for the panel to consider.

Mr Trussler also urged the panel to consider the impact of this application upon you, stating that it had heaped further weight upon you and that it will inevitably prolong these proceedings which have been ongoing for some time.

The panel accepted the advice of the legal assessor, which included reference to Rule 28 of ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’ and *The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi [2015] EWHC 764 (Admin)*.

In coming to its decision, the panel were reminded that its fundamental duty is to hold a hearing which is fair and just to all parties; the Registrant, the public and the NMC.

The panel noted that evidence of you submitting a timesheet on 31 December 2019 was available in statement form, and that this material had been with the NMC for some time. However, the panel considered that during the hearing, and in particular during your oral evidence yesterday, the content of the bundle and the context of the case as a whole, had been expanded upon significantly.

The panel agreed that there had been a significant omission on the part of the NMC, by not including the charges at the outset of proceedings. The panel also considered the impact of this application upon you, particularly given the late stage of proceedings.

However, the panel noted that the allegations are serious. They relate to dishonesty and honesty is one of the fundamental tenets of the nursing profession. The panel concluded that it was undoubtedly in the public interest for such matters to be adjudicated on. The panel also had regard to the Court's judgement in the case of *Jozi*, which affirmed that disciplinary panels are to play a more active role than a judge presiding over a criminal trial in order to ensure that a case is properly presented, that the charges adequately reflect the real mischief of the case and that the relevant evidence is placed before it.

The panel carefully considered Mr Trussler's submission, that the additional charges were "overkill," but determined that, given all that it had read and heard, the charges were proportionate and justified.

Accordingly, the panel decided to grant the NMC's application.

The panel acknowledged the impact of this decision upon you and agreed that you would undoubtedly require further time to seek legal advice and, if appropriate provide evidence.

Accordingly, the panel, of its own volition, considered its power to grant an adjournment pursuant to Rule 24 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004.' However, on advice from the legal assessor, the panel determined they would require further input from the advocates before reaching a conclusion.

### **Details of charge (as amended)**

That you, a registered nurse:

1. In relation to a night shift which was due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019
  - a. Failed to attend your shift at Patient A's home.
  - b. Claimed hours you had not worked on 4 November 2019 by submitting an inaccurate timesheet
2. Your conduct at charge 1(b) above was dishonest, in that you sought to create an impression that you had worked the shift due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019.
3. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift due to commence on evening of 4 November 20219 through to the morning of 5 November 2019 when you had not.
  - a. Night Clinical Checklist for 4 November 2019
  - b. Fluid Balance Chart for 4 November 2019
  - c. Night Shift Evaluation Sheet for 4 November 2019
  - d. MAR Chart for 4 November 2019
4. On 31 December 2019, failed to attend your night shift at Patient A's home
5. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift commencing on 31 December 2019 on 31 December 2019 when you had not:

- a. Night Clinical Checklist for 31 December 2019
  - b. Fluid Balance Chart for 31 December 2019
  - c. Night Shift Evaluation Sheet for 31 December 2019
6. Your actions at any or all of charge 3 and/or 5 were dishonest, in that you intended to create an impression that you had provided Patient A with the care they required when you had not.
  7. In relation to a night shift which was due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020, claimed hours that you had not worked
  8. Your conduct at charge 7 above was dishonest, in that you sought to create an impression that you had worked the night shift due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020

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

Mr Trussler informed the panel that you have made admissions to charges 4, **5a**, 5b, 5c and 7.

The panel therefore found the aforementioned charges proved, by way of your admission.

## **Background**

You were referred to the NMC on 24 January 2020 by Dr Wickramarachchi, Director of Phoenix Health and Recruitment (the Agency). You were employed by the Agency as a registered nurse, and you provided regular home night care to Patient A, who has a congenital deformity.

The Agency received a call from Patient A's mother (Person B), who stated that you had not attended two scheduled shifts, one of which was due to take place on 31 December 2019. As a result, the Agency started a local investigation, and you admitted that you completed medical notes for Patient A, despite not having attended the shift.

During the local investigation, it was further alleged that you did not attend a shift with Patient A on 4 November 2019, and completed medical notes for Patient A, and a timesheet to indicate that you had provided care, when you had not. You were dismissed from your role at the Agency on 20 February 2020.

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

Mr Trussler made a request that this case be held partly in private on the basis that proper exploration of your case is linked to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Barnor supported the application to the extent that any reference made to [PRIVATE] should be heard in private.

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

The panel decided that when matters related to [PRIVATE], the hearing will go into private, so to protect your privacy, and that of [PRIVATE].

## **Decision and reasons on facts**

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Barnor on behalf of the NMC and Mr Trussler 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 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 witness called on behalf of the NMC:

- **Dr Chamani Wickramarachchi:** Managing director of the Agency

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

### **Charge 1a**

That you, a registered nurse:

1. In relation to a night shift which was due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019

1a. Failed to attend your shift at Patient A's home.

**This charge is found NOT proved.**

In reaching this decision, the panel considered the documentary evidence before it, the live evidence of Dr Wickramarachchi, your oral evidence and the audio recording (Exhibit CW/01).

The allegation as detailed in the charge came to light after a call from Patient A's mother (Person B) to the Agency on 15 January 2020 after you had resigned from the Agency. Person B was concerned that there was now no cover for the night shifts that you had been working. You were informed by the Agency that it required a meeting with you, scheduled for 22 January 2020, and invited you to attend the office to discuss your shifts and rota.

The panel had regard to Exhibit CW/01 – the audio recording between Person B and the Agency – when Person B informed the Agency that you had not attended your allocated shift on 31 December 2019, and so you should not receive payment for that shift. During this phone call, Person B did not inform the Agency that you failed to attend your shift on 4 November 2019.

In response to panel questions, you explained that you were contacted by the Agency to attend a meeting on 22 January 2020. You were told by the Agency that it 'needed a meeting with you and to come to the office to discuss rotas. You said you were given no information about the full purpose of the meeting in advance and no documentation. You told the panel that at this meeting there were three members of staff from the Agency present.

You said that you were asked about the shifts you worked and you then mentioned that you may not have worked a shift on 4 November 2019 as Patient A was taking part in a sleep study around that time.

During this meeting you asked if the purpose of the meeting was in regard to an issue that you had raised with the Clinical Lead, Ms Paula Rowe (Ms Rowe) about cleaning Patient A's room. You were told that this was not the case and you were never told the purpose of the meeting was in relation to Person B's complaint.

The panel had sight of notes from this meeting which were produced on 4 February 2020, two weeks after the meeting. The notes recorded that this meeting lasted for approximately 55 minutes, however, the panel did not see any evidence that these notes were agreed or signed by you.

The panel determined that the notes of the meeting on 22 January 2020 did not provide reliable evidence as to your statements on the day. The panel noted the way in which the meeting was convened, and the quality of the written record. The meeting minutes comprised of two pages and the panel determined that these may not have been fully comprehensive. The panel further noted that there was no evidence that you had any opportunity to amend or confirm the meeting minutes.

The panel then had regard to the meeting minutes dated 13 February 2020.

You were accompanied by an RCN representative and you gave consistent evidence throughout the meeting that you had worked the shift on 4 November 2019. The panel noted that you were clear and recalled handing over in the morning the care of Patient A on the morning of 5 November 2019 to their father, who had signed the time sheet. The panel noted that under cross examination you stated that Person B was asleep that morning, and this is why Patient A's father had signed the timesheet. However, you conceded under cross examination that it was not possible that Patient A's father had signed this on 5 November 2019 at home as the timesheet was dated 8 November 2019.

Under cross-examination, you acknowledged that you worked with Patient A at school that week and Patient A's father had signed your timesheet when you handed over Patient A's care to him after school on 8 November 2019. The panel had regard to the signed

timesheet on the morning of 8 November 2019 indicating that was your final day of work that week.

