Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Monday, 5 January to Monday, 12 January 2026

Thursday, 22 October – Thursday, 29 October 2026

Virtual Hearing

Name of Registrant:	Multan Rasuli
NMC PIN	12D0622E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 17 September 2012
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Wayne Miller (Chair, Lay Member) Rachel Carter (Registrant Member) Claire Cawley (Registrant Member)
Legal Assessor:	Tracy Ayling KC (5 – 12 January 2026) Michael Hosford-Tanner (22 – 29 October 2026)
Hearings Coordinator:	Maya Khan (5 – 12 January 2026) Angela Nkansa-Dwamena (22 – 29 October 2026)
Nursing and Midwifery Council:	Represented by Leesha Whawell, Case Presenter (5 – 12 January 2026) Represented by James Holloway, Case Presenter (22 – 29 October 2026)
Facts proved by admission:	Charge 1 (in its entirety) and Charge 4
Facts proved:	Charges 2a, 2b, 3a, 3b, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 9a and 9b.
Facts not proved:	None

Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**
Final outcome:	**FTP impaired – Suspension order**

Details of charge (as amended)

That you a registered nurse, whilst working at Downhurst Residential Care Home (the Home);

1) On 4 June 2023:
   a. Failed to administer evening insulin to Resident A, as prescribed. **[PROVED BY ADMISSION]**

   b. In respect of Resident A's evening blood glucose level, failed to:
      i. Test it. **[PROVED BY ADMISSION]**
      ii. Record it. **[PROVED BY ADMISSION]**

   c. Incorrectly recorded in the paper medication administration chart that you had administered evening insulin to Resident A as prescribed. **[PROVED BY ADMISSION]**

   d. Incorrectly recorded in the paper medication administration chart that you had tested Resident A's blood glucose levels in the evening. **[PROVED BY ADMISSION]**

2) Your actions in charge 1) c) above were dishonest in that:
   a. You knew that you had not administered the evening insulin to Resident A. **[PROVED]**
   b. You intended to mislead anyone reading the paper medication administration chart into believing that the medication had been administered **[PROVED]**

3) Your actions in charge 1) d) above were dishonest in that:
   a. You knew that you had not tested Resident A blood glucose levels **[PROVED]**
   b. You intended to mislead anyone reading the paper medication administration chart that the blood glucose had been tested. **[PROVED]**

4) Around June 2023 practiced at the Home as an agency nurse, without being covered by the appropriate indemnity insurance. **[PROVED BY ADMISSION]**

5) Your actions in charge 4) above lacked integrity in that you carried out nursing duties without the appropriate insurance. **[PROVED]**

6) On 3 July 2023 at around 15.28 hours made one or more entries in the System One electronic record stating that you had on 4 June 2023 at around 17:00 hours:

a. attended on Resident A in the evening. **[PROVED]**
b. checked Resident A's blood glucose levels. **[PROVED]**
c. administered insulin to Resident A. **[PROVED]**

7) Your actions at charge 6 a) above were dishonest in that:
   a. You knew you had not attended on Resident A in the evening on 4 June 2023 **[PROVED]**
   b. You intended to mislead anyone reading the System One electronic record to believe you had attended on Resident A in the evening on 4 June 2023. **[PROVED]**

8) Your actions at charge 6 b) above were dishonest in that:
   a. You knew you had not checked Resident A's blood glucose levels in the evening on 4 June 2023. **[PROVED]**
   b. You intended to mislead anyone reading the System One electronic record to believe you had checked Resident A's blood glucose in the evening on 4 June 2023. **[PROVED]**

9) Your actions at charge 6 c) above were dishonest in that:
   a. You knew you had not administered insulin to Resident A in the evening on 4 June 2023. **[PROVED]**

b. You intended to mislead anyone reading the System One electronic record to believe you had administered insulin to Resident A in the evening on 4 June 2023. **[PROVED]**

Background

The NMC received a referral on 28 June 2023 from the Head of Nursing for Integrated Care at West London Mental Health NHS Trust (the Trust) regarding an incident that took place on 4 June 2023. At this time, you were employed as a Band 5 District Nurse at the Trust through an agency providing locum care.

On 4 June 2023, you were required to attend Downhurst Residential Care Home (the Home) to administer insulin in the morning and in the evening to Resident A. You attended Resident A in the morning but failed to attend later for the evening blood glucose monitoring and administration of insulin. However, you completed the evening part of the paperwork during the morning visit which made the records inaccurate and dishonest. Resident A told a member of staff at the Home that you had not attended to administer the evening insulin. As a result of this information and you not answering your phone, the Rapid Response Team were called. The Rapid Response Nurse, Joanna Dobosz (Ms Dobosz), attended the Home on 4 June 2023 and was unable to administer the evening insulin to Resident A because she had to accept that the drugs chart was accurate as it had been signed as administered by you.

Dorothy Sarpong (Ms Sarpong), your line manager, confirmed that the reading of the glucose levels was not accurate as you did not attend Resident A in the evening and could not have taken a reading for that level to be recorded and also that the insulin had not been administered. Ms Sarpong spoke to you about the incident the following day on 5 June 2023 and at that time you said that you had visited Resident A in the morning and in the evening. You gave a specific time of 20:15 hours and said that is when you administered insulin and checked the blood glucose levels. Your account of the incident was investigated by the Home as there was a concern about how you could have entered the Home in the evening due to the Home having a locked door policy. You would not have been allowed entry to the Home unless it was by way of another member of staff. You were asked to provide times that you entered the Home in order

for the CCTV to be checked, and it was at that point that you accepted that you had not attended the Home again in the evening for the evening visit and instead signed the drugs chart in the morning for the evening visit. You provided a local statement dated 15 June 2023 and a further reflective form stating that the incorrect entry for the evening was a mistake and that you forgot to visit to undertake the evening blood glucose monitoring and insulin administration and that this was accidental.

In addition to the paper records for Resident A, you completed electronic records at a later date on 3 July 2023. Those electronic records also recorded incorrectly that you had visited Resident A on the evening of 4 June 2023.

During the course of the NMC's investigation into this matter, there was also an investigation into whether or not you had the appropriate indemnity insurance in place. The Trust stated in a letter dated 12 June 2024 that your indemnity insurance was not covered by the Trust and it was expected that the agency would cover this. An email dated 14 June 2024 from the agency stated that you were not covered by their agency policy as you were a contractor. A further email from the agency dated 17 June 2024 stating that they do not hold indemnity cover and that the worker would be covered vicariously by the NHS and perhaps you may have been covered by your union. An email from the Royal College Nursing (RCN) dated 10 September 2024 stated that they would not comment on this issue. As both the agency and the NHS have confirmed that they did not cover your indemnity assurance at the time of this incident in June 2023, you had been practising as a nurse without it.

Request for unredacted Resident A's record dated June 2023

On Day 2 of the hearing, Tuesday 6 January 2026, the panel requested Ms Whawell, on behalf of the Nursing and Midwifery Council (NMC), to provide it with an unredacted version of Resident A's System One electronic record dated June 2023. The panel noted that there was a redacted section on this record which appeared to have been the entry allegedly made by you at 17:00 hours on 4 June 2023.

You did not raise any objections.

The panel accepted the advice of the legal assessor.

Ms Whawell provided an unredacted version of Resident A's System One electronic record dated June 2023 on the morning of Day 3. This showed that an entry was allegedly made by you at 17:00 hours on 4 June 2023.

Decision and reasons on application for an adjournment to obtain Ms Sarpong's supplementary statement

On Day 3 of the hearing, Wednesday 7 January 2026, the panel heard an application made by Ms Whawell to adjourn the hearing in order to afford her time to obtain a supplementary statement from Ms Sarpong in respect of Resident A's System One electronic record dated June 2023. She informed the panel that enquiries by the NMC have started in relation to Ms Sarpong, and she would be able to provide an update this afternoon.

You did not raise any objections to this application.

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

The panel concluded that it would grant the adjournment, on the basis that it would be within the timeframe of this hearing, for the NMC to obtain a supplementary statement from Ms Sarpong.

Resuming on the afternoon of Day 3

Ms Whawell informed the panel that Ms Sarpong was [PRIVATE] and would only be able to provide a supplementary statement or participate in the hearing on 12 January 2026, the last day of the hearing, if [PRIVATE].

Ms Whawell submitted that the NMC's position was that a supplementary statement from Ms Sarpong would not be required as evidence. She submitted that the NMC would seek to rely on the unredacted copy of Resident A's System One electronic record dated June 2023 given that it had dates and the time markers. She submitted that the unredacted copy of Resident A's System One electronic record dated June 2023 was a business document and it was fair and relevant to go before the panel.

You did not raise any objections.

Application and decision on amending the charges

Ms Whawell made an application under Rule 28 to amend the charges. She referred the panel to the proposed amendments and additional charges:

The charges will now read as follows:

That you a registered nurse, whilst working at Downhurst Residential Care Home (the Home);

1) On 4 June 2023:
   a. Failed to administer evening insulin to Resident A, as prescribed.

   b. In respect of Resident A's evening blood glucose level, failed to:
      i. Test it.
      ii. Record it.

   c. Incorrectly recorded **in the paper medication administration chart** that you had administered evening insulin to Resident A as prescribed.

   d. Incorrectly recorded **in the paper medication administration chart** that you had tested Resident A's blood glucose levels in the evening.

2) Your actions in charge 1) c) above were dishonest in that:
   a. You knew that you had not administered the evening insulin to Resident A.
   b. You intended to mislead anyone reading the **paper** medication administration chart into believing that the medication had been administered

3) Your actions in charge 1) d) above were dishonest in that:
   a. You knew that you had not tested Resident A blood glucose levels

b. You intended to mislead anyone reading the paper **medication administration chart** ~~blood glucose monitoring chart~~ that the blood glucose had been tested.

4) Around June 2023 practiced at the Home as an agency nurse, without being covered by the appropriate indemnity insurance.

5) Your actions in charge 4) above lacked integrity in that you carried out nursing duties without the appropriate insurance.

6) On 4 June 2023 at around 5pm made one or more entries in the System One electronic record stating that you had:

a. attended on Resident A in the evening.
b. checked Resident A's blood glucose levels.
c. administered insulin to Resident A.

7) Your actions at charge 6 a) above were dishonest in that:
a. You knew you had not attended on Resident A in the evening
b. You intended to mislead anyone reading the System One electronic record to believe you had attended on Resident A in the evening.

8) Your actions at charge 6 b) above were dishonest in that:
a. You knew you had not checked Resident A's blood glucose levels in the evening.
b. You intended to mislead anyone reading the System One electronic record to believe you had checked Resident A's blood glucose in the evening.

9) Your actions at charge 6 c) above were dishonest in that:
a. You knew you had not administered insulin to Resident A in the evening.

b. You intended to mislead anyone reading the System One electronic record to believe you had administered insulin to Resident A in the evening.

Ms Whawell submitted that these amendments and additional charges as applied for would assist in making the charges more accurate and reflect the evidence. She submitted that the redacted copy of Resident A's System One electronic record dated June 2023 was received by way of post investigative work and sent to you in December 2025. She submitted that Charges 1c, 1d, 2b and 3b would specify the paper medication administration chart. She submitted that additional charges in relation to dishonesty associated with the unredacted copy of the Resident A's System One electronic record dated June 2023 for the entry made at 17:00 hours on the 4 June 2023, would accurately reflect the seriousness of the allegations now before the panel.

