Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 20 April 2026- Thursday, 23 April 2026
Monday, 27 April 2026- Friday, 1 May 2026
Tuesday, 5 May 2026-Wednesday, 6 May 2026

Virtual Hearing

Name of Registrant:	**Belinda Jayne Kay**
NMC PIN:	98J0019E
Part(s) of the register:	V300 - Nurse Independent / Supplementary Prescriber (26 June 2007) Nursing - Sub part 1 RNA: Registered Nurse - Adult (01 October 2001)
Relevant Location:	Durham
Type of case:	Misconduct
Panel members:	Oluwasola Falola (Chair, Registrant member) Jason Flannigan-Salmon (Registrant member) Matthew Clarkson (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Sabrina Khan (20 April 2026-22 April 2026, 27 April 2026-1 May 2026) (6 May 2026) Bethany Seed (23 April 2026) Samara Baboolal (5 May 2026)
Nursing and Midwifery Council:	Represented by Mohsin Malik Case Presenter
Mrs Kay:	Present and represented by Libby Anderson, instructed by the Royal College of Nursing (RCN)

Facts proved by admission:	Charges 1, 3, 5a, 10a and 11
Facts proved :	Charges 2a, 2b, 6a, 6b, 8a, 8b, 8c, 8d, 9, 10b, 13, 14, 16, 17, 18 and 19
Facts not proved:	Charges 4, 5b, 7, 12 and 15
Fitness to practise:	**Impaired**
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 1 and 6.

In relation to charge 1, Mr Malik submitted that the proposed amendment is to clarify the wording so that it properly reflects the allegation that you had carried out the copying and pasting of notes from patient consultations. He submitted that this amendment is intended to improve the clarity and readability of the charge, ensuring that it accurately reflects the NMC's case and the evidence relied upon. He emphasised that this is not a substantive alteration but a refinement of language so that the charge is properly particularised.

Turning to charge 6, Mr Malik submitted that the proposed amendment is limited to correcting a typographical error. Specifically, the reference to "*relative F*" should read "*relative O*." He submitted that this correction ensures consistency with the evidence and avoids any ambiguity as to the identity of the individual referred to within the charge.

Mr Malik submitted that both proposed amendments are procedural in nature. He submitted that they do not alter the substance or seriousness of the allegations faced by you, nor do they introduce any new matters. He further submitted that the amendments accurately reflect the evidence already served and relied upon by the NMC.

Mr Malik submitted that there is no prejudice or injustice to you arising from these amendments. He submitted that you have been on notice of the factual matrix underpinning the charges and that the amendments do not place you at any disadvantage in responding to the case against you.

In those circumstances, Mr Malik submitted that it is fair and appropriate for the panel to allow the amendments. He submitted that the proposed amendments are just in all the circumstances and invited the panel to grant the application.

Ms Anderson on your behalf did not oppose the application.

The proposed amendment is as follows:

> "That you, a registered nurse, from around July 2019 until around October 2022:
>
> 1. Copied and pasted notes from patient consultations **you had carried out** to any or all of the unrelated patient records as set out in Schedule 1.
>
> 2. Did not conduct physical examinations and/or observations as per the following:
>
> a. On 20 September 2022 an abdominal examination on patient J.
>
> b. On 20 September 2022 an abdominal examination on patient K.
>
> 3. Added a patient L consultation to the wrong patient's record.
>
> 4. Failed to store a record of patient M's Quality of Life Assessment in their medical records.
>
> 5. On 22 April 2022 failed to:
>
> a. visit patient N in their care home residence to conduct a physical assessment, and/or
>
> b. prescribe antibiotics around the time of a 10:21 telephone consultation concerning patient N.

6. On or around:

a. 25 February 2022 on a DNACPR form for patient P, and/or

b. 30 May 2022 on a patient Consultation Information Sheet dated 30 May 2022 14:31 for patient P,

recorded that you had a conversation with relative ~~F~~ **O** concerning a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order for patient P.

7. On or around 20 September 2022 failed to conduct a full 'top to toe' assessment of child A.

8. On or around 20 September 2022 recorded in child A's Consultation Information Sheet dated 20 September 2022 10:17 that you conducted the following observations:

a. temperature check

b. respiratory rate

c. oxygen levels
d. heart rate

9. On 19 December 2021 during a consultation with patient X said to them words to the effect of "there's nothing wrong with it, stop being a fanny".

10. In August 2022:

a. in the presence of colleague X and other colleagues said words to the effect of “I am sick of the backstabbing bastards in this place”, and/or

b. shouted at, and/or pointed in the face of, colleague X, and/or said words to colleague X to the effect of “its private get it”.

11. Following the 19 December 2021 consultation with patient X (at Charge 9) recorded in the Consultation Information Sheet dated 19 December 2021 11:10 the words “chest examination normal”.

12. Your action at Charge ’11’ was dishonest because you knew you had not conducted a chest examination on patient X.

13. Your action at Charge ‘6a’ and/or ‘6b’ was dishonest in that you knew you never had any conversation with relative O concerning a DNACPR order.

14. Your action at any or all of Charge ‘8’ was dishonest because you knew you had not conducted the observations in any or all of ‘a’, ‘b’, ‘c’, or ‘d’.

15. You action at Charge ‘1’ was dishonest because you knew that the patient consultations you copied and pasted did not relate to the any or all of the patient records as set out in Schedule 1.

16. In respect of Charge ‘2a’ you recorded that you had conducted an abdominal examination on patient J.

17. In respect of Charge ‘2b’ you recorded that you had conducted an abdominal examination on patient K.

18. Your action at Charge ‘16’ was dishonest because you knew you did not carry out an abdominal examination on patient J.

19. Your action at Charge ‘17’ was dishonest because you knew you did not carry out an abdominal examination on patient K.

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

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

The panel noted that the proposed amendments relate to typographical and drafting matters. In respect of Charge 1, the amendment clarifies the wording so that it reads more accurately and coherently. In respect of Charge 6, the amendment corrects a typographical error by changing the reference from “relative F” to “relative O,” thereby ensuring consistency with the evidence.

The panel was satisfied that these amendments are procedural in nature and do not alter the substance or seriousness of the allegations against you. The panel further considered whether allowing the amendments would cause any prejudice or injustice to you. The panel concluded that it would not. You have been on notice of the factual basis of the allegations, and the amendments do not introduce any new matters or change the case you are required to meet.

The panel determined that allowing the amendments would not disadvantage you in the preparation or presentation of your case. On the contrary, the panel considered that the

amendments would improve the clarity and accuracy of the charges, which is in the interests of fairness to all parties.

In those circumstances, the panel concluded that it is fair, appropriate, and in the interests of justice to allow the amendments. Accordingly, the panel determined that Charges 1 and 6 should be amended as proposed.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Malik under Rule 31 to allow the written statement of Patient K into evidence.

Mr Malik submitted that the applicable legal principle is that hearsay evidence is prima facie admissible in proceedings before the Nursing and Midwifery Council, provided that it satisfies the requirements of relevance and fairness. He submitted that such evidence is not rendered inadmissible merely because it is hearsay. He further relied on Rule 31(1), which provides that, subject to relevance and fairness and following the advice of the legal assessor, the panel may admit oral, documentary, or other evidence, regardless of whether it would be admissible in civil proceedings.

Mr Malik referred the panel to the guidance set out in *Thornycroft v NMC* [2014] EWHC 1565 (Admin), in which a number of factors were identified as relevant when determining whether hearsay evidence should be admitted. He addressed each of those factors in turn.

In relation to whether the statement is the sole or decisive evidence, Mr Malik submitted that Patient K's statement is not the sole or decisive evidence in support of charge 2(b), namely that you did not conduct an abdominal examination, nor the associated dishonesty allegation. He submitted that there is corroborative evidence available to the panel. In particular, he referred to an email from Patient K to Jubilee Medical Group dated 1 October 2022, which confirms that you did not carry out an abdominal examination. He

submitted that this constitutes a contemporaneous record made closer in time to the incident.

Mr Malik further submitted that there is supporting evidence from Ms Sharon Raby, whose statement is contained in the exhibit bundle. He submitted that Ms Raby will be attending to give live evidence, and therefore you will have the opportunity to test her account through cross-examination. He submitted that her evidence corroborates Patient K's account, including the assertion that no abdominal examination was carried out. In those circumstances, he submitted that there are adequate means by which the reliability of Patient K's account can be tested.

Turning to the nature and extent of the challenge, Mr Malik acknowledged that the application is opposed and submitted that the panel would hear further from your representative in due course.

In respect of whether there is any reason for Patient K to fabricate her account, Mr Malik submitted that there is no evidence before the panel to suggest any motive for fabrication. He submitted that Patient K has been consistent in her account, and that her account is corroborated by other evidence. He further submitted that there is no indication of any prior issue or conflict between you and Patient K that would give rise to a motive to fabricate.

In relation to the seriousness of the charge, Mr Malik submitted that while the allegation is serious, the panel will note that you face multiple allegations, including a number of dishonesty charges, which are of significant gravity.

Turning to the issue of non-attendance, Mr Malik submitted that the Nursing and Midwifery Council has taken all reasonable steps to secure Patient K's attendance. He referred the panel to the hearsay bundle, noting that an introductory email was sent on 27 January 2026, followed by chasers on 2 and 3 March, and attempted telephone contact on 30 March and 17 April, all of which were unsuccessful. He further submitted that tracing

efforts were undertaken, including the use of an address, but these did not result in successful contact. He noted that the NMC discovered that it had been corresponding with an incorrect individual, confirming that the contact details held were inaccurate.

Mr Malik submitted that, in those circumstances, the NMC has exhausted all reasonable avenues to secure attendance. He emphasised that Patient K is not a registrant and therefore cannot be compelled to attend by way of a witness summons.

In relation to notice, Mr Malik submitted that you have had prior notice of the NMC's intention to rely on Patient K's statement, as the relevant bundles were served well in advance of the hearing.

In conclusion, Mr Malik submitted that the evidence is clearly relevant to the issues in the case and that its admission would be fair. He submitted that the statement is not sole or decisive, is supported by contemporaneous and corroborative evidence, and that reasonable steps have been taken to secure the witness's attendance. He further submitted that there is no evidence of fabrication and that you have had adequate notice of the material.

Accordingly, Mr Malik invited the panel to admit the hearsay statement of Patient K into evidence.

Ms Anderson submitted that the application to admit the hearsay evidence is opposed on the basis that it would be unfair to you for such evidence to be admitted in the absence of the witness.

Ms Anderson submitted that the objection extends not only to Patient K's witness statement and associated exhibits, but also to those parts of Ms Raby's evidence which recount what Patient K is said to have told her. She submitted that, in Patient K's absence, all such material constitutes hearsay and engages considerations of fairness.

Turning to the issue of non-attendance, Ms Anderson submitted that there is no good reason for Patient K's failure to attend. She submitted that the absence arises from deficiencies in the steps taken by the NMCl, rather than from any unavoidable or unforeseeable circumstance. She submitted that the hearing had been listed for a significant period, yet the first attempt to contact Patient K was not made until late January 2026. She further submitted that there was then a substantial gap in communication attempts until March 2026, at which point efforts intensified.

Ms Anderson submitted that, by the time it became apparent that the NMC had been corresponding with the wrong individual, it was too late to take effective alternative steps to secure attendance. She submitted that further reasonable enquiries could and should have been made, including contacting the medical practice to obtain updated contact details. In her submission, the failure to take such steps demonstrates that the non-attendance was neither unavoidable nor unforeseeable and therefore does not constitute a good reason.

