Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 14 – Friday, 18 September 2026

Virtual Meeting

Name of Registrant:	**Kathleen Berry**
NMC PIN:	07I0223S
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 – 13 September 2010
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	Susan Thomas (Chair, lay member) Chloe McCandlish-Boyd (Registrant member) Kiran Bali (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Franchessca Nyame
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 2d, 3a, 3b, 4a, 4b, 5a, 5b, 6a, 6b, 7, 8a and 8c
Facts not proved:	Charges 1c and 8b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

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 Ms Berry's registered email address by secure email on 9 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, date and the fact that this meeting would be heard virtually.

In the light of all of the information available, the panel was satisfied that Ms Berry 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, in your role as Deputy Manager:

1) On 4 March 2023, following the report of a sexual assault relating to Resident C, failed to:
    a) Report the incident to the CQC in a timely manner;
    b) Report the incident to safeguarding in a timely manner;
    c) Ensure that the records completed by colleagues were adequate to safeguard Resident C.

2) On 18 March 2023, you failed to carry out CPR on Resident A appropriately in that:
    a) You did not commence CPR immediately;
    b) Instructed Colleague B and Colleague C to move Resident A into her bed;
    c) Instructed Colleague B to determine whether Resident A had a DNR in place before commencing CPR;
    d) Told colleague C to start CPR on resident A despite being told that she was not trained to do so.

3) On 18 March 2023, you failed to tell the attending paramedics that:
    a) You had transported Resident A from the lounge to her bedroom while she was unresponsive;
    b) You had instructed Colleague B and Colleague C to place Resident A into her bed.

4) Your conduct at charge 3 lacked integrity in that:
    a) You knew you had moved Resident A from the lounge to their bedroom before commencing CPR;
    b) You knew you had asked one or more colleague to move Resident A to the bed.

5) On 18 March 2023, when the police attended:
    a) You told police that only you and Colleague A performed CPR on Resident A;
    b) Instructed Colleague A to provide inaccurate information to the attending police officer that it was just you and Colleague A who gave CPR to Resident A.

6) Your conduct in respect to charges 5(a) and/or 5(b) was dishonest in that:
    a) You knew Colleague D had also been involved in providing CPR;
    b) You intended to create the impression that only you and Colleague A had carried out CPR when this was not the case.

7) Your conduct in respect of charge 5(b) lacked integrity in that you knew you were encouraging Colleague A to lie to the police.

8) On 18 March 2023, you did not record in Resident A's notes that:
    a) You instructed Colleague B and Colleague C to move Resident A into her bed.
    b) You did not commence CPR immediately.
    c) That CPR was provided by Colleague D.

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

Background

Ms Berry (also known as Katrina) was referred to the Nursing and Midwifery Council (NMC) on 23 August 2023. This was in relation to alleged incidents which occurred at Millvina Care Home (the Home), where she worked as the Deputy Manager from 12 September 2022 until she was dismissed on 20 March 2023.

The alleged incidents are as follows:

4 March 2023

Resident C was sexually assaulted and it is alleged that Ms Berry did not make a referral to Safeguarding or the Care Quality Commission (CQC) in a timely manner. It is alleged that these steps were not completed until the Home Manager contacted the Director after receiving a text message from the Resident C's family on 5 March 2023 regarding the incident.

18 March 2023

Following Resident A's death, it is alleged that:

- Staff were not present in the residents lounge to appropriately monitor residents and this resulted in a delay in care provided to Resident A when their condition deteriorated
- Ms Berry transferred Resident A to their room from the lounge to perform CPR and allowed unqualified members of staff to perform it
- Ms Berry told paramedics that Resident A was in bed prior to CPR being performed and that it was the carers' fault that CPR commenced there
- Ms Berry asked carers to lie to the police about the incident and pressurised them to do so
- Ms Berry's record of the incident was inadequate and/or inaccurate

Decision and reasons on facts

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

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:

- Cheryl Morison (Ms Morison): Manager at the Home at the time of the alleged incidents.
- Abbi Odger (Ms Odger): Healthcare Assistant at the Home at the time of the alleged incidents.
- Lauren Salter (Ms Salter): Senior Care Assistant at the Home at the time of the alleged incidents.
- Ellena Krcmar (Ms Krcmar): Carer at the Home at the time of the alleged incidents.