The panel heard in Dr Wickramarachchi's oral evidence that the only way the Agency knew if a nurse had not worked an allocated shift was if the parents contacted the Agency about this, or if the nurse contacted the Agency to inform them. The panel also considered that the signed timesheet for the week of 4 November 2019 served as confirmation of the hours you had worked.

Notwithstanding the inconsistencies in your oral evidence, the panel also considered that if you had not worked on 4 November 2019, then it was highly likely that Person B would have reported that to the Agency. The panel had regard to the log of the call between Person B and the Agency dated 24 January 2020 at 12.30pm. This call related to a shift on 31 December 2019, and Person B is recorded as stating:

*'Lusina had always turned up for her shifts. This was the only one she had not. [Person B] clearly remembers this as she had to chase Lusina for an answer on that day.'*

In oral evidence, Dr Wickramarachchi said that she carried out an investigation regarding 4 November 2019 to see:

*'...whether there is any information about she is not working on 4<sup>th</sup> ...but we could not find anything'*

The panel further noted that the father of Patient A is unlikely to have signed the timesheet if you had failed to attend your shift. The panel determined that it was more likely than not that you had worked the shift on 4 November 2019, and therefore found charge 1a not proved.

## **Charge 1b**

1. In relation to a night shift which was due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019

- b. Claimed hours you had not worked on 4 November 2019 by submitting an inaccurate timesheet

Given the panel's reasons on charge 1a, it was not satisfied that you had submitted an inaccurate timesheet in respect of the shift on 4 November 2019. It therefore found charge 1b not proved.

### **Charge 2)**

2. Your conduct at charge 1(b) above was dishonest, in that you sought to create an impression that you had worked the shift due to commence on the evening of 4 November 2019 through to the morning of 5 November 2019.

**This charge is found NOT proved.**

In light of the panel's decisions in respect of charge 1a and 1b, the panel found this charge not proved.

### **Charge 3)**

3. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift due to commence on evening of 4 November 20219 through to the morning of 5 November 2019 when you had not.

- a. Night Clinical Checklist for 4 November 2019

- b. Fluid Balance Chart for 4 November 2019

c. Night Shift Evaluation Sheet for 4 November 2019

d. MAR Chart for 4 November 2019

**This charge is found NOT proved.**

In light of the panel's decisions in respect of charges 1a and 1b, the panel determined that the clinical documentation listed in this charge had been completed in accordance with care given by you to Patient A between 4 November and 5 November 2019. Accordingly, the panel found this charge not proved.

#### **Charges 4 and 5**

4. On 31 December 2019, failed to attend your night shift at Patient A's home
  
5. Completed one or more of the following documents indicating that you had provided care to Patient A during a night shift commencing on 31 December 2019 on 31 December 2019 when you had not:
  - a. Night Clinical Checklist for 31 December 2019
  - b. Fluid Balance Chart for 31 December 2019
  - c. Night Shift Evaluation Sheet for 31 December 2019

**The panel found charges 4 and 5 proved, by way of your admission.**

#### **Charge 6**

6. Your actions at any or all of charge 3 and/or 5 were dishonest, in that you intended

to create an impression that you had provided Patient A with the care they required when you had not.

**This charge is found proved in respect of charge 5 only.**

In reaching its decision, the panel was only considering dishonesty in respect of charge 5. The panel did not consider dishonesty in respect of charge 3 having found it not proved. The panel noted that these allegations were in relation to the night shift on 31 December 2019, and you had admitted that you had not worked that shift.

In your oral evidence, you stated that you informed Ms Rowe you could not work on 31 December 2019, as you had agreed to work over the Christmas period instead. You also stated that at the end of the night shift on 27 December 2019, you spoke to Person B to explain that you would not be coming in to work the shift on 31 December 2019.

The panel further noted that you stated in your oral evidence that you were informed on 30 December 2019 by Ms Rowe that she was unable to find a nurse to cover this shift, and you would have to work that shift. This was the last day that Ms Rowe was working for the Agency. You were advised to contact the out of hours team if you could not attend this shift.

The panel considered Dr Wickramarachchi's oral evidence, where she stated that agency nurses had a right to state the days they did not wish to work, and it was for the Agency to arrange appropriate cover in these circumstances.

As you did not work the night shift on 31 December 2019, you stated that you offered an alternative shift on 10 January 2020 to Person B. This was not your original assigned shift by the Agency. It was a Friday, which was a shift that was usually provided by Patient A's parents, and therefore you said that you would not be paid if you submitted a timesheet for this date. The panel had regard to the call log between the Agency and Person B on 16 January 2020 at 09.28, which said:

*'Mum heard nothing from Lusina so called her on the 31<sup>st</sup> to see if she was going in that night and was told no. Lusina then said she would make up the hours on the Friday. And Lusina worked 10 January 2020.'*

In addition, the panel had regard to the audio recording – CW/01 – where there was a discussion around the swapping of shifts between Person B and the Agency, where the Agency said all shift changes should be discussed with them, and not managed locally between the nurse and the family. In response, Person B was recorded as stating:

*'Normally if we had any appointments or overnights, we'd make them up at the weekend...you're probably right we've just been lucky to get away with that, with Paula for so long'*

You told the panel that that you were in a dilemma about what date you should put on the clinical records. You also stated you completed the night clinical checklist and fluid balance chart in relation to the care provided on 10 and 11 January 2020. You said that you dated the night shift evaluation sheet for the care provided to Patient A as 31 December 2019. When you completed the evaluation sheet on the morning of 11 January 2020, you put this date and stated, *'you left it at that'*. You did not explain your reasoning for this.

In response to questions from the panel about why you left the MAR record and the observation chart blank for 31 December 2019, you said that you signed the MAR record and the observation chart on 10 January 2020. These documents were not before the panel.

The panel considered that Patient A's records were critical clinical documents, essential for providing an accurate summary of care given to ensure safe patient care continuity and communication to the wider team. These records included:

- A clinical checklist details of the safe placement of the NG tube,

- Checking Patient A's BiPap machine and mask; and
- Ensuring that correct medication has been given.

The panel noted that you accepted that there could have been serious implications for both your colleagues and Patient A, by not providing an accurate record of care.

In panel questions, you were asked to recall what was going through your mind at the time when you were completing the Night Evaluation Sheet. You told the panel that

*'I did went for the shift on the 10 and I was just thinking to myself should I put the 10 because I was not assigned to work so at the beginning of the shift that is when I put like the 31 January but still in my mind I could feel like it was not right...'* [sic]

The panel applied the principles of *Ivey v Genting Casinos* [2017] UKSC 67, to establish dishonesty in its consideration. It decided to apply the two limbs of dishonesty to this case.

In regard to limb 1, the panel having considered your oral evidence, determined that you were well aware of what you were doing and the serious consequences of your actions.

In regard to limb 2, the panel determined that an ordinary member of the public would find your conduct dishonest, as providing an accurate record of patient care is a fundamental tenet of the nursing profession. The panel therefore found charge 6 proved.

### **Charge 7**

7. In relation to a night shift which was due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020, claimed hours that you had not worked

**This charge is found proved, by way of admission.**

## **Charge 8)**

8. Your conduct at charge 7 above was dishonest, in that you sought to create an impression that you had worked the night shift due to commence on the evening of 31 December 2019 through to the morning of 01 January 2020.

### **This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence, your statement and reflection dated 31 October 2023 in which you stated:

*'On the timesheet I claimed 31 December 2019 which I did not work and worked on 10 January which I did not claim.'*

The panel applied the principles of *Ivey v Genting Casinos* [2017] UKSC 67, to establish dishonesty in its consideration. It decided to apply the two limbs of dishonesty to this case.

In regard to limb 1, the panel having considered your oral evidence, determined that you knew your actions were dishonest, in that you knowingly submitted a timesheet in order to receive payment. It acknowledged that you had worked on 10 and 11 January 2020, but these shifts were not your assigned shifts and you would not have received payment for this.

