Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 20 June 2024 – Friday 28 June 2024

Virtual Hearing

Name of Registrant:	**Stephen Thomas Hodgson**
NMC PIN:	12A1057E
Part(s) of the register:	Registered Nurse Sub part 1 Adult nurse, level 1 (12 March 2012)
Relevant Location:	Newcastle upon Tyne
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay Member) Helen Chrystal (Registrant Member) Sabrina Sheikh (Lay Member)
Legal Assessor:	Tracy Ayling KC
Hearings Coordinator:	Maya Khan
Nursing and Midwifery Council:	Represented by Uzma Khan, Case Presenter
Mr Hodgson:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 2, 3, 4a, 4b, 4c and 5
Facts proved by admission:	N/A
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Hodgson was not in attendance and that the Notice of Hearing letter had been sent to Mr Hodgson's registered email address by secure email on 24 April 2024.

Ms Khan, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the contact email address held by the NMC and which was evidenced by a screenshot in the service bundle. Ms Khan also referred the panel to the witness statement in the service bundle which confirmed that the Notice of Hearing had been sent to Mr Hodgson's email address on 24 April 2024.

Ms Khan submitted that the Notice of Hearing has been served in good time and the NMC has complied with the requirements of Rules 11 and 34 of the Rules.
The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Hodgson's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.
In light of all of the information available, the panel was satisfied that Mr Hodgson has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Hodgson

The panel next considered whether it should proceed in the absence of Mr Hodgson. It had regard to Rule 21 and heard the submissions of Ms Khan who invited the panel to continue in the absence of Mr Hodgson.

Ms Khan told the panel that this hearing has already been adjourned once. She informed the panel that this hearing was initially scheduled for March 2024, but this did not take place as Mr Hodgson's legal representative was unavailable. Ms Khan said

Notice was served to Mr Hodgson in April 2024 where the June 2024 dates were confirmed to him. Mr Hodgson then responded to the NMC on 10 May 2024 stating that the June dates were not suitable for him due to an event taking place in his personal life. She referred the panel to the preliminary meeting determination dated 5 June 2024 in respect of an application for a further adjournment of this hearing which was refused. Ms Khan also told the panel that Mr Hodgson's legal representative informed the NMC that they are no longer representing him on 6 June 2024.

Ms Khan provided the panel with a 'Proceeding in Absence' (PIA) bundle including several attempts by the NMC to contact Mr Hodgson by email and telephone regarding his attendance at the hearing today. The PIA bundle included the following:

- Email from the NMC case officer dated 7 June 2024.
- Letter to Mr Hodgson enclosing the hearing bundles and asking about attendance on 12 June 2024.
- Email from the NMC case officer dated 17 June 2024.
- Email from Royal College of Nursing confirming that they are no longer representing Mr Hodgson dated 6 June 2024.

Ms Khan also referred the panel to an email from the Hearings Coordinator sent to Mr Hodgson dated 19 June 2024 asking him to confirm his attendance. However, there was no response from Mr Hodgson. It was Ms Khan's submission that the NMC have exhausted all efforts to contact Mr Hodgson and he has voluntarily absented himself.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Mr Hodgson. In reaching this decision, the panel considered the submissions of Ms Khan and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General*

Medical Council v Adeogba [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- The NMC have exhausted all efforts to contact Mr Hodgson.
- This hearing has already been postponed once.
- An application for an adjournment has already been refused.
- There has been no engagement or information from Mr Hodgson about his circumstances and therefore there is no guarantee that a further adjournment would secure his attendance.
- There are seven witnesses who are due to give live evidence in this case; not proceeding may inconvenience the witnesses and their employer(s).
- The charges relate to events that occurred in 2021 and further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Hodgson by proceeding in his absence. The evidence upon which the NMC relies has been sent to him. He will not be able to challenge the evidence relied upon by the NMC in person nor will he be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Hodgson. The panel will draw no adverse inference from Mr Hodgson' absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) On the night shift of 11-12 February 2021:

a) Did not take observations for Patient B.
b) Inaccurately recorded observations for Patient B that had not taken place.
c) Asked Colleague A to move Patient B to another department without the correct observations being done.
d) Incorrectly informed Colleague A that Patient B was ‘on room air’ when they were still using an oxygen mask.
e) Incorrectly informed Colleague A that you had been instructed to take Patient B off oxygen.