Jordan Stephenson	Colleague A
Lauren Salter	Colleague B
Abbi Odger	Colleague C
Ellena Krcmar	Colleague D

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

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

Charges 1a and 1b

> "That you, a registered nurse, on 4 March 2023, following the report of a sexual assault relating to Resident C, failed to:
>
> a) Report the incident to the CQC in a timely manner;
> b) Report the incident to safeguarding in a timely manner

This charge is found proved.

In reaching this decision, the panel took into account the Bloomcare Adult Safeguarding Policy, the Bloomcare Deputy Manager job description, Ms Morison's witness statement, and the WhatsApp text messages between Person A and Ms Morison and Ms Berry and Ms Morison dated 5 March 2023.

It is stated in the Deputy Manager's job description that:

> *'38. All staff, are in the front line in preventing harm or abuse occurring and in taking action where concerns arise. Protection, Prevention and Personalisation are the cornerstones to protecting adults at risk of harm.*
>
> *39. Understand and ensure that the home's Safeguarding Policy and Procedure is adhered to at all times.'*

The panel noted that the safeguarding policy states:

> *'CQC must be notified immediately about abuse or allegations of abuse concerning a person using your service if any of the following applies:*
> *• the person is affected by abuse*

- *they are affected by alleged abuse*
- *the person is an abuser*
- *they are an alleged abuse'*

This is reiterated in Ms Morison's statement:

> *'Miss Berry was the Deputy Manager at the Home…Their role would including* [sic]*…reporting to third parties such as safeguarding or the Care Quality Commission ("CQC")…*
>
> *Miss Berry has a duty to ensure all residents' safety, therefore, should have contacted the CQC, safeguarding and requested for a GP to visit Res C… Miss Berry would be aware of the duties through their induction to the Home and one to one session with the Regional Manager at the time.'*

The panel considered the safeguarding policy and Ms Berry's job description. It determined that it is clear that, as Deputy Manager at the Home, Ms Berry had a duty to adhere to the safeguarding policy, which included immediately notifying the CQC and safeguarding about resident abuse.

Having found that Ms Berry had a duty to report the incident, the panel then considered whether or not Ms Berry did this in a timely manner.

Person A (Resident C's daughter) texted Ms Morison on 5 March 2023 at 10:47 saying, *'my mum as been sexually assaulted…'* [sic]. This was after Person A's initial text message to Ms Morison on 4 March 2023 at 22:23, alerting her to an *'emergency'*.

On the morning of 5 March 2023, Ms Morison texted Ms Berry on WhatsApp:

> *'…Res C daughter she has contacted me to say her mum was sexually assaulted, have you been told.'*

to which Ms Berry responded:

‘I am aware…I was told me and u are only to do safeguarding which I was going to do on Monday morning…’

The panel noted that the incident is alleged to have occurred on 4 March 2023 (Saturday) and that Ms Berry had planned to action the safeguarding policy on Monday (6 March 2023). The panel also noted from Ms Morison’s witness statement that, *‘At 12:00 on 5 March 2023, Miss Berry notified the CQC and Safeguarding.’*

The panel bore in mind that the policy states the CQC and safeguarding must be notified *‘immediately’*. The panel therefore determined that Ms Berry had a duty to action the safeguarding policy on 4 March 2023 immediately when the incident was reported to her, which she did not. As such, the panel determined that Ms Berry failed to report Resident C’s sexual assault to the CQC and safeguarding in a timely manner.

The panel therefore found Charges 1a and 1b proved.

Charge 1c

“That you, a registered nurse, on 4 March 2023, following the report of a sexual assault relating to Resident C, failed to:

c) Ensure that the records completed by colleagues were adequate to safeguard Resident C.”

This charge is found NOT proved.

In reaching this decision, the panel considered Ms Morison’s witness statement.

Ms Morison wrote in her statement:

‘…there is reference to the Agency Nurse, Ms Omehu, not making records of this incident. Ms Omehu did not have access to their profile on PCS system therefore could not make these records. Following this incident, this should have been documented on PCS in full, the family should have been informed, safeguarding

should have been notified, and telemedicine should have been used. Miss Berry should have documented in the daily care notes as an entry when they were made aware of the incident.'

The panel did not have any evidence before it with regards to Resident C's care notes or medical records. Furthermore, it was unclear to the panel what Ms Berry's duties and responsibilities were in respect of other colleagues' record keeping, particularly that of an agency nurse.

The panel was not satisfied that the NMC had discharged its burden to prove that Ms Berry failed in her duty to ensure that the records completed by colleagues were adequate to safeguard Resident C.