The panel in its consideration applied limb 2 and the test for dishonesty, and was of the view that an ordinary member of public would consider your actions dishonest. The panel determined that you knowingly submitted a timesheet for a shift you had not worked in order to be paid for a shift that you did work on a later date. It noted that you had not informed the Agency of the change in dates of your shifts. Whilst there was no overall pecuniary advantage to you, honesty is a fundamental tenet of the nursing profession and patients and the public place their trust in nurses and expect them to maintain professional standards. The panel therefore found charge 8 proved.

## **Cross admissibility**

The panel determined that cross admissibility did not apply in this case. Whilst you have admitted claiming for hours not worked on the night shift due to commence on 31 December 2019 through to the morning of 1 January 2020, you explained that there was a specific set of circumstances on this date. You had offered to work over the Christmas period and had worked 24,25, and 26 December 2019. You told Ms Rowe and Person B in advance that you could not work on 31 December 2019 as it was New Year's Eve and you said you would be with your family. You received an email late on 30 December 2019 from Ms Rowe telling you to work as she had not been able to find another nurse to cover the shift.

In the recording of the phone call from Person B on 15 January 2020, Person B said that you had not worked the night shift commencing on 31 December 2019 and should not be paid for this. Person B mentioned another shift in January that you did not work but the agency confirmed on the call that this was a cancellation by the family. Person B did not say that you had not worked a night shift commencing on 4 November 2019.

Therefore, the panel considered that although the nature of the allegation that you claimed for hours that you did not work on 4 November 2019 and 31 December 2019 were similar, and that you had completed clinical records on both dates, the circumstances of each allegation were distinct.

Therefore, the panel determined that cross admissibility does not apply in this case, as there was no evidence provided that you had a propensity to commit acts similar to those in dispute.

## **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**

Ms Barnor invited the panel to find the facts found proved amounted to misconduct.

Ms Barnor referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, which defines misconduct as:

*'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances'*

Ms Barnor reminded the panel of the charges found proved. She referred the panel to the case of Nandi v General Medical Council [2004] EWHC 2317 (Admin), which states:

*'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*

Ms Barnor submitted that by applying the above quote to this case, the panel are considering your acts, as opposed to omissions, and that the charges found proved are serious in nature.

Ms Barnor submitted that four themes have been identified, and these are as follows:

#### **Failure to attend a scheduled shift**

Ms Barnor submitted that there was a clear failure to attend a schedule shift and referred the panel to the details in charge 4. She submitted that Dr Wickramarachchi set out comprehensively at paragraph 9 of her initial witness statement Patient A's serious health condition, and that as a result, they are fully dependent on a BiPap machine to support their breathing needs and external parties for their other care needs. She submitted that this also includes care that can only be provided by a nurse and that Patient A had undergone an independent assessment, which confirmed they required a care package.

Ms Barnor submitted that this assessment had been conducted to manage the risks associated with Patient A's condition, and by failing to attend your shift, you put Patient A at direct risk of harm. She also submitted Dr Wickramarachchi stated that the Agency were unaware of alternative care arrangements, and even if Patient A's parents were able to provide alternative care, your actions amount to serious misconduct, as it went against Patient A's assessed clinical package. She also submitted that Patient A was put at risk, as they did not receive the care expected, as a direct failure of you attending your scheduled shift.

Ms Barnor submitted that it is of limited relevance that you informed the Agency that you were not able to attend your shift on 31 December 2019, and that as part of your duty as a registered nurse, you were expected to attend your shift. She submitted that you should have contacted the out of hours team to explore options, but that you chose not to. She submitted that in regard to your failure to attend your scheduled shift on 31 December 2019, your actions fell well below the expected standards of a registered nurse, and amounted to serious misconduct.

### **Completion of Patient A's care records**

Ms Barnor went on to address the panel on the next theme – the completion of Patient A's records. She submitted that accurate record keeping is a fundamental tenet of nursing practice, and reminded the panel of Patient A's medical condition. She submitted that by intentionally documenting that you had provided care to Patient A when you had not, you placed them at a significant risk of harm. She submitted that other healthcare professionals would have relied on these inaccurate documents, and this could have had devastating consequences for Patient A. She submitted that in regard to the inaccurate completion of Patient A's care records, your actions fell well below the expected standards of a registered nurse, and amounted to serious misconduct.

### **Claiming for hours not worked**

Ms Barnor next addressed the panel on the charge relating to claiming for hours not worked – charge 7. She submitted that accurate record keeping is a fundamental tenet of nursing practice. She referred the panel to Dr Wickramarachchi's evidence, where she stated that agency staff were only paid for the hours worked. She submitted that Mr Trussler made the suggestion that you did not obtain nor seek any pecuniary advantage in claiming as you did, and that this was accepted. She submitted that by claiming hours not worked, you misused public funds to pay for a shift you did not work, notwithstanding that you later made the shift up.

Ms Barnor submitted that your deliberate and calculated actions could have had a ripple effect on the pool of public funds allocated to patient care, and further, could have had serious implications on Patient A's care package. She also submitted that if nurses were allowed to claim hours not worked and then work alternative shifts, this would place patients at a risk of harm, as it would be difficult to fully understand what care has been provided. She invited the panel to find that your actions, in that you claimed hours not worked as an abuse of your position and that this amounts to serious misconduct.

### **Dishonesty**

In regard to the theme of dishonesty, Ms Barnor submitted that nurses are privileged to occupy a position of trust in society and the public expects them to be honest. She submitted that by intentionally claiming for shifts not worked and completing Patient A's records to indicate you had provided care when you knew you had not, your actions fell well below the standards expected of a registered nurse. She submitted that if you wished to work on and be paid for 10 January 2020, you should not have claimed for the shift dated 31 December 2019, and informed the Agency of the change in rota. She submitted that instead, you chose to 'self help' in a dishonest manner, and invited the panel to find that charges 6 and 8 amount to serious misconduct.

Ms Barnor submitted that in cases such as this, where it relates to dishonesty, it is appropriate for the panel to consider where this type of dishonesty falls on the scale of seriousness. She referred the panel to the case of *Lusinga v NMC* [2017] EWHC 1458 (Admin).

Ms Barnor referred the panel to NMC guidance, namely SAN-4, and submitted that your actions as found proved fall within the following factors:

- a) misuse of power;
- b) personal gain from a breach of trust;
- c) direct risk to people receiving care; and

d) premeditated or longstanding deception.

In relation to dishonesty, she referred the panel to NMC Guidance – SAN-4 – and submitted that you were able to claim hours not worked as you were a lone worker, and that the Agency trusted their agency nurses to complete timesheets accurately. She submitted that you financially benefited from a breach of that trust, in that you worked a day more convenient for you, despite being allocated the shift on 31 December 2019. She also submitted that direct harm was caused to Patient A, in that they did not receive the care that they had been assessed for, and that your dishonesty was premeditated. She further submitted that you intentionally completed Patient A's notes for these dates, in the full knowledge that you had not worked those dates. She submitted that this dishonesty is not at the lower end of the spectrum.

Ms Barnor submitted that in regard to the charges found proved, the following sections of the Code have been breached: 1.2, 4, 8.2, 8.5, 10.1, 10.3, 20.1, 20.2, and 20.8.

Mr Trussler submitted that in regard to charges 5 and 6, the matters of misconduct and impairment are for the panel to consider. He submitted that the aforementioned charges do amount to misconduct, and he does not seek to persuade the panel otherwise. However, in regard to charges 4, 7 and 8, you accept that you would have done things differently. He referred the panel to your reflective statements, and submitted that a significant amount of time has passed since the allegations were first raised. He also submitted that you have practised without any issues since the referral. He submitted that prior to this referral, you had been a nurse for over 33 years without any concerns.