2) Your actions in charge 1b above were dishonest, in that you intended to mislead colleagues that you had taken observations when you had not.

3) Your actions in charge 1e above were dishonest, in that you intended to mislead Colleague A that you received these instructions when you had not.

4) On the night shift of 11-12 March 2021:
a) Did not take observations for Patient A
b) Inaccurately recorded observations for Patient A that had not taken place
c) Struck out the observations you had recorded for Patient A at a later time

5) Your actions in charge 4 above were dishonest, in that you intended to mislead colleagues that you had taken observations when you had not.

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

Background

Mr Hodgson joined the NMC register on 12 March 2012 and commenced employment at Northumbria Healthcare NHS Foundation (the Trust) on 26 September 2016 as a Band 5 nurse.

On 3 November 2021, the NMC received a referral from the Director of the Trust in relation to an alleged incident which took place during a night shift on 11 February 2021. Patient B was brought into the emergency care department by a paramedic, and Mr Hodgson advised a colleague that he had conducted observations on Patient B. Mr Hodgson was witnessed not to have conducted the observations and recorded arbitrary data in the patient's electronic record system.

A further incident took place on 11 and 12 March 2021 where Mr Hodgson had not undertaken observations in respect of Patient A, who had been brought in for triage, and inaccurately recorded observations for Patient A, with his set of the observations subsequently struck out. Further, he is alleged to have provided inaccurate information in respect of Patient A to colleagues.

The Trust carried out a full investigation which led to a disciplinary finding. The disciplinary hearing which was held on 20 May 2021 resulted in Mr Hodgson's dismissal. This was subsequently appealed but the appeal panel upheld the original decision.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Hodgson.

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

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

- Ms 1: Senior Sister and Emergency Department Unit Manager at the Trust
- Colleague A: Band 5 A&E Nurse at the Trust
- Ms 3: Registered Nurse employed as Nurse at the Trust
- Ms 4: Trainee Nursing Associate at the time of the incident
- Mr 5: Registered Nurse employed by the Trust in the emergency department
- Mr 6: Registered Nurse and employed as an Operations Manager at the Trust

The panel also saw written evidence from Dr 7, a doctor on duty at the time of incident on 11-12 February 2021.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred it to the cases of *Ivey v Genting Casinos* [2017] UKSC 67 and *R v Barton and Booth* [2020] EWCA Crim 575. It considered the witness and documentary evidence provided by the NMC.

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

Charge 1

That you, a registered nurse:

1) On the night shift of 11-12 February 2021
    a) Did not take observations for Patient B

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from two witnesses, Ms 1 and Colleague A, and the document *'Discussion with Stephen Hodgson Band 5 ED RN regarding concerns on nightshift 11/2/21 – concerns/allegations'* produced by Ms 1.

The panel took account of Colleague A's witness statement which stated:

> *'Throughout the shift on 11 February 2021, I felt that Stephen was avoiding doing the more "menial" tasks that didn't interest him. When someone was very poorly, he would be there ready to "go, go, go", but as soon as the person was stable, he was nowhere to be seen. I was left with all the clearing up and doing patient checks. When I came back from my break, I found Stephen stood around chatting even though there was plenty of work to do.'*

The panel had sight of the document titled *'Discussion with Stephen Hodgson Band 5 ED RN regarding concerns on nightshift 11/2/21 – concerns/allegations'* produced and signed by Ms 1 and Mr Hodgson on 26 February 2021. The document stated:

> *'12/2/21 – I met with Stephen in the ED office regarding incident on night of 11/2/21…*
>
> - *Stephen immediately apologised after hearing these concerns and stated that he had not performed appropriately on the shift.'*

The panel considered that the oral and written evidence of both Colleague A and Ms 1 were consistent.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 February 2021, Mr Hodgson did not take observations for Patient B. Accordingly, the panel found Charge 1a proved on the balance of probabilities.

Charge 1b

That you, a registered nurse:
1) On the night shift of 11-12 February 2021
b) Inaccurately recorded observations for Patient B that had not taken place.