Charge 2 in its entirety

"That you, a registered nurse, on 18 March 2023, you failed to carry out CPR on Resident A appropriately in that:

a) You did not commence CPR immediately;
b) Instructed Colleague B and Colleague C to move Resident A into her bed;
c) Instructed Colleague B to determine whether Resident A had a DNR in place before commencing CPR;
d) Told Colleague C to start CPR on resident A despite being told that she was not trained to do so."

This charge is found proved.

In reaching its decision, the panel had regard to the local statements of Ms Salter (Colleague B) and Ms Odger (Colleague C) dated 19 March 2023, the minutes from Ms Morison's meeting with Ms Salter dated 21 March 2023, and her meeting with Ms Odger dated 22 March 2023. It also took into account Bloomcare's Basic Life Support policy dated July 2022 and Ms Morison's witness statement.

The panel noted the CPR policy which states:

> *'Dial 999 and ask for an ambulance. If possible, stay with the victim and get someone else to make the emergency call.*
> *Start CPR and send for an AED as soon as possible.'*

In her local statement, Ms Salter wrote:

> *'Res A was sat in a wheelchair at the dining room table as soon as we seen her you could tell she had passed away, Katrina approached Res A shaking her, shouting her name…Katrina wheeled Res A into her room and advised me and Abbi to get Res A onto her bed. Katrina told me to ring 999 and check for a DNR whilst Abbi stayed with Res A. No DNR was in place so CPR was commenced on the bed…'*

The panel noted that Ms Salter gave the same account in her meeting with Ms Morison on 21 March 2023:

> *'Response- Katrina approached her touching the top of her left arm asking 'are you ok' 'are you alive'*
> *CM- What happened next*
> *Response- Katrina pushed to her room and asked me and abbi to transfer her onto her bed, then katrina asked for me to check if she had a dnar, which she didnt'* [sic]

Ms Odger gave a similar account in her local statement:

> *'Katrina then wheeled Res A into her bedroom and told me and Lauren to put her on the bed. Katrina told Lauren to ring 999 whilse she checked if Res A had a DNR in place, and asked me to stay with Res A. Katrina came back in to say we had to start CPR, Katrina asked me if I knew how to do CPR I told her no…'* [sic]

and in her meeting with Ms Morison on 22 March 2023:

‘Response–Katrina then told me and Lauren to put Res A on the bed, then told Lauren to phone the ambulance and she also left the room to check if she had a DNR at the nurses station. I then heard Katrina shout 'Oh Shit I have got to start CPR. She then came in and started CPR and told me I had to do CPR. I told Katrina I didn't know how to do CPR and she told me again I had to do it. Again I told her I didn't know how to do it.’

In light of the evidence before it, the panel considered that Ms Berry was under a duty to implement the basic life support training and policy and commence CPR as soon as she found Resident A was unresponsive, which she did not.

The panel considered Ms Salter and Ms Odger’s evidence that Ms Berry had asked them to move Resident A to her bedroom to be consistent, as well as their evidence that Ms Berry asked Ms Salter to find out if Resident A had a DNR prior to commencing CPR. The panel also considered that it was more likely than not that Ms Berry asked Ms Odger to do CPR on Resident A despite not knowing how to do so.

The panel therefore found Charge 2 proved in its entirety.

Charge 3 in its entirety

“That you, a registered nurse, on 18 March 2023, you failed to tell the attending paramedics that:

a) You had transported Resident A from the lounge to her bedroom while she was unresponsive;
b) You had instructed Colleague B and Colleague C to place Resident A into her bed.”

This charge is found proved.

In reaching this decision, the panel had regard to the local statements of Ms Berry, Jordan Stevenson (Mr Stevenson), a Carer at the Home, Ms Salter and Ms Odger, as well as its decision on facts at Charge 2.

The panel noted that, in her local statement, Ms Berry took responsibility for transporting Resident A to her bedroom:

> *'I noticed Res A lying back in her chair it looked like she was sleeping however when I went over to check she was ok I found that she was diseased. I took her to her room...'* [sic]

In his local statement, Mr Stevenson wrote:

> *'I overheard Katrina telling the paramedic it was the carers fault that* [Resident A] *was on the bed, even though Abbi informed me Katrina told them to put Res A on the bed.'* [sic]

Similarly, Ms Odger said in her local statement:

> *'Katrina told the paramedics that it was mine and Lauren's fault for* [Resident A] *being on the bed.'*

and Ms Salter said in her local statement:

> *'Katrina informed the paramedic it was the care staffs fault as we put* [Resident A] *there when in fact Katrina who advised us to put her on the bed.'*

The panel, having found Charge 2 proved, found that Ms Berry did not commence CPR on Resident A immediately because she had moved Resident A to her bedroom and asked Ms Salter and Ms Odger to transfer her from her wheelchair to her bed. The panel considered the evidence of Ms Salter, Ms Odger and Mr Stevenson to be consistent and therefore gave it more weight.