Mr Trussler reminded the panel of your oral evidence, and submitted that at the time of the incidents, you were stressed, and wanted to spend time with your family, and that you made it clear to the Agency you were not available to work on 31 December 2019. He submitted that in regard to the risk to Patient A, this was mitigated as Person B was also providing care to them a number of times a week. He also submitted that this was not an instance where you did not notify anyone that you could not attend your shift, and that you

accept in hindsight you would have done things differently. He also submitted that you acknowledge that your actions at the time were wrong, but that you did inform Person B , and made arrangements with Person B to provide care to Patient A on another occasion. He stated that at the time you were unsure as to what you should put on the clinical record, but you have since reflected on your actions.

Mr Trussler submitted that the issues around clinical records are more serious, but with regard to your timesheet, Ms Barnor's submissions to suggest fraud is worded too strongly, and this detail was not charged to you. He submitted that it is accepted that you did not benefit from the claim, and that you worked the shift and you were not paid extra. He submitted that it is accepted that the clinical records were incorrectly completed. He submitted that the records for claiming hours not worked are a different order to misleading clinical records, which crosses the misconduct threshold. He invited the panel it was only your actions in respect of completing incorrect clinical records that were so serious as to amount to misconduct.

### **Submissions on impairment**

Ms Barnor addressed the panel on the issue of impairment and reminded the panel 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.

Ms Barnor referred the panel to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), in particular, paragraph 74:

*'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'.*

Ms Barnor also referred the panel to the four points as outlined by Dame Janet Smith in the 5<sup>th</sup> Shipman Report. She submitted that all four points as listed below can be answered in the affirmative in this case:

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

Ms Barnor submitted that all four limbs are engaged in this case. She submitted that in regard to limb a, by not attending your scheduled shift, Patient A was placed at risk of unwarranted harm. she submitted that they required a certain amount of clinical care, that by failing to attend you deprived them of the care required. She submitted that further, by inaccurately completing his records, other clinicians caring for Patient A would have had an inaccurate picture of the care that had been provided to them and potentially provided care that was not clinically indicated or appropriate.

In regard to limbs b and c, Ms Barnor submitted that practising effectively, preserving safety, and promoting professionalism and trust are fundamental tenets of the profession. She submitted that nurses occupy a position of trust and are required to keep to and uphold the standards expected of them in the Code. She also submitted that you placed Patient A at unwarranted risk of harm by failing to attend your shift and inaccurately completing Patient A's records. She also submitted that you have brought the nursing profession into disrepute, as you sought to perpetuate fraud against the Agency for your own personal gain. She submitted that your actions raise questions around your professionalism and trustworthiness in the workplace.

Ms Barnor also submitted that your actions demonstrate a flagrant departure from the fundamental tenets of honesty and integrity, and safe and effective practice. She submitted that members of the public would be extremely concerned to learn that a nurse trusted to go into a vulnerable patient's home to provide care had falsified timesheets and medical records, and that consequently they may be deterred from seeking home nursing care when needed, thus placing potential patients at risk of harm.

In regard to limb d, Ms Barnor submitted that the panel have already concluded that you were dishonest when you claimed hours not worked on 31 December 2019, and inaccurately completed Patient A's clinical records for that shift.

Ms Barnor referred the panel to NMC guidance FTP-16, and referred the panel to the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin). This case asks the questions:

- (i) whether the concern is easily remediable;*
- (ii) whether it has in fact been remedied; and*
- (iii) whether it is highly unlikely to be repeated.*

Ms Barnor submitted that by intentionally not attending scheduled shifts without the necessary authorisation from your employer, and dishonesty, especially that was premeditated and deliberate, is strongly indicative of a character flaw. She submitted that the misconduct in this case is the type that cannot be easily addressed through insight, training or supervised practice. She also submitted that you have provided limited evidence to demonstrate the misconduct in this case has been addressed. She referred the panel to your testimonials and training certificates, and submitted that despite this, there is little evidence to indicate how you have embedded the training into your practice, or how you would act if you were to find yourself in a similar situation in the future. She submitted that the testimonials are somewhat generic, and there is no evidence before the panel to support any insight into your dishonest conduct. She submitted that it remains likely that the conduct will be repeated.

Ms Barnor submitted that you have in the past, and continue to present a risk of putting patients at unwarranted risk of harm, that a finding of impairment on public protection is necessary. She submitted that this is a serious case, your actions have had a detrimental impact on public confidence, and the NMC as its regulator and involves fundamental breaches of tenets of practising effectively, honestly and with integrity, and the duty of candour. She submitted that this is a case that should also be marked with a finding of current impairment on the ground of public interest.

Mr Trussler submitted that in regard to impairment, there have been no instances of repetition since the referral, and that you have taken steps to reflect and develop insight. He referred the panel to the positive testimonials regarding your professional practice, and urged the panel to give the testimonials the appropriate weight. He submitted that you acknowledge the impact your actions had, and that you are remorseful. He also submitted that the incidents as found proved were out of character for you, and that you wish to assure the panel that you do not intend to repeat the conduct found proved. He invited the panel not to find your fitness to practice currently impaired on the grounds of public protection or in the wider public interest.

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

## **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 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

## **8 Work cooperatively**

To achieve this, you must:

**8.2** maintain effective communication with colleagues

## **10 Keep clear and accurate records relevant to your practice**

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

**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

**10.3** 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

## **20 Uphold the reputation of your profession at all times**

**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...

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively as well as the circumstances of the case as a whole.

The panel next considered each charge found proved in turn, and if it was so serious as to amount to misconduct.

### **Charge 4**

The panel noted that you admitted this charge. The panel took account of the circumstances surrounding your failure to attend the night shift, and noted that you had told the Agency on a number of occasions that you could not attend your night shift on 31

December 2019 and that you had informed Person B of this. You had offered and had worked over the Christmas period and made it clear you wanted to spend time with your family. Notwithstanding this, you told the panel in your evidence that Ms Rowe emailed you at short notice on 30 December 2019, on the day of her departure from the organisation, stating that she had been unable to locate cover for the shift, and requested that you attend.

The panel determined that the responsibility to secure alternative care arrangements was on the Agency. It heard from Dr Wickramarachchi, who stated in her oral evidence that if nurses were not available to provide care, it was the responsibility of the Agency to find alternative care, or notify the family that the shift could not be covered. The panel noted that you had taken all reasonable steps to inform both the Agency and Person B in advance that you were not available to work on 31 December 2019.

The panel carefully considered Ms Barnor's submissions, specifically on the point that you had failed to contact the out of hours service to explore options, and secure alternative care arrangements for Patient A. However, the panel was mindful of the specific wording of the charge which is limited to your failure to attend the night shift.

The panel therefore determined that given the particular circumstances in respect of this charge, your actions were not so serious as to amount to misconduct.

### **Charge 5**

The panel noted that you have made an admission to this charge, which related to you completing clinical records for care provided to Patient A, when you had not. These records included a record of checking vital clinical equipment, in particular, ensuring Patient A's nasogastric (NG) tube was in situ, and that their BiPAP breathing machine was in working order. In addition, you completed the fluid balance chart for Patient A on a date in January 2020, but dated it 31 December 2019. Similarly, you also completed the Night Evaluation Sheet for care given on 11 January 2020 with the date at the top of the record

noted as 31 December 2019. Providing written documents for care you had not provided to Patient A placed them at risk of harm. Patient A was vulnerable, with a complex health condition, requiring careful monitoring and clinical intervention to keep them safe. If they had been admitted to hospital, other clinical staff would have been relying on inaccurate information, putting Patient A at risk.

The panel therefore determined that your actions were so serious as to amount to misconduct.

### **Charge 6**

The panel noted that whilst you completed these records for care that was given on 10 January 2020, you knowingly entered the wrong date on the clinical records to give the impression care was provided to Patient A on 31 December 2019. The panel considered that your dishonest conduct arose in the context of your professional practice in relation to the care of a vulnerable patient with complex health needs, who was placed at a risk of harm through your actions.

The panel therefore determined that your actions were so serious as to amount to misconduct.