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Colleague A, Dr 7 and the document *'Discussion with Stephen Hodgson Band 5 ED RN regarding concerns on nightshift 11/2/21 – concerns/allegations'* produced by Ms 1.

The panel took account of Colleague A's witness statement which stated:

> *'I then discovered that he had falsified observations for a patient ("Patient B") and avoided carrying out the relevant checks. Stephen had told me that Patient B was on room air, but when I went to attend to her, I noticed she was still on a mask. Initially, I thought Stephen may have just made a mistake. However, I then noticed that the blood pressure recorded by Stephen was completely different to what was showing on the machine. Stephen had also told me that Patient B wasn't responding, yet I found her to be alert. Everything Stephen had recorded was completely different to what I could see.'*
>
> *'I was also concerned about the blood pressure reading Stephen had entered while I was on my break. The blood pressure monitor hadn't been cycled for 1 hour 21 minutes, yet he had recorded 35 a reading minutes ago. This reading wasn't visible anywhere on the monitor. I do not know where that blood pressure reading could have come from, other than Stephen had falsified it.'*

The panel had sight of the document titled *'Discussion with Stephen Hodgson Band 5 ED RN regarding concerns on nightshift 11/2/21 – concerns/allegations'* produced and signed by Ms 1 and Mr Hodgson on 26 February 2021. The document stated:

'12/2/21 – I met with Stephen in the ED office regarding incident on night of 11/2/21…

- *Stephen stated that he did incorrectly input patient observations and should have checked the patient properly prior to going on his break.*
- *Stephen accepts that he should have provided continuity in care by taking his patients up to the ward. And that this is not acceptable.*
- *Stephen acknowledges that his communication with his colleague was poor and his attitude was not in keeping with trust values.'*

The panel took account of Dr 7's witness statement which stated:

'I recall that observations were taken by [Colleague A], who then went on a break. These were repeated by Stephen and the NEWS score dropped as a result. When [Colleague A] came back, she queried the [observations] and later showed me on the blood pressure monitor that they had not been taken. [This] incident was also discussed with one of the charge nurses. It looked as though the observations had just been guessed. I felt this may have been Stephen being a bit work avoidant, as the lowered NEWS meant he would not need to transfer the patient. This reflects how Stephen was generally - if something was interesting, he'd be right there; otherwise, he wasn't very forthcoming.'

The panel considered that the written evidence of both Colleague A and Dr 7 were consistent.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 February 2021, Mr Hodgson inaccurately recorded observations for Patient B that had not taken place. Accordingly, the panel found Charge 1b proved on the balance of probabilities.

Charge 1c

That you, a registered nurse:

1) On the night shift of 11-12 February 2021

c) Asked Colleague A to move Patient B to another department without the correct observations being done.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Colleague A.

The panel took account of Colleague A's witness statement which stated:

> *'…when I returned from my second break, Stephen told me that Patient B had a bed on another ward (HASU) and was ready for a transfer. I asked Stephen to wait before going on his break, as I knew that Patient B would need an escort. Stephen told me that Patient B did not need an escort because her NEWS score was now 4. He also told me that Patient B was now on room air. It was while I was attending to Patient B that I became concerned about the observations Stephen had recorded for her. I also became concerned about the information Stephen had handed over to me verbally about Patient B's condition.'*

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 February 2021, Mr Hodgson asked Colleague A to move Patient B to another department, without the correct observations being done as found proven in charge 1a and 1b. Accordingly, the panel found Charge 1c proved on the balance of probabilities.

Charge 1d

That you, a registered nurse:

1) On the night shift of 11-12 February 2021

d) Incorrectly informed Colleague A that Patient B was ‘on room air’ when they were still using an oxygen mask.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Colleague A.