In relation to fairness, Ms Anderson submitted that the evidence of Patient K is, in reality, the sole and decisive evidence in respect of charge 2(b), namely whether you conducted an abdominal examination. She submitted that only you and Patient K were present during the consultation, and therefore only those two individuals can give direct evidence of what occurred.

Ms Anderson submitted that the purported corroborative material does not, in fact, provide independent support. She submitted that Ms Raby was not present at the consultation and can only speak to what she was told by Patient K. Accordingly, her evidence is itself hearsay. While she may be cross-examined, Ms Anderson submitted that such cross-examination would be of limited utility, as it cannot test the underlying reliability or accuracy of Patient K's account.

Similarly, Ms Anderson submitted that the email relied upon does not constitute true corroboration but rather repeats Patient K's account. She submitted that there is no independent evidence capable of verifying whether an abdominal examination took place.

Ms Anderson further submitted that, in the absence of Patient K, there is no meaningful opportunity to challenge her credibility or reliability. She submitted that it would not be possible to explore whether Patient K may be mistaken in her recollection, or whether there are inconsistencies or inaccuracies in her account. She emphasised that such matters can only properly be tested through oral evidence.

Ms Anderson submitted that the inability to cross-examine Patient K gives rise to significant prejudice to you. She submitted that, through no fault of your own, you would be deprived of the opportunity to properly test evidence which goes directly to a central issue in the case.

She acknowledged that you have had notice of the NMC's intention to rely on this evidence. However, she submitted that such notice does not cure the fundamental unfairness arising from the inability to challenge the evidence.

In all the circumstances, Ms Anderson submitted that there is no adequate way to mitigate the prejudice and unfairness that would result from the admission of this hearsay evidence. She therefore invited the panel to refuse the application and to exclude the evidence of Patient K.

The panel accepted the advice of the legal assessor.

The panel applied the relevant legal principles, including those set out in *Thornycroft v NMC*, and addressed the relevant factors in turn.

The panel first considered whether the evidence of Patient K is sole or decisive in relation to charge 2(b). The panel determined that it is not. The panel noted that there is

supporting evidence from Ms Raby, who will be attending to give live evidence. The panel considered that her evidence provides an avenue through which aspects of Patient K's account can be tested by way of cross-examination. Accordingly, the panel concluded that the hearsay evidence is not sole or decisive.

The panel then considered the nature and extent of the challenge to the evidence. The panel acknowledged that the application is opposed and that you dispute the reliability of Patient K's account. However, the panel was satisfied that there remains a sufficient opportunity to test the evidence indirectly through the cross-examination of Ms Raby, who will give evidence as to what she was told by Patient K.

The panel considered whether there is any reason to believe that Patient K may have fabricated her account. The panel found that there is no evidence before it to suggest any motive for fabrication, nor any indication of a breakdown in the relationship between you and Patient K which might give rise to such a motive.

The panel next considered the seriousness of the charge. The panel acknowledged that the allegations are serious. However, the panel also noted that this allegation forms part of a wider set of allegations, including multiple dishonesty charges. The panel did not consider that the seriousness of the allegation, in itself, rendered the admission of the hearsay evidence unfair.

The panel then considered whether there is a good reason for Patient K's non-attendance. The panel noted that no clear reason has been provided as to why Patient K has not attended. However, the panel considered the steps taken by the NMC to secure her attendance.

The panel was satisfied that reasonable steps have been taken. These included multiple attempts to contact Patient K via email and telephone, as well as efforts to trace her through alternative means. The panel acknowledged that incorrect contact details had initially been used, but was satisfied that further attempts were made once this issue came

to light. The panel also recognised the practical limitations in compelling the attendance of a non-registrant witness.

Finally, the panel considered whether you had prior notice of the NMC's intention to rely on this evidence. The panel was satisfied that you had been provided with the relevant material in advance of the hearing and were aware that the NMC intended to rely on Patient K's statement.

Having weighed all of these factors, the panel concluded that the admission of the hearsay evidence would be fair. The panel determined that the evidence is relevant, not sole or decisive, and that its admission would not cause unfair prejudice to you, particularly in light of the opportunity to test aspects of the evidence through cross-examination of Ms Raby.

Accordingly, the panel determined to admit the hearsay evidence of Patient K but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Application to redact the witness statement of Mrs Gillian Johnson

Ms Anderson submitted that the application concerns two specific passages within the witness statement of Mrs Gillian Johnson, namely paragraph 24 and paragraph 39, and that the panel should exercise its case management powers to redact those passages on the basis of relevance and fairness.

In relation to paragraph 24, Ms Anderson submitted that no issue is taken with the first sentence, which refers to your behaviour in 2019, as this is directly relevant to the allegations before the panel. However, she submitted that the remainder of the paragraph, beginning with the reference to matters "*even prior to 2019*," should be redacted. She submitted that this material predates the allegations under consideration and is therefore not relevant to the issues the panel must determine.

Ms Anderson further submitted that the material is vague, unparticularised, and lacking in specificity. The timing of the alleged concerns is unclear, and there is no detail as to the nature or context of those concerns. In her submission, such evidence cannot be properly tested and serves no legitimate evidential purpose. She submitted that its inclusion would be prejudicial to you, as it introduces unspecified historic concerns which are not the subject of any formal charge. Accordingly, she submitted that it would be unfair for the panel to consider this material and invited the panel to redact the passage and disregard it in the course of the proceedings.

Turning to paragraph 39, Ms Anderson submitted that similar considerations arise. She focused in particular on the third sentence onwards, which refers to an allegation that you had pinned a colleague against a wall and told her to mind her own business. Ms Anderson submitted that this is a serious allegation, amounting in effect to an allegation of assault, yet it does not form part of the charges before the panel.

She further submitted that the source of this allegation is unclear and unreliable. The evidence is second-hand, attributed to an unidentified third party, and the witness herself is unable to recall who provided the information. Ms Anderson submitted that this renders the evidence inherently unreliable and incapable of proper scrutiny.

Ms Anderson submitted that the inclusion of such material would be highly prejudicial to you, as it introduces an unproven and uncharged allegation of a serious nature. She submitted that you would be placed at a significant disadvantage in seeking to respond to or challenge this evidence, given its vague and unparticularised nature.

In those circumstances, Ms Anderson submitted that the material is not relevant to the issues before the panel and that its admission would be unfair. She therefore invited the panel to redact the relevant passages of paragraph 24 and paragraph 39, and to put those matters entirely out of its mind when determining the case.

Mr Malik submitted that the panel should approach the issue of redaction by reference to relevance and fairness.

In relation to paragraph 24, Mr Malik submitted that the application to redact should be refused. He submitted that this paragraph addresses the way in which you treated staff and colleagues, which is directly relevant to the allegations the panel is required to determine. He submitted that you face charges concerning your conduct towards colleagues, and therefore evidence describing the nature and impact of that conduct is plainly material.

Mr Malik further submitted that the paragraph provides context as to the effect of your behaviour on those around you, including colleagues who will be giving live evidence. He submitted that such evidence assists the panel in understanding the broader factual matrix, including issues relating to professional conduct, workplace behaviour, and, where relevant, considerations of patient safety and public protection.

In those circumstances, Mr Malik submitted that paragraph 24 is directly relevant, and that it would be inappropriate to redact it. He submitted that any concerns as to weight or reliability can properly be addressed by the panel at the fact-finding stage.

Turning to paragraph 39, Mr Malik adopted a different position. He submitted that he does not oppose the application to redact this passage. He acknowledged that the material appears to be hearsay, derived from an unidentified member of staff, and that its evidential basis is therefore limited.

Mr Malik submitted that, in fairness to you, and given the nature of the allegation described within that paragraph, he does not object to it being removed. He accepted that the panel may consider that its inclusion could give rise to concerns of unfairness or prejudice.

Accordingly, Mr Malik submitted that while paragraph 24 should remain as part of the evidence, he raises no objection to paragraph 39 being redacted, leaving the matter ultimately to the panel's determination.

The panel accepted the advice of the legal assessor.

The panel considered the application to redact the relevant passage of evidence.

The panel noted the legal assessor's advice that it would generally be inappropriate to edit or redact evidence at this stage of the proceedings. The panel placed significant weight on that advice. The panel was mindful that its role at this stage is not to determine the weight to be attached to the evidence, but rather to ensure that all relevant material is available for proper consideration at the fact-finding stage.

The panel determined that it is appropriate for the evidence to remain in its current form. The panel was satisfied that any concerns as to relevance, reliability, or weight can properly be addressed at a later stage, when the panel undertakes its assessment of the facts. The panel emphasised that it will evaluate the evidence in the round and determine what weight, if any, should be attached to the passage in question.

The panel further noted that you will have the opportunity to challenge the evidence through cross-examination and that the panel may also ask questions of the witness to clarify any matters arising from the disputed passages.

In those circumstances, the panel concluded that it would be inappropriate to redact the passage at this stage. The panel therefore determined that the evidence should remain unedited, with issues as to weight and relevance to be considered at the appropriate stage in the proceedings.

Application to admit the addendum statement and accompanying exhibit into evidence

Ms Anderson submitted that the panel is invited to permit the admission of the addendum statement and accompanying exhibit into evidence.

Ms Anderson submitted that the exhibit consists of the template referred to in your original witness statement, which is already before the panel. She submitted that this material forms an integral part of your account and provides important context to the matters in issue.

In particular, Ms Anderson submitted that the addendum statement and exhibit are highly relevant to Allegation 1, which concerns the copying and pasting of patient consultation notes. She submitted that the template goes directly to a central aspect of your case, namely the explanation for the manner in which entries may have been recorded.

Ms Anderson further submitted that the admission of this material would not cause any unfairness to the NMC. She submitted that the nature of the evidence is straightforward, that it relates to matters already identified within your evidence, and that the NMC would have a full opportunity to consider and, if necessary, challenge the material.

Conversely, Ms Anderson submitted that it would be unfair to you if the addendum statement and exhibit were not admitted. She submitted that the material is central to your defence and that excluding it would deprive you of the opportunity to fully present your case on a key allegation.

In those circumstances, Ms Anderson submitted that the evidence is plainly relevant, that its admission would be fair, and that the panel should therefore permit the addendum statement and exhibit to be admitted into evidence.

Mr Malik did not oppose the application.

The panel accepted the advice of the legal assessor.

The panel has considered the application to admit the addendum statement and accompanying exhibit into evidence.

The panel noted that no objection was raised to the admission of this material by the NMC.

The panel also noted that the document in question, which you intend to rely upon in support of your case and that it is appropriate for it to be put to the NMC's witness in cross-examination. The panel was satisfied that the material is relevant to the issues it is required to determine, particularly in relation to the allegations concerning the recording of patient consultation notes.

The panel further considered whether the admission of the addendum statement and exhibit would give rise to any unfairness or prejudice. In light of the absence of objection from the NMC and given that the material can be properly explored in evidence, the panel was satisfied that its admission would not cause any injustice to either party.

In those circumstances, the panel determined that it is fair and appropriate to admit the addendum statement and accompanying exhibit into evidence.

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

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

Mr Malik indicated that he supported the application.

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

The panel determined to go into private session in connection with highly sensitive matters, [PRIVATE] as and when such issues are raised in order to protect your privacy and confidentiality.

Background

The NMC received an employer referral from Jubilee Medical Group (the Group) concerning your professional practice as an Advanced Nurse Practitioner (ANP) working within a GP Practice setting. At the time of the concerns, although you were working at the Group, your employment arrangements were through Hallam Medical Recruitment Agency (the Agency), rather than being directly employed by the Group.