On the balance of probabilities, the panel was satisfied that Ms Berry failed to tell paramedics that she had transported Resident A from the lounge to her bedroom while she was unresponsive and instructed Ms Salter and Ms Odger to place her into her bed.

The panel therefore found Charge 3 proved in its entirety.

Charge 4 in its entirety

"Your conduct at charge 3 lacked integrity in that:

a) You knew you had moved Resident A from the lounge to their bedroom before commencing CPR;
b) You knew you had asked one or more colleague to move Resident A to the bed."

This charge is found proved.

In reaching its decision, the panel took into account local statements of Mr Stevenson, Ms Salter, Ms Odger and Ms Berry, as well as its decision on facts at Charge 3.

The panel found that Ms Berry failed to tell paramedics that she had transported Resident A from the lounge to her bedroom while she was unresponsive, and that she had instructed Ms Salter and Ms Odger to place her into her bed.

The panel considered that it had cogent evidence from Mr Stevenson, Ms Salter and Ms Odger that Ms Berry attributed Resident A's movement and presence on her bed to care staff, namely Ms Salter and Ms Odger. The panel noted that this was despite Ms Berry knowing that she had personally moved Resident A to her bedroom and further instructed Ms Salter and Ms Odger to place her on her bed.

The panel therefore determined that Ms Berry's actions at Charge 3 lacked integrity.

As such, the panel found Charge 4 proved in its entirety.

Charge 5 in its entirety

"That you, a registered nurse, on 18 March 2023 when the police attended:

a) You told police that only you and Colleague A performed CPR on Resident A;
b) Instructed Colleague A to provide inaccurate information to the attending police officer that it was just you and Colleague A who gave CPR to Resident A."

This charge is found proved.

In reaching its decision, the panel took into consideration the statements of Ms Berry, Ms Salter and Mr Stevenson (Colleague A), and the minutes for Mr Stevenson's meeting with Ms Morison dated 21 March 2023.

The panel noted the account of Mr Stevenson regarding what was reported to the police about the incident. He said in his local statement:

> *'Then Katrina procedured to tell me what I needed to say to the police and I needed to lie because she did. Felt under pressure when giving statement because Katrina wouldn't leave the room, so I felt like I couldn't tell the truth. Once my statement has finished & Katrina proceed with her duty, I notice the police going back upstairs to Lime Street. That's when I went up to him and spoke to him in private to tell him the truth because Katrina wasn't there.'* [sic]

This was reiterated in the minutes of his meeting with Ms Morison:

> *'Katrina then came down to the unit I was on and told me in front of myself and Lauren that it will only be myself getting questioned by police as I am the only one referenced in her report doing CPR and told me what was in her report word for word, her body language was perceived by myself that she wanted me to repeat the same statement, I was told to go in the office with Katrina where the police were present, the deputy stayed in the office during the interview it was hard to answer the questions due to Katrina's body language it was uncomfortable, I didn't feel I could honestly answer the questions due to her being my line manager I felt I was in a predicament due to her behaviours.*

After the interview I went upstairs to lime street to see the Police officer who had interviewed me, the officer was standing outside the corridor doors, I approached him and asked if I could have a quiet word with himself. We went into Scotland Road lounge that was empty and gave him the honest answers and told him why I could not do this in front of the Deputy manager, he apologized and said in hindsight she shouldn't have been present in the room…' [sic]

The panel noted that Ms Salter corroborated this account in her witness statement:

'Mr Stevenson came down after the police had interviewed them and said that Miss Berry had said that only themselves and Mr Stevenson had been involved in the CPR for Res A. Miss Berry said they did not think it was suitable to get everyone involved. They said this to me after the police had left.'

The panel considered the evidence of Ms Salter and Mr Stevenson against Ms Berry's evidence. It determined that their evidence was cogent and consistent, therefore carrying more weight than Ms Berry's account of events.

On the balance of probabilities, the panel found that Ms Berry told the police that only she and Mr Stevenson performed CPR on Resident A and that she had instructed him to do the same.

Therefore, the panel found Charge 5 proved in its entirety.