The panel took account of Colleague A’s witness statement which stated:

> *‘[Stephen] told me that Patient B was now on room air. It was while I was attending to Patient B that I became concerned about the observations Stephen had recorded for her. I also became concerned about the information Stephen had handed over to me verbally about Patient B’s condition.’*

The panel considered that during the oral evidence of Colleague A, she explained that she remembers Mr Hodgson informing her that Patient B was on ‘on room air’ because as stated in her written witness statement *‘this really doesn’t happen often’.* Colleague A said a patient must be gradually weaned off an oxygen mask before returning to room air and therefore it was highly unlikely that Patient B would be ‘on room air’.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 February 2021, Mr Hodgson incorrectly informed Colleague A that Patient B was ‘on room air’ when they were still using an oxygen mask. Accordingly, the panel found Charge 1d proved on the balance of probabilities.

Charge 1e

That you, a registered nurse:

1) On the night shift of 11-12 February 2021

e) Incorrectly informed Colleague A that you had been instructed to take Patient B off oxygen.

This charge is found proved.

In reaching this decision, the panel took into account the written evidence from Colleague A, Dr 7 and the Investigation Report produced by the Investigation Officer Mr 6.

The panel took account of Colleague A's witness statement which stated:

> *'Stephen had told me that Patient B was on room air, but when I went to attend to her, I noticed she was still on a mask. Initially, I thought Stephen may have just made a mistake. However, I then noticed that the blood pressure recorded by Stephen was completely different to what was showing on the machine. Stephen had also told me that Patient B wasn't responding, yet I found her to be alert. Everything Stephen had recorded was completely different to what I could see '.'*
> *'When I asked about the oxygen, he said that [Dr 7] had told him to take this off. I explained I had spoken to [Dr 7] about this. I also asked Stephen, "How many patients have you had where you've completely removed O2 and not had to wean it down?" Stephen became very defensive at this point. He accused me of having a bad attitude. I explained that I knew I had to report my concerns and, as I didn't know Stephen that well, I hadn't felt comfortable to approach him directly by myself. In relation to the blood pressure readings, Stephen said that he had taken them, but they'd now been removed from the monitor. I suggested that IT might be able to recover them, but he became less defensive and quietened down at that point. I told Stephen that I hadn't reported him to be horrible, but I was concerned about patient safety. I explained that it is my role to raise concerns if I have them and I would expect Stephen to do the same if he had concerns about me or my practice.'*

The panel considered Dr 7's written statement which stated:

‘I can't recall having a conversation with Stephen about the patient. I think it is unlikely I would have told Stephen to take the patient off their oxygen completely - it is more likely that I would have suggested weaning the patient off the oxygen gradually. It is possible that I may have had a conversation with Stephen about taking oxygen off another patient and Stephen could have misunderstood which patient I was referring to.’

The panel considered the written evidence of Colleague A, Dr 7 and Mr 6’s investigation report to be consistent.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 February 2021, Mr Hodgson informed Colleague A that he had been instructed to take Patient B off oxygen. Accordingly, the panel found Charge 1e proved on the balance of probabilities.

Charge 2

2) Your actions in charge 1b above were dishonest, in that you intended to mislead colleagues that you had taken observations when you had not.

This charge is found proved.

The panel first considered its previous findings with respect to Charge 1b.
The panel then went on to consider whether Mr Hodgson’s actions in relation to Charge 1b were dishonest. It had regard to the test set out in *Ivey v Genting Casinos* which outlines the following*:*

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

The panel also had regard to the NMC Guidance entitled *‘Making decisions on dishonesty charges’ (reference DMA 8)* updated on 27 February 2024. Within this Guidance, Fitness to Practise Committee (FtPC) panels are advised to decide whether

the conduct indeed took place and if so, what was the registrant's state of mind at the time. Panels are reminded to consider the following:

- *'What the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*
- *Whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *Whether there is evidence of alternative explanations, and which is more likely.'*

The panel is satisfied that Mr Hodgson was dishonest in his actions. In reviewing the evidence in relation to charge 1b, the panel considered the oral and written evidence from Colleague A.

