

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

**Substantive Meeting
Friday, 16 October 2026 – Wednesday, 21 October 2026**

Virtual Meeting

Name of Registrant:	Sarah Louise Williams
NMC PIN:	07B2867E
Part(s) of the register:	Nurses part of the register Sub part 1 RNC: Children's nurse, level 1 (25 September 2007)
Relevant Location:	Dudley
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, lay member) Mary Pocock (Registrant member) Chantelle Whitehead (Lay member)
Legal Assessor:	Mark Sullivan
Hearings Coordinator:	Adaobi Ibuaka
Facts proved:	Charges 1a, 1b, 1c, 1d, 2, 3, 4, 6a, 6b, 7, 8, 9, 11 and 12
Facts not proved:	Charges 1e, 1f, 5 in its entirety and 10
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)
Final outcome:	FTP impaired - striking off order

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Miss Williams' registered email address by secure email on 30 July 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Miss Williams has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse,

- 1) On 1 April 2022, in relation to Patient A,
 - a) Did not go through their medical history.
 - b) Did not outline any risks of the "Tear Trough Filler" procedure.
 - c) Did not use gloves.
 - d) Did not wear an apron.
 - e) Used the incorrect filler.
 - f) Injected filler into the wrong area.

That you, a registered nurse, whilst employed by Dunedin Complex Care (“Dunedin”) as a Complex Care Regional Manager,

- 2) On 6 December 2022, claimed expenses of £167 from Dunedin as payment towards staff training that did not take place.
- 3) On 1 May 2023, claimed expenses of £320 from Dunedin as payment towards staff training that did not take place.
- 4) On 30 May 2023, told Colleague 1 to pay £246 belonging to Dunedin, to your personal bank account, with the intention of keeping it.
- 5) In relation to Patient B,
 - a) On the dates listed in Schedule 1, documented details of client and care plan reviews that you did not actually carry out.
 - b) Failed to complete risk assessments.
 - c) On 14 April 2023, documented a risk assessment of a ceiling hoist and suction machine without attending their home.
- 6) In relation to Patient C, on the dates listed in Schedule 2,
 - a) Documented details of client and care plan reviews that you did not actually carry out.
 - b) Falsified their signature on the client and care plan reviews.
- 7) Your actions at charge 2 were dishonest in that you claimed expenses for staff training which you did not pay for.
- 8) Your actions at charge 3 were dishonest in that you claimed expenses for staff training which you did not pay for.

- 9) Your actions at charge 4 were dishonest in that you took £246 from Colleague 1, knowing it did not belong to you, and that you had no authorisation to do so.
- 10) Your actions at charges 5(a), (b) and (c), were dishonest in that you deliberately sought to mislead any third-party reviewing Patient B's care documentation into believing that care plan reviews and risk assessments had taken place, when you knew this was not true.
- 11) Your actions at charge 6(a) were dishonest in that you deliberately sought to mislead any third-party reviewing Patient C's care documentation into believing that care plan reviews and risk assessments had taken place, when you knew this was not true.
- 12) Your actions at charge 6(b) were dishonest in that you sought to mislead any third-party reviewing Patient C's care documentation into believing that Patient C had signed the documentation, when you knew this was not true, as you had signed the documentation on Patient C's behalf.

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

Schedule 1:

- i. 14 April 2023.
- ii. 20 June 2023.

Schedule 2:

- i. 1 April 2023.
- ii. 30 May 2023.

Background

Miss Williams has been a Registered Nurse, specialising in Children's Nursing since 25 September 2007.

090164/2022

On 10 August 2022, the Nursing and Midwifery Council ("NMC") received a referral from a member of the public ("Patient A") raising concerns about a "Tear Trough Filler" procedure Miss Williams had performed at Patient A's home address on 1 April 2022.

Miss Williams had advertised her aesthetics business on the NextDoor app, describing herself as a registered nurse. Patient A contacted Miss Williams for an appointment and prior to performing the procedure, she informed Miss Williams she had not received a consultation form to which Miss Williams responded it was fine to proceed without one. Miss Williams did not go through Patient A's medical history or the risks of the procedure.

Miss Williams performed the procedure on Patient A's sofa and did not wear any gloves. The following day, Patient A had a lot of bruising, which is known to be a common side effect. However, a few days later, Patient A could see lumps under her eyes and knew this wasn't normal as she'd had the procedure elsewhere before and so contacted Miss Williams who told her she needed more filler. Patient A agreed and paid Miss Williams a further £100 for additional filler. This was on top of the £200 she had already paid for the procedure.

A week later Patient A's eyes were worse, she had blurred vision, and her eyes were very swollen. She contacted Miss Williams again and told her she was going to have to seek medical advice as her vision had become so bad. Patient A attempted to contact Miss Williams but could not reach her.

Patient A contacted 3 other aestheticians who all advised emergency treatment was required to dissolve the filler. Patient A visited one of the aestheticians the same day. Patient A had to pay to have emergency treatment.