Charge 6 in its entirety

"Your conduct in respect to charges 5(a) and/or 5(b) was dishonest in that:

a) You knew Colleague D had also been involved in providing CPR;
b) You intended to create the impression that only you and Colleague A had carried out CPR when this was not the case."

This charge is found proved.

When considering the issue of dishonesty, the panel applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67:

> '*1. The Panel must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his/her belief is a matter of evidence going to whether he/she held the belief, it is not an additional requirement that his/her belief must be reasonable; the question is whether it is genuinely held;*
>
> *2. Once his/her actual state of mind as to knowledge or belief as to facts is established, the question whether his/her conduct was honest or dishonest is to be determined by the Panel by applying the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what he/she has done is, by those standards, dishonest.*'

The panel first considered Ms Berry's subjective state of mind, namely whether she knew Ms Krcmar (Colleague D) had also been involved in providing CPR and/or intended to create the impression that only she and Mr Stevenson had carried out CPR when this was not the case.

Ms Odger said in her statement:

> *'By the time me and Jordan got upstairs, Ellena was in there doing CPR and her and Jordan was swapping doing CPR.'*

In her witness statement, Ms Krcmar said:

> *'I believe Miss Berry asked me if I had CPR training. I cannot recall how long I gave chest compressions for.*
>
> *A male carer, Jordan, came upstairs to assist with the chest compressions when I got tired.'*

The panel noted that this account was also consistent with Mr Stevenson's:

> *'When I arrived upstairs and got into the bedroom Ellena was in there already doing CPR on the resident. I was there as a guidance for Ellena to take breaks from performing CPR. Myself and Ellena procedure with CPR until paramedics arrived.'*

However, the panel noted that Ms Berry said in her local statement:

> *'I had Jordon with me as he was competent in cpr together we took turns until ambulance arrived.'*

The panel considered that Ms Berry's account to the police was inconsistent with the evidence of Ms Odger, Ms Krcmar and Mr Stevenson whose accounts all indicate that other staff besides Ms Berry and Mr Stevenson were involved in the CPR performed on Resident A. The panel also took into account its decision on facts for Charge 5 and the evidence it relied upon.

The panel was of the view that the evidence before it indicates that Ms Berry was heavily involved in the incident and therefore would have been aware that Ms Krcmar assisted in performing CPR on Resident A. Thus, the panel determined that Ms Berry withholding from her statement that Ms Krcmar was involved is supporting evidence that she intended to create the impression that only she and Mr Stevenson had carried out CPR on Resident A when that was not the case.

The panel was of the view that members of the public would expect a registered nurse, particularly the Deputy Manager of a care home, especially when a resident has passed away, to provide the police with an accurate report of events rather than withhold information. Consequently, the panel was satisfied that Ms Berry's state of mind would be regarded objectively as dishonest by the standards of ordinary decent people.

For these reasons, the panel concluded that Ms Berry's actions at Charge 5 were dishonest. Therefore, the panel found Charge 6 proved in its entirety.

Charge 7

"Your conduct in respect of charge 5(b) lacked integrity in that you knew you were encouraging Colleague A to lie to the police."

This charge is found proved.

In reaching its decision, the panel had particular regard to local statement of Mr Stevenson, the witness statement of Ms Salter, the minutes for Mr Stevenson's meeting with Ms Morison dated 21 March 2023, and its decision on facts at Charges 3, 5 and 6.

The panel found that Ms Berry instructed Mr Stevenson to tell the police that only they performed CPR on Resident A, and that her creating this impression was dishonest. The panel noted that Mr Stevenson *'felt pressured'* to lie to the police because Ms Berry did not leave the room when he initially gave his statement. The panel considered that Ms Berry abused her position of power to influence Mr Stevenson to adopt her account of the incident, which she knew was inaccurate. The panel determined that this lacked integrity.

The panel therefore found Charge 7 proved.

Charges 8a and 8c

"That you, a registered nurse, on 18 March 2023 you did not record in Resident A's notes that:

a) You instructed Colleague B and Colleague C to move Resident A into her bed.
c) That CPR was provided by Colleague D."

This charge is found proved.

In reaching its decision, the panel took into account Ms Berry's incident report in respect of Resident A dated 18 March 2023.

Ms Berry's report reads as follows:

'…i found that [Resident A] *was diseased. I took her to her room and lay her on the bed. DNAR not in place so commenced CPR. I had Jordon with me as he was competent in cpr together we took turns until ambulance arrived.'* [sic]

The panel noted that nowhere in Ms Berry's report is it recorded that, once she moved Resident A to her room, she instructed Ms Odger and Ms Salter to place Resident A on the bed, or that Ms Krcmar assisted in performing CPR.