### **Charge 7**

The panel noted that you made an admission to this charge, in that you claimed for hours not worked on 31 December 2019. The panel took account of the specific circumstances surrounding your actions, as set out above. It also noted that you deliberately claimed these hours, in order to ensure that you were paid. However, you did work a shift on 10-11 January 2020 to replace this, and ensure Patient A did not lose a day from the assessed care package. Therefore, the panel determined that whilst there was no pecuniary advantage to you, and there was no misuse of public funds, you were claiming to be paid for a shift on a date you did not work. In addition, the panel determined that there were

wider implications of your actions, in that you were recorded as working on a day you did not, should there have been any need for an investigation or review of care provided to Patient A.

The panel determined that your actions, in that you submitted a timesheet for a shift you did not work fell short of the standards expected of a registered nurse.

The panel therefore determined that your actions were so serious as to amount to misconduct.

### **Charge 8**

The panel noted that this charge relates to dishonesty, and that you knowingly and deliberately sought to create an impression that you worked a night shift due to commence on 31 December 2019, when you did not. Whilst the panel was informed that there was custom and practice to make arrangements to change working days, you stated that all previous changes had been discussed with Person B and Ms Rowe. On this occasion, you made a local arrangement with Person B, and knowingly claimed for the shift as originally scheduled on 31 December 2019, in order to receive payment for a shift you worked on a later date. The panel noted that after Ms Rowe had left the organisation, you failed to inform the out of hours service of the arrangements you put in place, and that you would not be working on 31 December 2019.

The panel determined that your dishonesty in creating an impression that you worked the night shift on 31 December 2019, when you in fact worked a shift on a later date fell well below the expected standards of a registered nurse.

The panel therefore determined that your actions were so serious as to amount to misconduct.

## Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, namely DMA-1, updated on 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.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

The panel determined that limbs a, b, c and d are all engaged in this case for the reasons set out below. When considering the issue of future risk, the panel considered the principles derived from R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin):

- (i) whether the concern is easily remediable;*
- (ii) whether it has in fact been remedied; and*
- (iii) whether it is highly unlikely to be repeated.*

The panel noted that the inaccurate completion of Patient A's clinical records put them at risk of harm. The panel noted that you stated in your second witness statement that:

*'As for the dates, I admit I was not thinking straight. It was a silly mistake. I don't deny that.'*

The panel also noted that you said in your reflective statement:

*'...I also feel remorseful and apologetic at what happened and felt I should have apologised for mistakes and failings at the time and perhaps this should have not escalated to this point. I have taken responsibility about what happened and have learnt from this incident and I am now self aware and will be on the guard in the future so that this wont happen again...' [sic]*

The panel noted that your misconduct arose on a single incident (although the consequences of your actions went beyond 31 December 2019). The panel also noted that you were placed under a significant amount of pressure by the Agency to attend work when you were not available. You told the panel that these pressures affected your mental health, and you sought counselling help. In addition, the panel had sight of an email from you to the Agency dated 13 December 2019 at 13.04 stating:

*'I feel I am not well enough to do the job I need to be off rather than going in with a disturbed mind (stressed) as one tends to make errors. hence decided to reduce to what I can feel comfortable doing' [sic]*

In your evidence, you also described the negative impact pressure of work was having on [PRIVATE].

The panel considered that you had shown remorse and some insight in both your witness statements and your reflective piece. However, the panel considered that these documents lacked depth, detail and specificity. As a result, the panel was not satisfied that if you were faced with a similar set of circumstances in the future how you would respond differently. The panel heard no evidence of coping mechanisms you have developed in response to workplace pressures, despite the additional training you have undertaken, or

evidence of what actions you would take to ensure you can maintain and uphold the standards expected of a registered nurse.

The panel acknowledged the positive testimonials provided by your line managers, and other registered professionals, who all attested to your commitment to your nursing practice, your patients, your reliability and trustworthiness. The panel was mindful however, that these did not speak directly to the to the specific circumstances you found yourself in.

The panel determined that your actions brought the nursing profession into disrepute, by adversely affecting the public's view of how a registered nurse should behave. The panel concluded that there is a risk of repetition in the future, due to your underdeveloped insight. It also noted that by completing inaccurate clinical records, you breached a fundamental tenet of the nursing profession. You said this was a mistake when you were working under pressure, but again due to your underdeveloped insight, the panel concluded there is a risk of repetition in the future.

The panel further determined that you acted dishonestly by completing the incorrect date for Patient A's clinical records, and claiming for hours on a date you did not work. The panel determined that there remains a risk of repetition, as you have not provided evidence of insight as to how you would respond differently in the future. The panel were particularly concerned about your decision making in respect of clinical records, and the potential risk of harm to patients if such documents were deliberately completed inaccurately. The panel therefore concluded that your fitness to practise is impaired on the grounds of public safety.

The panel went on to consider where the dishonesty found proven sits on the spectrum of seriousness. It had regard to the NMC guidance on sanctions for the highest risk cases – SAN-4 – (as referred to by Ms Barnor in her submissions), which sets out the following factors to consider when determining seriousness:

- *‘Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- *Misuse of power*
- *Personal or financial gain from a breach of trust*
- *Direct risk to people receiving care*
- *Premeditated, systematic or longstanding deception.’*

The panel went on to consider each of the above points in turn.

### **Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care**

The panel determined that the professional duty of candour was not directly engaged in this case, as defined in the joint NMC and GMC Guidance on *‘Openness and honesty when things go wrong: the professional duty of candour’*, last updated 13 December 2024. You did not attend your shift on 31 December 2019, and you made a local arrangement with Person B to attend a shift on a later date. The panel considered that you were open and honest with the family of Patient A as to the care you were unable to provide to Patient A. However, you were not open and honest with the Agency about these arrangements being made.

The panel determined that you deliberately misrepresented the date on Patient A’s clinical records in order to reconcile the clinical records to the preexisting shift rota. You were therefore not open or honest about the actual date on which you had delivered care to Patient A, which could have placed them at risk of harm had they required any further care provided by other healthcare professionals.

### **Misuse of power**

The panel took account of Ms Barnor's submissions that your dishonesty in claiming hours not worked was an abuse of your position as an agency worker working independently in a patient's home, and making alternative arrangements for your own convenience. The evidence before the panel did not suggest this was the case. You told the Agency in advance that you were not available to work on 31 December 2019. Under the Agency's own policies in the Handbook (Exhibit CW/13), it is the Agency's responsibility to arrange appropriate nursing cover. When this did not materialise, you offered an alternative date to Person B. It determined that your actions were driven by the specific set of circumstances as set out above.

### **Personal or financial gain from a breach of trust**

There was no evidence before the panel to demonstrate that you benefited financially, as the hours worked on 10-11 January 2020 balanced against the hours worked and paid on 31 December 2019.

### **Direct risk to people receiving care**

The panel acknowledged that Patient A not receiving their scheduled care on 31 December 2019 would ordinarily place them at risk of harm. However, the panel noted that the care package in place with the Agency was not a full time arrangement, and that Patient A's family members would provide the care on the days when the Agency were not due to attend. The panel noted that you informed Person B that you were not working on 31 December 2019.

The panel determined that your actions in completing the dates on the clinical records incorrectly did put Patient A at risk of harm. These would have provided incorrect information regarding their clinical care and health status, if other health professionals needed to rely upon them.

### **Premeditated, systematic or longstanding deception**

The panel noted that your actions were related to a single incident (although the consequences of your actions went beyond 31 December 2019) and arose from a specific set of circumstances, rather than being systematic or longstanding deception.

Having deliberated on the factors to consider when determining seriousness, the panel determined that your dishonesty was serious. However, it acknowledged the significant mitigating features in this case, and the specific circumstances in which your dishonesty arose.