Ms Whawell referred the panel to the case of *The Professional Standards Authority v The Health and Care Professions Council, Benedict Doree* [2017] EWCA Civ 319.

Ms Whawell submitted that the unredacted copy of Resident A's System One electronic record dated June 2023 show clear evidence of further inaccurate record keeping on 4 June 2023 in regard to an evening insulin administration to Resident A. She submitted that this ought to be added to the charges in order to properly reflect the gravity and the extent of the alleged conduct that you not only created a dishonest record in the morning, but you also furthered that dishonesty at 17:00 hours by making an additional dishonest record.

In relation to fairness, Ms Whawell submitted that the facts stage has not concluded. You still have the right to give evidence before the panel, and you can exercise that right by giving an explanation on oath in respect of the charges. She submitted that you have had an opportunity to consider the amendments and you have had a copy of the proposed amendments since 09:30 hours this morning. She submitted that the NMC's overriding objective is to protect the public, promote public confidence and maintain public standards. In this case, the charges ought to be amended to reflect the gravity of the alleged conduct as reflected in the now unredacted evidence.

You objected to the amendments and the new charges.

You explained that this process has been going on for two and a half years and the NMC had sufficient time to produce accurate charges. You said that it is unfair for you to suddenly be given new charges and it is making it difficult for you [PRIVATE].

The panel accepted the advice of the legal assessor.

The panel considered that the proposed amendments and additional charges arose following its request of an unredacted copy of Resident A's System One electronic record dated June 2023. It was of the view that splitting the charges in relation 4 June 2023, would indicate that there were two alleged incidents of dishonesty.

The panel noted that although it is late in the proceedings, the NMC has not yet closed its case, and you have not yet had the opportunity to open your case.

With respect of the additional charges relating to System One, the panel was satisfied that you were served all the bundles of evidence in December 2025 and that although the dates and time in the new allegations had been served redacted, they relate to you as the author and the same date of the allegation. Therefore, the panel was satisfied that it would not be unfair to amend the charges as you would have been expected to know of your own entry in Resident A's System One electronic record dated 4 June 2023.

The panel concluded that there was no unfairness to you in making these amendments and adding new charges at this stage and this could be made without injustice. It further concluded, taking account of Ms Whawell's submissions, that not doing so would be undercharging the alleged conduct.

Panel decision to request further evidence

Ms Whawell updated the panel with regard to Ms Sarpong's attendance. She informed the panel that Ms Sarpong emailed the NMC paralegal on Day 3 of the hearing, 7 January 2026, at 16:19 hours the following:

'To answer the questions I would need to access [System One]. Unfortunately as previously mentioned I am [PRIVATE] and do not have access to the system. I have [PRIVATE] which will inform me how quickly I will be able to return to work. I am feeling confident that I should be back on Monday.'

Ms Whawell told the panel that the NMC paralegal has confirmed that Ms Sarpong understands that the NMC are seeking assistance from her own knowledge and experience of System One. Ms Whawell told the panel that there has been no further update from Ms Sarpong and she is mindful of chasing her given that she is [PRIVATE].

Ms Whawell directed the panel to the NMC guidance '*DMA-5: Directing further investigation during a hearing'* which states:

'There are a number of reasons why a panel may direct us to carry out further investigations. These include:

- *New information has come to light that neither we nor the nurse, midwife or nursing associate have seen, which could undermine our case, support our case, or support the case of the nurse, midwife or nursing associate.*
- *The information currently before a panel is obviously incomplete or does not cover all the areas of concern. One example of this could be missing pages from patient notes, or from some other important document.*
- *Further information is essential to clarify or expand on evidence already obtained*
- *The nurse, midwife or nursing associate has provided new information about the context in which the incident occurred which would have a material impact on the outcome of the case*

If it's clear to the panel that evidence exists that it requires in order to make its decision, but we have not provided it with that evidence, it should consider whether to adjourn the hearing to allow us to gather that evidence. In making this decision the panel should consider the following:

- *Whether the evidence is important to an issue it has to decide.*

- *Whether the evidence needs to be tested, perhaps through asking questions of witnesses.*
- *Whether the panel can consider its decisions and reach a satisfactory conclusion without this evidence.*
- *Our overarching duty to protect the public, and the panel's duty to make a decision that satisfies the overarching objective in a fair and proportionate way.*
- *The overall fairness of the proceedings. As well as the nurse, midwife or nursing associate's right to a fair hearing, this also includes fairness to the people involved in the events the case is about, and fairness to us in exercising our statutory function of protecting the public.*
- *The public interest in the expeditious disposal of the case and the potential inconvenience caused by any delay to the registrant and any witnesses'*

You raised no objections.

The panel accepted the advice of the legal assessor.

The panel considered the *DMA-5* guidance. It determined that the new information that came to light from the unredacted copy of Resident A's record which appeared to be significant and raised further questions which needed to be answered.

The panel was of the view that dishonesty is a serious allegation and therefore this evidence should be properly considered and needs to be tested.

The panel carefully considered its position and was mindful of its duty to be fair to you and the NMC and its overarching duty to protect the public. It also considered the public interest in the expeditious disposal of the case and balanced the potential inconvenience caused by a delay and it concluded that it cannot continue without further evidence from another witness. In light of this, the panel invited Ms Whawell to continue her efforts to produce a supplementary witness statement from Ms Sarpong during the course of this scheduled hearing.

Panel's decision for an adjournment

On Day 5 of the hearing (Friday 9 January 2026), the panel invited Ms Whawell to give an update in regard to Ms Sarpong. Ms Whawell informed the panel that there had been no further update as of yet, Ms Sarpong had been telephoned however there was no answer.

The panel decided to resume the hearing at 15:00 hours to afford Ms Whawell further time to secure further witness evidence.

At 15:00 hours, Ms Whawell informed the panel that the NMC paralegal had no further capacity to chase Ms Sarpong today and may have more capacity on Monday but could not guarantee that a supplementary statement will be secured in time for the panel to consider it.

Ms Whawell also informed the panel that Angela Lovelace (Ms Lovelace) had confirmed the Home did not have the blood glucose chart and the Trust confirmed it could not source the blood glucose chart.

Ms Whawell invited the panel to consider, given the amount of time already spent on this, whether it would be productive to continue waiting for Ms Sarpong's supplementary statement.

You did not have any submissions.

The panel determined that it did not consider it unreasonable for the NMC to make contact with Ms Sarpong on Day 6, Monday 12 January 2026, to progress the matter based on the information provided by Ms Sarpong in her email to the NMC Paralegal on 7 January 2026.

The panel concluded that there is realistic likelihood that this matter could be resolved in a timely manner.

Day 6, Monday 12 January 2026

At 11:00 hours, Ms Whawell informed the Hearings Coordinator by email that the NMC Paralegal had made contact with Ms Sarpong and was in the process of drafting a

witness statement. At 11:47 hours, Ms Whawell sent another email to the Hearings Coordinator stating that Ms Sarpong would be available this afternoon to give evidence.

At 15:00 hours, the witness statement had not yet been provided to the panel, and it was mindful of the time of day as it was yet to hear oral evidence from Ms Sarpong.

At 15:30 hours, the panel invited in the parties.

At 16:00 hours, Ms Whawell informed the panel that the NMC Paralegal sent through a draft witness statement to Ms Sarpong at 12:50 hours. Unfortunately, the NMC Paralegal had not heard back since that draft witness statement was sent and the NMC Paralegal had chased Ms Sarpong in relation to that statement however, there had been no response.

You said that you understood what has happened and you did not raise any issues.

The panel accepted the advice of the legal assessor.

The panel decided that it had no choice but to adjourn the hearing for a resuming date.

Interim order

The panel invited Ms Whawell to make any submissions on whether the NMC sought to impose an interim order.

Ms Whawell submitted that the NMC did not wish to apply for an interim order. She submitted that it is a matter for the panel. She submitted that if the panel did impose an interim order, the appropriate time frame should be 18 months to afford the NMC sufficient time to relist the matter.

You told the panel that you wished to return to nursing in the future when the NMC case had closed. You said that the NMC investigation has been difficult because it has stopped you from being able to do the one thing that you desire. You said that you are passionate about nursing, and you always wanted to help patients and their families.

You said that if you had the opportunity to practise as a nurse you would return to Watford Community as a bank nurse. However, right now you are waiting for the NMC case to conclude because you would prefer to return to nursing with a clear mind.

The panel accepted the advice of the legal assessor.

The panel was satisfied that there is sufficient information before it to establish an evidential basis for the allegations. It was satisfied that the information comes from credible sources and is cogent in nature. In particular, the panel noted your admissions to Charges 1 and 4. It noted that during the course of the hearing, it requested an unredacted copy of Resident A's record and a further alleged incident of dishonesty had arisen as a result of obtaining that document. It further noted that four new charges were added and it had heard evidence from three witnesses.

The panel considered the serious and dishonest nature of the allegations and the likelihood of repetition. It considered that the allegations involved (as well as the charges you have admitted) incorrectly and dishonestly entering information in Resident A's records. The alleged conduct would give rise to a real risk of harm to residents as future staff members would be relying on the records to carry out care for that resident. The panel determined that the alleged conduct, if repeated, would create a real risk of serious harm.

The panel acknowledged the written reference from your colleague dated 10 October 2025, and it noted that this is the first time you are before your regulator. However, the panel was mindful that the allegations are extremely serious and were allegedly repeated on a second occasion and therefore it was not persuaded that the risk of repetition is mitigated despite the information produced today. The panel concluded that there is a real risk of harm if you were allowed to practise without restriction at this time. The panel decided that some form of interim order is necessary on the ground of public protection.

The panel determined that an interim order is also in the public interest, in order to maintain confidence in the professions and the NMC as regulator. The panel was satisfied that public confidence in the profession could be seriously damaged if you were allowed to practise without restriction at this time. The panel determined that

public trust in the profession would be undermined if a nurse were permitted to practise whilst these serious dishonesty allegations are under investigation.

The panel noted that this interim order will affect your ability to working as a registered nurse and, as a consequence, you may be caused financial hardship. In applying the principle of proportionality, the panel determined that the need to protect the public and the wider public interest outweighed your interests in this regard.

The panel considered whether to impose an interim conditions of practice order. The panel decided that there were workable conditions that could be formulated that would sufficiently protect the public and meet the public interest.

As such, it determined that the following conditions are necessary, proportionate and appropriate:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your nursing practice to one substantive employer, which must not be an agency.

2. You must undertake medicine management training.

3. At any other time, you are working you must ensure that you are indirectly supervised by another registered nurse of an equivalent or higher band.

4. You must attend meetings with your line manager or supervisor on a fortnightly basis to discuss your conduct and performance in the workplace.

5. You must send the NMC a report seven days in advance of the next NMC hearing or meeting from either your line manager or supervisor, regarding your conduct and performance in the workplace.

6. You must keep the NMC informed about anywhere you are working by:

a. Telling your case officer within seven days of accepting or leaving any employment.

b. Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:

    a. Telling your case officer within seven days of accepting any course of study.

    b. Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:

    a. Any organisation or person you work for.

    b. Any employers you apply to for work (at the time of application).

    c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:

    a. Any clinical incident you are involved in.

    b. Any investigation started against you.

    c. Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a. Any current or future employer.

    b. Any educational establishment.

    c. Any other person(s) involved in your retraining and/or supervision required by these conditions.