095404/2023

On 11 July 2023, the NMC received a referral from the Clinical Director of Dunedin Complex Care (“the Company”). At the time of the concerns, Miss Williams was employed as a Complex Care Regional Paediatric Nurse Manager, and her role was predominantly to support clients and their teams in the community setting.

Concerns were raised that on 25 May 2023, Colleague 1 informed Miss Williams that they had been overpaid by the Company. Miss Williams told Colleague 1 to repay £246 of overpaid wages to Miss Williams’ personal account and that she would return the overpaid wages to the Company bank account. Colleague 1 made the payment to Miss Williams’ personal bank account as advised, but Miss Williams did not return this money to the Company.

Colleague 1 was overpaid for a second month and informed Miss Williams. On this occasion, Miss Williams advised Colleague 1 to inform the Finance Director who would be able to deduct the overpayment from the following month’s salary. Colleague 1 sought advice from the Company Clinical Director. Miss Williams was suspended on 29 June 2023 pending an investigation but resigned on 30 June 2023.

‘The Company had further concerns about Miss Williams’ as follows:

- *Miss Williams documented on 2 occasions that she had undertaken risk assessments of a patient;*
- *Miss Williams submitted documents/client reviews, including patient signatures, to indicate they have been completed despite failing to attend the patient’s home to do so;*
- *Miss Williams approached the Company’s Finance director for payment to book her staff on a training course for the sum of £487 however staff confirmed the training did not happen.’*

Decision and reasons on facts

At the outset of the meeting, the panel noted the Case Management Form (CMF) dated 8 March 2026, where Miss Williams made full admissions to charges 2, 3, 4, 7, 8 and 9.

The panel therefore finds charges 2, 3, 4, 7, 8 and 9 proved in their entirety, by way of Miss Williams' admissions.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and from Miss Williams.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Patient A: Patient;
- Julia Jones: Mother of Patient C;
- Lena Walliman: Clinical Director of Dunedin Complex Care;
- John Gunn: Finance Director of Dunedin Complex Care;
- Lesley Roberts: Colleague 1 (Support worker).

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

It considered the documentary evidence provided by both the NMC and Miss Williams.

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

Charges 1a – 1d

- 1) *On 1 April 2022, in relation to Patient A,*
 - a) *Did not go through their medical history.*
 - b) *Did not outline any risks of the “Tear Trough Filler” procedure.*
 - c) *Did not use gloves.*
 - d) *Did not wear an apron.*

These charges are found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Patient A, dated 12 March 2025, which stated the following;

‘Sarah contacted me to let me know she had purchased the filler and Sarah told me the procedure would be carried out at my home. We arranged a date and time for Sarah to come to my house to perform the procedure. When Sarah arrived, she asked if I had received the consultation form for the procedure which she said she had sent by email. I told Sarah I hadn’t received it and asked her if we needed to complete one before we went ahead. Sarah responded to say it was fine to proceed without. Sarah didn’t go through my medical history or risks of the procedure. I wasn’t given any forms or documentation to complete. Sarah then proceeded to put her handbag on the windowsill and asked me to lie on my sofa. She took the products out of her handbag and injected the filler. Sarah did not use gloves. Sarah finished the procedure in about 5 minutes and left after I paid the remaining balance.’

This confirmed what Patient A had stated in the NMC referral form, dated 10 August 2022, where she stated the following, in the questions about ‘*what happened*’ and ‘*was anything out of the ordinary?*’;

'She arrived at my home and carried out the procedure on my sofa without any infection control put in place nor did she fill out a patient questionnaire to check for health and medication contra indications...

No questions regarding medical history, put products to be used on my window ledge, injected me while sitting on my sofa, no apron used or gloves.'

The panel noted that Patient A's statement was consistent with her initial referral to the NMC and the panel had no evidence to undermine her credibility on this point. The panel therefore preferred the evidence of Patient A and placed weight on her allegations. It noted that Miss Williams in her application for agreed removal, dated 30 June 2025, provided no further challenge to these charges. Therefore, the panel, on the balance of probabilities, finds charges 1a, 1b, 1c and 1d proved.

Charge 1e)

1) On 1 April 2022, in relation to Patient A,

e) Used the incorrect filler.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Patient A, dated 12 March 2025, which stated the following;

'I contacted three other aestheticians ... I visited one the same day who confirmed ... the wrong type of filler was used due to the firmness and lumps...'

This confirmed what Patient A stated in the NMC referral form, dated 10 August 2022, where she stated the following, in the questions about *'what happened'?*;

‘...I visited one the same day who confirmed that ... the wrong type of filler used as due to the firmness and lumps it was a cheaper filler that had been used and was unlicensed for use around the eyes ... I heard back from Sarah later and she apologised for taking a while to come back to me as she’d been working her day job, I sent her copies of what the other aesthetic companies had said and I asked her what filler she had used, she confirmed she’d used the ... lip filler which isn’t licensed for under eye use...’