The panel heard from Colleague A and considered the written evidence which stated:

> *'The temperature reading Stephen recorded for Patient B also didn't match up with the reading I took…Stephen recorded Patient B's temperature as 37.9, whereas I recorded the temperature to be 35.9. This is a temperature difference of two degrees, which is quite a significant change to take place in just 30 minutes. Such a quick temperature change doesn't really happen, unless the patient already has a very high temperature and we are administering antibiotics whilst actively taking measures to cool them down. This did not apply to Patient B, who was in a hospital bed covered in blankets. It was not cold in the room. The only explanation I can think of for the different readings would be if Stephen had used a different thermometer to me – but there was already a thermometer in the room when I came in. I can't understand why that thermometer would it be there if it wasn't the thermometer used by Stephen.'*
>
> *'…In relation to the blood pressure readings, Stephen said that he had taken them, but they'd now been removed from the monitor. I suggested that IT might be able to recover them, but he became less defensive and quietened down at that point. I told Stephen that I hadn't reported him to be horrible, but I was concerned about patient safety. I explained that it is my role to raise concerns if I*

have them and I would expect Stephen to do the same if he had concerns about me or my practice.

… I understand that Stephen was spoken to the next day and admitted to falsifying the observations.'

The panel considered whether there was any alternative explanation for why Mr Hodgson recorded observations for Patient B which in fact did not take place, such as the ward being busy. However, it took account of the oral evidence from Colleague A who said that the ward was not busy at all and therefore Mr Hodgson faced no difficulty or delay in his responsibility to conduct Patient B's observation.

The panel considered that Mr Hodgson was an experienced nurse, recently selected for promotion to a Band 6 role, in a position of trust and would have been expected to know the implications of failing to conduct observations on a patient which is indicative of his state of mind to conceal his lack of activity.

Having regard to all the evidence, the panel determined, Mr Hodgson's actions in relation to Charge 1b would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found that Mr Hodgson's actions at Charge 1b were dishonest in that he intended to mislead colleagues that he had taken observations when he had not. The panel therefore found Charge 2 proved on the balance of probabilities.

Charge 3

3) Your actions in charge 1e above were dishonest, in that you intended to mislead Colleague A that you received these instructions when you had not.

This charge is found proved.

The panel first considered its previous findings with respect to Charge 1e.

The panel is satisfied that Mr Hodgson was dishonest in his actions. In reviewing the evidence in relation to charge 1e, the panel considered the oral and written evidence from Colleague A and Dr 7.

The panel considered that Mr Hodgson was an experienced nurse, recently selected for promotion to a Band 6 role, in a position of trust and would have been expected to know the implications of taking a patient off oxygen. The panel considered it more likely than not that his telling Colleague A that he was told to do so as per the doctor's instructions was untrue and intended to conceal the fact that his initial statement to Colleague A had been revealed as misleading.

Having regard to all the evidence, the panel determined that Mr Hodgson's actions in relation to Charge 1e would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found that Mr Hodgson's actions at Charge 1e were dishonest in that he intended to mislead Colleague A that he received these instructions when he had not.

The panel therefore found Charge 3 proved on the balance of probabilities.

Charge 4

4) On the night shift of 11-12 March 2021:

a) Did not take observations for Patient A

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Ms 3 and Ms 4.

The panel took account of Ms 3's witness statement which stated:

‘At the time of the incident, the student nurse [Ms 4] highlighted to me that the registrant had not recorded any observations. I do not recall seeing the registrant take any observations and was informed that the patient would be moved directly to a room in red zone. I did not see him examine the patient. The registrant made some notes on the computer, I did not see which notes he added or completed, instead of taking observations. To the best of my recollection, I can be sure the nurse did not take any observations because I was present throughout the handover and assisted in taking the observations myself once the registrant had gone for his break [Mr 5] another nurse had taken over from the registrant.’

The panel also considered Ms 4’s written statement which stated:

‘It was everyone’s duty to look after the patient regardless of our grades. Anyone could have conducted the observations but Stephen did not delegate this to neither of us before going on his break. As I said in my statement, I did not see Stephen leave his chair to take any observations.’

The panel considered that the written evidence of both Ms 3 and Ms 4 were consistent. It further considered that during both Ms 3 and Ms 4’s oral evidence, they told the panel that there was no reason for Mr Hodgson to fail his duty to conduct observations for Patient A as the ward was quiet and Patient A was the only patient.

In the Trust’s fact-finding interview on 12 March 2021 directly after the night shift, Mr Hodgson said *‘Don’t think I done her obs, think it was one of the HCA’s’.*

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 March 2021, Mr Hodgson did not take observations for Patient A. Accordingly, the panel found Charge 4a proved on the balance of probabilities.