The panel decided to impose the interim conditions of practice order for a period of 18 months to allow the NMC sufficient time to relist this matter.

That concludes this determination.

This decision will be confirmed to you in writing.

The hearing resumed on Thursday, 22 October 2026. The panel went on to hear further oral evidence from Ms Sarpong.

Decision and reasons on application to amend the charge

Prior to the close of the NMC's case, the panel heard an application made by Mr Holloway, on behalf of the NMC, to amend the wording of Charges 6, 7a, 7b, 8a, 8b, 9a and 9b.

Mr Holloway submitted that the proposed amendments were necessary to accurately reflect the evidence in Ms Sarpong's supplementary witness statement, particularly regarding the timing of the entries made in System One. He referred the panel to Rule 28 of the Rules and submitted that, as no findings of fact had yet been made, the charges could be amended at this stage without injustice.

Mr Holloway submitted that the supplementary evidence confirmed that the entry dated 4 June 2023 at 17:00 hours was entered retrospectively by you on 3 July 2023 at 15:28 hours, after you had been instructed not to visit patients and after the referral to the NMC on 28 June 2023. He submitted that you have been notified of the proposed amendments on 21 October 2026 and you had also been given the opportunity to challenge Ms Sarpong's evidence. He submitted that the amendments would therefore cause no injustice and were required to ensure that the charges accurately reflected the evidence.

Original Charges

6) On 4 June 2023 at around 5pm made one or more entries in the System One electronic record stating that you had:

a. attended on Resident A in the evening.
b. checked Resident A's blood glucose levels.
c. administered insulin to Resident A.

7) Your actions at charge 6 a) above were dishonest in that:
   a. You knew you had not attended on Resident A in the evening
   b. You intended to mislead anyone reading the System One electronic record to believe you had attended on Resident A in the evening.

8) Your actions at charge 6 b) above were dishonest in that:
   a. You knew you had not checked Resident A's blood glucose levels in the evening.
   b. You intended to mislead anyone reading the System One electronic record to believe you had checked Resident A's blood glucose in the evening.

9) Your actions at charge 6 c) above were dishonest in that:
   a. You knew you had not administered insulin to Resident A in the evening.
   b. You intended to mislead anyone reading the System One electronic record to believe you had administered insulin to Resident A in the evening.

Proposed Amendments

6) On ~~4 June 2023 at around 5pm~~ **3 July 2023 at around 15.28 hours** made one or more entries in the System One electronic record stating that you had **on 4 June 2023 at around 17:00 hours**:

   a. attended on Resident A in the evening.
   b. checked Resident A's blood glucose levels.
   c. administered insulin to Resident A.

7) Your actions at charge 6 a) above were dishonest in that:

a. You knew you had not attended on Resident A in the evening **on 4 June 2023**.
b. You intended to mislead anyone reading the System One electronic record to believe you had attended on Resident A in the evening **on 4 June 2023**.

8) Your actions at charge 6 b) above were dishonest in that:

a. You knew you had not checked Resident A's blood glucose levels in the evening **on 4 June 2023**.
b. You intended to mislead anyone reading the System One electronic record to believe you had checked Resident A's blood glucose in the evening **on 4 June 2023**.

9) Your actions at charge 6 c) above were dishonest in that:

a. You knew you had not administered insulin to Resident A in the evening **on 4 June 2023**.
b. You intended to mislead anyone reading the System One electronic record to believe you had administered insulin to Resident A in the evening **on 4 June 2023**.

You indicated that you had no objections to this application, nor did you challenge the evidence as to the date and time when you made the relevant entries on the System One electronic records concerning the evening of 4 June 2023.

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

The panel considered that the proposed amendments would improve the accuracy and clarity of the charges by specifying the relevant dates. It noted that you had received notice of the proposed amendments and had raised no objection. The panel was therefore satisfied that allowing the amendments would cause no injustice to you.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accurately reflect the evidence.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you that you made full admissions to Charges 1a, 1b, 1c, 1d and 4.

The panel therefore finds Charges 1a, 1b, 1c, 1d and 4 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 you and Mr Holloway.

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:

- Angela Lovelace: Registered Manager of the Home at the material time.

- Dorothy Sarpong: District Nurse Team Manager at the Trust at the material time.

- Joanna Dobosz: Rapid Response Staff Nurse at the material time.

The panel did not hear live evidence from you. You informed the panel that you had decided instead to make submissions.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included a good character direction.

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

Charges 2 and 3

2) Your actions in charge 1)c) above were dishonest in that:
   a. You knew that you had not administered the evening insulin to Resident A.
   b. You intended to mislead anyone reading the paper medication administration chart into believing that the medication had been administered

3) Your actions in charge 1)d) above were dishonest in that:
   a. You knew that you had not tested Resident A blood glucose levels
   b. You intended to mislead anyone reading the paper medication administration chart that the blood glucose had been tested.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Lovelace, Ms Sarpong and Ms Dobosz. The panel also had regard to your documentary evidence and your oral submissions.

The panel first considered your admissions to Charges 1c and 1d, in that you had incorrectly recorded in the paper medication administration chart that you had

administered evening insulin to Resident A and had tested Resident A's blood glucose level. Having found these charges proved by admission, the panel went on to consider whether your actions were dishonest. It had regard to the test set out in *Ivey v Genting Casinos* [2017] UKSC 67 which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel had regard to Ms Sarpong's witness statement dated 18 September 2024 and Resident A's MAR chart.

In her witness statement, Ms Sarpong stated:

> *'As Mr Rasuli's line manager, I spoke to him on 5 June 2023 and I asked him what had happened, he confirmed that he had seen the resident on 4 June 2023 in the morning and in the evening. Mr Rasuli stated he had received a message from the triage nurse in the hub advising him to visit Res A at the end of his shift as she had gone out with her family. Mr Rasuli reported that he had visited at 20:15 and he had administered the insulin as prescribed, and the blood glucose was within a normal range. Mr Rasuli confirmed that he had given the insulin and checked blood sugar levels. He also confirmed that he had a code to get into the Home, so it is possible that no one saw him go in.*
>
> *As his manager at the time, I questioned Mr Rasuli about what time he visited Res A. When the rapid response team visited Res A the drug chart had been signed so they refused to give the insulin as they were not sure whether Res A had been given the insulin or not. I also sent a member of my staff, a team leader, to the Home to get a copy of the drug chart for me so we can check whether it was signed or not. She took a photo of the chart and sent it to me, and we clearly saw Mr Rasuli's signature on the MAR chart confirming insulin had been administered…*

I was advised by Angela that nobody has the key to enter the building and if anyone has the code it would be the internal code but not the code to the front door. When I asked Mr Rasuli, he admitted that would be correct which corroborated what was told to me by the home about access. This information proved that he did not visit the resident when he said he had in the evening. There was evidence he had attended in the morning but not the evening as he couldn't get in without the code and no one allowed him access in the evening, so he did not attend. The Home only remembers rapid response attending but not Mr Rasuli…'

On the evening of 4 June 2023, Resident A returned to the Home after an impromptu outing with her son. Resident A, who had capacity notified staff at the Home that evening that she had not received her evening insulin. Staff had previously tried to speak to you on your telephone but, were unable to make contact with you. The Home contacted the Rapid Response team who attended on the evening to administer insulin to Resident A, but it was not administered as the paper records completed by you indicated that you had already attended to check Resident A's blood glucose level and administered insulin that evening.

The following morning, Ms Lovelace contacted Ms Sarpong to raise concerns about the inconsistencies around the purported visit made by you. The panel noted that your first account to Ms Sarpong, on 5 June 2023, was that you had attended the Home on the previous evening, conducted the necessary blood glucose test and administered insulin to Resident A. You told Ms Sarpong that you had been told by the triage nurse in the hub, after your visit in the morning, that Resident A was going to be out with family for her evening meal and that you should call at the end of your shift, near 20:00 hours. You told Ms Sarpong that you had attended the home at 20:15 hours.

Staff had not seen you visit the Home on evening of 4 June 2023, but you told Ms Sarpong that you had the code to enter the Home, and it was possible no one saw you enter the Home.

On 7 June 2023, Ms Sarpong suggested to you that you did not have the external door code for the Home, but only the codes for the internal doors, and you accepted this.

Ms Sarpong went on to state that it was only when you were questioned again later on 7 June 2023 and the prospect of the CCTV footage being checked, that you admitted that you had not attended the Home on 4 June 2023 evening.

The panel noted your assertion in your written response on 15 June 2023, that you had been told by the triage nurse in the hub that Resident A was going to be out with family for her evening meal and that you should call later, but you had then forgotten to attend later at the Home. However, the account from Ms Sarpong was that you did not learn that Resident A would be absent until much later than your morning visit as it was a last-minute decision made by Resident A's son and by that stage you had already recorded the evening reading.

There was evidence in the nursing notes that your office had been contacted during the day on 4 June 2023 and requested attendance to the Home at about 16:00 hours, and that Resident A had returned to the Home around 17:00 hours.

The panel had regard to your local written statement dated 15 June 2023 and oral submissions, in which you admitted that the evening entry had been completed in the morning but maintained that it had been made *"as a mistake".* You explained that your unusual behaviour arose from work pressure and a heavy workload, rather than from any intention to deceive.

So, your written account for the internal investigation was that you had attended the Home in the morning and that the evening reading had been entered inadvertently.

The panel took account of the evidence that you worked hard and were managing a heavy workload, which was supported by Ms Sarpong's evidence. However, it also noted that you did not give oral evidence and that your assertions could not therefore be tested.

The panel decided to place greater weight on the evidence of Ms Sarpong and Ms Lovelace. The panel found Ms Lovelace and Ms Sarpong to be clear and credible

witnesses who demonstrated a sound understanding of the relevant systems and the events at the material time. It also found no reason to doubt the evidence of Ms Sarpong and Ms Lovelace, whose accounts were consistent and given in a professional capacity and supported by the documentary evidence. Their accounts are also consistent with your later admissions.

The panel noted from the Medication Administration Records (MAR charts) for Resident A that you knew Resident A, were familiar with the Home, had previously completed the same records and understood that you were required to attend to her in both the morning and the evening. You would therefore have known that a further visit was required that evening. It found that, on 4 June 2023, you attended the Home in the morning, completed both the morning and evening boxes and did not return for the evening visit, nor were you contactable by phone that shift, although on duty as a community nurse on a long day shift, namely from 08:00 hours to 20:00 hours. The panel took into account your explanation for this, in that you had recently acquired a new telephone. It would have been your duty as a community nurse to update your contact details with your employer.

The panel considered the differing accounts you gave when asked about your attendance. It noted that you admitted that you had not attended in the evening only when it had become apparent that your account could be checked against CCTV footage. Had the evening entry been a genuine mistake, the panel would have expected you to acknowledge it at an earlier stage. The panel could not identify a credible basis upon which the handwritten entry could have been made inadvertently. It considered it significant that the evening reading of 8.9mmol/L differed from the morning reading of 7.8mmol/L, and had you been interrupted or re-entered the reading as you suggested, the panel would have expected the two figures to be the same or similar. It also considered that it would have been difficult to select the evening box during the morning visit without noticing that it related to a later attendance.