It has been alleged that between the dates of July 2019 and October 2022 a series of breaches of professional conduct and in particular you deliberately falsified medical records. The Group provided the NMC with information which suggests a pattern of inaccurate and/or falsified patient records. The Group has raised further concerns around your conduct towards staff and patients, and the adequacy of your patient assessments.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Anderson, who informed the panel that you made full admissions to charges 1, 3, 5a, 10a and 11.

The panel therefore finds charges 1, 3, 5a, 10a and 11 proved in their entirety, by way of your admissions.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Gillian Johnson, Business Manager at the Group
- Witness 2: Lorraine Stainsby, Advanced Nurse Practitioner and Clinical Lead at the Group
- Witness 3: Relative O, Senior Practice Nurse at the Group
- Witness 4: Sharon Raby, Advanced Nurse Practitioner at the Group
- Witness 5: Tony Andrew Harrison, Advanced Nurse Practitioner at the Group
- Witness 7: Colleague X/Patient X, [PRIVATE]

The panel also had regard to the written evidence of additional witnesses, including:

- Witness 6: Patient K, registered patient at the Group

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and you.

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

Charge 2a

> "That you, a registered nurse, from around July 2019 until around October 2022:
>
> Did not conduct physical examinations and/or observations as per the following:
> a. On 20 September 2022 an abdominal examination on patient J."

This charge is found proved.

The panel considered all the evidence available in relation to charge 2a, including patient accounts, corroborating witness testimony, documentary evidence, audit logs, and your own evidence.

The panel had before it the statement of Patient J, who clearly stated that no abdominal examination had been conducted. The panel also noted corroborating evidence from Mr Harrison, who spoke directly with Patient J shortly after the consultation. In his evidence, Mr Harrison recounted that Patient J said, "*Belinda never laid a hand on me"*, a statement the panel found striking, clear, and compelling.

The panel also considered the absence of any credible motive for Patient J to fabricate her account. The panel determined that there was no animosity between Patient J and you, nor any suggestion of bias or improper influence.

The panel then examined all the material evidence presented to it. These showed that you spent insufficient time in the patient's record to conduct and document a proper abdominal examination. In particular, the panel noted that the consultation lasted approximately five minutes, which the panel accepted would not realistically allow for a full abdominal examination, requiring the patient to lie down on the examination couch, palpation of the abdomen, and further clinical steps, alongside documentation.

The panel considered your explanation that you could not recall the consultation but that if you had documented the examination, it must have taken place. The panel gave this limited weight. The panel was of the view that a lack of recollection cannot outweigh positive, consistent evidence from the patient and corroborating witnesses. Further, your reliance on your usual practice was insufficient to displace the objective evidence.

The panel concluded that the evidence of Patient J, corroborated by the testimony of Mr Harrison and supported by documentary access logs, was more persuasive and reliable than your generalised assertions. The panel noted that there were no issues between you and the witness which you confirmed during your oral evidence. It therefore concluded that there would be no reason for the witness Mr Harrison, to fabricate their account both in statement and during his oral evidence.

Accordingly, the panel found charge 2a proved on the balance of probabilities.

Charge 2b

> "That you, a registered nurse, from around July 2019 until around October 2022::

Did not conduct physical examinations and/or observations as per the following:
b. On 20 September 2022 an abdominal examination on patient K."

This charge is found proved.

The panel adopted the same careful evaluative approach as in charge 2a. The panel reviewed the account provided by Patient K, who also stated that no abdominal examination was performed. Although Patient K did not provide live oral evidence, the panel accepted the hearsay statement after considering its admissibility and reliability. The panel observed that the hearsay evidence was consistent, contemporaneous, and unchallenged by any evidence suggesting fabrication.

The panel also relied on the consistent corroboration provided by Ms Raby, who spoke with Patient K following the consultation. Ms Raby confirmed that Patient K had been clear that no abdominal examination took place. The panel noted that neither Ms Raby nor Mr Harrison had any animosity toward you and had spoken positively about working with you. This absence of motive to fabricate strengthened their credibility.

The panel considered the similarities between the accounts of Patients J and K. Both described the absence of any physical contact consistent with an abdominal examination. Both consultations occurred on the same day, within a short timeframe. The panel found that this pattern increased the plausibility of the patients' evidence.

The panel also considered your lack of specific recollection and your assertion that if you had recorded the examinations, they must have been carried out. As with charge 2a, the panel gave this little weight in light of the positive, specific, and credible evidence from the patients.

The consultation times were extremely short, around five minutes, which the panel found incompatible with performing a full abdominal examination requiring the patient to lie on a

couch, hands-on palpation, assessment for pain or tenderness, and subsequent documentation.

The panel determined that an abdominal examination is an intimate and clearly perceptible procedure, involving touch, pressure, and physical repositioning. The panel was of the view that such an examination is not something a patient would simply forget.

Taking all the evidence together, including the statements of Patients J and K, the corroborating testimonies of Nurses Harrison and Raby, and the documentary access logs, the panel was satisfied on the balance of probabilities that you did not conduct an abdominal examination on Patient K.

Accordingly, charge 2b is found proved.

Charge 4

> "That you, a registered nurse, from around July 2019 until around October 2022::
>
> Failed to store a record of patient M's Quality of Life Assessment in their medical records."

This charge is found not proved.

The panel considered the evidence carefully and concluded that the NMC had not met the burden of proof on the balance of probabilities. The charge alleges a failure on your part, which required the NMC to establish that you personally held the duty to store, scan, or upload the completed Quality of Life Assessment (QLA) into Patient M's clinical record.

The panel first considered the documentary evidence demonstrating that a QLA was completed, initiated by a GP and completed by you and that this document could not later

be located within the patient's electronic record. However, the absence of a document within the clinical system did not, in itself, prove that it was your professional responsibility to store it there.

The panel reviewed the evidence of Mrs Johnson, the practice's business manager, who stated that she did not know what the QLA process entailed and did not describe any policy indicating that clinicians were responsible for scanning or uploading such documents. The panel also considered the oral evidence of Ms Stainsby, an experienced clinician at the practice. Ms Stainsby stated that it was the administrative team, specifically secretaries or Pas, who were responsible for scanning paper documents into the electronic system. She described the recognised administrative process within the practice, including a "*scanning pile*" located in the administrative office, where clinicians routinely placed documents to be scanned by administrative staff. The panel regarded this evidence as highly relevant in determining where responsibility for storing such documents lay.

The panel also considered your evidence. You stated that after completing the QLA, you delivered the document to the care home and then provided it to administrative staff for scanning. You explained that you reasonably believed the document had been added to the record because that was the established practice. You also noted that you routinely submitted documents for scanning and did not personally upload or scan them yourself.

The panel considered whether an overarching professional responsibility nevertheless required you to verify the storage of the document. While the panel agreed that clinicians must ensure the accuracy and completeness of clinical records, this obligation must be interpreted in light of clear roles and systems within the workplace. The panel received no documentary evidence of any policy, standard operating procedure, or written guidance requiring you personally to scan, upload, or verify the uploading of QLA forms. This absence was reinforced by witnesses.

Given the lack of evidence that scanning was your responsibility, combined with the consistent testimony describing administrative staff as responsible for document uploads, the panel concluded that the NMC had not established that you failed in a duty that rested upon you personally.

On the balance of probabilities, the panel determined that the responsibility for scanning the QLA document lay with administrative staff, not with you. Without evidence of a duty, a breach could not be proved.

Accordingly, charge 4 is found not proved.

Charge 5b

> "That you, a registered nurse, from around July 2019 until around October 2022::
>
> On 22 April 2022 failed to:
>
> b. prescribe antibiotics around the time of a 10:21 telephone consultation concerning patient N."

This charge is found not proved.

The panel considered the evidence carefully and concluded that the NMC had not established, on the balance of probabilities, that you failed in a duty to prescribe antibiotics during the telephone consultation with Patient N's carer.

The panel first considered the meaning of "*failed to prescribe*," which requires the NMC to establish both:

1. That you ought to have prescribed antibiotics at that time, and
2. That your omission constituted a departure from required clinical standards.

The panel noted that the evidence did not identify any policy, standard operating procedure, NICE guidance requirement, or local protocol that mandated the prescribing of antibiotics during this consultation. This absence was specifically highlighted by Ms Stainsby. Ms Stainsby confirmed that no formal policy existed directing prescribing decisions in such circumstances and that the decision ultimately rested with the clinician's clinical judgment.

The panel also considered your oral evidence. You provided a detailed, clinically reasoned explanation for not prescribing antibiotics. You stated that:

- Patient N had received two recent courses of antibiotics;
- You wished to avoid unnecessary prescribing, particularly in light of risks associated with E-Coli and C-Diff;
- You sought a urine sample to ensure sensitivities before initiating treatment; and
- No "*red flag*" symptoms were described during the carer's report.

Further, you stated that you had "*safety netted*" the decision by advising the care home to contact the service again if Patient N's condition deteriorated. The panel considered this safety-netting advice to be an appropriate clinical safeguard and evidence of a reflective decision-making process.

The panel also reviewed the evidence from the carer. His account indicated that Patient N was alert and oriented, and that observations, while showing a slightly raised blood glucose level that morning, were otherwise stable.

While the panel acknowledged that an alternative clinician (Ms Stainsby) might have chosen to prescribe antibiotics, the panel emphasised that a difference of clinical opinion does not establish a failure. The panel must determine whether your decision fell outside the range of acceptable professional practice. The panel found that it did not.

The NMC did not present evidence demonstrating a mandatory requirement to prescribe antibiotics in this situation, nor evidence that your decision was inconsistent with reasonable clinical judgment.

Accordingly, the panel found that the NMC had not proved charge 5b on the balance of probabilities.

Charge 6a

"That you, a registered nurse, from around July 2019 until around October 2022:

6. On or around:

a. 25 February 2022 on a DNACPR form for patient P, and/or

recorded that you had a conversation with relative O concerning a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order for patient P."

This charge is found proved.

The panel considered the evidence in relation to charge 6a and was satisfied, on the balance of probabilities, that you recorded on Patient P's DNACPR form that a discussion had taken place with Relative O when, in fact, no such discussion had occurred.

The panel reviewed Relative O's oral testimony and her detailed written statement where she stated:

> *"… I spoke to Belinda about not having had the discussion and she said the she had discussed it with me and perhaps I had forgotten. This further upset me as to how she could think anyone could possibly forget such an important conversation*

and dealing with the decisions that would need to me made from that conversation….
….I had a conversation with Lorraine Stainsby, another Vawas Nurse and explained my concerns over the DNACPR…. She discussed what should have taken place by way of informing me and the family of what is covered by a DNACPR."

The panel found her evidence to be clear, consistent, unwavering, and credible. During cross-examination, when asked whether the conversation had taken place, Relative O responded emphatically "*absolutely not*," repeating this with conviction.

Relative O also gave compelling evidence regarding family dynamics. She explained that a decision as significant as a DNACPR order would always be discussed among family members. She stated that she would have remembered such a conversation because of its importance and the implications it would have for Patient P's future care. The panel accepted this reasoning.

The panel next considered your evidence. You stated that you believed you had discussed the DNACPR decision following a multidisciplinary team meeting and that Relative O may simply have forgotten. The panel rejected this suggestion. Given the seriousness of DNACPR decisions and their impact on future medical interventions, the panel found it implausible that a close family member would forget such a discussion. The panel was of the view that the suggestion that she would forget was highly implausible.

The panel also recognised that both you and Relative O had previously worked together and that there was no animosity between you. This lack of motive to fabricate strengthened the reliability of her account.