The panel considered whether your dishonesty was indicative of a deep seated attitudinal issue, and referred to the NMC Guidance – DMA-1 – which refers to a deep seated attitudinal issue as:

*‘A deep seated attitudinal issue refers to an ingrained mindset or belief system that is contrary to these values and behaviours expected of the profession...’*

The panel determined that you have breached the fundamental tenets of the nursing profession, namely honesty and record keeping, these related to a single incident and a specific set of circumstances. Having regard to these factors, the panel concluded that the concerns in your case were potentially capable of being remediated through specific training on workplace pressures and assertiveness and through further developed insight.

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

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

### **Decisions and reasons on application for interim order**

Ms Barnor made an application to impose an interim suspension order for a period of 6 months. She submitted that an interim order is necessary on the grounds of public safety and public interest. She submitted that giving the panel's decision on the facts, an interim suspension order would be most appropriate. She referred the panel to NMC guidance – INT-2 – and submitted the following:

- There is a direct link between the concerns and your clinical practice, and the concerns arose during the course of your work as a nurse;
- Patient A was placed at significant risk of physical harm; and
- The panel has already determined that the misconduct is likely to be repeated in the future, and that you are impaired on the grounds of public interest, in that there would be serious damage to public confidence and trust in the profession.

Ms Barnor submitted that the most appropriate order would be that of an interim suspension order. She submitted that an interim conditions of practice order would be insufficient to address the risks in this case. She also submitted that the panel would struggle to fashion relevant, workable, or measurable conditions to mitigate the risk of dishonesty, and that patients using services would be put at risk, as determined by the panel in its decisions on your fitness to practise.

Mr Trussler submitted that he agrees with Ms Barnor in regard to the matters being considered by the panel. He referred the panel to its decisions on the stages considered thus far, and submitted that you were involved in a single incident, and that you were under considerable amounts of pressure. He also submitted that up until this referral, you had an unblemished record, and that since the referral, you have had no issues raised regarding your clinical practice.

Mr Trussler submitted that an interim order is not necessary as you have practised without any concerns. He submitted that you are remorseful, and do not intend to repeat such conduct. He referred the panel to your training certificates, and submitted that you should be allowed to practise unrestricted.

Mr Trussler submitted that protecting the public is paramount, and that the public is sufficiently protected. He also submitted that the panel did not find in its previous decisions that there was a risk of significant harm. He further submitted that the panel referred to a risk of repetition, as opposed to your conduct was likely to be repeated. He submitted that imposing an interim order would have a significant impact on you, and that an interim order is not necessary.

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

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 charges found proved, and the reasons set out in its previous decisions in reaching the decision to impose an interim order.

The panel acknowledged that you have practised unrestricted without issue since 2019. However, having made a decision that your fitness to practise is currently impaired, the panel determined that it would not be appropriate to allow you to continue to practise without restriction at this time. It noted that the concerns were raised in relation to your clinical practice, and whilst you have demonstrated some insight, it remains underdeveloped at this time. The panel concluded that as there is a risk of repetition, it could not be satisfied you would not repeat the conduct as found proved if you found yourself in similar circumstances in the future.

The panel noted the impact any kind of interim order would have on you, but determined that this is outweighed by the need to protect the public and meet the wider public interest.

The panel considered the nature of the charges found proved. It noted that whilst the concerns were raised during your clinical practice, they are not directly linked to your clinical skills. It therefore decided that an interim conditions of practice order would not be appropriate, proportionate or workable in this case, due to the reasons already identified in the panel's determination on the finding of facts and fitness to practise.

The panel went on to consider an interim suspension order. It decided to impose an interim suspension order for a period of 6 months, in order to sufficiently protect the public and meet the wider public interest. It considered the nature of the case, and decided to impose an interim order for a period of 6 months to cover the period during which the case will be concluded.

This hearing went part heard on Wednesday, 29 April 2026.

The hearing resumed on Wednesday, 13 May 2026.

## **Sanction**

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance, '*The sanctions available*' (SAN-2).

## **Submissions on sanction**

Ms Barnor submitted that the NMC is seeking the imposition of a striking-off order. She reminded the panel that sanctions are not designed to punish registrants, and any

sanction imposed must not do more than necessary to protect the public and meet the public interest, balanced against your right to practise in your chosen field.

She addressed the panel on the aggravating and mitigating features of this case. In respect of aggravating features, she submitted that the below are engaged:

- Premeditated and deliberate acts of dishonesty;
- Patient A was especially vulnerable due to their serious health condition, leading them to require higher levels of nursing care;
- Misconduct which deliberately or recklessly put Patient A at risk of harm;
- Dishonesty which spanned more than one day, albeit occurred in the context of one incident; and
- Limited insight.

Ms Barnor submitted that the following mitigating features arise in this case:

- No previous Fitness to Practise history;
- No repetition of the misconduct since the referral;
- Expressed remorse for your actions; and
- Personal mitigation, including you were experiencing difficulties with the agency as well as [PRIVATE].

In respect of the personal mitigation, Ms Barnor submitted that personal mitigation is of limited relevance in Fitness to Practise proceedings.

Ms Barnor addressed the panel on all the sanctions available to it, in ascending order. She submitted that imposing no order or imposing a caution order would not be appropriate in these circumstances, in light of the panel's findings on misconduct. She submitted that imposing no order would be an extremely rare finding, and would be inappropriate in light of the risk to the public you have been found to continue to pose. In respect of a caution

order, Ms Barnor submitted that it is only appropriate in cases whereby there are no ongoing public protection concerns, which is not applicable in your case.

In respect of a conditions of practice order, Ms Barnor indicated that this is most appropriate when there are identifiable, clinical issues which could be addressed and rectified. She submitted that your misconduct involved dishonesty, in that you deliberately misrepresented dates to reconcile them with shift rotas, in order to cover up that you did not attend your shift. She further submitted that dishonesty, as a conduct, is unlikely to be addressed through supervision or courses. She submitted that no conditions could be devised which would address dishonesty, and she submitted that imposing a conditions of practice order would place vulnerable patients, particularly those in community settings like Patient A, at an unwarranted risk of harm. Consequently, a conditions of practice order is not appropriate in these circumstances.

Ms Barnor then addressed the panel on the imposition of a suspension order, and she referred the panel to the NMC Guidance, '*Suspension order*' (SAN-2d) as well as '*Deciding between suspension and strike off*' (SAN-3). She submitted that your misconduct is at the most serious end of the spectrum, calling into question your suitability to continue practising. She submitted that dishonesty is incompatible with ongoing registration.

Ms Barnor submitted that a period of suspension can be appropriate where a period out of practice can assist a practitioner in developing their insight. However, pursuant to *General Medical Council v Patel* [2018] EWHC 171, she submitted that the panel must consider if it is realistic for your insight into your dishonesty to sufficiently develop with a period of suspension. She submitted that, notwithstanding your engagement with the NMC process, the panel found your insight continues to lack depth, detail and specificity, six years after the misconduct. Ms Barnor submitted that your insight remains insufficient despite the time which has passed, and consequently, it is unlikely that your insight will be fully developed in one years' time with a period of suspension.

Further, Ms Barnor referred the panel to the principles derived from *Professional Standards Authority v the General Pharmaceutical Council and Onwughalu* [2014] EWHC 2521 (Admin), and she submitted that a period of suspension to allow you time to grasp your insight would be inappropriate. She further submitted, pursuant to *Professional Standards Authority v (1) Nursing and Midwifery Council and (2) Judge* [2017] EWHC 817 (Admin), that it would be unsupported wishful thinking that you may develop insight whilst suspended from practice. In these circumstances, Ms Barnor submitted that a suspension order would not be the appropriate order to impose.

Ms Barnor then addressed the panel on a striking-off order. She submitted that your misconduct is on the higher end of the seriousness spectrum, which raises fundamental questions regarding your professionalism. She further submitted that, pursuant to NMC Guidance, '*Sanctions for the highest risk cases*' (SAN-4), honesty is of central importance in nursing practice, and a practitioner who has been dishonest is always at risk of being struck-off. She reminded the panel that this is more likely in cases where patients were placed at a deliberate risk of harm.