The panel considered whether you intended to mislead, to conceal that you were not to return in the evening, or had made a mistake. It attached less weight to your account of a mistake because it had not been tested in oral evidence and was undermined by the

different readings entered for the morning and evening. Additionally, the panel could find no credible alternative explanation for your actions. The panel considered that, irrespective of the workload, as a registered nurse, you were expected to attend to Resident A in person in the evening, complete the documentation accurately and act honestly. It was satisfied that, given your familiarity with the Home, Resident A and the relevant paperwork, you would have known that it was wrong to record inaccurate information.

The panel took account of the fact that you are of good character, given that you have not previously been before a fitness to practise committee of the NMC, and it took into account of the testimonial you provided.

However, the panel concluded that there was clear evidence of at least two false assertions by you on different occasions over three days, concerning the central fact now admitted by you, namely that you did not attend the Home on the evening of 4 June 2023. The panel was able to test your assertion of a mistake, by considering your false explanations, the handwritten records you incorrectly completed in the morning of 4 June 2023, which purported to relate to a specific examination of Resident A on the evening of 4 June 2023 to care for Resident A, but which you failed to do. Additionally, the panel noted that when you attended in the morning, you completed a reading for the evening, which was an improbable mistake because it was clearly a box for the evening result rather than the morning and it was also a different figure to that written in the morning box.

The panel noted that although there was no evidence of actual harm, Resident A was a vulnerable and elderly patient, aged 91 years, and your actions had the potential to cause serious harm. The panel considered that the absence of actual harm did not diminish your professional obligations, and that the false entries were not what any registered nurse would have considered as trivial or only administrative in nature, on top of the overall importance of completing Resident A's medication administration chart accurately and honestly.

Having considered the evidence as a whole, the panel found it more likely than not that you did not intend to return that evening and that the sequence of actions you took was deliberate and intended to mislead and to conceal your intended failure to administer care to Resident A that evening. It concluded that your conduct would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charges 2 and 3 proved in their entirety.

Charge 5

5) Your actions in charge 4) above lacked integrity in that you carried out nursing duties without the appropriate insurance.

This charge is found proved.

In reaching this decision, the panel took into account your oral submissions and documentary evidence. The panel also considered your admission to Charge 4.

The panel had regard to an email you sent to the NMC dated 31 May 2024, in which you stated:

> *'Hi dear , I didn't have insurance at the time of incident , I keep thinking that I'm still member Of the RCN but I wasn't…'* [sic]

The panel found that you practised as a nurse without the appropriate professional indemnity insurance for a period of approximately two years. The panel considered your explanation that this arose as a mistake. However, given the length of time involved, it determined that any genuine error ought reasonably to have come to your attention at a much earlier stage.

Additionally, the panel took account of the documentary evidence, including your evidence that you had actively cancelled the direct debit for your professional indemnity insurance. The panel considered that, upon cancellation, it is likely that you would have

received notification confirming that your cover had ceased. It also noted that you had provided no evidence that alternative indemnity arrangements were in place during the relevant period. In particular, there was no evidence that indemnity cover was provided by the Trust, the agency through which you worked or the RCN following your cancellation of the direct debit.

The panel considered that maintaining appropriate indemnity insurance is a fundamental professional responsibility and that registered nurses are expected to understand and comply with this requirement in order to protect patients, the public and themselves. It considered that you should have been aware of the need to ensure that adequate indemnity arrangements remained in place throughout your practice.

The panel concluded that your conduct demonstrated a lack of integrity. It concluded that this matter did not arise from a single administrative oversight, but from the prolonged failure to ensure that appropriate indemnity cover was maintained over a significant period. The panel was of the view that your explanation that you were busy did not absolve you of your professional responsibility as it remained your duty to ensure that your indemnity insurance was renewed and maintained.

As with Charges 2 and 3 above, the panel took into account your good character when considering the evidence of this charge. Registered nurses are expected to adhere to the ethical standards of the profession. The NMC Code of Conduct provides that registered nurses must ensure that they have appropriate indemnity cover in place for their practice and the Code provides that registered nurses must act with integrity. The panel considered that the high standards expected of registered nurses reasonably means that the need to have indemnity insurance in place would be known by all registered nurses to be important. Accordingly, a failure to have indemnity cover in place demonstrates a lack of integrity and a breach of the trust which the public places on registered nurses.

Accordingly, the panel found Charge 5 proved.

Charge 6

6. On 3 July 2023 at around 15.28 hours made one or more entries in the System One electronic record stating that you had on 4 June 2023 at around 17:00 hours:

    a. attended on Resident A in the evening.
    b. checked Resident A's blood glucose levels.
    c. administered insulin to Resident A.

This charge is found proved.

In reaching its decision, the panel considered the oral and documentary evidence of Ms Sarpong, in addition to your oral submissions.

During her oral evidence, Ms Sarpong explained the operation of the System One record-keeping system, including the allocation and use of smartcards and user credentials. She described how each user is issued with an individual smartcard and then create their own personal PIN or password, enabling them to access the system and make entries under their unique identification. She stated that it was highly unlikely that another individual could have accessed the system and made entries using your credentials. This was further supported by her supplementary witness statement dated 24 September 2026.

In her oral evidence, Ms Sarpong further explained the audit trail functionality within System One. She described how she was able to review the system data and identify both the date of the patient interaction and the date upon which the relevant entries were added. Her evidence demonstrated that the records in question were entered approximately one month after the purported events.

The panel also considered the screenshots and patient records contained within the documentary evidence, including a screenshot of a retrospective summary of Resident A's care on 4 June 2023 and Patient A's unredacted records (Exhibit DS/9). The screenshot showed that the record for Resident A's care purportedly given by you on

the evening of 4 June 2023 was entered on 3 July 2023. These records were consistent with Ms Sarpong's explanation of the audit trail and supported her evidence that the entries had been made under your unique user credentials. When questioned by the panel in relation to the screenshot from System One, Ms Sarpong told the panel that this showed that you had recorded this as a face-to face visit. She went on to explain that you would have selected this from a drop-down menu on System One.

The panel accepted Ms Sarpong's evidence regarding the security measures in place within the system. It attached significant weight to her evidence, which it found to be clear, consistent and credible.

The panel was satisfied that access to System One was controlled through individually assigned smartcards and personal PINs, and that users were responsible for entries made using their credentials. It noted that Ms Sarpong's evidence on this issue was not challenged by you in cross-examination. The panel had regard to the unredacted version of the System One record for Resident A. Within this document, the panel noted that the entry made by you contained information including, that you visited Resident A at 17:00 hours on 4 June 2023, checked Resident A's blood glucose levels and administered insulin.

The panel further noted that you did not deny making the entries. Rather, your case was that you had been asked to update your records and complete outstanding documentation. Your submissions therefore amounted to an explanation for the late entries rather than a denial that you had made them.

Taking all of the evidence into account, the panel was satisfied on the balance of probabilities, that it was you who made the entries in question on System One.

Accordingly, the panel found Charge 6 proved.

Charges 7a and 7b

7. Your actions at charge 6 a) above were dishonest in that:

a. You knew you had not attended on Resident A in the evening on 4 June 2023
b. You intended to mislead anyone reading the System One electronic record to believe you had attended on Resident A in the evening on 4 June 2023.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Ms Lovelace and Ms Sarpong. The panel also had regard to your documentary evidence and your oral submissions.

Charge 7a

The panel considered the chronology of events surrounding the material time. It noted that the visit in question was said in the System One records to have occurred on 4 June 2023 at 17:00 hours. By 7 June 2023, concerns had already arisen regarding whether you had attended the visit, as evidenced by the email correspondence between Ms Lovelace and Ms Sarpong. The panel also considered your subsequent written account on 15 June 2023, in which you stated that, when questioned about the matter, you *"panicked"*.

The panel further noted that on 26 or 27 June 2023, you were removed from patient-facing duties and referred to the NMC. The referral was received by the NMC on 28 June. Notwithstanding these events, you subsequently made an entry on System One on 3 July 2023 purporting to record a visit by you to Resident A at 17:00 hours on 4 June 2023.

The panel accepted that the creation of retrospective entries was not, in itself, unusual within a busy clinical environment. In her oral evidence, Ms Sarpong stated that whilst it was contrary to policy, it was not unusual for patient records to be updated up to a month after the event. The panel also accepted your assertion that you had been asked to update and complete outstanding records once you were taken off patient-facing

duties. However, the panel considered that those factors did not explain the content of the entry that was made.

The panel was satisfied that, when completing the System One entry on 3 July 2023, you knew that you had not attended Resident A at 17:00 hours on 4 June 2023. The panel considered that the date would have been of particular significance to you and would have been prevalent in your mind as, at this time, you were already aware that concerns had been raised regarding your attendance. You had already admitted to Ms Sarpong and confirmed in your written account that you had not attended the Home, you had been removed from patient-facing duties and an investigation was underway. The entry was made approximately one week after you had been removed from patient-facing duties due to these concerns and the panel therefore concluded that you knew the information you were recording was inaccurate.

You submitted that you completed the System One entry purely as part of overall catching up of missing and uncompleted records relating to your visits. You stated that you had no intention to mislead, because you had already admitted that you had not visited Resident A in the evening of 4 June 2023.

As with Charges 2 and 3 above, the panel took into account your good character when considering the evidence on this charge but considered the evidence conclusive.

The panel considered that accurate record-keeping is a fundamental professional obligation and is essential to the provision of safe and effective care. Even if the entry made by you would not have misled Ms Sarpong, to whom you had made your admission, this was a formal record which must be accurate and other nurses might not be aware of your admission, and would rely on the entry made by you.

The panel already found that the incorrect entry made by you in the paper nursing records was intended to mislead and was dishonest. The panel also took into account that you had not admitted the dishonesty in the paper nursing records until you were told that your false account would be checked by reference to CCTV. The panel

determined that you knowingly created an inaccurate electronic patient record despite being aware that the event recorded had not taken place. Although the panel was unable to identify a clear motive for doing so, it was satisfied that the evidence demonstrated a deliberate act rather than an inadvertent mistake and that as a registered nurse you were aware of the importance of accurate records, and that inaccurate records would be misleading for subsequent staff providing care to Resident A. The panel considered that your actions were dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 7a proved.

Charge 7b

Having found that you knowingly created an inaccurate electronic patient record, the panel went on to consider whether you intended to mislead.

The panel noted that the entry was made within an official patient record to which access was restricted to authorised healthcare professionals. It considered that such records are relied upon by clinicians and other professionals involved in a patient's care to obtain an accurate account of assessments, interventions and contacts with patients.

The panel was satisfied that any healthcare professional reviewing Resident A's records would reasonably have believed, on the basis of the System One entry, that you had attended to Resident A on the evening of 4 June 2023 and provided the care you had documented. The panel was of the view that the entry was therefore capable of misleading others and creating a false impression that the visit had occurred.

The panel took into account that, on 7 June 2023, you had ultimately admitted that you had not attended the visit on 4 June 2023. However, by the time the entry was made on 3 July 2023, you already knew that the information being recorded was false. The panel considered that there was no legitimate clinical or administrative purpose in creating a record of an event that you knew had not taken place.

The panel further had regard to the wider evidence concerning your responses when concerns were first raised. The evidence demonstrated that you did not immediately acknowledge that you had failed to attend the visit and only later accepted this when confronted with the available evidence and the prospect of your false account being tested against CCTV. The panel considered this relevant when assessing your intention at the time the entry was made.