The panel noted that Patient A's evidence was consistent and clear, she had been told by one aesthetician, that the incorrect filler had been used. However, the panel were not provided with any evidence of the professional background or qualifications of the practitioner providing this opinion. The panel was of the view that the NMC had not provided sufficiently expert evidence confirming that this was the incorrect filler. Despite what Patient A reported Miss Williams as having said, there is no evidence that she admitted that she had used a product that was unlicensed for under-eye use. Although Miss Williams confirmed she had not used the right equipment the panel could not determine that this related to the product itself. Furthermore there is no evidence from Patient A to suggest in her messages to Miss Williams that the incorrect filler was used.

Therefore, the panel determined that the NMC have not discharged its evidential burden and therefore on the balance of probabilities finds this charge not proved.

Charge 1f)

1) *“On 1 April 2022, in relation to Patient A,*

f) Injected filler into the wrong area.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the NMC referral form, dated 10 August 2022 and the witness statement of Patient A, dated 12 March 2025, which stated the following;

'I contacted three other aestheticians, and all said I needed emergency treatment to dissolve the filler as it had been injected in the wrong area I visited one the same day who confirmed that it was in the wrong place ...'

The panel also had before it photographs of Patient A which supported the description given in her statement. The panel also had regard to screenshot messages between Patient A and Miss Williams, which were exhibited by Patient A on the 12 March 2025.

The text messages demonstrate Patient A sending pictures of her face to Miss Williams, describing it as *'painful'*, stating that a *'doctor has asked me to have details of exactly what filler was used as he made need to dissolve it if not in right place.'* Patient A later tells Miss Williams that she has to get the fillers *'dissolved as its misplaced and caused my vision problems'*.

The panel considered that Patient A was recounting the explanations of the three aestheticians she asked, whose professional background have not been established by the NMC. The panel considered that in the absence of an expert witness, that could have either examined Patient A or assess the photographs to establish the cause of Patient A's presentation, it could not on the balance of probabilities determine that Miss Williams injected the filler into the wrong area. The panel also noted that in the contemporaneous screenshot messages with Patient A, Miss Williams said *'I apologise it took wrong on you. That is a risk with any aesthetic procedure which everybody is aware of.'* The panel could not assume that a poor outcome established that the filler was injected into the wrong area.

Therefore, the panel determined that the NMC have not discharged their evidential burden of proof and find that on the balance of probabilities this charge is not proved.

Charge 5a)

5) *In relation to Patient B,*

a) *On the dates listed in Schedule 1, documented details of client and care plan reviews that you did not actually carry out.*

Schedule 1:

- i. 14 April 2023.
- ii. 20 June 2023.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Lena Walliman (Ms Walliman), dated 9 May 2025, stating the following;

*'I was contacted by a patient on Sarah's caseload who I shall refer to as [Patient B]. [Patient B] contacted me to advise they didn't want to continue working with Dunedin. This was unusual as Dunedin had a good reputation. When I met with [Patient B], they told me they had seen Sarah only once, which was a meeting which I also attended. When I reviewed [Patient B's] records there were two client reviews for [Patient B] completed by Sarah on 14 June 2023 (**Exhibit LW/1**) and 20 June 2023 (**Exhibit LW/2**). Sarah had not attended the how for either of them.'*

The panel also had regard to exhibits LW/1 AND LW/2 which are Patient B's 'Client and Care Plan Review' documents, dated 14 April 2023 and 20 June 2023. The panel noted that they had not been provided with any policy, procedure or witness evidence which set out how a review should be undertaken or that the review could only be completed in Patient B's house. The location box of the 20 June 2023 review document was also blank. The panel noted that there is also no evidence before it to support that Miss Williams claimed to have conducted the review in the house. The panel also had regard to the fact that Patient B had not been asked if either client and care plan review had taken place nor had Patient B been asked about the contents of either form. The panel considered that the signatures were electronic and that Patient B had not been asked if they had signed either review document.

Therefore, the panel, on the balance of probabilities, finds this charge not proved.

Charge 5b and 5c)

5) *In relation to Patient B,*

b) Failed to complete risk assessments.

c) On 14 April 2023, documented a risk assessment of a ceiling hoist and suction machine without attending their home.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Lena Walliman (Ms Walliman), dated 9 May 2025, stating the following;

*'I was contacted by a patient on Sarah's caseload who I shall refer to as [Patient B]. [Patient B] contacted me to advise they didn't want to continue working with Dunedin. This was unusual as Dunedin had a good reputation. When I met with [Patient B], they told me they had seen Sarah only once, which was a meeting which I also attended. When I reviewed [Patient B's] records there were two client reviews for [Patient B] completed by Sarah on 14 June 2023 (**Exhibit LW/1**) and 20 June 2023 (**Exhibit LW/2**). Sarah had not attended the how for either of them.*

Every time you are in a patient's property you need to complete a risk assessment but if Sarah wasn't at the property, then these weren't being completed. It was the regional nurse manager's role to complete these and not one which was delegated to team members. For the client review for [Patient B] on 14 April 2023 Sarah has documented that she has risked assessed the ceiling hoist and new suction machine but if Sarah wasn't at the home this would not have been possible. A risk assessment of a hoist would include checking the slings were safe with no rips or tears, or frayed edges, so you need to be physically there for it. This could have resulted in injury to the patient or staff member if the hoist wasn't fit for purpose.'