Finally, the panel noted that concerns regarding the DNACPR being completed without consultation were raised contemporaneously, shortly after discovery of the document, adding further credibility to Relative O's evidence.

In light of the credible testimony of Relative O, corroborated by contemporaneous concern and unchallenged by any documentary evidence to the contrary, the panel was satisfied that you recorded on the DNACPR form that a discussion had taken place when it had not.

Accordingly, charge 6a is found proved.

Charge 6b

“That you, a registered nurse, from around July 2019 until around October 2022:

6. On or around:

b. 30 May 2022 on a patient Consultation Information Sheet dated 30 May 2022 14:31 for patient P.

recorded that you had a conversation with relative O concerning a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order for patient P”

This charge is found proved.

The panel considered charge 6b together with charge 6a, noting that the factual issues and the evidence supporting each charge were materially identical.

The panel observed that the Consultation Information Sheet dated 30 May 2022 at 14:31 recorded that you had spoken to Relative O about the DNACPR order. As with the DNACPR form, this documentation stated that a conversation had taken place. During your oral evidence you confirmed that you had completed this relevant documentation. The panel compared this with the evidence provided by Relative O, who expressly denied having had any such conversation with you on any occasion, whether in February or May 2022. In her written evidence she stated:

"…I have now been shown the consultation that BK entered in my mum's records on the 30th May, and I cannot agree with the majority of what has been documented by BK."

The panel found Relative O's evidence highly credible. Her account was consistent between her written statement and her oral evidence. She accepted that the DNACPR decision itself was clinically appropriate and did not challenge its content. This strengthened her credibility because she had no reason to deny a discussion if one had occurred.

Furthermore, the panel considered your evidence that any discussion may have been informal or "*in passing*." However, the panel found that a DNACPR discussion is a significant and sensitive matter. The panel was of the view that such a conversation would not be undertaken casually or without clear communication, nor would it reasonably occur in a corridor in the brief manner you described.

The panel also noted that this issue had been addressed during disciplinary processes, and the concerns had been raised promptly after the family discovered the DNACPR documentation. This contemporaneity added further weight.

Given the credible and consistent evidence of Relative O, the implausibility of her simply forgetting such a significant conversation, and the absence of any justification for the contrary account recorded in the Consultation Information Sheet, the panel was satisfied that no discussion took place.

Accordingly, charge 6b is found proved.

Charge 7

"That you, a registered nurse, from around July 2019 until around October 2022:

6. On or around 20 September 2022 failed to conduct a full ‘top to toe’ assessment of child A.”

This charge is found not proved.

The panel considered the evidence presented in relation to charge 7 and concluded that the NMC had not established, on the balance of probabilities, that you failed to conduct a “full top-to-toe assessment” of Child A. The panel found significant evidential gaps regarding what such an assessment required and therefore could not find a failure to perform it.

The panel first examined the evidence relating to the consultation with Child A. The documentary record showed that you had undertaken and recorded elements of an assessment. However, the question for the panel was whether the NMC had proved that a full top-to-toe assessment, as alleged, was required and that you failed to undertake it.

The panel noted that neither the NMC nor any witness provided the panel with a written policy, protocol, or standard operating procedure defining what a “full top-to-toe assessment” entails, particularly for a child under five. This absence of definition was explicitly acknowledged by witnesses during the hearing. In particular, both the clinician witness, Ms Stainsby, and you, although describing aspects of what such an assessment might ordinarily include, were unable to identify any policy, guidance, or mandated standard that specified the components of a top-to-toe assessment.

The panel further noted Ms Stainsby’s evidence that there was no specific practice policy or standard operating procedure outlining what clinicians were required to document or examine during such an assessment of a child. The panel considered this an important deficiency in the NMC’s case, as the NMC must establish both the existence of a duty and a breach.

The panel also noted that while Ms Stainsby and others offered experiential views about what they believed a top-to-toe assessment should involve, these were opinions rather than grounded in documented standards. The panel concluded that such opinions could not substitute for clear, objective evidence defining the required standard.

Although the panel acknowledged that the clinical records demonstrated limited documentation of examination findings, the absence of documentation alone was insufficient to establish that the assessment itself was not conducted. Furthermore, without a defined standard, the panel could not determine whether the examination you conducted fell below the required level of completeness.

The burden of proof rested with the NMC. In the absence of any clear definition, policy, or authoritative guidance setting out what a “full top-to-toe assessment” must include, the panel could not determine that a failure had occurred.

Accordingly, charge 7 is found not proved.

Charge 8

“That you, a registered nurse, from around July 2019 until around October 2022:

8. On or around 20 September 2022 recorded in child A’s Consultation Information Sheet dated 20 September 2022 10:17 that you conducted the following observations:

a. temperature check
b. respiratory rate
c. oxygen levels
d. heart rate

This charge is found proved.

The panel considered the evidence carefully and determined that charge 8 (a–d) was proved based on your own admissions during oral evidence.

Although you did not admit the charge at the outset, during cross-examination by Mr Malik, you accepted that you had recorded observations in Child A's Consultation Information Sheet, including the temperature, respiratory rate, oxygen saturation, and heart rate. You acknowledged that these entries were made by you.

The panel noted that the charge does not require proof that the observations were actually conducted. Charge 8 addresses only whether you recorded that you had performed these observations. On this specific point, the panel accepted your oral admission that the entries in the consultation record were completed by you.

The panel took account of the Consultation Information Sheet dated 20 September 2022 at 10:17, which contains four recorded observations with numerical values. These entries are attributed to you. You confirmed in evidence that the record was your work and that you entered the observations in the normal course of documentation.

The panel considered whether any ambiguity existed as to whether you had recorded these observations. There was none. The consultation record plainly contains the entries, and you accepted that you authored them. Your admission, supported by the documentary evidence, was sufficient to prove the factual allegations.

Although the panel noted parental evidence indicating that these observations had not actually been performed, this relates directly to charge 14, not charge 8. For the purpose of charge 8, the only question was whether you recorded them. The panel was entirely satisfied that you did.

Accordingly, charge 8a, 8b, 8c, and 8d are each found proved.

Charge 9

“That you, a registered nurse, from around July 2019 until around October 2022:

9. On 19 December 2021 during a consultation with patient X said to them words to the effect of “there’s nothing wrong with it, stop being a fanny”.”

This charge is found proved.

The panel considered all the evidence relating to this charge and concluded, on the balance of probabilities, that you did say words to the effect alleged to Patient X during the consultation on 19 December 2021.

The panel first considered the evidence of Patient X, who provided both a written statement and oral testimony. The panel found her evidence to be clear, consistent, and compelling. During her oral evidence, Patient X reiterated on multiple occasions that you used the words “*stop being a fanny*,” explaining that this was memorable because “*it’s not every day someone calls you a fanny*.” The panel gave significant weight to this level of detail, which suggested a strong and reliable recollection.

The panel noted that Patient X’s account had been consistent over time. She described the comment in her initial complaint and repeated it in her NMC statement months later. This consistency, combined with her clear recollection during oral evidence, reinforced her credibility.

The panel next considered your account. You denied using the phrase alleged. The panel also noted that you admitted to using inappropriate language in charge 10a. The panel considered this relevant as evidence of a pattern of behaviour consistent with the alleged comment.

The panel then examined the timing and circumstances of the complaint. Although the complaint was not raised immediately, the panel did not consider this delay to undermine

Patient X's credibility. The panel accepted that individuals may delay raising concerns out of embarrassment or uncertainty. The content of the complaint, including explicit recollection of the phrase "*stop being a fanny*," weighed strongly in favour of her account.

The panel also considered that Patient X had no apparent motive to fabricate the allegation. There was no evidence of animosity between you and Patient X. Nor did she stand to gain from making the allegation. The panel therefore found no basis to doubt her honesty.

Furthermore, the panel noted that your demeanour and use of language in other workplace interactions, evidenced by your admission to using the phrase "*I'm sick of the backstabbing bastards in this place*" (charge 10a), supported a finding that you were capable of using informal and inappropriate language in professional settings.

Taking all these factors together, the consistent, credible, and memorable detail of Patient X's evidence; the absence of any motive to fabricate; your own admission of using inappropriate language; and the contextual consistency of behaviour, the panel found, on the balance of probabilities, that you did say words to the effect of "there's nothing wrong with it, stop being a fanny" during the consultation on 19 December 2021.

Accordingly, charge 9 is found proved.

Charge 10b

"That you, a registered nurse, from around July 2019 until around October 2022:

10. In August 2022:

b. shouted at, and/or pointed in the face of, colleague X, and/or said words to colleague X to the effect of "its private get it".

This charge is found proved.

The panel considered the evidence presented in relation to charge 10b and was satisfied, on the balance of probabilities, that the allegation was proved.

The panel placed significant weight on the evidence of Colleague X, whose written statement and oral testimony were consistent, coherent, and credible. She described a confrontation initiated by you, during which you raised your voice, pointed towards her face, and said words to the effect of “it’s private, get it.” The panel accepted that while recollections of tone and gesture may vary Colleague X’s account was clear in identifying shouting and an aggressive manner.

The panel found no evidence of any motive for Colleague X to fabricate the incident. There was no suggestion of personal animosity prior to the confrontation. Rather, the transcript reflects that Colleague X, and you had a working relationship without known conflict, and that the incident arose because you believed she had been discussing private matters about you.

The panel also took into account your partial admission. While you denied pointing your finger and denied raising your voice to the level described, you accepted that you had told Colleague X words to the effect of “*it is private*,” consistent with the allegation. Your admission that a heated exchange occurred supported the core factual basis of the charge.

Further, the panel considered your use of inappropriate language in charge 10a, which demonstrated a pattern of emotionally charged and unprofessional expression in the workplace. This contextual behaviour, admitted by you, was consistent with Colleague X’s account of your conduct during this incident.

The panel therefore concluded that Colleague X's account was more persuasive, being consistent, credible, and supported by your partial admission and by the pattern of behaviour evidenced elsewhere in the charges.

Accordingly, charge 10b is found proved.

Charge 12

"That you, a registered nurse, from around July 2019 until around October 2022:

12. Your action at Charge '11' was dishonest because you knew you had not conducted a chest examination on patient X."

This charge is found not proved.

The panel considered whether your action in recording "chest examination normal" amounted to dishonesty. Applying the required legal test of dishonesty derived from the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, the panel first considered your state of knowledge at the time, and then assessed whether, in light of that knowledge, ordinary decent people would regard your conduct as dishonest.

The panel emphasised that dishonesty is a serious finding and must be supported by clear evidence. In this case, the panel concluded that the NMC had not discharged the burden of proving dishonesty on the balance of probabilities.

The panel accepted that you recorded the words "chest examination normal," as established in charge 11. However, the central question for charge 12 was whether, when making that entry, you knew that you had not performed any form of chest examination and nevertheless intended to mislead by documenting one.

The panel considered your oral evidence carefully. You stated that you carried out a visual assessment of Patient X, which included observing her colour, respiratory effort, and general presentation. You explained that in hindsight you would have recorded this differently, for example, as "*visual chest assessment*", but that at the time you believed your visual assessment fell within your understanding of "*chest examination*." You acknowledged the imprecision but denied any intention to deceive.

The panel considered this explanation and found it plausible. It was consistent with your pattern of practice as evidenced elsewhere in the charges, namely, your tendency toward poor documentation or administrative imprecision, rather than deliberate falsification. The panel noted that your earlier admissions regarding copying and pasting in charge 1 and mis-recording other examination findings reflected a pattern of carelessness or slapdash record-keeping, rather than intentional deception.

The panel also noted that you did not dispute that improvements in your documentation were necessary, and you accepted that the wording you chose was not ideal. However, this did not amount to proof that you deliberately intended to mislead.