As with Charges 2 and 3 above, the panel took into account your good character when considering the evidence on this charge but considered the evidence to be compelling.

Taking all of the evidence together, the panel was satisfied that the only reasonable inference was that you intended anyone reading the record to believe that you had attended Resident A on 4 June 2023 when, in fact, you had not. The panel therefore concluded that the entry was made with the intention of misleading others. The panel therefore concluded that your actions were dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 7b proved.

Charges 8a and 8b

8. Your actions at charge 6 b) above were dishonest in that:
    a. You knew you had not checked Resident A's blood glucose levels in the evening on 4 June 2023.
    b. You intended to mislead anyone reading the System One electronic record to believe you had checked Resident A's blood glucose in the evening on 4 June 2023.

These charges are found proved.

The panel relied on the same evidence and chronology as set out in relation to Charges 7a and 7b.

The panel was satisfied that, when you made the System One entry on 3 July 2023, relating to Resident A on 4 June 2023, you knew that you had not attended the evening visit. It follows that you also knew that you had not undertaken any of the clinical tasks recorded within that entry, including checking Resident A's blood glucose level.

The panel considered that the entry formed part of Resident A's official clinical records. Such records are relied upon by healthcare professionals involved in the ongoing care and treatment of patients and must therefore be accurate, complete and contemporaneous and that the integrity of patient records is fundamental to safe and effective clinical practice.

As with Charges 2 and 3 above, the panel took into account your good character when considering the evidence on this charge but considered the evidence to be compelling.

The panel accepted that you had been asked to update outstanding records. However, this request could not have been intended to condone or justify recording clinical interventions that you knew had not taken place. The panel found that you knowingly entered information into the patient record that was false.

Whilst the panel was unable to identify a clear motive for your actions, it was satisfied that your conduct was deliberate as you were aware that you had neither attended Resident A, nor carried out the blood glucose monitoring recorded in the entry yet, you chose to document these interventions as having occurred. The panel therefore concluded that the entry was made with the intention of misleading others. The panel therefore concluded that your actions were dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 8 proved.

Charges 9a and 9b

9. Your actions at charge 6 c) above were dishonest in that:

a. You knew you had not administered insulin to Resident A in the evening on 4 June 2023.
b. You intended to mislead anyone reading the System One electronic record to believe you had administered insulin to Resident A in the evening on 4 June 2023.

These charges are found proved.

The panel again relied on the evidence and findings set out in relation to Charges 7a, 7b, 8a and 8b.

The panel found that you knowingly created a false clinical record indicating that you had attended Resident A, checked the resident's blood glucose level and administered insulin, when you knew that none of those events had occurred.

In considering the seriousness of the conduct, the panel had particular regard to the vulnerability of Resident A and the clinical significance of insulin administration. The panel considered the purpose of maintaining accurate patient records is to ensure continuity of care and to enable healthcare professionals to make safe and informed clinical decisions. Falsely recording that medication has been administered creates a significant risk that other healthcare professionals may rely on inaccurate information when planning or delivering care.

As with Charges 2 and 3 above, the panel took into account your good character when considering the evidence on this charge but considered the evidence to be compelling.

The panel considered that, had the false entry not been identified, it had the potential to create a misleading picture of Resident A's treatment and clinical condition. The conduct therefore created a risk of serious harm to a vulnerable patient.

The panel concluded that your actions represented a significant breach of the fundamental professional obligations of honesty, integrity and accurate record-keeping. By knowingly recording that insulin had been administered when it had not, you

undermined the reliability of the electronic clinical record and the trust placed in registered professionals. The panel concluded that your actions were dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 9 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, 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 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 Holloway invited the panel to take the view that the facts found proved amount to misconduct. He referred to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a:

> *'…word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be*

found by reference to the rules and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances…'

Mr Holloway also referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) which outlines that misconduct connotes a serious breach which indicates that a nurse's fitness to practise is impaired, and the adjective serious must be given its proper weight and in other contexts and has been referred to as conduct which would be regarded as deplorable by fellow practitioners.

Mr Holloway submitted that, at the relevant time, you were subject to the provisions of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code). He submitted that your actions in the charges found proved breached Sections 1.2, 1.4, 10.3, 12.1, 20.1 and 20.2.

Mr Holloway submitted that your actions in relation to Resident A constituted very serious breaches of the Code. He submitted that you failed to provide the required care to a vulnerable resident on the evening of 4 June 2023, failed to deliver fundamental care effectively, and falsified clinical records and in doing so, you failed to act with honesty and integrity.

Mr Holloway submitted that you had a choice on whether to attend to Resident A as required and you chose not to do so and that this decision was already apparent when you attended Resident A earlier that morning. He submitted that by signing the medication chart during the morning visit to indicate that Resident A's evening blood glucose levels had been checked and insulin administered, you had carried out a deliberate act demonstrating that you had no intention of returning later that day.

Mr Holloway submitted that you therefore took a conscious and premeditated decision not to attend Resident A in the evening and that such conduct demonstrated a significant departure from the fundamental tenets of the profession.

Mr Holloway submitted that the dishonesty extended beyond the medication chart entries and included the subsequent entry made on System One. He submitted that this

later entry compounded the dishonesty and increased the seriousness of your misconduct. He further submitted that you failed to maintain appropriate professional indemnity insurance, contrary to your obligation under the Code. He submitted that this represented a further breach of professional standards and demonstrated a lack of integrity.

Mr Holloway submitted that, by deliberately failing to attend Resident A, falsifying records and practising without the required indemnity arrangements in place, you breached fundamental provisions of the Code. He invited the panel to find that each of the charges found proved amount to misconduct.

Mr Holloway submitted that dishonesty is a matter of particular seriousness because honesty is of central importance to the nursing profession. He submitted that allegations involving dishonesty will always be treated seriously, but that the dishonesty in this case was particularly serious as it exposed a vulnerable resident to a risk of serious harm and the deception was premeditated in order to avoid a required attendance.

Mr Holloway submitted that fellow practitioners would regard your behaviour, in that you purposefully failing to attend a vulnerable patient, whilst creating records designed to convey the false impression that appropriate checks had been carried out and insulin administered, as deplorable. He submitted that your actions were a serious departure from the fundamental tenets of the profession and professional standards expected of a registered nurse.

Submissions on impairment

Mr Holloway submitted that, if the panel was satisfied that the facts found proved amount to misconduct, the next stage would be to consider whether your fitness to practise is currently impaired by reason of that misconduct. He submitted that impairment is a forward-looking assessment and that the question for the panel is not simply what occurred in the past, but whether, by reason of the misconduct found proved, your fitness to practise is impaired as of today's date.

Mr Holloway referred the panel to the NMC's guidance on impairment (*DMA-1*), which explains that impairment is not defined in legislation and is a matter for the panel's professional judgement. He submitted that the key question is whether you remain capable of practising safely, effectively and without restriction. He submitted that if the concerns found proved indicate a continuing risk to public safety, a risk to public confidence in the nursing profession, or a risk to professional standards, a finding of impairment will be required.

Mr Holloway referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and outlined the summary of Dame Janet Smith's 'test' outlined within the 5th Shipman report. He submitted that you had acted in the past so as to place a patient at an unwarranted risk of harm and remained liable to do so in the future.

Mr Holloway submitted that you had worked as a community nurse since May 2020 and you were fully aware of the requirements of your role. He submitted that you knew that Resident A required attendance both in the morning and the evening and you knew that blood glucose monitoring and insulin administration were required and that those interventions needed to be accurately recorded.

Mr Holloway submitted that there were clear, well-established and unambiguous processes in place which you chose not to follow. He submitted that by completing the evening medication entries during the morning visit, you knowingly created inaccurate records before any evening attendance had occurred. He submitted that this demonstrated a conscious decision not to comply with established professional processes.

Mr Holloway acknowledged that the NMC could not definitively identify your motive. However, he submitted that it was not illogical to suggest that the conduct was motivated by convenience, time-saving or some other personal consideration.

Mr Holloway accepted that this was a single incident however, he submitted that your dishonesty was maintained for some time. He submitted that the dishonest entry was

made on 4 June 2023, you denied any wrongdoing when questioned by Ms Sarpong the following day and you persisted with subsequent explanations in which you characterised the matter as an error rather than a deliberate course of conduct.

Mr Holloway submitted that Resident A was exposed to an unwarranted risk of harm. He referred to the evidence of Ms Sarpong that insulin was a life-saving medication and not only was Resident A deprived of insulin at the appropriate time, but the inaccurate records also prevented others from administering the medication. He submitted that the Rapid Response Team relied upon the records and, because those records indicated insulin had already been given, they were unable to administer further insulin due to the obvious risk of double dosing.

Mr Holloway submitted that you are yet to demonstrate a full appreciation of those risks and, accordingly, there remains a risk of repetition.

Mr Holloway submitted that your actions had brought the nursing profession into disrepute. He submitted that your misconduct went directly to patient safety, which lies at the heart of nursing practice and your actions were not what was expected of a registered nurse.

Mr Holloway submitted that, by failing to attend Resident A as required, you failed to prioritise people and failed to practise effectively. He submitted that by maintaining inaccurate and dishonest records, you failed to preserve safety and failed to promote professionalism and trust. Similarly, he submitted that by practising without appropriate indemnity arrangements in place, you failed to comply with a basic professional obligation.

Mr Holloway submitted that the principles reflected within the Code underpin safe, effective and compassionate nursing care. He submitted that your deliberate decision not to attend Resident A, together with the pre-planned falsification of records, constituted a serious breach of those fundamental tenets.

Mr Holloway submitted that honesty and integrity are central to nursing practice and that allegations involving dishonesty are always treated seriously by the regulator. He referred to the NMC's guidance on dishonesty (*FTP-2a*) and submitted that the panel should consider both what occurred and the impact of the dishonesty on public protection and public confidence. He submitted that there is limited evidence of any contextual factors capable of mitigating your dishonesty. He submitted that whilst you had referred to working long hours, six or seven days per week, and seeing a high volume of patients, those circumstances did not explain or justify the deliberate creation of false records.

Mr Holloway submitted that the panel should next consider whether the concerns are capable of remediation, whether they have been remedied and whether they are highly unlikely to be repeated. He accepted that aspects of Charges 1 and 6 might ordinarily be capable of remediation through retraining or supervised practice. However, he submitted that the dishonesty was inextricably linked to the underlying conduct and was indicative of a deeper attitudinal concern.

Mr Holloway submitted that dishonesty of this nature cannot readily be addressed through training alone. He referred the panel to the NMC guidance which states that cases involving attitudinal concerns and serious departures from professional standards may be less capable of remediation.

Turning to insight, Mr Holloway submitted that you have demonstrated limited insight. He acknowledged that you have accepted some responsibility for aspects of the concerns however, he submitted that you have not fully reflected on the misconduct or demonstrated a sufficient understanding of what went wrong. He submitted that you have not provided a satisfactory explanation for why you acted as you did, nor have you demonstrated how you would avoid similar circumstances arising in the future.

Mr Holloway submitted that you have not yet fully acknowledged the risk of harm to patients, the damage your actions could have caused to public confidence in the profession and the extent to which your conduct fell short of professional standards. He

submitted that there was little evidence that you have reflected meaningfully on the indemnity insurance issue.