The panel have already found that there was no evidence before it to say that the client and care plan reviews needed to be completed face to face. The panel also considered

that if Miss Williams was not in Patient B's home then there was no need for her to complete a risk assessment.

The panel considered that it had not been provided with the risk assessment of the ceiling hoist and suction machine mentioned by Ms Walliman and the evidence before it records that Miss Williams carried out a review of the risk assessments and does not document that she carried out the risk assessment itself. The panel determined that the NMC have not discharged their burden of proof, and on the balance of probabilities finds this charge not proved.

Charge 6a)

6) *In relation to Patient C, on the dates listed in Schedule 2,*

a) *Documented details of client and care plan reviews that you did not actually carry out.*

Schedule 2:

- i. 1 April 2023.
- ii. 30 May 2023.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Julia Jones (Ms Jones, Patient C's mother), dated 15 November 2024, which stated the following;

'...During the time that Sarah was assigned to support [Patient C] ...in July 2023 Lena contacted me ... and asked me if she had ever carried out a client review with [Patient C] I informed Lena that Sarah had never carried out a client review with [Patient C], and I also advised her of other concerns I had. I exhibit the email conversation as JJ/01..

Patient C lacks understanding, so everything has to be explained to her in simple terms. Patient C wouldn't understand what a review meeting was, for instance, and

what it actually entailed, and why it was needed....There is no way at all [client and care plan reviews] were carried out with patient C. Patient C has difficulties with both understanding and communicating, and would not have been able to complete these review'

The panel had sight to exhibit JJ/1 which was the email conversation between Ms Jones and Ms Walliman, dated 17 July 2023, where Ms Jones stated the following;

'Sarah never did a client review with me or [Patient C]. The reviews you sent me, are most definitely not signed by [Patient C] doesn't know what a signature is, let alone sign a form.'

The panel also had sight of exhibit JJ/2 which was the 'Client and Care Plan Review' documents for Patient C, dated 1 April 2023 and 30 April 2023. Both documents had been electronically signed by the nurse manager, which Miss Williams does not deny.

The panel also considered exhibit LW/6, which is an email correspondence between Ms Jones and Ms Walliman dated 7 July 2023, stating the following:

'Hi Lena

I just wanted to say thanks for the other day, letting ... and myself in to your meeting. I'm glad we were able to get a few things sorted, and I appreciate your continued support.

As requested, I'll give you some of the incidents we had with Sarah.

Sarah never did a client review with me; she kept saying she would arrange one, but it never happened.

Sarah was always in a rush, if she ever came to the house to see [Patient C] , she wouldn't stay longer than 10 minutes, then couldn't get out of here quick enough.

Sarah never did a risk assessment at the bungalow. She never assessed [Patient C] needs, or asked if she needed anything.'

The panel noted that Miss Williams did not provide any written submissions to this charge and denies it in the CMF.

The panel determined that it preferred the evidence of Ms Jones and Ms Williams, as they corroborated one another and referred to contemporaneous evidence. The panel noted that some of the review questions required Patient C to provide a graded opinion. The panel considered the evidence of Patient C's mother in respect of Patient C's level of understanding and that she would not have been able to complete the reviews. The panel thought it was unlikely that Patient C could have provided the information attributed to her in the review form. The panel determined on the balance of probability, that it would not have been possible for Miss Williams to have conducted a review with Patient C, without the participation or knowledge of her mother. Patient C's mother states that no such review ever took place. The panel is therefore satisfied that when Miss Williams completed the client and care plan review forms on the dates listed in the schedule above, that she had not actually carried out any review. Therefore, the panel finds this charge proved.

Charge 6b)

6) In relation to Patient C, on the dates listed in Schedule 2,

b) Falsified their signature on the client and care plan reviews.

Schedule 2:

- i. 1 April 2023.*
- ii. 30 May 2023.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to the witness statement of Ms Jones, dated 15 November 2024, which stated the following;

'[Patient C] can't read or write, she can barely spell her first name, and is just practicing her surname, she doesn't know it at all. [Patient C] lacks understanding, so everything has to be explained to her in simple terms. [Patient C] wouldn't understand what a review meeting was, for instance, and what it actually entailed, and why it was needed.'

The panel had sight to exhibit JJ/1 which was the email conversation between Ms Jones and Ms Walliman, dated 17 July 2023, where Ms Jones stated the following;

'Sarah never did a client review with me or [Patient C] . The reviews you sent me, are most definitely not signed by [Patient C] doesn't know what a signature is, let alone sign a form.'

The panel also had sight of exhibit JJ/2 which was the 'Client and Care Plan Review' documents for Patient C, dated 1 April 2023 and 30 April 2023. Both documents had an electric signature which purports to be that of Patient C and Miss Williams.