Ms Barnor submitted that your dishonesty was in two parts, namely the claiming of hours you did not work and the subsequent dishonesty involving Patient A's records. She submitted that, whilst these are under the guise of one incident, these were two separate acts of dishonesty, at different times. She further submitted that your actions were deliberate and serious, and your insight has been found to be insufficient, which is unlikely to be fully developed with a period of suspension.

In all the circumstances, Ms Barnor submitted that public confidence in the nursing profession and the NMC as its regulator cannot be maintained if you are not removed from the register. She submitted that a striking-off order is the only sanction which would protect the public and maintain public confidence. She referred the panel to the principles derived from the case of *Professional Standards Authority v (1) Nursing and Midwifery Council and (2) Namusisi* [2023] EWHC 1230 (Admin), and she submitted that where there has been no insight into failings and there is a significant risk of repetition, the most

appropriate sanction is a striking-off order. She therefore invited the panel to impose such an order.

Mr Trussler reminded the panel that the NMC initially sought a period of suspension. He submitted that a substantial number of the allegations against you which have been found not proved, and there has been no repeat of your misconduct since the referral.

Mr Trussler noted that the NMC Sanctions Guidance was updated in late January 2026, however, he invited the panel to consider its findings that your dishonesty occurred in the course of one incident, borne out of a specific set of personal circumstances. He submitted that this limits the risk of you repeating your conduct. Further, he submitted that these proceedings have been distressing for you, and you are keen to not repeat your actions. He submitted that you have shown some insight, and you are remorseful of the poor judgment you made. He submitted that you have reflected on that, and you have since completed training on the duty of candour, on 30 September 2025.

Mr Trussler submitted that the panel has found that the conduct is remediable, and the misconduct was one event which occurred in context of a particular and difficult personal circumstances. Therefore, he submitted that a conditions of practice order would be appropriate, to allow you to continue providing valuable nursing service and keep your career whilst managing any risks. When asked by the panel what possible conditions he considered appropriate, Mr Trussler submitted that you identified open lines of communication being a concern. As such, mechanisms where you can speak to someone, such as a specified point of contact, whilst you are in difficulty would be beneficial. He also submitted that further training courses may also be beneficial.

The panel accepted the advice of the legal assessor.

## 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. 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 determined that the following aggravating features were applicable in your case:

- conduct which deliberately or recklessly puts Patient A at risk of suffering harm, by deliberately falsifying the dates of documentation in relation to their care;
- deliberate breaches of the Code, in that you made a conscious decision to falsify the dates of records;
- limited insight into your misconduct; and
- Patient A was particularly vulnerable, given their complex condition, requiring 24-hour nursing care in their home.

The panel noted Ms Barnor's submissions that your misconduct, whilst it occurred within a single incident, consisted of several individual acts of dishonesty. The panel considered whether this amounted to a pattern of behaviour. However, the panel bore in mind its earlier decision in respect of your fitness to practise above. Although there were several individual acts, all of these were as a consequence of your decision not to work the night shift on 31 December 2019. It determined that your misconduct did not amount to a pattern of behaviour.

The panel also considered whether you were dishonest in giving your evidence. The panel in particular considered your change of account in respect of the handover sheet, during cross examination. The panel noted that when confronted with documentation, you conceded the point made by Ms Barnor, which was that the handover sheet could not

have been signed at the time you claimed. The panel further noted that you did not seek to place blame upon anyone else and that you were giving evidence about events which occurred over 6 years ago. The panel was not satisfied therefore that your change in account was borne out of dishonesty.

Further, the panel also considered the fact that you had denied a number of these charges which had been found proven by the panel. In considering the principles derived from *Sawati v GMC* [2022] EHC 283 (Admin), the panel bore in mind that you are entitled to deny the allegations and defend yourself. The panel did not consider the charges found proved (which you denied) to amount to dishonesty in your giving of evidence.

On whether your conduct amounted to premeditated behaviour, the panel bore in mind its earlier findings that you made a deliberate and conscious decision to falsify the dates on Patient A's medical records as well as your own time sheet. The panel noted that you did not do the same in respect of Patient A's MAR chart or observation records. The panel was satisfied that this was conscious decision-making on your part.

However, in considering whether this decision-making process was premeditated, the panel considered your evidence that you found yourself in a difficult position working a shift that you were not rostered for and you were in a quandary, about what date to record on the clinical records. The panel bore in mind the difficulty you were having with the agency at the material time. Bearing this in mind, the panel determined that it was not a premeditated, longstanding or systematic deception, despite it being a conscious decision on your part at the time. Similarly, the panel determined that whilst you submitted a timesheet for a shift you did not work and this was a conscious decision this was in response to the situation you found yourself in.

The panel determined the following mitigating features were applicable in your case:

- early admission of some of the facts, albeit you denied dishonesty;

- evidence that you have worked safely and professionally since the incidents, including positive testimonials from colleagues, commenting on your current good practice in similar areas of work;
- relevant training courses in safeguarding, medication management, record keeping and duty of candour undertaken since the misconduct; and
- some evidence of reflective practice and references to clinical supervision.

The panel also determined the following personal mitigating features were applicable in your case:

- lack of support from the employer, including the pressure to continue attending work when you have described that this pressure to attend work created the potential for you to make mistakes, and was contrary to the employer's own practice; and
- the impact of the significant pressures to work additional shifts [PRIVATE].

The panel also bore in mind that you expressed remorse for your actions, and that you were apologetic to the NMC. However, it noted that there was no indication before it that you directly apologised to Patient A or Person B for your actions.

Bearing the above in mind, the panel then considered what sanction, if any, to impose.

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' (SAN-2b) in which the following is stated:

*'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 your actions were serious, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public, and consequently, it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on 'Conditions of practice order' (SAN-2c) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- ...
- ...
- ...
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel considered that your misconduct does not relate to your clinical skills, but rather concerns surrounding your professionalism and conduct, namely your decision-making in an unsupportive working environment and your dishonesty. The panel bore in mind Mr Trussler's submissions that further training may be undertaken to address the underlying concerns, and the panel accepted his submissions insofar as further training on understanding your decision-making process which led to you your actions would be of benefit to you and your reflective practice. The panel bore in mind its decision on

impairment above, in that the conduct is remediable with sufficient insight, reflection and remediation.

However, the panel considered the ongoing risk you continue to pose to patients whilst you further develop your insight, given the nature of your role and the pressurised environment you may find yourself in. The panel reminded itself that it found there is a risk of repetition, and the panel was not satisfied that this risk can be sufficiently mitigated through the imposition of conditions on your practice. The panel determined no workable conditions could be devised which would provide you with the oversight and guidance you need, should you find yourself in a similar situation, given the nature of your role which may be solitary. The panel therefore determined that a conditions of practice order is inappropriate in these circumstances.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on '*Suspension order*' (SAN-2d) 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.'*

The panel also had regard to the key considerations as set out in SAN-2d to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*

- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel considered the above in turn.

The panel reminded itself of its earlier decision on seriousness above, and had regard to the NMC Guidance, '*Sanctions for the highest risk cases*' (SAN-4). The panel noted that your misconduct was serious, and does relate to your professionalism. However, the panel determined, based on its findings above, that the conduct was not at the most serious end of the spectrum, particularly given it related to a specific set of circumstances and a number of actions that were part of a single incident, as opposed to a systematic or longstanding deception.