Mr Holloway submitted that you did not self-report the concerns, you did not draw the failings to your employer's attention, and you did not accept all of the concerns at an early stage. Rather, your initial response was to deny wrongdoing and seek to explain the events as a mistake.

Mr Holloway submitted that, despite having continued to practise for a period thereafter, you have not demonstrated any specific remedial steps directed towards understanding why the misconduct occurred, addressing the dishonesty, or reducing the risk of repetition. He submitted that you have yet to objectively analyse the root causes of your behaviour and fully address the concerns identified. Accordingly, Mr Holloway submitted that the concerns have not been fully remediated and that your insight remains limited.

Mr Holloway submitted that, in considering whether the conduct is highly unlikely to be repeated, the panel should note that full insight has not been demonstrated. He submitted that your misconduct did not arise from unique or exceptional circumstances but rather, it occurred during routine professional practice involving established procedures which you knowingly failed to follow.

Mr Holloway submitted that whilst you should be credited for engaging with the regulatory process and for the evidence of previous good character before the panel, the absence of full insight and remediation means that the risk of repetition had not been eliminated.

Mr Holloway submitted that the panel must consider whether a finding of impairment is necessary to uphold proper professional standards and maintain public confidence in the profession and the regulatory process. He submitted that this case involved deliberate dishonesty directly connected to clinical practice and patient care. He submitted that the dishonesty exposed a vulnerable patient to a risk of harm and undermined the trust which patients, colleagues and the public are entitled to place in registered nurses.

Mr Holloway submitted that a well-informed member of the public would expect such conduct to be marked by a finding of impairment. Accordingly, he invited the panel to find that your fitness to practise is currently impaired on both public protection and public interest grounds.

You combined your submissions on misconduct and impairment.

You addressed the panel and submitted that you hoped your submissions would still be capable of making a difference to the panel's assessment. You said that you accepted the seriousness of the proceedings and wished to explain the circumstances in which the events occurred.

You submitted that patient safety, compassionate care, professionalism and public confidence are not matters which rest solely with an individual practitioner. However, you also submitted that they are collective responsibilities, shared by individual professionals, teams and organisations. You said that care is delivered within a system and that the wider working environment should be considered when assessing what occurred in your case.

You submitted that, at the relevant time, you were working under significant pressure as an agency nurse. You described working six days per week, regularly undertaking 12-hour shifts and managing approximately 25 to 28 patient visits per day. You stated that you often felt unsupported and isolated within the role.

You accepted that what occurred should not have happened and acknowledged that, at the relevant time, your fitness to practise was impaired by the circumstances in which you were working. You submitted that the pressures of the role affected your judgement and decision-making and whilst you did not seek to avoid personal responsibility, you submitted that the panel should also consider the role played by the working environment and workload demands.

You submitted that healthcare organisations also have responsibilities towards patient safety and staff wellbeing. You questioned why the focus had been placed solely upon

your actions when, in your view, excessive workloads and insufficient staffing also contributed to risks to patient care. You submitted that the circumstances you experienced were not unique and were capable of affecting any nurse working under sustained pressure.

You said that, at the time, you frequently felt overwhelmed by the volume of work allocated to you and described occasions when additional visits were added to an already full workload. You said that these pressures left you stressed, frustrated and struggling to think clearly.

You submitted that the events which led to these proceedings should be viewed in the context of several years of sustained pressure. You said that the concerns did not arise because of any inherent dishonesty in your character, but rather because you had reached a point where the cumulative pressures of work had adversely affected your judgement.

You submitted that you are not a dishonest person and that those who know you personally would not recognise you from the description of your conduct presented during these proceedings. You said that it was difficult for a panel to gain a full understanding of your character from documentary evidence alone.

You submitted that, following these events, you worked within the Watford Community Nursing service between 2024 and 2025. You said that the working conditions there were markedly different, with significantly fewer patients allocated per shift and safeguards in place to prevent staff from exceeding safe working hours. You submitted that this experience demonstrated to you the importance of maintaining appropriate workload boundaries and ensuring that safe systems of work are in place.

You stated that, during that period of employment, you were able to practise safely and effectively. You said that you had sufficient time to complete records properly, provide appropriate care to patients and maintain a healthier balance between your professional and personal life. You informed the panel that the agency, through whom you worked at Watford closed, and you have not worked as a nurse since this period of employment.

You told the panel that your experience since the incident has strengthened your understanding of the need to recognise and manage workplace pressures. You said that if faced with similar circumstances in the future, you would be more prepared to decline additional work where it could compromise patient safety or your own wellbeing.

In relation to the finding of dishonesty, you submitted that the panel should view your actions in the context of the pressures you were experiencing at the time. You maintained that your conduct was entirely out of character and submitted that there is no realistic risk that you would act in a similar manner in the future.

In relation to the lack of professional indemnity insurance, you stated that this arose because you became excessively focused on work and patient care to the detriment of other professional responsibilities. You submitted that this was an oversight rather than a deliberate disregard of professional obligations.

You told the panel that, after the incident, you took time away from practice to spend time with your family and reflect on what had occurred. You subsequently returned to nursing practice and worked within community services.

You submitted that your continued desire to return to nursing reflects your commitment to the profession and to helping others. You said that your motivation was not financial but stemmed from a genuine wish to care for patients and contribute positively to their wellbeing.

When asked by the panel whether there were any particular circumstances on 4 June 2023 that explained the events, you said that you could not identify a specific reason on that day. You described the incident as occurring within the context of prolonged workplace pressures and fatigue and that, even some weeks later, when you made the System One entry, your thinking had not been clear, and you were not functioning as you ordinarily would.

You accepted that mistakes had been made but maintained that they should be understood in the context of those pressures rather than as a reflection of your true character.

In conclusion, you submitted that you had learned from the events, that you would not place yourself in a similar working situation in the future, and that there is no risk of repetition. You invited the panel to conclude that your fitness to practise is no longer impaired and to allow you the opportunity to return to the profession you have worked hard for.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments and advice to first consider each of the charges separately.

Decision and reasons on misconduct

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

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

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

To achieve this, you must:

…

***1.2** make sure you deliver the fundamentals of care effectively*

…

***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

…

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*

…

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

***12.1** make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice*

…

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*

…'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it determined that, taken separately, each charge, except Charge 6, amounts to serious misconduct.

Charges 1a – 1d

In relation to Charges 1a–1d, the panel determined that your failures amounted to misconduct. The panel noted that you did not administer Resident A's insulin, undertake the required blood glucose check or make an accurate record of the care provided and the panel considered each of these failures to be a significant departure from

acceptable standards, amounting to misconduct. It considered that Resident A was not new to you; having treated her recently, you had developed a good relationship with her, and you would have known that you were required to return to administer her medication. Additionally, the panel noted that although Resident A had capacity, her care needs were such that she relied upon nursing staff to provide this basic care safely and competently. The panel considered that the administration of medication, the monitoring of blood glucose levels and the maintenance of accurate records are fundamental aspects of nursing practice and your failures placed an elderly and vulnerable resident at risk of unwarranted, serious harm.

Further, the panel considered that because the record incorrectly indicated that insulin had been administered, other healthcare professionals could have been misled and Resident A could not safely receive an appropriate corrective dose, thereby delaying treatment. In light of this, the panel concluded that your conduct fell seriously below the standards expected of a registered nurse and would be considered deplorable by fellow practitioners.

Charges 2a and 2b

In relation to Charges 2a and 2b, the panel found that your conduct was dishonest and amounted to serious misconduct, which fellow practitioners would find deplorable. Having failed to administer Resident A's insulin, you deliberately created a false paper record indicating that it had been administered. The panel considered that this was not an inadvertent recording error. It considered that the differing readings entered in the two boxes, together with your familiarity with the relevant documentation, supported the conclusion that your actions were deliberate and intended to mislead anyone relying upon the record. The panel considered this dishonesty to have been premeditated and although no actual harm was caused, your conduct exposed Resident A to a risk of harm and could have resulted in serious consequences for her health. It also undermined the integrity of the clinical record and the ability of other healthcare professionals to provide safe and appropriate care.

Charges 3a and 3b

In relation to Charges 3a and 3b, the panel found that your conduct was dishonest and amounted to serious misconduct, which fellow practitioners would find deplorable. It found that you did not test Resident A's blood glucose level but nevertheless created a record purporting to show that a test had been undertaken. The panel noted that the figure recorded differed from the morning reading and considered that this was inconsistent with an accidental duplication or simple mistake. It considered that you completed these records regularly and were familiar with the process and the significance of the information being entered. For reasons similar to those set out in respect of Charges 2a and 2b, the panel concluded that the false entry was deliberate, was intended to mislead and created a risk that subsequent care would be based upon inaccurate clinical information.

Charge 4

In relation to Charge 4, which was proved by your admission, the panel determined that practising without an appropriate indemnity arrangement amounted to misconduct. It considered that you did not have indemnity cover for a period of approximately two years, which made it unlikely to have been an oversight. The Code makes clear that nurses must have an appropriate indemnity arrangement in place when practising, so that members of the public are protected should something go wrong. The panel determined that by continuing to practise without such cover, you placed both patients and yourself at risk. The panel concluded that this represented a serious departure from the standards expected of a registered nurse and would be considered deplorable by fellow practitioners.

Charge 5

In relation to Charge 5, the panel found that your conduct demonstrated a lack of integrity and amounted to misconduct. It considered that you had personally cancelled your indemnity cover and then continued to practise for a prolonged period on the

assumption that you were covered by the agency or the Trust, without taking adequate steps to confirm that this was the case. The panel considered that integrity is fundamental to maintaining public confidence and trust in the nursing profession. It determined that by carrying out your role for approximately two years without ensuring that an appropriate indemnity arrangement was in place, you failed to act with the responsibility and candour expected of a registered nurse. The panel concluded that this conduct had the potential to undermine public confidence in the profession and would be considered deplorable by fellow practitioners.

Charge 6

With respect to Charge 6, the panel noted that the charge did not allege that the entries you made were inaccurate. Rather, it provided the factual background to Charges 7–9. Those charges contained the specific allegations that the matters recorded at Charges 6a, 6b and 6c were inaccurate. Although you did not admit making the entries alleged in Charge 6, the panel considered that as the charge did not specifically allege that the entries were inaccurate, not admitting the charge did not in itself amount to misconduct. The panel therefore determined that Charge 6 did not amount to misconduct.

Charge 7

In relation to Charge 7, the panel determined that your conduct amounted to serious misconduct. It considered that you made a retrospective entry in Resident A's electronic record, documenting that you had attended the Home and provided care on the evening of 4 June 2023, when you knew that you had not done so. The panel considered that concerns had already been raised about the visit and that you were therefore aware of the significance of the entry when you made it. It considered that this was not an innocent mistake or a failure of recollection, but rather, it was the deliberate creation of false and inaccurate clinical information intended to give the misleading impression that care had been provided.

The panel considered that accurate and contemporaneous record keeping is a fundamental requirement of nursing practice. Clinical records must provide a reliable account of the care delivered so that other healthcare professionals can make safe and informed decisions. The panel determined that by knowingly falsifying Resident A's records, you undermined the integrity of the records, intended to mislead others into thinking that the visit had not taken place and created a risk that subsequent care would proceed on a false basis. The panel concluded that your actions fell seriously below the standards expected of a registered nurse, breached fundamental requirements of honesty and record keeping, and would be considered reprehensible by fellow practitioners.