Charge 4b

4) On the night shift of 11-12 March 2021:

b) Inaccurately recorded observations for Patient A that had not taken place

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence from Ms 4.

The panel took account of Ms 4's witness statement which stated:

> *'When [Mr 5] took over from Stephen so he could go on his break When Stephen left, [Mr 5] asked me if anything needs to be done, I informed him that the observations hadn't been done. The paramedic also confirmed that this. [Mr 5] and I conduced the observations. When I went to input the observations on Nerve Centre, I realised that Stephen had already inputted observations. At the time, I wasn't aware that the observations had been struck out – they were not struck at the time we did our observations. I cannot recall the timing, but I believe we conducted the observations within a short time of Stephen leaving the corridor.'*

Whilst Mr 5 also looked at Nerve Centre and said he could not remember seeing a previous set of observations recorded or struck out, the panel preferred Ms 4's evidence as her memory was clearer whereas Mr 5 openly said during his oral evidence that he could not remember all the details. It considered the written evidence of Ms 4 and the investigation report produced by Mr 6 to be consistent.

In the Trust's investigatory meeting with Mr Hodgson on 12 March 2021 directly after the night shift, he said he could not remember inputting observations and could not offer an explanation about how they had been put into the system. In the Trust's investigatory meeting with Mr Hodgson on 23 April 2021 he denied writing down his log-in details in a way that could be accessed by other staff members.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 March 2021, Mr Hodgson inaccurately recorded observations for Patient A that had not taken place. Accordingly, the panel found Charge 4b proved on the balance of probabilities.

Charge 4c

4) On the night shift of 11-12 March 2021:

c) Struck out the observations you had recorded for Patient A at a later time

This charge is found proved.

In reaching this decision, the panel took into account its previous findings in relation to charge 4b and considered the investigation report produced by Mr 6.

The panel had sight of the electronic records of Mr Hodgson's log ins into the Nerve Centre which appeared to show him searching for records and a screenshot of a struck-out record. It then considered the written evidence of Ms 4 (as set out above) in relation to charge 4c. The panel concluded that the written evidence of Ms 4 and the investigation report produced by Mr 6 to be consistent. Although this evidence was not corroborated by Mr 5, the panel noted that he was unsure about many details after the passage of time.

In the Trust's fact-finding meeting on 12 March 2021, Mr Hodgson did not provide an alternative explanation as to how his Nerve Centre account had been used to input and then strike out Patient A's observations and he was adamant that he had not revealed his log in details to anyone else.

Having regard to the evidence, the panel was satisfied that on the night shift of 11-12 March 2021, Mr Hodgson struck out the observations he had recorded for Patient A at a later time. Accordingly, the panel found charge 4c proved on the balance of probabilities.

Charge 5

5) Your actions in charge 4 above were dishonest, in that you intended to mislead colleagues that you had taken observations when you had not.

This charge is found proved.

The panel first considered its previous findings with respect to Charge 4.

The panel is satisfied that Mr Hodgson was dishonest in his actions. In reviewing the evidence in relation to charge 4.

The panel bore in mind that Ms 3 and Ms 4, during their oral evidence, said that there was no reason for Mr Hodgson to fail in his duty to conduct observations for Patient A as the ward was quiet and Patient A was the only patient.

The panel considered the Investigation Report produced by Mr 6. It considered the Disciplinary Hearing notes dated 20 May 2021 in which Mr Hodgson was asked the reasons why the records were struck out. The notes stated:

> *'[Q]: Did you log on and scratch that record out?*
> *SH: No*
> *[Q]: Is there a reason you think anyone else would have? What would have been the motivation for someone to log in to your details, for that patient and scratch those out?*
> *SH: I can't comment'*

The panel considered that Mr Hodgson was an experienced nurse, recently selected for a promotion to a Band 6 role, in a position of trust and would have been expected to know the implications of failing to conduct observations on a patient which is indicative of his state of mind to conceal his lack of activity in not conducting the observations. The panel, having considered the electronic records, came to the conclusion that it was more likely than not that, after being challenged by Ms 4 whilst exiting the ward for his break, he had then attempted to cover his tracks by striking out the false record from another device during his break.