In assessing whether it is possible for you to be fit to practise in the future, the panel bore in mind the NMC Guidance, '*Deciding between suspension and strike off*' (SAN-3). It states:

*'Determining the proportionate sanction is often difficult when the Committee is deciding between a suspension or a striking-off order. In such cases, the Committee should:*

- *consider all of the relevant aggravating and mitigating factors.*
- *consider that, unless the Committee directs otherwise, a suspension order will be reviewed before its expiry and may be extended. However, the Committee*

*cannot direct that the suspension must be extended on review. As such the Committee should consider whether public confidence in the profession would be protected if the professional returned to practice after one year, or ever.*

- *Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*
- *Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

The panel bore in mind the aggravating and mitigating features it identified above. The panel considered that Patient A was particularly vulnerable, and your conduct did place them at an unwarranted risk of harm. However, the panel also considered that not all incidents of dishonesty are of equal seriousness. It bore in mind its findings that your dishonesty was not a pattern of behaviour, but occurred in response to a specific set of circumstances. The panel considered that you communicated that you felt '*unsafe*', but you were nonetheless placed under undue pressure to attend the shifts.

In considering your insight and attitude to addressing the concerns, the panel bore in mind its earlier finding that you presently demonstrate limited insight into your misconduct. The panel considered Ms Barnor's submissions and the principles derived from the decision in *Judge*, and it reminded itself that it must not engage in wishful thinking and impose a period of suspension without a realistic prospect of you addressing the concerns at the end of the suspension.

The panel noted that, in *Judge*, the practitioner was found to have demonstrated no insight.

The panel determined that, in these circumstances, your case differs. The panel considered that you have demonstrated remorse, and you have begun to demonstrate some insight into your failings. The panel noted your reflective piece, which stated:

*'I also feel remorseful and apologetic at what happened and felt I should have apologised for mistakes and failings at the time and perhaps this should have not escalated to this point. I have taken responsibility about what happened and have learnt from this incident and I am now self aware and will be on the guard in the future so that this wont happen again. I owe the NMC a full apology about my conduct regarding this incident which fell short of the NMC code of conduct.'*

Your reflective piece also referenced a clinical supervision, and you undertaking reflective practice with colleagues. The panel considered that, whilst you have not specified how you would ensure that *'this won't happen again'*, you have begun to develop some insight into your failings and have expressed your desire to not repeat your conduct.

Furthermore, the panel also bore in mind the testimonials you have received, which comment on your current practice. Your line manager at your current place of employment, in a testimonial dated 5 July 2025, stated:

*'I can confirm that Lusina has been open and honest about her NMC proceedings. There has not been any issues regarding Lusina's practice from her colleagues and clients. I hold monthly meetings with our clients and they give feedback on our nurses and all I have heard about Lusina's practice are praises...'*

Your colleague, who is a registered nurse who has worked with you since February 2021, in a testimonial dated 3 July 2025, stated:

*'Throughout our professional relationship, Lusina has shown unwavering dedication to the nursing profession. One of Lusina's standout qualities is her organisational ability and proactive nature. She is consistently thorough in the care she provides and her*

*documentation, reliable with time keeping, assertive, and always maintaining a calm and focused demeanour even in high-pressure environments. Importantly, she has demonstrated her commitment to maintaining high professional standards, ensuring best practices are upheld at all times. She is not afraid to offer constructive guidance or correction to team members where necessary, always doing so with professionalism and the goal of improving patient outcomes [...] her removal from the register would be a significant loss, particularly to patients with complex needs who benefit greatly from her...'*

The panel also had sight of a testimonial from another registered nurse who has worked with you, dated 29 June 2025, commenting on how you have reacted in similar situations:

*'At care agency A, we worked as lone workers but I had an opportunity of working alongside Lusina [...] I observed that she took it as her duty to protect the health and well being of the client we both took care off. According to my Knowledge Lusina used to attend all her scheduled shifts. The agency was short staffed and found it very difficult to cover the shifts for the client. Lusina would try to be very flexible to try and meet the needs of the client.'*

Bearing all the above in mind, the panel considered that, alongside working with no further concerns since 2019, you have engaged in clinical supervision and reflective practice. The panel considered that reflective practice is a skill which, at this stage, you need to further develop for any future Fitness to Practise Committee to be satisfied that you no longer pose a risk to the public. However, the panel determined that what you have demonstrated thus far and the indication from both your line manager and registered nurse colleagues indicates that there is a realistic prospect that you can further develop your insight into your failings.

Taking this into account, the panel was satisfied that the considerations of wishful thinking, pursuant to *Judge*, is not engaged in this case. The panel also noted that the case law referred to by Ms Barnor was in relation to cases of a differing or more serious nature. The panel determined that your actions occurred in a specific set of circumstances and there is

a realistic prospect you have capacity to further develop your insight and remediation. The panel therefore was satisfied that a period of suspension is appropriate.

The panel also considered that you have engaged with the NMC process.

The panel was therefore satisfied that it is possible that you could be fit to practise in future, and a period out of practice would be sufficient to allow you to strengthen your practice through reflection and development of insight and remediation. The panel determined that this was not wishful thinking, and your current level of insight indicates that it is realistically possible for you to return to safe practice in the future.

The panel also determined that the public confidence in the profession can be maintained through a period of suspension, given you have demonstrated some insight into your failings. The panel further determined that public confidence in the profession and the NMC as its regulator can be maintained by the fact you have undergone a rigorous Fitness to Practise process which has been ongoing for several years and with your temporary removal from the register, to mark the seriousness of your conduct but to also recognise the ability for you to return to safe nursing practice. The panel was also mindful that you would have to demonstrate to any future panel that your fitness to practise is no longer impaired, and have completed the necessary development before you can return to practice.

The panel considered the NMC Guidance, '*Striking-off order*' (SAN-2e), which stated:

- *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?*

Based on its observations above, the panel was satisfied that public confidence in the profession can be maintained with a temporary removal from the register, and the misconduct is not on the highest end of the seriousness spectrum which would necessitate a permanent removal. Further, the panel was satisfied that in-depth insight and reflection, if demonstrated, could keep the public safe and maintain public confidence, albeit it noted that that in-depth insight has not been demonstrated at this stage. However, it was satisfied that there is a realistic prospect that, after a period of suspension, you would have gained insight and strengthened your practice such that the risk you currently pose would have reduced, given the insight you have begun to demonstrate thus far.

Taking all this into account, the panel was satisfied that, whilst the charges do raise questions regarding your professionalism, honesty and integrity and are serious in nature, it is not sufficiently serious to necessitate the imposition of a striking-off order. The panel bore in mind that this was a number of actions as part of a single incident as opposed to a systematic or longstanding deception in an unsupportive working environment.

The panel therefore concluded that a striking-off order would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel noted the hardship such an order may cause you. However, this is outweighed by the public protection and public interest considerations in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the misconduct, and to allow you sufficient time to fully develop your insight into your misconduct.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at the review hearing and continued engagement with the NMC process;
- Up-to-date reflective piece which demonstrates your understanding of your misconduct and your learning, including how you would respond differently in a similar situation, and if appropriate, live evidence from you on these points at a review hearing;
- Evidence of completed training which relates to situational awareness, ethical decision-making when under pressure, human factors and dishonesty, and demonstrable practice of this training undertaken;
- Evidence of completed training on managing workplace pressures as well as respectful assertiveness, and demonstrable practice of this training undertaken;
- Updated testimonials or references detailing how you have developed in your reflective practice and how you have applied it in your workplace.

This will be confirmed to you in writing.

## **Interim order**

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

## **Submissions on interim order**

Ms Barnor invited the panel to impose an 18-month interim suspension order to cover any relevant appeal period before the substantive suspension order takes place. She submitted that, based on the panel's findings on impairment and sanction, this interim order would be on both public protection and public interest grounds.

Ms Trussler did not oppose the application.

The panel accepted the advice of the legal assessor.

## **Decision and reasons on interim order**

The panel determined that not to impose an interim suspension order would be incompatible with its earlier findings.

The panel considered the NMC guidance, '*Interim orders after a sanction is imposed*' (SAN-6). 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 reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel bore in mind that, should you appeal the substantive suspension order, you would be able to practise without restriction during the appeal period if no interim order was imposed. The panel concluded that an interim suspension order is consistent with its findings on impairment and sanction.

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

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

That concludes this determination.