Charge 8

In relation to Charge 8, the panel determined that your conduct amounted to serious misconduct for reasons similar to those set out in respect of Charge 7. The panel accepted that you had been asked to update outstanding records. However, that request could not reasonably have been understood as authorising or condoning the recording of clinical interventions (monitoring of Resident A blood glucose levels) that had not taken place. The panel considered that as an experienced registered nurse, you would have understood the distinction between completing an outstanding record of care actually provided and creating a record of care that had never been delivered. The panel found that you knowingly entered false information into Resident A's clinical record and did so in circumstances where the entry was liable to be relied upon by colleagues.

Charge 9

With respect to Charge 9, the panel determined that your conduct breached fundamental tenets of honesty, integrity and accurate record keeping and amounted to serious misconduct. It considered that you knowingly recorded inaccurate information with regards to the administration of insulin in a clinical record which you understood would be relied upon by other healthcare professionals involved in Resident A's care.

The panel considered that such records must be truthful, complete and dependable. A knowingly false entry has the potential to obscure whether care has been provided, impede proper clinical oversight and expose a resident to avoidable risk. The panel considered that your conduct was deliberate rather than accidental and had the potential to undermine public confidence in the nursing profession. The panel concluded that your actions fell far below the standards expected of a registered nurse and would be considered deplorable by fellow practitioners.

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. 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 had regard to the test set out in *Grant* and determined firstly that all four limbs were engaged in relation to your past conduct.

With respect to limb a), the panel found that you had placed Resident A, an elderly and vulnerable patient, at an unwarranted risk of harm by failing attend the Home and subsequently not checking and accurately recording her blood glucose level and administering insulin. Your inaccurate records stated that this care had been provided

and these falsified entries prevented other healthcare professionals from relying upon the clinical record and could have delayed or precluded appropriate corrective treatment.

In relation to limb b), the panel considered that your failure to attend to Resident A, administer her medication and make accurate clinical records would bring the nursing profession into disrepute. The panel also took account of your having practised for approximately two years without an appropriate indemnity arrangement. Taken together, this conduct had the potential to bring the nursing reputation into disrepute.

With respect to limb c), the panel determined that you had breached fundamental tenets of the nursing profession, including honesty, integrity, patient safety and accurate record keeping. You also failed to comply with the professional requirement to maintain an appropriate indemnity arrangement. The panel considered these obligations to be central to safe and trustworthy nursing practice.

In respect of limb d), the panel found that you had acted dishonestly on two separate occasions, approximately one month apart. When asked whether you had attended Resident A, you stated that you had done so and created records to that effect, despite knowing that the visit and the recorded care had not taken place. The panel considered that this was deliberate dishonesty concerning matters of direct clinical importance and 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 was aware that this is a forward-looking exercise, and accordingly it went on to consider whether your misconduct was remediable and whether you have already remediated your misconduct.

The panel considered the questions outlined in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that the medication administration and record keeping failings were, in principle, capable of remediation through reflection, training and evidence of safe practice. However, the panel recognised that dishonesty is more difficult to remediate because it may reflect an underlying attitudinal concern.

The panel had regard to NMC guidance (*DMA-1*) on dishonesty and considered whether your conduct demonstrated a deep-seated attitudinal issue. The panel considered that the charges found proved in this case have called your openness, honesty and integrity into question as it found that on two separate incidents, occurring nearly one month apart, you created false patient records. The panel considered this to be serious dishonesty rather than an isolated lapse and that your conduct also demonstrated that you had not put Resident A's needs first. In these circumstances, the panel concluded that the concerns were attitudinal in nature.

In considering whether the concerns had been remedied, the panel took account of your oral submissions, your admissions, testimonial evidence, your apology and your reflective accounts in which you recognised that Resident A had been placed at risk. It also noted the steps you said you would take in future, including reducing your working hours, allowing sufficient time to complete records, spending more time with patients and being truthful when difficulties arise. The panel noted that the testimonial from a former colleague who worked with you at the Trust described you as being a caring and professional nurse. The author also confirmed the heavy workload and pressures you both faced at the Ealing District Nursing Team in 2023.

Further, the panel noted that you said that you had worked as a district nurse at a Trust in Watford between 2024 and 2025 and that no concerns had been raised during your practice. Nevertheless, the panel considered that you had not provided a testimonial from your last employment as a registered nurse at Watford Community Hospital, nor from your current employment which is not said to be a nursing role. Additionally, the panel considered that there is no evidence of relevant training, limited evidence of strengthened practice and no clear account of your current employment, save for the fact that it appears you are working in a non-registered role.

The panel considered your reflections to be limited as they did not adequately address the actual and potential impact of your actions on Resident A, your colleagues, the wider public or the reputation of the nursing profession, nor did they demonstrate a fully developed understanding of why your dishonesty was so serious. The panel therefore

concluded that, although you had begun to recognise the impact of your actions and had shown some developing insight, the concerns had not been fully remediated.

The panel then considered whether repetition was highly unlikely. It was of the view that it had insufficient evidence before it with regards to your subsequent registered practice to be satisfied that the conduct would not recur. It noted that although you had recognised what went wrong, you continued to attribute your actions to your state of mind at the time, workload, working hours and the wider working environment. The panel accepted that those matters provided relevant context but considered that you had not fully confronted your personal responsibility for knowingly making false entries and not having indemnity insurance. It also noted that you had not accepted the concerns when they were first raised and that the entries were deliberate rather than accidental or mistaken.

The panel considered whether you had demonstrated the features of insight identified in *FTP-16b*, including an ability to assess the events objectively, recognise what went wrong, accept your role and responsibilities, understand what should have been done differently and explain how you would avoid similar conduct in future. It considered that although your reflections addressed some of these matters, the panel was not satisfied that they demonstrated sufficiently developed insight. It remained concerned that, if faced with a similarly pressurised situation, you may again respond dishonestly. In light of your limited insight and remediation, the panel determined that a significant risk of repetition remains.

The panel therefore considered that you are liable, in the future, to repeat the actions which breached each of the four limbs of *Grant*.

The panel took account of the contextual factors advanced during this case. It accepted the evidence that the service was particularly busy following the COVID-19 pandemic, that you carried a high caseload and worked hard, and that records were sometimes completed a significant time after the event. It also noted your evidence that you worked alone, felt isolated and [PRIVATE]. However, while these factors provided context, the panel considered that this did not excuse your failure to attend Resident A in the

evening or your subsequent creation of false clinical records, which put them at risk of harm. The panel further noted that you retained responsibility for managing your workload, escalating pressures and declining work where necessary to preserve patient safety.

The panel considered that you were working in a patient-facing role and knowingly failed to return to provide essential care to a vulnerable patient. You then falsified the clinical records to indicate that the care had been provided therefore exposing Resident A to a risk of harm. Given the panel's findings of limited insight, remediation and a continuing risk of repetition, it decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel also determined that a finding of current impairment was required on the grounds of public interest. The panel considered that a reasonable and well-informed member of the public would be seriously concerned that a registered nurse had failed to provide essential care, falsified patient records and practised without an appropriate indemnity arrangement. It was of the view that such conduct undermines trust in the nursing profession and represents a serious departure from proper professional standards. The panel concluded that public confidence in the profession and the need to uphold those standards would be undermined if a finding of impairment were not made.

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

Sanction

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

In reaching this decision, the panel 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).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Holloway submitted that the appropriate and proportionate sanction in this case is a striking-off order. He then went on to identify the following aggravating features in this case namely: placing Resident A at a significant risk of harm, failing to demonstrate the professional duty of candour, breaching the trust placed in you by falsifying medical records, a pattern of behaviour over a period of time, deliberate breaches of the Code, premeditated behaviour, dishonesty was directly linked to clinical practice, attitudinal and behavioural issues and lack of insight, remorse and remediation.

Mr Holloway referred the panel to the NMC's Sanctions Guidance (SAN-1) which outlines that an absence of, or very limited, insight is likely to be a significant aggravating factor because it is difficult for a professional to address concerns without first understanding and acknowledging them.

With respect to mitigating features, Mr Holloway acknowledged that you have no previous fitness to practise history and that the panel had received evidence as to your good character. However, he submitted that the absence of previous regulatory concerns carries less weight when a case involves attitudinal issues which remain insufficiently addressed. He further submitted that limited supporting evidence has been provided by you in relation to any personal mitigating circumstances.

Mr Holloway reminded the panel that the exercise of balancing aggravating and mitigating factors is not an arithmetical one, as different factors carry differing weight depending upon the circumstances of the case.

Addressing the available sanctions in ascending order, Mr Holloway submitted that taking no further action would be unsuitable in this case as there is a need to uphold professional standards. He submitted that this case did not involve the exceptional level of insight and remediation that might justify such an outcome and that there were no exceptional circumstances warranting no sanction.

In relation to a caution order, Mr Holloway submitted that this case was not at the lower end of the spectrum of impaired fitness to practise. He submitted that none of the circumstances outlined within *SAN-2b* were evident in your case.

Turning to a conditions of practice order, Mr Holloway submitted that the central concern was not your clinical competence but your decision-making. He submitted that whilst conditions might be capable of addressing aspects of clinical practice, there were no workable, measurable or proportionate conditions capable of addressing the deliberate falsification of records, dishonesty, and the attitudinal concerns identified. He submitted that a registered nurse would be fully aware of the seriousness of falsifying clinical records and that your dishonesty, together with practising without appropriate indemnity insurance, raised significant concerns regarding your attitude towards professional obligations.

In relation to a suspension order, Mr Holloway submitted that such a sanction would not be an appropriate disposal of this case as it is unrealistic that you could return to unrestricted practice in the future. He also submitted that it would be insufficient to protect the public, maintain public confidence in the profession, or uphold proper professional standards. He submitted that your misconduct could not properly be characterised as an isolated lapse rather, when faced with your failure to provide care, you chose to deliberately falsify records and subsequently sought to mislead colleagues. He reminded the panel of its findings that you had deliberately created

inaccurate records with the intention of misleading others and concealing your failure in attending to Resident A on 4 June 2023.

Mr Holloway submitted that you have not demonstrated sufficient insight into the concerns and you have failed to meaningfully engage with the internal factors which had contributed to your misconduct. He submitted that your focus throughout the proceedings had largely been on external circumstances rather than your own decision-making and behaviour.

For these reasons, Mr Holloway argued that it was unrealistic to conclude that a period of suspension would result in you being able to return to safe, effective and unrestricted practice. He submitted that there remains a risk of repetition and referred the panel to the guidance on deciding between suspension and striking-off (*SAN-4*), particularly the need to consider whether it is realistically possible that a professional's insight and attitude will change positively during a period of suspension.

Mr Holloway therefore submitted that a striking-off order was the only appropriate and proportionate sanction. He submitted that this case raised fundamental questions about your professionalism and integrity and that public confidence in the profession would be undermined if you were permitted to remain on the register. He referred the panel to *SAN-2e*, which identifies cases involving dishonesty and breaches of the professional duty of candour as among those most likely to require consideration of a striking-off order. He submitted that this case closely reflects examples within the guidance, including deliberately covering up when things have gone wrong, particularly where there is potential for harm to service users, and premeditated or sustained deception.

Whilst acknowledging that dishonesty does not inevitably result in striking off, Mr Holloway submitted that you have not demonstrated sufficient remorse, insight or remediation to satisfy the panel that the concerns have been adequately addressed or that there was no risk of repetition.