The panel contrasted this charge with other charges involving dishonesty. The panel was of the view that in those charges, the evidence showed clear contradictions between your documentation and compelling witness evidence. In the present charge, however, your explanation was sufficiently credible to raise doubt as to whether you subjectively appreciated the statement to be false at the time you made it.

Furthermore, the NMC did not produce evidence demonstrating that you consciously intended to create a misleading clinical record. Ordinary decent people, considering a practitioner who performed a visual assessment and then imprecisely documented it, would more likely regard this as poor practice rather than dishonesty.

Accordingly, the panel found that the NMC did not establish that you acted dishonestly when recording the chest examination entry.

Charge 12 is therefore not proved.

Charge 13

"That you, a registered nurse, from around July 9 until around October 2022:

13. Your action at Charge '6a' and/or '6b' was dishonest in that you knew you never had any conversation with relative O concerning a DNACPR order."

This charge is found proved.

The panel considered whether your actions in charges 6a and 6b, recording that a DNACPR discussion had taken place with Relative O, were dishonest. After reviewing all the evidence, the panel concluded that the NMC had established dishonesty on the balance of probabilities.

The panel first recalled its earlier findings in charges 6a and 6b, where it determined that no conversation regarding the DNACPR order took place and that your documentation stating otherwise was inaccurate. This provided the factual foundation for assessing dishonesty.

To determine dishonesty, the panel applied the legal test derived in the case of *Ivey*:

- What did you know or believe at the time?
- Would ordinary decent people consider your conduct dishonest in light of that knowledge or belief?

The panel considered your explanation that any conversation with Relative O might have occurred informally, or that she might have forgotten. The panel rejected this evidence. It found that you knew you had not had the discussion you recorded. The DNACPR

conversation you documented was described as a formal, substantive discussion, yet the panel found that no such discussion occurred at all, formally or informally.

The panel considered it highly unlikely, if not impossible, that you mistakenly believed a DNACPR conversation had occurred. DNACPR decisions are among the most serious and sensitive clinical decisions. Any discussion with a family member about this topic would be memorable, carefully conducted, and clearly documented.

By contrast, your description of a brief "*in passing*" conversation in a corridor lacked credibility and was inconsistent with the type of discussion required by professional standards. The panel therefore concluded that you knew you had not had such a conversation.

The panel found Relative O to be a highly credible witness. Her evidence was consistent across her written statement and her oral testimony. She denied unequivocally, twice under cross-examination, that a DNACPR discussion took place, saying "*absolutely not*." She also demonstrated an understanding of family dynamics, explaining that any DNACPR conversation would have necessitated discussion among siblings, which had not occurred.

Given the gravity of DNACPR decisions, the panel considered it implausible that she would fail to recall such a conversation.

The panel noted that concern about the DNACPR documentation was raised promptly upon discovery. This contemporaneity reinforced the reliability of Relative O's account and undermined your suggestion of a forgotten conversation.

The panel determined that ordinary decent people would consider your actions dishonest. It was of the view that recording a significant and sensitive conversation that did not occur, especially one relating to life-sustaining treatment, is a serious breach of trust. Such an

entry could mislead future clinicians, distort decision-making, and deprive a family of involvement in critical healthcare planning.

This was not a matter of poor documentation or administrative error. It was an affirmative act of recording a conversation that the panel found you knew had never taken place.

Accordingly, the panel found that your conduct in charges 6a and 6b was dishonest.

Charge 13 is therefore proved.

Charge 14

“That you, a registered nurse, from around July 2019 until around October 2022:

14. Your action at any or all of Charge ‘8’ was dishonest because you knew you had not conducted the observations in any or all of ‘a’, ‘b’, ‘c’, or ‘d’.”

This charge is found proved.

The panel considered whether your conduct in recording observations for Child A, namely temperature, respiratory rate, oxygen saturation, and heart rate was dishonest. Having already found in charge 8 that you recorded these observations, the panel now examined whether you knew that you had not carried them out and whether ordinary decent people would consider the recording of such false entries dishonest.

The panel first reaffirmed its findings in charge 8: you recorded the observations in the Consultation Information Sheet dated 20 September 2022 at 10:17. The entries included specific numerical values for each observation.

Separately, the panel had before it evidence from Child A’s mother, as relayed by clinician witness Ms Stainsby, who stated:

“I spoke to the child’s mother who informed me that when they came in for an assessment, Belinda did not conduct any observations on the child. The mother reported that the child still had a cough and now has an inhaler. Observations were recorded in the consultation notes for the child, but the mother told me that Belinda had not done any observations.”

The panel found this hearsay account reliable and credible, particularly given the absence of any motive to fabricate.

The panel considered your explanation that the mother may have been distracted on her phone during the assessment and therefore might not have noticed the observations being carried out.

The panel rejected this explanation entirely.

The panel was of the view that a child under five does not attend alone; a parent is present throughout. Observations such as temperature checks, oxygen saturation, and pulse measurement require visible, hands-on interaction, ear thermometers, finger or toe pulse oximetry clips, and timing respiratory rate while observing the child. Such actions cannot plausibly occur unnoticed. A parent, concerned about their child’s illness, would not disengage from the assessment to the point of missing all four observation procedures.

The panel found the mother’s account consistent with the circumstances and common sense.

The panel further noted that performing clinical observations without the parent’s attention or consent would itself be inappropriate. It was of the view that you would be expected to ensure that the parent was engaged and aware of what you were doing. Thus, your attempt to explain the absence of parental awareness was inconsistent with safe professional practice and undermined your credibility.

The panel concluded that you knew you had not conducted the observations. There was no credible alternative explanation for how you could have carried out four separate observations without the parent noticing, nor did you describe any recollection of doing them.

Your testimony did not establish that you could have believed the observations were completed. Instead, the panel found that you knowingly recorded values which had not been measured.

Having found that you knew the observations had not been performed, the panel considered whether ordinary decent people would regard documenting such false entries as dishonest.

The panel concluded they would.

Falsifying observations in a paediatric consultation:

- misleads future clinicians,
- creates a falsely reassuring clinical picture,
- undermines safeguarding,
- and presents a direct risk to patient safety.

This was not a case of poor documentation, error, or misunderstanding. It was the deliberate recording of clinical findings that you knew to be untrue.

Accordingly, the panel found that your recording of observations you had not conducted was dishonest.

Charge 14 is therefore proved.

Charge 15

"That you, a registered nurse, from around July 2019 until around October 2022:

15. You action at Charge '1' was dishonest because you knew that the patient consultations you copied and pasted did not relate to the any or all of the patient records as set out in Schedule 1."

This charge is found not proved.

The panel considered whether your conduct in charge 1, copying and pasting consultation notes into unrelated patient records, was dishonest. Having already found charge 1 factually proved on the basis of your admission, the panel now assessed whether the NMC had established that your actions were dishonest.

Dishonesty requires proof of two elements:

- Your knowledge or belief at the time of the conduct; and
- Whether ordinary decent people would consider your conduct dishonest in light of that knowledge or belief.

The panel carefully examined the evidence supporting each element.

The NMC advanced no evidence demonstrating that you knowingly inserted notes into the wrong records with an intention to mislead, deceive, or disguise your actions. Instead, the panel noted multiple indications throughout the transcript that your conduct reflected:

- poor administrative practice;
- over-reliance on templates;
- time pressure; and
- a chaotic approach to record-keeping,

rather than deliberate falsification.

The panel considered the audit findings, which demonstrated repeated copying of template language and clinically inappropriate phrases (for example, repeated use of "*no peristalsis present*"). However, nothing in the audit evidence showed that you inserted these entries with awareness that they were false in relation to individual patients.

The panel found your explanation, that you used a template and adapted it but did not always check or adjust it carefully, to be consistent with a pattern of administrative carelessness rather than intentional wrongdoing. This interpretation was reinforced by your limited insight into appropriate record-keeping.

The panel also considered the broader context of your workload and the pressures described in your oral evidence. Although contextual considerations cannot excuse misconduct, they may inform whether you had the requisite knowledge for dishonesty. The panel accepted that your work environment was pressured and that you appeared disorganised in your approach to documentation.

Nothing in the evidence established that you knew the copied material was inappropriate for the specific patients at the time you entered it.

Ordinary decent people would distinguish between:

- a clinician deliberately fabricating clinical findings to deceive, and
- a clinician using a template improperly due to poor practice, haste, or disorganisation.

The panel concluded that your actions fell into the latter category.

The panel emphasised that dishonesty involves deceit, impropriety, intent to mislead, or at least a conscious appreciation that one's actions are misleading. The evidence fell short of demonstrating any such state of mind.

The panel also noted that, unlike the DNACPR entries (found dishonest in charge 13), nothing in charge 15 concerned a sensitive or consequential decision. Rather, the panel determined that the issue concerned administrative documentation errors.

Although the inaccuracies in the copied notes were concerning and could mislead others, the panel found insufficient evidence that you intended to do so, or that you knew the notes were unrelated to the patient when you copied them.

Based on the absence of evidence establishing that you acted with knowledge of falsity or intent to mislead, and considering how ordinary decent people would view your conduct, the panel determined that dishonesty was not proven.

Accordingly, charge 15 is found not proved.

Charge 16

"That you, a registered nurse, from around July 2019 until around October 2022:

16. In respect of Charge '2a' you recorded that you had conducted an abdominal examination on patient J."

This charge is found proved.

The panel considered the evidence relating to charge 16 and was satisfied, on the balance of probabilities, that you recorded that you had conducted an abdominal examination on Patient J, as alleged.

The panel's earlier factual finding in charge 2a established that no abdominal examination took place. Charge 16 concerns only whether you nonetheless recorded that such an examination had been carried out.

The panel reviewed the relevant consultation entry, which clearly stated that an abdominal examination had been performed. You did not dispute that you authored the consultation record. This was confirmed in your oral evidence, in which you maintained that if an examination was documented, you believed you would have performed it. While the panel did not accept that explanation in respect of whether the examination occurred (as determined under charge 2a, it remained clear that the documentation itself originated from you.

The panel also noted that your legal representative did not challenge the provenance of the entry during cross-examination, and no evidence was presented to suggest that anyone else created or altered it.

In addition, the evidence of clinicians Mr Harrison and Ms Raby, who each spoke with Patients J and K and obtained consistent accounts that no abdominal examination had taken place, supported the panel's finding that the documentation was inconsistent with the events of the consultation. The panel noted that Mr Harrison reported Patient J stating, "*Belinda never laid a hand on me*," a phrase the panel found especially compelling.

The panel emphasised that charge 16 is a factual allegation, whether you recorded the examination, not whether doing so was dishonest. Dishonesty is considered separately under charge 18.

Given your acceptance of authorship of the notes, the presence of the abdominal examination entry in the clinical record, and the absence of any evidence that another person made the entry, the panel found that you did record that you conducted an abdominal examination on Patient J.

Accordingly, charge 16 is found proved.

Charge 17

“That you, a registered nurse, from around July 2019 until around October 2022:

17. In respect of Charge ‘2b’ you recorded that you had conducted an abdominal examination on patient K.”

This charge is found proved.

The panel considered the evidence relating to charge 17 and was satisfied, on the balance of probabilities, that you recorded that you had conducted an abdominal examination on Patient K.

The panel had the benefit of its earlier finding in charge 2b, namely that no abdominal examination was conducted on Patient K. Charge 17 concerns only the documentary entry you made stating that such an examination had taken place.