The panel considered the witness statement of Ms Walliman, dated 9 May 2025, which stated the following;

*'There was another Patient who I shall refer to as [Patient C] where Sarah had completed the client review and signed on the patient's behalf. [Patient C] has limited capacity and is unable to read or write so all documentation is signed by her mum. If the patient is unable to sign, then you have someone else sign or you don't sign at all and write 'Unable' in the signature box. In this case Sarah had signed for [Patient C]. This was against policy, and it gives the wrong impression that the patient is happy with what has been documented. I produce as **Exhibit LW/6** a copy of the care records for [Patient C] which includes an email from the patient's mum to confirm Patient is not capable of signing.'*

The panel noted that Miss Williams did not provide any written submissions to this charge and denied it in the CMF.

The panel determined that it preferred the evidence of Ms Jones and Ms Williams, as they corroborated one another and referred to contemporaneous evidence. The panel accepted the evidence before it that Patient C could not read or write, but she has limited ability to write her own name. The panel taking all the above into account, determined that on the balance of probability, Miss Williams on the dates listed in the schedule above, did falsify the signature of Patient C on the client and care plan reviews. Therefore, the panel finds this charge proved.

Charge 10

10) Your actions at charges 5(a), (b) and (c), were dishonest in that you deliberately sought to mislead any third-party reviewing Patient B's care documentation into believing that care plan reviews and risk assessments had taken place, when you knew this was not true.

This charge is found NOT proved.

In reaching this decision, the panel took into account its decisions on charge 5a, 5b, and 5c. The panel found charge 5 in its entirety not proved and therefore, finds charge 10 not proved.

Charge 11

11) Your actions at charge 6(a) were dishonest in that you deliberately sought to mislead any third-party reviewing Patient C's care documentation into believing that care plan reviews and risk assessments had taken place, when you knew this was not true.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to their earlier findings in charge 6a and to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 6.

The panel having found charge 6a proved above, considered if there was any other explanation, other than to mislead a third-party into believing that that client and care plan reviews had been carried out.

The panel had regards to Miss Williams claims that she had been [PRIVATE] at the time she was working with Patient C.

'I've made many judgement errors with Dunedin and I can only apologise but I do believe that [PRIVATE] has had such a large impact and I don't think I should have even been working at that period.'

However, there was no evidence before it to suggest that [PRIVATE] had a direct impact on her actions. Therefore the panel determined that on the balance of probabilities, Miss Williams deliberately sought to mislead any third-party reviewing Patient C's care documentation into believing that care plan reviews and risk assessments had taken place, when she knew this was not true. The panel was satisfied that if Miss Williams' intention was to mislead, then any reasonable person would find that dishonest. Therefore the panel finds this charge proved.

Charge 12

12) Your actions at charge 6(b) were dishonest in that you sought to mislead any third-party reviewing Patient C's care documentation into believing that Patient C had signed the documentation, when you knew this was not true, as you had signed the documentation on Patient C's behalf.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it.

The panel had regard to their earlier findings in charge 6b and to the case of *Ivey v Genting*.

The panel having found charge 6b proved above, considered if there was any other explanation, other than to mislead a third party into believing Patient C signed the Client and care plan review forms.

The panel had regards to Miss Williams claims that she had been struggling with [PRIVATE] at the time she was working with Patient C.

'I've made many judgement errors with Dunedin and I can only apologise but I do believe that [PRIVATE] has had such a large impact and I don't think I should have even been working at that period.'

The panel considered its findings that Miss Williams did falsify Patient C's signature on the client and care plan reviews she documented, and there was no evidence before it to suggest that [PRIVATE] had a direct impact on her actions. It determined that the act of falsifying a signature would be considered dishonest by any reasonable person, especially as it has been accepted that Patient C did not have capacity and that Miss Williams did not obtain her mother's signature, or write '*unable*' as per policy. Therefore the panel determined that on the balance of probabilities, Miss Williams was dishonest in that she sought to mislead any third-party reviewing Patient C's care documentation into believing that Patient C had signed the documentation, when she knew this was not true, as she had signed the documentation on Patient C's behalf. Therefore the panel finds this charge 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 Miss Williams' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

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

Representations on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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 NMC in its written submissions invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Miss Williams' actions amounted to misconduct, namely 4, 4.2, 6, 6.2, 10, 10.3, 13, 12.1, 14, 14.1, 18, 18.1, 20, 20.1, 20.2, 21, 21.3, 21.4 and 21.5. The NMC submitted that these breaches of the Code are serious and amount to misconduct. It submitted that misconduct in any area of nursing practice places the reputation of the profession and patients at risk of harm and Miss Williams has departed from the basic duties of a registered nurse.

The NMC submitted that Miss Williams demonstrated poor professional practice by performing a procedure on Patient A without conducting the necessary medical checks and failing to adhere to standard precautions for infection control. It further submitted that Miss Williams advertised herself as a registered nurse for her aesthetics business and injected an incorrect filler into the wrong area of Patient A's under eye, which caused

significant harm. The NMC submitted that Patient A suffered pain and complications that had to be corrected by another professional. It submitted that such behaviour falls seriously short of the standards expected of a nurse and amounts to serious misconduct.