The panel therefore found Charges 8a and 8c proved.

Charge 8b

"That you, a registered nurse, on 18 March 2023 you did not record in Resident A's notes that:

b) You did not commence CPR immediately.

This charge is found NOT proved.

In reaching its decision, the panel considered Ms Berry's incident report in respect of Resident A dated 18 March 2023.

Ms Berry recorded the following:

'*…i found that* [Resident A] *was diseased. I took her to her room and lay her on the bed. DNAR not in place so commenced CPR.'*

The panel determined that, although it is not explicitly stated in Ms Berry's report, the timeline she recorded, and her wording of events indicates that CPR was not started immediately.

The panel therefore found Charge 8b not 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 Ms Berry's 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, Ms Berry's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC's written representations on misconduct read as follows:

> *'21. We consider the following provision(s) of the Code have been breached in this case:*
>
> *1 Treat people as individuals and uphold their dignity*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *1.5 respect and uphold people's human rights*

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

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 some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
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

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:
11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.1 only act in an emergency within the limits of your knowledge and competence
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.4 keep to the laws of the country in which you are practising.
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

22. The NMC considers the misconduct serious because:

i. Ms Berry failed to and failed to report Resident C's assault to the CQC.

ii. Ms Berry is alleged to have failed to carry out and/or supervise CPR. She is alleged to have indicated to an unqualified member of staff to carry out CPR.
iii. Ms Berry entered incorrect entry to the Resident's health records to cover up the delay in the care provided to them.
iv. Ms Berry acted dishonestly/demonstrated a lack of integrity on multiple occasions in that she was not forthcoming with emergency services and told colleagues to lie to emergency services.'

The NMC's written representations on impairment read as follows:

'27. It is the submission of the NMC that each of the above can be answered in the affirmative in this case for the following reasons:

a. Ms Berry has put Residents at unwarranted risk of harm by failing to safeguard a resident and providing inadequate emergency care;
b. Ms Berry has breached a fundamental tenet of nursing by being unprofessional;
c. Ms Berry acted dishonestly in attempting to cover-up her conduct by making inaccurate records and providing inaccurate statements to others. She has also encouraged her staff to provide inaccurate statements to ambulance staff and the police.
d. Ms Berry has brought the profession into disrepute for the matters stated above as well as acting dishonestly and encouraging colleagues to act dishonestly;

28. Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

29. We consider the registrant has displayed no insight. We take this view because no reflections have been provided.

30. We consider the registrant has not undertaken relevant training in respect of the issues of concern.

31. We note the registrant has not worked since the issues of concern.

32. We consider there is a continuing risk to the public due to the registrant's lack of insight and failure to undertake relevant training. Ms Berry has also not had the opportunity to demonstrate strengthened practice through work in a relevant area.

Public interest

33. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that: "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."

34. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper 13 professional standards and conduct and/or to maintain public confidence in the profession.

35. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which has not been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

36. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to

uphold proper professional standards and conduct or to maintain public confidence in the profession.

37. We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. The registrant's conduct engages the public interest because the registrant deliberately took risks with patient safety and is alleged to have acted dishonestly and deliberately put patients at risk of harm. As the public will be entitled to expect that the nurses caring for them behave honestly, a finding of impairment is necessary to uphold professional standards and conduct and maintain public confidence in the profession.'

The panel accepted the advice of the legal assessor which included reference to NMC guidance and a number of relevant judgments.

Decision and reasons on misconduct

In reaching 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.'*

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 Ms Berry's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.5 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

10 Keep clear and accurate records relevant to your practice

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 some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising.

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

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

The panel was mindful that breaches of the Code do not automatically result in a finding of misconduct.

The panel found that Ms Berry failed in a number of her duties as Deputy Manager at the Home on 4 and 18 March 2023. It considered Ms Berry's failures to be made more serious by her lack of integrity and dishonesty, all of which occurred in course of her clinical practice. The panel was particularly concerned that Ms Berry abused her seniority to pressure a junior colleague to also be dishonest. The panel was of the view that Ms Berry's non-disclosure of important information created a false narrative which could have impacted the police investigation and residents' family.