The clinical record for Patient K contained a clear entry indicating that an abdominal examination had been performed. You did not dispute authorship of this record. In your oral evidence, you again relied on the assertion that if you documented the examination, you would have carried it out. However, as determined under charge 2b, the panel found that the examination did not occur.

The panel also considered the corroborating evidence from Ms Raby, who reported that Patient K had stated that no abdominal examination occurred. The panel noted that Ms Raby stated that Patient K had been clear and consistent on this point. The panel accepted this evidence as credible, reliable, and without any apparent motive to fabricate.

The panel observed that the findings in both Patient J's and Patient K's cases followed a similar pattern:

- Clinical records stated abdominal examinations were conducted.
- Both patients stated no such examinations took place.
- Staff witnesses corroborated the patient accounts.
- You could not recall the consultations and relied instead on assumptions based on your supposed usual practice.

The panel found this pattern significant.

However, charge 17 required only proof that you recorded that the examination had occurred. This was supported by:

- The presence of the abdominal examination entry in Patient K's Consultation Information Sheet.
- Your acceptance that you authored the clinical record.
- The absence of any suggestion that the entry was made by another clinician or in error by administrative staff.

The panel was satisfied that you did record that you had carried out an abdominal examination when, as previously found, no such examination took place.

Charge 17 is therefore proved.

Charge 18

"That you, a registered nurse, from around July 2019 until around October 2022:

18. Your action at Charge '16' was dishonest because you knew you did not carry out an abdominal examination on patient J."

This charge is found proved.

The panel considered whether your conduct in recording an abdominal examination for Patient J, when no such examination took place, was dishonest. The panel had already determined in charge 16 that you documented having conducted an abdominal examination, and in charge 2a that no examination was performed. The issue here was whether you acted dishonestly in making that record.

To determine dishonesty, the panel applied the *Ivey* test:

- What did you know or believe at the time you made the entry?
- Would ordinary decent people regard your conduct as dishonest in light of that knowledge or belief?

The panel found that you knew the abdominal examination had not been carried out. This conclusion was supported by several factors:

a. The nature of an abdominal examination

An abdominal examination is a hands-on clinical assessment requiring the patient to lie on an examination couch, exposing the abdomen, and receiving palpation and physical touch. The panel was of the view that it is not a subtle or ambiguous procedure. A clinician is aware of whether such an examination occurred.

b. Patient J's evidence

Patient J stated unambiguously that "*Belinda never laid a hand on me*," as reported by Mr Harrison, whose evidence the panel found credible and reliable. The phrasing was so specific and memorable that the panel accepted it as strong corroboration that no examination took place.

c. Consultation duration

Consultations, referenced during the hearing, showed a very short duration, around five minutes, which the panel found was insufficient time to conduct a full abdominal examination and complete documentation.

d. Your inability to recall the consultation

You stated you had no memory of the consultation and relied on the assumption that you "*must have done it*" if it was documented. The panel found this explanation unsatisfactory. The panel was of the view that a lack of recollection could not substitute for proof that the examination took place, nor could it justify recording an examination that was not conducted.

Based on this evidence, the panel found it more likely than not that you knew the examination had not occurred when you recorded it.

The panel then considered whether ordinary decent people would regard your conduct as dishonest.

The panel concluded they would.

a. Falsifying an abdominal examination is materially misleading

Recording an examination that did not occur gives an inaccurate and potentially unsafe clinical picture. Future clinicians reviewing the notes would be misled into believing that key components of the assessment had been completed.

b. This was not a documentation error

The panel noted that false entry was not the result of a typographical mistake or a template error. It was a specific assertion that a clinically significant, physical assessment had been carried out.

c. Comparison with your other conduct

Unlike charge 15, where the panel found deficiencies in administrative skill and template misuse, this charge involved a specific, concrete, hands-on examination. The panel could not accept that such an examination could be confused with or mistaken for any other clinical task.

d. The conduct created a misleading picture of patient safety

The panel considered that ordinary decent people would regard knowingly entering false clinical information about a physical examination as dishonest, given the impact on patient care and professional integrity.

The panel therefore found that when you recorded an abdominal examination for Patient J, knowing that no such examination had taken place, you acted dishonestly.

Accordingly, charge 18 is proved.

Charge 19

“That you, a registered nurse, from around July 2019 until around October 2022:

19. Your action at Charge ‘17’ was dishonest because you knew you did not carry out an abdominal examination on patient K.”

This charge is found proved.

The panel considered whether your conduct in recording an abdominal examination for Patient K, when no such examination occurred, was dishonest. Having determined in charge 17 that you recorded such an examination, and in Charge 2b that no abdominal examination took place, the panel now assessed your state of knowledge and the dishonesty test.

To determine dishonesty, the panel applied the two-stage *Ivey* test:

- What you knew or believed at the time you made the record, and
- Whether, in light of that knowledge or belief, ordinary decent people would consider your conduct dishonest.

The panel concluded that you knew you had not performed an abdominal examination on Patient K when you recorded it.

This conclusion was supported by several key evidential factors:

a. Nature of an abdominal examination

As discussed in relation to Patient J, an abdominal examination is a hands-on physical assessment requiring palpation, the patient lying on an examination couch, and other deliberate clinical steps. These actions are intrusive, memorable, and cannot occur inadvertently or be mistaken for a visual check.

The panel considered it impossible that a clinician could forget whether or not such an examination had been conducted.

b. Patient K's evidence

Although Patient K's evidence was admitted as hearsay, the panel had already ruled it admissible and reliable. Patient K stated clearly that no abdominal examination took place.

The panel noted that this account was consistent with that of Patient J and raised no concerns about motive or credibility.

c. Corroborating witness evidence

The panel relied on the testimony of Ms Raby, who spoke directly with Patient K following the consultation. Ms Raby stated that Patient K had been firm and unambiguous that no examination occurred. The panel found her account straightforward, consistent, and without any indication of bias.

d. Absence of plausible alternative explanation

You stated that you could not recall the consultation but assumed you would have performed the examination if you had written it down. The panel found this explanation inadequate, noting that reliance on usual practice cannot displace clear contradictory evidence from the patient and witnesses.

e. Consultation timing

As with Patient J, documentation indicated extremely short consultation times, too short to permit a full abdominal examination and proper documentation. This supported the conclusion that the examination did not occur and that you knew it had not occurred.

Based on this evidence, the panel concluded that you knew the abdominal examination had not taken place when you recorded it.

The panel next considered whether ordinary decent people, in possession of the facts as you knew them, would regard your conduct as dishonest.

The panel determined they would.

a. Falsifying a physical examination is inherently misleading

Recording that an abdominal examination was performed when you knew it was not misleads other healthcare professionals and presents a falsely reassuring clinical picture. It undermines safe and effective care.

b. This was not an administrative error

Unlike the template issues considered under charge 15, this was not carelessness or an oversight. It involved documenting a specific invasive examination requiring physical contact, which the panel determined you knew you had not undertaken.

c. Repetition across two patients

The identical pattern seen in both Patients J and K strengthened the panel's conclusion that your conduct was not merely accidental. This consistency was relevant in assessing your intention and state of mind.

d. Seriousness of falsifying clinical records

Ordinary decent people would consider knowingly entering false clinical information, particularly regarding a physical examination, to be dishonest and a serious breach of professional trust.

The panel therefore found that when you recorded that you had carried out an abdominal examination on Patient K, knowing that no such examination had taken place, you acted dishonestly.

Accordingly, charge 19 is proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Malik submitted that the facts found proved amount to serious professional misconduct. He reminded the panel of the guidance given by Lord Clyde in *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, that misconduct is *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He also referred to *Killeen v General Medical Council* [2006] EWHC 2193 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), noting that misconduct must be viewed as a serious breach indicating that a nurse's fitness to practise is impaired.

Mr Malik submitted that your conduct fell far short of the standards set out in The Code: Professional standards of practice and behaviour for nurses and midwives (2015) and therefore amounted to serious professional misconduct. He submitted that practising

effectively and upholding the reputation of the nursing profession form fundamental responsibilities. He submitted that you had a professional duty to act appropriately, honestly, and with integrity, but you failed to do so.

Mr Malik submitted that the charges found proved were serious and involved repeated clinical dishonesty, including falsifying patient records and placing patients at risk of harm. He submitted that the facts proved include failing to carry out physical examinations, adding a consultation to the wrong patient record, and recording a conversation about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order that never took place. Mr Malik stressed that DNACPR decisions are among the most serious and sensitive clinical decisions and recording a fabricated conversation relating to life-sustaining treatment was a grave breach of trust. He submitted that such actions could mislead future clinicians and distort care planning, depriving families of their right to involvement in crucial healthcare decisions.

Mr Malik submitted that this was not a case of poor documentation but an affirmative act of dishonesty. He submitted that you knew the entries were false. He submitted that falsifying clinical records about examinations and observations presented a distorted and potentially unsafe clinical picture, and doing so without parental knowledge or consent in respect of a child was wholly inappropriate and unsafe.

Mr Malik went on to highlight your inappropriate and aggressive behaviour towards a colleague, including shouting and pointing a finger in their face. Such behaviour, he said, is wholly inconsistent with the standards expected of a registered nurse. He submitted that you were rude and abrupt and failed to recognise the impact your actions had on your colleague.

Mr Malik submitted that honesty lies at the heart of nursing practice. Quoting *Khan v General Medical Council* [2008] EWHC 581 (Admin), Mr Malik said that the courts have consistently held dishonesty to be at the top end of the spectrum of gravity in cases of professional misconduct. He submitted that falsifying clinical records on multiple occasions

amounted to a serious departure from the Code and would be regarded as deplorable by fellow practitioners.

Mr Malik invited the panel to find that you breached, among others, sections 1.1, 1.2, 1.4, 2.6, 8.2, 10.3, 20.1, 20.2, 20.3, 20.5 and 20.8 of the Code. He submitted that your conduct represented a sustained pattern of dishonest and unprofessional behaviour directly linked to your clinical practice. He submitted that it seriously undermined public confidence in the nursing profession, jeopardised patient safety, and betrayed your fundamental duty of candour.

For all these reasons, Mr Malik submitted that your actions constituted serious professional misconduct.

Ms Anderson submitted that, when considering whether the facts found proven amount to misconduct, it is necessary to distinguish between those charges involving dishonesty and those which do not. She accepted that the findings which include dishonesty, namely charges 2 with 16, 17, 18 and 19, charge 6 with charge 13, and charge 8 with charge 14, plainly fall into the category of conduct that must amount to misconduct. Those findings, she submitted, involve dishonesty and the underlying behaviours connected to that dishonesty.

However, Ms Anderson submitted that the remaining charges, which do not involve dishonesty, do not amount to misconduct for the purposes of these proceedings.

In relation to charge 1 (copying and pasting from the template), Ms Anderson submitted that the panel accepted your explanation that you were copying from a template, not from one patient record into another. She submitted that the panel found that although you made errors in using and adapting the template, those errors amounted to administrative carelessness rather than intentional wrongdoing. Ms Anderson submitted that while it may not have been best practice, it was not sufficiently serious to amount to misconduct.

On charge 3 (inserting notes into the wrong patient's record), Ms Anderson submitted that this was a simple, one-off human error. On that basis, she argued that it does not amount to misconduct.

Turning to charge 5a (the visit to Patient N), Ms Anderson submitted that you accepted there was no in-person visit but that you carried out a telephone consultation instead. She reminded the panel of the evidence heard about the COVID-19 restrictions in place at the time, which effectively prevented you from attending the care home in person. This was confirmed both by your evidence and by the NMC witnesses, Ms Johnson and Ms Stainsby.