Mr Holloway submitted that your misconduct was exceptionally serious, fell far below the standards expected of a registered nurse, created a real risk of harm to a vulnerable

resident and revealed deeper attitudinal and behavioural concerns. He submitted that those concerns remained largely unaddressed and that your failures demonstrated a continuing risk to patient safety and to public confidence in the profession.

Accordingly, Mr Holloway invited the panel to impose a striking-off order. He submitted that for the avoidance of doubt, the NMC did not seek to rely on your denial of the allegations as an aggravating feature in this case.

You addressed the issue of sanction with oral submissions and acknowledged that many of the points raised during the sanction stage have already been addressed in your previous submissions and written evidence. You reiterated that you accept responsibility for your actions and were not seeking to blame others for what had occurred. However, you submitted that the circumstances in which the incident arose should also be considered when assessing sanction.

You submitted that insufficient weight had been given to evidence showing workplace pressures within the service, including staffing shortages, workload demands and operational difficulties. You referred to evidence previously given by witnesses regarding these working conditions and maintained that they had formed part of the context in which the incident occurred. Whilst accepting personal responsibility for your actions, you submitted that the incident could not properly be viewed in isolation from those wider circumstances and pressures.

You also referred to testimonial character evidence which had been provided during the proceedings, including from a nursing colleague at the Trust, who had ceased working for the Trust because of the unsafe workload and you said you too should have left. You submitted that colleagues who had worked alongside you would be able to attest to your professionalism, reliability and commitment to patient care throughout your career and your hard work was acknowledged by Ms Sarpong, your manager at the Trust.

You told the panel that you have always worked hard, been dependable and have frequently supported colleagues and services, particularly during the COVID-19 pandemic, when you said you had not taken a single day off. You submitted that, aside

from the matters before the panel, your professional record reflected a committed and caring practitioner.

You explained that you had been reluctant to approach your most recent employer for further supporting statements because of concerns about the impact that disclosure of the ongoing proceedings may have had on your employment and professional reputation. You said that you had worked effectively at the Watford Community Hospital and that there had been no complaints from them. You said that you believed that your own submissions regarding your character and work ethic would be sufficient for the panel's consideration.

You accepted that you bear the responsibility for your actions. However, you submitted that a number of factors had contributed to your poor decision-making at the time. You said that the circumstances surrounding the incident were highly unusual and that the conduct found proved did not reflect your character or of how you have practised throughout your career.

You submitted that you have experienced significant stress as a result of these proceedings and described the process as having had a profound personal impact upon you. You stated that you have reflected extensively upon the events in question and maintained that you would never repeat such conduct. You told the panel that people are capable of learning from mistakes and changing their behaviour and submitted that it would be wrong to conclude that, because you had acted dishonestly on this occasion, that you would inevitably behave in the same way in the future.

You emphasised to the panel how important nursing is to you and described it as the profession to which you have devoted most of your adult life to. You said that continuing to practise was extremely important both to you personally and to the people you cared for. You submitted that you remain committed to the values of the profession and wished to continue contributing to healthcare.

In relation to future practice, you stated that you have already made changes to the way you approached your work. You explained that you had reduced your working hours in a subsequent role and had become more mindful of maintaining a manageable workload.

You told the panel that, in the future, you would be prepared to challenge unsafe practices, decline excessive workloads and refuse to compromise patient safety, even if doing so might place your employment at risk.

You assured the panel that patient safety would remain your priority and submitted that the lessons you have learned from these proceedings would ensure that such events would not be repeated. In relation to sanction, you submitted that a striking-off order would be disproportionate. You invited the panel to consider a lesser sanction, such as a caution order or a period of suspension for one year, which would provide you with an opportunity to demonstrate that you have reflected upon the concerns identified and could return to safe and effective practice.

You submitted that your conduct arose in exceptional circumstances, was not indicative of your usual practice, and should not define your entire professional career. You invited the panel to take account of the wider context in which the misconduct occurred, your previous good character and your commitment to nursing, and you would work similar hours to those you worked at Watford, and insist that your workload is manageable. You submitted that there was no realistic prospect of repetition, that you would be committed to patient safety and that you remain capable of making a positive contribution to the profession if permitted to remain on the register.

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 bore 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:

- Conduct which deliberately put people receiving care at risk of suffering harm
- Breach of trust

- Deliberate breaches of the Code, including practising for a significant period of time without indemnity insurance.
- Dishonesty relating to clinical practice
- Limited insight
- Limited evidence of remediation
- Falsification of clinical records

The panel also took into account the following mitigating features:

- Early admission of some of the facts
- Demonstration of remorse
- Workload pressures in a post-COVID environment
- Lack of support in the workplace and being a lone, agency worker

The panel gave further consideration to the aggravating and mitigating factors identified in this case when assessing the seriousness of your misconduct and determining the appropriate sanction. Having weighed these factors, the panel concluded that the aggravating features carried greater weight and outweighed the mitigating factors. The panel therefore determined that your misconduct was serious.

The panel had regard to NMC guidance (*SAN-4*) when assessing the seriousness of your dishonesty. The panel noted that your dishonesty arose within the course of your professional practice and related directly to the care of a patient.

The panel was satisfied that your dishonesty was deliberate. Whilst the misconduct arose from one incident in which you failed to attend Resident A, you subsequently created false records on two separate occasions, approximately one month apart, recording that you had attended when you had not. However, you did admit, two days after the incident that you had not attended Resident A in the evening and after that admission, there would have been no confusion in the internal investigation. The panel therefore concluded that although the dishonesty occurred on two separate occasions, the second occasion was a repeat of the earlier paper information recorded later on the electronic record, which related to the same incident.

Having regard to all the circumstances, the panel concluded that your dishonesty was serious, even though no patient harm actually occurred because Resident A reported that you had not attended in the evening.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate, nor in the public interest to take no further action as this would not protect the public.

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 considered that whilst you have demonstrated some insight and remorse, your insight remains limited and there remains a risk of repetition. 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 placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*

- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel concluded that the concerns in this case centred primarily on dishonesty and professional conduct rather than deficiencies in clinical competence. Whilst there may be identifiable aspects of clinical practice capable of remediation through training or supervision, the panel was not satisfied that conditions could adequately address the dishonest conduct and lack of integrity found proved. The panel considered that dishonesty and lack of integrity represent an attitudinal concern which cannot readily be monitored through conditions of practice. It was therefore not possible to formulate workable conditions that would adequately address the regulatory concerns or sufficiently protect the public. Accordingly, the panel determined that a conditions of practice order would not be appropriate.

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.'*

The panel considered the NMC guidance for deciding between a suspension order and a striking off order, set out in *SAN-3*:

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

- *consider all of the relevant aggravating and mitigating factors.[1]*
- *consider that, unless the Committee directs otherwise, a suspension order will be reviewed before its expiry and may be extended.[2] However, the Committee cannot direct that the suspension must be extended on review. As such the Committee should consider whether public confidence in the*

profession would be protected if the professional returned to practice after one year, or ever.[3]

- *Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*
- *Professionals are under an obligation to cooperate with their regulator.*[4] *Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

The panel gave careful consideration to this guidance and the example given at the end of the guidance which highlighted the importance of whether a registered nurse has engaged with the proceedings. The panel considered that there were more aggravating than mitigation features. However, the panel accepted that you have some developing insight, have expressed genuine remorse and have engaged fully in the NMC fitness to practise process. The panel considered that there is a realistic prospect that you will strengthen your practice during a suspension period. In these circumstances, the panel considered that public confidence in the profession would be protected if you demonstrated to a reviewing panel that you have strengthened your practice through further remediation and reflection.

The panel took into account the evidence that you have been a hard-working registered nurse, confirmed by your manager at the Trust and that you were working under pressure caused by a very heavy workload, in the difficult period shortly after the COVID-19 outbreak. The pressure on you was compounded by the fact that you were operating as a lone working agency nurse, who felt unsupported, and who would have found it difficult to control the workload requested of you. You now accept that this did not excuse your dishonest actions but that you will certainly in future control your workload.

The panel considered that a suspension order would satisfy the overarching objective of protecting the public, maintaining public confidence in the profession and upholding proper professional standards. In reaching this conclusion, the panel took account of the seriousness of your misconduct whilst also recognising that you have demonstrated remorse and some meaningful insight into your actions and that you have the potential to be a safe and effective practitioner in the future. The panel took account of the fact that there had been no regulatory concerns about your work as a registered nurse, or other evidence of dishonesty, either before June 2023 or during the year that you worked as a registered nurse in another Trust subsequent to 2023.

The panel also took account of the contextual factors advanced by you, whilst recognising that these did not excuse your misconduct. It noted that you had accepted responsibility for your actions and the panel accepted that you had expressed genuine remorse for the risk posed to Resident A and for the impact of your actions on your colleagues and the reputation of the profession. The panel considered that temporary removal from the register was necessary to manage the risk currently posed and to allow you a further opportunity to strengthen your insight and remediation. It was also satisfied that public protection could be maintained through a period of suspension.

The panel further considered that it was realistic that you could return to unrestricted practice in the future as it recognised that you have provided some reflective accounts, demonstrated remorse, accepted responsibility for your actions and engaged fully with the regulatory process. The panel also had regard to the positive testimonial and your previous good character.

The panel did go on to consider whether a striking-off order would be proportionate. It accepted that the charges found proved raised fundamental questions regarding your professionalism and integrity and it also recognised that dishonesty is among the types of cases most likely to result in a striking-off order. The panel noted that your misconduct involved dishonesty within clinical practice and conduct that placed a vulnerable patient at risk of harm.

However, the panel was satisfied that fully informed public confidence in the profession and proper professional standards could be maintained by the imposition of a lengthy suspension order. The panel considered that you have demonstrated remorse, developing insight and a willingness to remediate. The panel further concluded that there remains a realistic prospect that, following a period of suspension, you could strengthen your insight, address the concerns identified and reduce the risk of repetition.

In all the circumstances, the panel concluded that a striking-off order would be disproportionate at this time. It was satisfied that a suspension order represented the least restrictive sanction capable of achieving the overarching objective. Accordingly, the panel determined that a striking-off order was not necessary in this case.

Balancing all of these factors the panel concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of your misconduct.

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

Any future panel reviewing this case would be assisted by:

- Further reflection on your professional accountability, in relation to the concerns.
- Documentary evidence of relevant training relating to honesty, integrity, professional ethics and accountability and record keeping.
- Written testimonials from recent paid and/or unpaid employment, including fellow staff and also line managers.
- Written testimonial from your most recent nursing employer, including fellow staff and also line managers.
- Continued engagement with the NMC and these proceedings.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 suspension 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 Holloway. He invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and otherwise in the public interest. He submitted that as the suspension order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

You submitted that you supported this application.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary on the grounds of public protection and otherwise in the public interest. The panel had regard to the sanction it has imposed; namely a suspension order and the reasons for that, and its findings and reasons on the facts, misconduct and impairment.

The panel determined that in view of its findings and reasons overall, only an interim suspension order would be consistent with its determination, and it would also be proportionate. The panel determined that, in imposing an interim suspension order, public interest would continue to be upheld. In the panel's judgement, this outweighs your own interests during the potential appeal period or the 28-day notice period.

The panel therefore determined to impose an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.