Having regard to all the evidence, the panel determined that Mr Hodgson's actions in relation to Charge 4 would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found that Mr Hodgson's actions at Charge 4 were dishonest in that he intended to mislead colleagues that he had taken observations when he had not. The panel therefore found Charge 5 proved on the balance of probabilities.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Khan invited the panel to take the view that the facts found proved amount to misconduct. She identified the specific, relevant standards where Mr Hodgson's actions amounted to misconduct. She drew the panel's attention to a number of sections of the Code that she said had been breached.

Ms Khan submitted that although there is no evidence before the panel to suggest that any patients were harmed by the conduct, there was a considerable risk of harm as Mr Hodgson not only failed to take observations in relation to two patients; he also falsified observations. She submitted that Mr Hodgson acted dishonestly in his practice by placing two patients at risk of serious harm.

Ms Khan submitted that, in all of the circumstances of the case, Mr Hodgson's actions and the charges proved are a departure from good professional practice and are sufficiently serious to constitute serious misconduct.

Submissions on impairment

Ms Khan moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). In paragraph 76 of *CHRE v NMC and Grant*, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Khan submitted that all four limbs of *Grant* are engaged. In relation to the first limb, Ms Khan submitted that Mr Hodgson had directly put patients at risk of harm. She submitted that these patients were vulnerable from the outset, requiring emergency treatment and Mr Hodgson failed to evaluate and assess their needs.

In relation to the second and third limbs, Ms Khan submitted that Mr Hodgson put patients at risk of harm on more than one occasion, first in February 2021 and then again in March 2021. She submitted that Mr Hodgson's actions have brought the nursing profession into disrepute, and he has breached fundamental tenets of the nursing profession by failing to promote professionalism and trust and acting in a thoroughly dishonest manner by falsifying records. She submitted that those records would have been relied on by other colleagues and if the records did not reflect the accuracy of the patient's circumstances, incorrect treatment could have been given to those patients, placing them at risk of serious harm.

Ms Khan submitted that registered professionals occupy a position of trust in society. She submitted that the public expects nurses to provide safe and effective care and conduct themselves in a way that promotes trust and confidence. She submitted that the conduct in this case undermines the public's trust and confidence in the profession and could result in patients, and members of the public, being deterred from seeking nursing assistance when needed.

In relation to the fourth limb, Ms Khan submitted that the NMC considers there to be a continuing risk to both public protection and the wider public interest due to Mr Hodgson's actions which are directly linked to his clinical practice and dishonesty. Ms Khan submitted that despite Mr Hodgson's acknowledgement of the incidents in February 2021, he repeated the same behaviour a month later in March 2021 and therefore there is a risk of repetition and a risk of significant harm to patients in the future should Mr Hodgson be permitted to practise as a nurse again.

Ms Khan invited the panel to find impairment on the ground of public protection. She submitted that dishonesty is difficult to remediate. She submitted that Mr Hodgson has not submitted a reflective statement to the panel, he failed to attend this hearing and there is no evidence that he has addressed any concerns or risks identified in the case and therefore there remains a risk of repetition of the relevant misconduct.

Ms Khan also invited the panel to find impairment on the ground of public interest. She submitted that Mr Hodgson's breaching the professional duty of candour by covering up

what he had done is deplorable and amounts to serious misconduct. The conduct of Mr Hodgson has brought the nursing profession into disrepute and served to undermine public confidence and trust in the profession. She submitted that Mr Hodgson's conduct raises fundamental questions about his integrity and trustworthiness as a registered professional and seriously undermines public trust in nurses, midwives and nursing associates.

The panel accepted the advice of the legal assessor which included reference to the principles contained in *Grant* and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

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 also had regard to the NMC's Guidance on misconduct (FTP-2a) and the Guidance on seriousness, with particular regard to dishonesty (FTP-3). The panel also bore in mind the context in which these charges arose, pursuant to the Guidance.

The panel considered the 'Introduction' section of the Code, which outlined:

> '*The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary*.'