Ms Anderson further submitted that the absence of a physical visit did not prevent you from completing an effective clinical assessment. She submitted that the panel found that you provided a detailed and clinically reasoned explanation for not prescribing antibiotics and that you gave appropriate safety-netting advice. On that basis, she submitted that: first, an in-person assessment was not possible; and second, your remote assessment was clinically sound.

For those reasons, she submitted that charge 5a does not amount to misconduct.

With respect to charges 9, 10 and 11 (relating to Patient X/Colleague X), Ms Anderson submitted that none of these amounts to misconduct.

Regarding charge 9, involving the phrase "stop being a fanny", Ms Anderson submitted that although the language was plainly inappropriate and not best practice, it does not necessarily indicate a lack of kindness, respect or compassion. She submitted that it may have been an ill-judged attempt at tough reassurance or humour. This was a single, isolated incident, and in her submission, not sufficiently serious to amount to misconduct.

For charge 10a, relating to the phrase "I'm sick of the backstabbing bastards in this place", Ms Anderson submitted that while the language was unprofessional, it was directed at

nobody in the workplace and had nothing to do with colleagues. It was an expression of frustration about your private life, uttered only after colleagues asked what was wrong when they noticed you were upset. Ms Anderson submitted that strong language occasionally arises in workplaces and, in this context, did not meet the threshold for misconduct.

Regarding charge 10b (the corridor incident with Colleague X), Ms Anderson submitted that the wider context is essential. The incident occurred during an emotionally charged period when you had become the subject of workplace gossip among several individuals. Given [PRIVATE], the further gossip and triangulation in the workplace understandably caused upset. She submitted that this appeared to be a one-off incident that could have been avoided with better management support and oversight. Although it could have been handled better, she submitted that it does not amount to misconduct.

Finally, in respect of charge 11 (recording a chest examination), Ms Anderson submitted that the panel accepted there was no dishonesty. She submitted that the only matter left to consider was the fact of documenting the chest examination. Ms Anderson submitted that at the time you genuinely believed the visual assessment you performed fell within the definition of a chest examination, and the panel found that explanation plausible. On that basis, she submitted that this conduct does not amount to misconduct.

Submissions on impairment

Mr Malik submitted that the panel must now consider whether your fitness to practise is currently impaired. Impairment, he noted, is not defined in statute, but the question is whether you can practise safely and effectively without restriction as of today's date.

Mr Malik referred to the four questions posed by Dame Janet Smith in the Fifth Shipman Report, as approved in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin):

1. Whether you have in the past acted, and/or are liable in the future to act, so as to put a patient at unwarranted risk of harm;

2. Whether you have in the past brought, and/or are liable in the future to bring, the nursing profession into disrepute;

3. Whether you have in the past breached, and/or are liable in the future to breach, one of the fundamental tenets of the nursing profession; and

4. Whether you have in the past acted dishonestly, and/or are liable to act dishonestly in the future.

Mr Malik submitted that all four limbs are engaged. Your actions caused actual and potential harm to patients and relatives. He submitted that Relative O and her family suffered distress from not being consulted on a DNACPR decision you recorded inaccurately. He submitted that colleagues were subjected to rude and demeaning treatment that caused psychological harm. He submitted that Patients J and K were placed at unwarranted risk because abdominal examinations were not conducted, and falsified child observations created a falsely reassuring clinical picture. These actions, he submitted, directly endangered patient safety.

Mr Malik submitted that your misconduct brought the nursing profession into disrepute and breached fundamental tenets of honesty, integrity, and compassion. He emphasised that your conduct demonstrated attitudinal concerns and that, without full insight and remediation, the risk of repetition remained.

Turning to insight and remediation, Mr Malik referred to *Cohen v General Medical Council* [2008] EWHC 581 (Admin), which requires panels to assess whether concerns are easily remediable, have in fact been remedied, and are highly unlikely to be repeated. He drew attention to your reflective statement, which, in his submission, showed limited

self-awareness. He submitted that it focused on personal circumstances rather than acknowledging wrongdoing, harm caused, or impact on the profession. He submitted that there was no recognition of the effect of your dishonest behaviour on patients, families, or colleagues.

Mr Malik submitted that the proven dishonesty reveals deep-seated attitudinal issues that are not easily remediable. He submitted that you have not accepted responsibility or demonstrated meaningful reflection. He submitted that the absence of genuine insight or remediation means there remains a real risk of repetition, and therefore a continuing risk to public protection.

Mr Malik further submitted that impairment must also be considered in the wider public interest. Citing *Grant* and *R (on the application of Young) v General Medical Council* [2009] EWHC 1923 (Admin), he reminded the panel that a finding of impairment may be necessary to uphold proper professional standards and maintain public confidence in the profession. He referred to NMC guidance (DMA-1) which lists serious and sustained dishonesty, breach of duty of candour, and knowingly taking risks with patient safety as examples of conduct likely to require a finding of impairment.

He submitted that your behaviour, dishonesty, falsification of records, unsafe clinical practices, and failure to uphold the duty of candour undermines the values at the core of nursing: integrity, honesty, respect, and professionalism. He submitted that these deep-rooted attitudinal issues erode trust in the profession and diminish public confidence if not addressed by a formal finding of impairment.

Accordingly, Mr Malik submitted that both on public protection grounds and in the wider public interest, your fitness to practise is currently impaired.

Ms Anderson submitted that all relevant charges have already been addressed and that the focus for the panel must now be whether you are impaired as of today, rather than at the time of the events between 2019 and 2022.

Ms Anderson submitted that a finding of current impairment is not warranted. She reminded the panel that the conduct is now several years old, and that the correct question is whether, on the evidence before the panel today, there is any current or ongoing risk to the public, to public confidence, or to professional standards if you were permitted to practise without restriction.

Ms Anderson submitted that the concerns raised in this case can be and have been addressed by the steps you have taken since leaving your nursing role in 2022. She submitted that although you have not worked as a registered nurse since then, you have remained in clinical practice as a senior care assistant, keeping your skills current and preventing skill-fade. This ongoing practice, she submitted, shows continued engagement with safe and up-to-date care.

Ms Anderson submitted that the concerns arising from practice, distinct from dishonesty, are highly remediable, and that you have in fact remediated them. She referred to the significant amount of training you have undertaken, including documentation and record-keeping, duty of care, person-centred practice, dignity in care and mental health. She submitted that your certificates, contained within the impairment bundle, demonstrate a targeted and thoughtful approach to addressing the shortcomings identified.

Ms Anderson submitted that this was not a superficial response: you selected training that directly aligned with the concerns raised, particularly around inconsistent or inadequate record keeping. She submitted that your detailed reading logs, containing extensive reflection, further demonstrate sustained learning and insight.

Ms Anderson submitted that the panel should consider your deeper reflective piece together with the embedded reflection throughout the reading logs. She submitted that you now show a deep appreciation of the need for honesty and integrity, and that you have reflected on your communication with patients and colleagues.

Ms Anderson acknowledged that dishonesty is always serious, but submitted that in this case the dishonest conduct was limited to a narrow window in 2022, occurring against a backdrop of extreme personal pressure. She submitted that testimonials within the bundle repeatedly describe you as honest and trustworthy, reinforcing that the behaviour found proved was wholly out of character when set against a 40-year career with no previous regulatory concerns.

Ms Anderson submitted that insight is something that develops over time and not "*like a light switch*." Nonetheless, she asserted that you have developed meaningful insight into your failings and their impact, as demonstrated through remorse, reflection, and acknowledgement of where improvement was required.

Ms Anderson submitted that the risk of repetition is highly unlikely. She referred to your long and otherwise unblemished career, the fact the concerns arose in a single workplace over a short period, and the strong character references provided by colleagues aware of the NMC referral.

She further submitted that [PRIVATE]. She did not advance these matters as an excuse, but as an explanation for why your performance in that period diverged so markedly from four decades of safe and dependable practice.

[PRIVATE].

Ms Anderson submitted that these changes mean you are not going to find yourself in the same circumstances again, and even if future pressures arise, you now have the tools to prevent them affecting your practice in the way they once did.

Ms Anderson submitted that the extensive remediation, reflection and insight demonstrate there is no ongoing risk to patient safety. She submitted that you now fully appreciate the importance of performing and recording observations accurately, and your further training evidences strengthened skills in document management and record keeping.

Ms Anderson submitted that a finding of impairment is not necessary on public interest grounds, arguing that a well-informed member of the public, aware of your personal circumstances at the time and the steps you have taken since, would be reassured rather than concerned. The age of the allegations, now more than four years old, further reduces the need for a public interest impairment finding.

Ms Anderson submitted that your practice is not currently impaired. She invited the panel to conclude that the concerns have been addressed, insight has been developed, and repetition is highly unlikely. For all these reasons, she submitted that no finding of impairment is required on any ground.

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

Decision and reasons on misconduct

The panel first considered whether the facts found proved amounted to misconduct. The panel reminded itself that misconduct involves serious professional wrongdoing which falls well below the standards expected of a registered nurse. The panel also had regard to the NMC Code and considered whether your conduct represented a serious departure from fundamental professional standards.

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:*
>
> *1.1 treat people with kindness, respect and compassion*

1.2 make sure you deliver the fundamentals of care effectively'

'10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.3 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'

'19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that the proved charges, considered both individually and cumulatively, amounted to misconduct. The panel considered that the misconduct included recording clinical examinations and observations which had not been carried out, recording DNACPR discussions which had not taken place, acting dishonestly in relation to clinical documentation, using inappropriate language towards a patient, and behaving unprofessionally towards a colleague.

The panel considered that these matters were not minor errors or isolated lapses. They formed a pattern of serious misconduct involving multiple patients and colleagues. The panel was particularly concerned by the dishonest recording of clinical information, including abdominal examinations, observations for a child, and DNACPR discussions. These were significant clinical matters and the panel considered that inaccurate entries of this nature could mislead future clinicians and expose patients to a risk of harm.

Dishonesty was a central feature in several charges. The panel found dishonesty proved in relation to charges 13, 14, 18 and 19. These charges concerned deliberate recording of events which the panel found you knew had not occurred. The panel distinguished those findings from charges 12 and 15, where dishonesty had not been found proved. In respect of the proved dishonesty charges, the panel concluded that the entries could not properly be attributed to mere carelessness, misunderstanding or imprecision. They represented a serious abuse of professional trust.

The panel considered these to be core standards underpinning safe, ethical and effective nursing practice. The panel concluded that your conduct, particularly the dishonest

recording of clinical information, was incompatible with the standards expected of a registered nurse.

The panel therefore found that your actions did fall seriously short of the conduct and standards expected of a nurse and the facts proved amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to 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 finds that patients were put at serious risk of harm and were caused emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel acknowledged that you had provided a reflective piece, training certificates, reading logs and testimonials. The panel also acknowledged that you had demonstrated some elements of remorse and had undertaken some post-incident training. However, the panel noted that some of the training evidence was not recent and that your insight remained limited, particularly in relation to the dishonesty findings. The panel also when reviewing the testimonials submitted noted that they were not recent. The panel would have benefited from more up-to-date testimonials.

The panel was concerned that you continued to deny dishonesty in circumstances where the panel had found that you knowingly recorded false clinical information. The panel considered that your explanations frequently relied on stress, workload and contextual factors rather than any acceptance of responsibility. The panel found that there remained a tendency to characterise dishonest conduct as poor practice, misunderstanding or error. The panel considered that, without full insight into the dishonest and unacceptable nature of your conduct, there remains a real risk of repetition, particularly if you were to return to an autonomous clinical role. The panel therefore found impairment on public protection grounds.