The panel therefore found that Ms Berry's actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

In reaching its decision, the panel had regard to the NMC Guidance *'*DMA-1: Impairment' (last updated 28 January 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 *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 considered that Ms Berry put residents at unwarranted risk of harm by failing to action her safeguarding duties in a timely manner in respect of Resident C and failing to follow basic life support principles with regard to Resident A. The panel was of the view that Ms Berry's dishonesty and lack of integrity brought the nursing profession's reputation into disrepute. Additionally, the panel found that Ms Berry's misconduct had breached

sections of the Code, and it determined that her actions also breached the fundamental tenets of the nursing profession, particularly honesty, integrity and the duty of candour. The panel also determined that Ms Berry was dishonest in that she intentionally created false impressions by withholding significant information from her care notes and her dishonest police statement.

The panel concluded that all four limbs of the above test were engaged in respect of Ms Berry's actions in the past.

The panel had regard to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered Ms Berry's liability to act similarly in the future. It took into account the following questions:

> ‘*‘whether the concern can be addressed by taking steps to strengthen practice*
> *whether the concern has been addressed*
> *whether it is highly unlikely that the conduct will be repeated’*

The panel was of the view that some limited elements of Ms Berry's clinical failures could be addressed, for example, with further training. However, the panel considered that it would be difficult to remediate dishonesty and the pressuring of others to be dishonest. The panel determined that Ms Berry's dishonesty and lack of candour was indicative of a deep-seated attitudinal issue.

The panel did not have any evidence before it from Ms Berry which demonstrated remorse, insight, reflection or steps taken to strengthen her practice. The panel noted that Ms Berry has not practised since she was dismissed from the Home, thus she has not been able to demonstrate safe and effective practice.

The panel took into consideration that these were two specific incidents, which occurred only weeks apart. It also noted that Ms Berry's failings were across wide-ranging areas of nursing practice such as record keeping, communication with colleagues, knowledge of responsibilities as a senior staff member and her ability to effectively perform procedures. It recognised that Ms Berry's misconduct is serious, made even more serious by her dishonesty. The seriousness together with the lack of insight and remediation, the panel

determined that there is a high risk of repetition in this case. The panel therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel bore in mind the overarching objective 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. The panel was of the view that a well-informed member of the public would be appalled to learn that a registered nurse found to have failed in her duties, and had lied about the events to the police and others following a resident's death. Subsequently, Ms Berry has failed to demonstrate either insight or any engagement with the NMC, and therefore the public would not expect her to practise unrestricted.

The panel therefore determined that a finding of impairment on public interest grounds is required to maintain public confidence in the nursing profession and the NMC as a regulator, and to declare and uphold proper professional standards for members of the profession.

Having regard to all of the above, the panel was satisfied that Ms Berry's fitness to practise is currently impaired.

Sanction

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

Representations on sanction

'38. We consider the following sanction is proportionate:

Striking-off Order

39. The aggravating features in this case include:

a. Lack of insight into failings; and

b. Conduct which put people receiving care at risk of suffering harm.

40. The mitigating features in this case are that the registrant worked to implement the action plan raised by the CQC to improve the conditions in the home around January 2023.

41. Due to the seriousness of the allegations 'no further action' and a caution order are not appropriate.

42. A conditions of practise order is not suitable as the Registrant's concerns are attitudinal in nature. It is submitted that there are no workable conditions which can be implemented. Further, conditions are likely to directly or indirectly put patents at risk of harm. Ms Berry is also not currently working and has expressed that she no longer wishes to work as a nurse, conditions are therefore unlikely to be successful.

43. A suspension order is also inappropriate because the charges relate to more than a single instance of misconduct. Ms Berry has also not provided any reflections and therefore poses a significant risk of repeating behaviour.

44. A striking-off order is appropriate because Ms Berry's actions are incompatible with the fundamental questions of professionalism in respect of her alleged dishonesty and lack of integrity. The guidance at SAN-3e indicates that the court have supported decisions to strike-off where there has been a lack of honesty or trustworthiness.

45. The NMC submits that public confidence cannot be maintained in the profession if Ms Berry is not struck off from the register. Cases were a registrant breaches the professional candour to be open and honest, including covering up and falsifying records, victimising/hindering colleagues from raising concerns or otherwise contributing to a culture which supresses openness about the safety of care will be considered particularly serious. Similarly, cases in which the registrant is directly responsible through management of exposing people receiving care to harm, especially where their evidence shows that they put their needs as a nurse, or the needs of the organisation before their duty to ensure the safety and dignity of people receiving care will also be considered particularly serious.