The NMC submitted that Miss Williams falsely claimed expenses from the Company for staff training that did not take place on two occasions and withheld money that was meant for the Company, which was highly dishonest and unethical. It further submitted that Miss Williams falsely documented details of multiple patients and care plan reviews that she did not carry out, which was misleading and placed them at risk of harm.

The NMC submitted that honesty and integrity are the cornerstones of the nursing profession and Miss Williams' dishonest conduct is a significant departure from the standards of a registered nurse. It further submitted that the public interest is engaged as Miss Williams' misconduct has the potential to damage public confidence in the profession.

Therefore the NMC submitted that Miss Williams' conduct and behaviour is such that it amounts to misconduct.

Miss Williams did not make any submissions in regard to misconduct.

Representations on Impairment

The NMC invites the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The NMC referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin)

The NMC invited the panel to find Miss Williams' fitness to practise impaired on the grounds that all the limbs of *Grant* are engaged in this case. The NMC submitted that Miss Williams put Patient A at risk of harm and in fact did cause significant harm. It submitted that Patient A had to pay additional money and seek emergency treatment following the procedure with Miss Williams due to the risk that permanent damage would be caused to

her eyesight. The NMC further submitted that similar actions in the future could lead to a further risk of harm and distress to patients if not addressed.

The NMC submitted that Miss Williams used her professional status as a registered nurse to draw people into taking up her services. On the NextDoor app, Miss Williams placed an advert in which she described herself as a '*registered nurse*' for her aesthetics business which permitted patients to believe she was capable to carry out the work. It further submitted that nurses occupy a position of privilege and trust and are expected to always be professional. Patients, their families and colleagues must be able to trust nurses to ensure their conduct justifies both their patients' and the public's trust in the profession, at all times. Miss Williams' actions are liable to bring the profession into disrepute.

The NMC submitted that Miss Williams has breached fundamental tenets of the nursing profession by behaving dishonestly in claiming expenses for staff training that was not paid for and falsifying care information on a number of occasions. Repeated dishonest conduct whilst in a position of trust highlights the risk Miss Williams poses and the likelihood that the dishonest conduct would be repeated.

The NMC submitted that Miss Williams returned a completed Case Management Form (CMF) on 8 March 2026 in which she accepts charges 2, 3, 4, 7, 8 and 9. She accepts that she was not open and transparent and was [PRIVATE] at the time.

It further submitted that Miss Williams admits impairment on the CMF, but denies falsely documenting details of patient's care plans and reviews and deliberately trying to mislead a third party reviewing the patient's documentation.

The NMC submitted that it considers there to be a continuing risk to the public because whilst Miss Williams has shown some remorse in her actions, there are underlying attitudinal concerns. When Patient A first told Miss Williams about the issues she was having, Miss Williams advised on having more filler inserted without assessing the patient first. Patient A also chased Miss Williams for reimbursement of the money paid for the treatment however Miss Williams stated, '*I understand your frustration but what happened can happen I also would have happily dissolved them but u went else square....*'[sic]

The NMC submitted that Miss Williams has not worked as a registered nurse since the concerns were raised. As such, a risk of repetition remains.

The NMC submitted that it is in the public's interest that a finding of impairment was made in this case, to declare and uphold proper standards of conduct and behaviour. It submitted that given the nature and seriousness of the dishonesty and falsification of records, the public would be shocked to hear that a registered professional acted in such a dangerous and dishonest manner. The NMC submitted that Miss Williams placed Patient A at significant risk and did in fact cause her harm. Miss Williams dishonestly misappropriated the Company's funds and deliberately falsified patients' documentation. It further submitted that the public rightly expects nurses to always perform their duties safely, honestly and behave in a professional manner, and that the absence of a finding of impairment risks undermining public confidence in the profession.

Miss Williams did not make any submissions in regard to impairment but admitted impairment on the CMF, dated 8 March 2026.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel was of the view that Miss Williams' actions did fall significantly short of the standards expected of a registered nurse, and that Miss Williams' 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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.3 encourage and empower people to share in decisions about their treatment and care

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

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:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

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

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then went on to consider whether the charges found proved amounted to misconduct.

In relation to charge 1a, the panel found that Miss Williams' conduct amounted to serious professional misconduct. The panel determined that obtaining relevant medical history from a patient was a fundamental safeguard for undertaking an injectable procedure; and Miss Williams proceeding without it, failed to establish whether the proposed treatment was appropriate, thereby exposing Patient A to a potentially avoidable risk.

In relation to charge 1b, the panel found that Miss Williams' conduct amounted to serious professional misconduct. The panel determined that explaining the risk of a procedure is essential to obtaining properly informed consent. By Miss Williams undertaking the procedure without providing that information, she deprived Patient A of the opportunity to make a properly informed decision about the treatment.

In relation to charges 1c and 1d, the panel found that Miss Williams' conduct was not sufficiently serious as to amount to misconduct. The panel determined that although it was not best practice, it fell below the threshold required for misconduct.