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 determined that a finding of impairment on public interest grounds is required because members of the public would be deeply concerned if a nurse who had dishonestly recorded false clinical information, falsely documented DNACPR discussions, and falsified records relating to physical examinations were permitted to practise without restriction.

The panel concluded that a finding of impairment is necessary to declare and uphold proper professional standards, particularly in relation to honesty, integrity and accurate record keeping. It also considered that public confidence in the profession and in the regulatory process would be seriously undermined if a finding of impairment were not made.

The panel therefore determined that your fitness to practise is currently impaired on both public protection and public interest grounds.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2, Last Updated: 28/01/2026, SAN-3, and SAN-4).

Submissions on sanction

Mr Malik informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Malik submitted that the following aggravating factors are present in this case:

- Abuse of position of trust

- Risk of harm to vulnerable patients
- Limited insight
- Limited remediation
- Limited remorse

Mr Malik submitted that the following mitigating factors are present:

- Early admissions to charges

Mr Malik submitted that taking no action, or imposing a caution order would not be appropriate or proportionate, given the nature and seriousness of the misconduct in the charges found proved. Mr Malik submitted that your misconduct is not at the lower end of the spectrum, and he further submitted that dishonesty is very serious.

Mr Malik submitted that you provided a reflective piece this morning ahead of this stage, and that it is a matter for the panel to consider whether this reflection is genuine and mitigates the risk.

Mr Malik submitted that imposing a conditions of practice order would be neither appropriate nor proportionate in the circumstances of this case. He submitted that this case relates to dishonesty, which is difficult to remediate through retraining or conditions. He submitted that the charges found proved were not minor errors, but formed a pattern of misconduct.

Mr Malik submitted that the misconduct calls into question your ability to continue practising. He submitted that there is a real risk to the safety of patients and the public accessing services, if you were allowed to continue practising.

Mr Malik submitted that the concerns in this case are not easily remediable. He submitted that there is no evidence before the panel to support that you have taken steps to strengthen your practice and address the concerns. In relation to whether a suspension

order is appropriate and proportionate, Mr Malik submitted that temporary removal from the register would be insufficient to maintain the public confidence in the nursing profession.

Mr Malik invited the panel to impose a striking off order. He submitted that the nature and seriousness of your misconduct calls into question your integrity and professionalism. He submitted that public confidence in the nursing profession can only be maintained by removing you from the register. Mr Malik submitted that the misconduct in this case is fundamentally incompatible with remaining on the NMC register.

Mr Malik referred the panel to NMC Guidance SAN-4. He submitted that honesty is of central importance to the nursing practice. He submitted that dishonesty will always put the public at risk. He submitted that these were not isolated instances of misconduct, but a pattern of dishonest conduct involving several patients and colleagues.

Mr Malik submitted that the misconduct was a serious abuse of professional trust, and patients were caused emotional harm as a result of your misconduct.

Mr Malik submitted that the evidence of training provided by you was not recent, and your insight was limited, especially in relation to the panel's findings of dishonesty. Mr Malik submitted that you continue to deny the dishonesty in circumstances where the charges were found proved by the panel. Mr Malik submitted that there is a real risk of repetition if you were to return to a nursing role. He invited the panel to impose a striking off order.

Ms Anderson invited the panel to consider the mitigating factors and your reflective piece in making its decision on sanction. She submitted that you acknowledge the seriousness of the concerns, and submitted that a lesser sanction from strike off, namely a suspension order, is appropriate and proportionate in this case.

Ms Anderson submitted that NMC Guidance SAN-2(d) states that suspension may be appropriate in cases where the misconduct is serious but not fundamentally incompatible with continued practice.

Ms Anderson submitted that you are a nurse who, aside for 2022, had an otherwise unblemished career. She submitted that you have started to develop insight, and that you would be able to return to practice in due course if you were allowed time to further develop your insight.

Ms Anderson submitted that you could return to unrestricted practice in the future if the panel allowed you the time and opportunity to come to terms with the findings of this hearing, and develop your insight and remediation. She submitted that a suspension order would protect the safety of the public and maintain public confidence in the nursing profession. Ms Anderson submitted that a lengthy suspension would mark the seriousness of your misconduct.

Ms Anderson submitted that “All dishonesty is serious, but not all dishonesty is equal”. She submitted that your dishonesty falls on the lower end of the spectrum. She submitted that you accepted some of the allegations, and this should be taken into consideration by the panel when making its decision. She submitted that you have provided two reflective documents which show your remorse and the development of insight. She submitted that it is difficult to demonstrate “full insight” when you have not fully accepted the allegations against you.

Ms Anderson referred the panel to the positive character references provided on your behalf. She submitted that there are mitigating circumstances in this case, in that the allegations took place during the Covid-19 pandemic, within a toxic work environment, [PRIVATE].

Ms Anderson invited the panel to impose a suspension order.

The panel accepted the advice of the legal assessor, who referred it to the relevant guidance and case law, including NMC Sanction Guidance SAN-1, SAN-2, SAN-3, and SAN-4.

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 took into account the following aggravating features:

- Dishonest conduct
- Abuse of a position of trust
- conduct which put people receiving care at an unwarranted risk of suffering harm
- deliberate breaches of the Code
- Pattern of misconduct involving more than one patient, occurring over a period of time
- Emotional harm caused to patients and relatives
- Deep-seated attitudinal concerns

The panel also took into account the following mitigating features:

- Some early admissions of the facts
- Some developing insight
- Expressed remorse
- Personal mitigation in that [PRIVATE], and a toxic work environment
- Positive character references provided
- Relevant training courses undertaken

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 misconduct in this case was very serious, and involved dishonesty over a period of time. Further, patients were put at an unwarranted risk of harm as a result of your misconduct. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) 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 not at the lower end of the spectrum, 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. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

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

The panel took into account its finding that there are deep-seated attitudinal concerns, as well as its finding of misconduct which relates to dishonesty. The panel determined that a conditions of practice order would not be appropriate in the circumstances, as there are no relevant, proportionate, workable or measurable conditions that could be formulated to

protect patients and to uphold professional standards. The panel took into account that it is difficult to formulate conditions to address attitudinal concerns and dishonesty, as these issues are not directly linked to clinical practice.

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'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

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

The panel also had regard to the key considerations as set out in the NMC Guidance 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.'

Whilst the panel acknowledged that the risks identified could be managed by you being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved.

The panel took into account that you have demonstrated limited insight, with some insight being shown through a reflective piece which was sent to the panel on the morning of the hearing for the sanction stage. The panel also took into account the seriousness of the misconduct, and the dishonesty which took place over a period of time. The panel was not satisfied that there is a realistic possibility that a period of temporary suspension would allow you to address the concerns to such a level where you could return to practise safely.

The panel concluded that suspension was insufficient in this case for the following reasons.

- The dishonesty was repeated, deliberate and extended over a significant period.
- The misconduct affected multiple patients and undermined the reliability of their clinical records.
- You held a senior autonomous role as an advanced nurse practitioner, which increased the seriousness of the misconduct.
- There was a lack of meaningful insight, remediation, or assurance that behaviour would not be repeated.

The panel considered that public confidence would be seriously undermined if a registrant who had repeatedly falsified clinical records were permitted to return to practice after a period of suspension. The panel further concluded that suspension would fail to adequately mark the gravity of the misconduct or uphold the reputation of the profession.

The panel concluded that none of the lesser sanctions were capable of addressing the seriousness of your misconduct, the risk to the public, or the need to maintain confidence in the profession.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). The panel took into account that your conduct involved deliberate dishonesty which occurred over a period of time, and resulted in a real risk of unwarranted harm to patients and resulted in emotional harm to patients and relatives. Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

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

The panel acknowledged that you have demonstrated some insight. However, the panel was not satisfied that this insight was sufficient to mitigate the seriousness and risk of harm in this case. Your insight is very limited and does not acknowledge the impact that dishonest conduct has on the nursing profession, patients, and public confidence.

The panel took into account that you produced a reflective piece, dated 5 May 2026, which was put before the panel shortly before submissions on sanction were made by Mr Malik and Ms Anderson. The panel took into account that this reflection did not demonstrate any insight into the panel's findings of dishonesty, in that you knowingly recorded false clinical information within multiple patient records which could mislead future clinicians.

You stated in your reflective statement:

> '*I recognise that my documentation did not clearly and comprehensively reflect the assessments I undertook. I understand how this could be interpreted as inaccurate or misleading and may raise concerns regarding honesty and integrity*.'

Further, the panel noted that your reflective piece appeared to deflect responsibility from yourself in relation to the misconduct. There was no recognition that assessments and examinations of patients did not take place but only that your record keeping was not clear and comprehensive. This does not reflect the findings of the panel in that records were falsified and no examinations or assessments took place. In explaining the misconduct and your conduct in the charges found proved, you frequently use the Covid-19 Pandemic and work environments, and your health as an explanation for your "poor judgment" in falsifying the patient records.

While the panel took your mitigation into account, and acknowledge the impact it would have had on you at the time, it was concerned that there remains a risk of repetition of dishonesty.

The misconduct in this case is very serious, in that you deliberately falsified several patient records on numerous occasions. The nature of the falsified records were very serious, involving the dishonest recording of clinical information, including abdominal examinations, observations for a child, and DNACPR discussions with their relatives. The panel found this dishonesty inexcusable. The panel found that these were also significant clinical

matters which risked misleading future clinicians and therefore exposing patients to a risk of harm.

The panel considered Ms Anderson's submission that your dishonesty was on the lower end of the spectrum, however, it was of the view that the dishonesty in this case is on the high end of the spectrum and very serious.

The panel considered that your dishonesty was deliberate. Patients were put at an unwarranted risk of significant harm as a result of your dishonesty and misconduct, as you falsified patient records. The panel was of the view that your misconduct is fundamentally incompatible with remaining on the NMC register.

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel acknowledged that you have been working as a registered nurse since 2001, and it considered the positive character testimonials that you provided. However, the panel was not satisfied that this mitigates the risk of harm and repetition, given the nature and seriousness of the charges found proved and misconduct.

The panel carefully balanced the impact of a striking-off order on you against the wider public interest. The panel accepted that striking-off is the most serious sanction available and would have serious significant consequences for you. However, the panel concluded that your own conduct had rendered continued registration incompatible with standard expected of a registered nurse. Having rejected all lesser sanctions for clear and reasoned grounds, the panel was satisfied that only a striking-off could:

- Adequately protect the public;

- Maintain confidence in the nursing profession and the regulatory process; and
- Properly mark the gravity of your misconduct.

The panel therefore concluded that a striking-off order was necessary, proportionate and the minimum sanction capable of meeting the statutory objectives of the NMC.

The panel had regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves.

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

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Malik.

Mr Malik submitted that an interim order was necessary in this case to cover the appeal period following the panel's substantive decision. He submitted that an interim suspension order for a period of 18 months was appropriate and proportionate.

Mr Malik submitted that the substantive order would not take effect until 28 days after the hearing. He further submitted that, should you lodge an appeal within the prescribed period, the substantive order would be suspended pending the determination of that appeal. In those circumstances, you would otherwise be permitted to practise without restriction during the appeal process.

Mr Malik submitted that permitting unrestricted practice during that period would fail to provide adequate protection to the public and would not address the wider public interest considerations, including maintaining public confidence in the profession and upholding proper professional standards and conduct.

Accordingly, Mr Malik submitted that an interim suspension order was required to remain in place for a period of 18 months, as this was likely to reflect the time required for any appeal to be resolved. He submitted that such an order was necessary, proportionate, and in the public interest.

Ms Anderson did not oppose the application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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.

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

That concludes this determination.