46. Ms Berry has placed residents at risk of harm (which ultimately materialised) due to her omissions. In respect of Resident C, she failed to ensure that safeguarding referrals were made urgently and that Resident C's family was informed. The guidance at SAN-3e states that safeguarding people form harm, abuse and neglect is an integral part of the standards and values set out in the code. Therefore, any allegation involving the neglect of vulnerable people will always be treated seriously.

47. Further, Ms Berry failed to appropriately carry out CPR in a timely manner. This may have reduced the success rate of the CPR. In addition to this, she herself provided the police/ambulance staff incorrect information and encouraged her colleagues to do the same. Following the above, Ms Berry made inaccurate records to Resident A's notes. This conduct was dishonest as it was an attempt to conceal her wrongdoing.

48. This conduct is contrary to the reasonable conduct which the public would expect from nurses. There is a real risk of serious damage to the public confidence if Ms Berry was allowed to continue practise given the seriousness of the allegations.

49. The above is supported by the Assistant Registrar's decision that this matter is not suitable for Agreed Removal because "[t]he concerns involve the kind of conduct that's fundamentally incompatible with being a registered professional and at this time, there's not enough information to understand the full scope and seriousness of the concerns".'

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found Ms Berry's 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. and regard to the NMC Guidance 'SAN-2: The

sanctions available' (last updated: 28 January 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:

- Ms Berry abused her a position of trust in that she pressured a junior colleague to lie to the police;
- Ms Berry's misconduct recklessly put those receiving care at risk of suffering harm;
- Ms Berry's actions breached sections of the Code;
- Ms Berry failed to attend this hearing and engage in the Fitness to Practise (FTP) process without good reason;
- Ms Berry has not demonstrated any insight;
- The misconduct in this case relates to vulnerable residents in a care home; and
- Ms Berry's dishonesty was premeditated in that she lied in her notes and to the police, and pressured a junior colleague to lie.

The panel considered the mitigating feature put forward by the NMC, specifically that Ms Berry worked to implement the action plan raised by the CQC to improve conditions at the Home. The panel was of the view that this was not relevant to the facts found proved and therefore does not act mitigation. The panel determined that there are no mitigating features in this case.

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 'SAN-2b: Caution order' 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 Ms Berry's 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 Ms Berry 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 Ms Berry's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance 'SAN-2c: Conditions of practice order'. Having regard to the nature and seriousness of Ms Berry's conduct, the panel considered her dishonesty and lack of integrity and that it was indicative of deep-seated attitudinal issues. The panel determined that, in these circumstances, it could not formulate workable conditions to protect patients and to uphold professional standards. Furthermore, the panel noted that Ms Berry has not returned to nursing since the incidents or engaged with the FTP process. The panel was of the view that there is no evidence before it which suggests Ms Berry would comply with a conditions of practice order. The panel therefore determined that a conditions of practice order would not be appropriate or proportionate.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on 'SAN-2d: Suspension order' in which the following factors on when a suspension order may be appropriate are set out:

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*

- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could possibly be managed by Ms Berry being temporarily removed from the Register, it considered that, due to the seriousness of the facts found proved, particularly the charges relating to dishonesty and her lack of integrity, and the deep-seated attitudinal issues identified, it would not be sufficient to uphold public confidence in the nursing profession and maintain professional standards. Given Ms Berry's lack of engagement, lack of insight and reflection, together with the lack of 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.

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

In considering a striking-off order, the panel had regard to the NMC Guidance *'*SAN-4: Sanctions for the highest risk cases'. In particular:

> *'Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):*

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- *misuse of power*
- *…*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception.*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *spontaneous conduct*
- *…*
- *incidents outside professional practice.'*

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 *'*SAN-2e: Striking-off order':

- *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 considered Ms Berry's conduct to raise fundamental questions about her professionalism, namely her dishonesty, lack of candour and the deep-seated attitudinal issues identified. As the panel considered Ms Berry's actions to be very serious, it

determined that to allow her to remain on the register and continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel noted that it has not had sight of any evidence in which Ms Berry has demonstrated insight, reflection or remediation. Therefore, the panel was not satisfied it had any evidence that, after a period of suspension, there would be a realistic prospect of Ms Berry gaining insight and strengthening her practice.

The panel determined that Ms Berry's actions were a significant departure from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register.

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

Interim order

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

Representations on interim order

The NMC made the following representations in respect of imposing an interim order:

> *'50. If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *51. If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with 15 continued registration, we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary to protect the public and otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

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

That concludes this determination.