In relation to charges 2, 3 and 4 the panel found that Miss Williams' conduct amounted to serious professional misconduct. The panel determined that accepting employers funds for training which was not paid for, involved a breach of professional trust. It noted that the relative modest amount did not diminish the importance of honesty in Miss Williams' financial dealings. The panel determined that Miss Williams instructing a colleague to transfer money into her personal account, with the intention of keeping it, was a serious misuse of her professional position, as well as a breach of the position of trust placed in Miss Williams by her colleague and employer.

In relation to charges 7, 8 and 9, the panel found that Miss Williams' conduct amounted to serious professional misconduct. The panel determined that honesty and integrity are the cornerstone of the nursing profession and Miss Williams' conduct in these charges, fell below the standards expected of a nurse.

In relation to charges 6a, 6b, 11 and 12, the panel found that Miss Williams' conduct amounted to serious professional misconduct. The panel determined that her actions in these charges created misleading evidence of completed oversight of client and care reviews and could undermine the reliability of patient records. It noted that this could cause safety issues and safeguarding concerns if not carried out. It also noted that the accuracy of the care records were seriously compromised, which could have an impact on the ability of those overseeing patient care. The panel considered that honesty and integrity are the cornerstone of the profession and Miss Williams' conduct in these charges, fell far below the standards expected of a registered nurse.

The panel found that Miss Williams' actions in charges 1a, 1b, 2, 3, 4, 6a, 6b, 7, 8, 9, 11 and 12 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that limbs a – d of the *Grant* test are engaged. The panel finds that patients were put at risk as a result of Miss Williams' misconduct. Miss Williams' misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not take charges relating to dishonesty seriously.

In deciding whether Miss Williams' fitness to practice is currently impaired the panel went on to consider whether she had demonstrated any insight into her failures. The panel had regard to written submissions from Miss Williams in the NMC agreed removal form, dated November 2023 and emails between Miss Williams and NMC dated 21 March 2026, where she expresses that she *is '...saddened by my actions and take full responsibility'*. The panel also had regard to the email dated 8 March 2026, where Miss Williams stated that she would *'happily pay all reimbursements to Dunedin'*. However, there is no evidence before the panel that she has paid it back. The panel noted in Miss Williams' CMF dated 8 March 2026, she accepted that her fitness to practise is impaired by her misconduct.

The panel considered that although Miss Williams has apologised for some of her actions, it is not clear which actions she is apologising for and which actions she is taking responsibility for. Miss Williams has not provided the panel with a reflective piece, or evidence of retraining, which could demonstrate her insight into her actions. Nor has she demonstrated that she has insight into how her actions have affected patients, colleagues, the nursing profession and the NMC as its regulator. The panel noted that Miss Williams explained in her email correspondence that she [PRIVATE]at the time the incidences

occurred. However, she does not explain what impact this had on her ability to be honest and provide safe care as nurse. The panel determined that Miss Williams had very limited insight into her failings.

The panel then considered whether there was evidence before it of steps taken to strengthen her practice. The panel carefully considered the evidence before it and noted that Miss Williams had applied to be removed from the register and there was no evidence before the panel to demonstrate any strengthening of her practice, or a demonstration that she has fully appreciated the consequences of her behaviours. The panel considered that the concerns were wide ranging, including repeated dishonesty, thereby demonstrating evidence of deep seated attitudinal issues.

The panel had regard to the case of *Cohen* and the NMC guidance DMA-1. It considered whether the misconduct in this case was easily remediable. The panel was satisfied that the misconduct in this case was capable of being remediated.

However, due to Miss Williams' very limited insight and absence of remediation (especially in regards to the finding of dishonesty), there was a real risk of repetition of similar conduct that could cause both physical and emotional harm. The panel therefore 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 determined that a finding of impairment on public interest grounds is required because the public would be concerned if a nurse who had been repeatedly dishonest, breached the fundamental tenets of the nursing profession and had not sufficiently demonstrated insight and remediation with regard to their failings, was allowed to practice unrestricted. The panel also determined that members of the public would be hesitant, or even reluctant, to engage with members of the profession if they knew that there was a

risk of them being victims to dishonest behaviour and having their care records falsified particularly where patients are vulnerable.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Williams' fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Representations on sanction

In its written submissions the NMC submitted that a striking-off order would be the most appropriate order.

The NMC submitted that the following are aggravating factors:

- Lack of insight
- Conduct which put people receiving care at a risk of suffering harm (some harm caused)

The NMC submitted that there are no mitigating factors in this case. The NMC referred the panel to the sanctions available to it and The NMC guidance on '*Striking off order*' (SAN-

2e Last Updated: 28/01/2026) and '*Sanctions for the highest risk cases*' (SAN-4 Last Updated: 31/07/2026).

The NMC submitted that the conduct of Miss Williams is fundamentally incompatible with being a registered nurse. Public confidence in nurses cannot be maintained if Miss Williams is not struck off. It submitted that striking Miss Williams off the register is the only sanction sufficient to protect patients, members of the public, and maintain professional standards. The NMC further submitted that there is no amount of insight and reflection that would maintain public confidence in the profession and uphold professional standards. It submitted that there is no realistic prospect that after suspension, Miss Williams will have gained insight and strengthened her practice such that the risk she poses will have reduced.

The NMC submitted that Miss Williams deliberately breached the professional duty of candour by failing to provide sufficient follow up care and advice, which caused the patient harm. Furthermore, it submitted that Miss Williams falsified a patient risk assessments and reviews which could have caused harm to her patients.

The NMC submitted that Miss Williams received financial gain through a breach of trust by obtaining money from Colleague 1 and promising to pay it back to the Company but instead, she failed to return the money. Miss Williams also obtained money from the Company finance director to pay for staff training which she failed to book which suggests systematic deception.

Therefore, the NMC submitted that in the circumstances of this case and Miss Williams' misconduct being fundamentally incompatible with continued registration, the only appropriate sanction is one of strike off.

Miss Williams did not provide written submissions in respect to sanction, but has applied to be removed from the Register.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Williams' fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated dishonest conduct involving three separate financial incidents rather than a single lapse.
- Financial gain through breaches of trust involving Miss Williams' employer and a colleague.
- Misuse of the trust associated with her managerial role when directing a colleague to transfer company money into her personal account.
- Dishonest recording of two Patient C reviews, compromising the reliability and authenticity of care documentation. Denial of falsifying a signature which is intrinsically dishonest conduct.
- Deliberate breaches of the Code
- Very limited insight.
- Vulnerability of the person receiving care

The panel also took into account the following mitigating features:

- Admission to the financial conduct and corresponding dishonesty charges
- An expression of remorse and apology, including an acknowledgment that her conduct fell below the standards expected of her as a registered nurse
- Miss Williams' account of [PRIVATE]

The panel recognised that Miss Williams' personal circumstances could provide important context and admissions demonstrated limited insight. However, without supporting evidence the panel gave those matters limited weight. Furthermore, the panel did not consider that the material demonstrated sufficient understanding and remediation. It

additionally distinguished expressions of regret and a wish to leave nursing from evidence that the underlying concerns have been addressed.

The panel considered the dishonesty in this case and had regard to the NMC guidance SAN-4, particularly; '*Cases involving dishonesty*'. In assessing the seriousness of Miss Williams' dishonesty, it noted the following:

'Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):...

- *misuse of power*
- *personal or financial gain from a breach of trust*
- *...*
- *...'*

The panel were satisfied that the above factors applied in this case. The panel further considered that not only did Miss Williams' conduct pose a risk of harm to others, she also breached the trust placed on her by her employers and colleague.

The panel had regard to the same guidance and noted the following in SAN-4:

'...Professionals who have behaved dishonestly can engage with the Committee to:

- *Show that they feel remorse*
- *Recognise that they acted in a dishonest way*
- *Explain, with evidence, how this will not happen again.'*

Miss Williams has recognised she was dishonest in respect of the admitted charges. The panel noted that there was some remorse from Miss Williams but was not satisfied she had sufficiently recognised the impact that her dishonesty had on others, nor did she explain how this would not happen again.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on 'Caution order' (Reference: SAN-2b Last Updated: 28/01/2026) 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 Miss Williams' misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Miss Williams practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on Miss Williams' registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). The panel having had regard to the nature and seriousness of Miss Williams' conduct, noted that the concerns relate to dishonesty which demonstrates a deep seated attitudinal issue and it would not be possible to formulate conditions that would adequately address these issues. The panel considered that Miss Williams had indicated she did not want to continue working a nurse, therefore imposing a conditions of practice order would be unworkable. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards. The panel therefore determined that a conditions of practice order would not be appropriate in the circumstances.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on ‘*Suspension order*’ (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 was not satisfied that the risks identified could be addressed by Miss Williams being temporarily removed from the Register, and considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Considering Miss Williams’, limited insight, repeated dishonesty, lack of remediation, together with no evidence of training and

development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely. The panel found that the nature of the misconduct and the wide ranging issues of dishonesty are such that the public confidence in the profession would not be upheld if Miss Williams was allowed to return back to the profession after a period of suspension. The panel determined that it would be highly unlikely that she would be able to develop her insight and address the concerns to a level that would maintain public confidence in the profession, protect the public and satisfy the public interest.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on '*Sanctions for the highest risk cases*' (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case*'.

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

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

The panel found that the proved conduct was very serious and Miss Williams' actions were incompatible with the standards expected of a registered nurse. Her misconduct

represented a serious breach of the fundamental tenets of the profession, including honesty and openness.

The panel considered that fully informed members of the public would be extremely concerned and shocked if a registered nurse who had falsified client and care review forms, breached the trust of her employer and colleague and had not demonstrated significant insight or meaningful remediation, were permitted to remain on the register.

Miss Williams' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Williams' actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Williams' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Miss Williams in writing.

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC. The NMC submitted that an interim order of suspension should be imposed on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

Miss Williams did not submit any written representations in respect of interim order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for the appeal period before the striking-off order comes into effect.

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

That concludes this determination.