The panel was of the view that Mr Hodgson's actions did fall significantly short of the standards expected of a registered nurse, and that his 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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

4 Act in the best interests of people at all times

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

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

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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…

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

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 found that Mr Hodgson's actions both individually and collectively did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct. The panel determined that honesty is a fundamental tenet of nursing, and Mr Hodgson's dishonest conduct was deliberate and repeated despite being found out on the first occasion.

The panel considered Mr Hodgson's action in that he repeatedly failed to conduct observations, falsified patient records, incorrectly informed Colleague A that Dr 7 had given him instructions to take Patient A off oxygen when this had not happened, and he attempted to cover up his dishonesty by striking out the patient records on the Nerve Centre system. The panel considered that Mr Hodgson was in a position of trust as an experienced nurse recently promoted to a Band 6 role.

The panel considered the NMC Guidance (reference: FTP-3a) on *'Seriousness',* which states as follows, is engaged in this case:

> *'breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records…or otherwise contributing to a culture which suppresses openness about the safety of care…'*

For the reasons above, the panel concluded that Mr Hodgson's actions both individually and collectively amounted to misconduct.

Decision and reasons on impairment

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

The panel was aware that there is no statutory Guidance on what constitutes impairment. However, it was guided by NMC Guidance and the leading Case of *Grant.* In paragraph 76 of *CHRE v NMC and Grant*, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

With regard to the first limb, the panel considered that Patient A and Patient B were both vulnerable patients in an emergency setting. The panel had regard to the evidence of Ms 1, Colleague A, Ms 3 and Ms 4 and determined that this evidence was sufficient for it to find that Patient A and Patient B were put at serious risk of harm as a result of Mr Hodgson's failure to conduct observations, falsifying patient records and wrongly informing Colleague A of instructions he said were given by Dr 7.

With regard to the second and third limbs, the panel found that Mr Hodgson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel determined that it is a fundamental tenet of nursing for a registrant to be open and honest, and to act with integrity. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find that Mr Hodgson's misconduct was a breach of the fundamental tenets of the profession.

With regard to the fourth limb, the panel had found that Mr Hodgson had been dishonest on more than one occasion. It took account that Mr Hodgson accepted his failings and had acknowledged his conduct in the incidents on 11/12 February 2021, but he repeated the same type of dishonest behaviour a month later on 11/12 March 2021. The panel considered that during the Trust's investigation interview Mr Hodgson stated "no comment" when asked why he had struck out the patient records in relation to the incidents of March 2021. As a result, the panel is not satisfied that the conduct would not be repeated.

With regard to future risk, the panel considered the comments of Silber J in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) namely (*i) whether the concerns*

are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.

The panel was not satisfied that the misconduct in this case is capable of being easily remediated. It also took account of the fact that Mr Hodgson had not produced any evidence for the panel today demonstrating strengthened practice. There is no reflective statement to show that Mr Hodgson acknowledges the harm he has caused to Patient A, Patient B and colleagues or how he would act in the future. The panel determined that Mr Hodgson's repeated dishonesty in March 2021 following his acceptance of his failings in February 2021, is indicative of attitudinal concerns. It determined that, in light of these circumstances, the concerns in this case would be extremely difficult to remediate and the panel had no evidence before it of any attempt to do so.

The panel is of the view that there is a risk of repetition based on the facts found proved in this case and that this was not a one-off incident. It considered that Mr Hodgson's dishonesty, in a case such as this, was not easy to remediate and he failed to demonstrate any insight and remediation. It reminded itself of the NMC Guidance (reference: FTP-3a) on *'Seriousness'* and determined that Mr Hodgson deliberately breached the professional duty of candour by covering up when things had gone wrong. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 a fully informed member of the public would be concerned if allegations of this nature which are serious, were not to result in an impairment finding given the repeated history of both lack of patient care and dishonest acts.

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 Mr Hodgson's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Hodgson's 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 Mr Hodgson off the register. The effect of this order is that the NMC register will show that Mr Hodgson 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 careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Khan submitted that the NMC would seek the imposition of a striking off order. She submitted that a striking-off order is the only order that would maintain public confidence in the profession and uphold proper standards of conduct and behaviour. She submitted that a striking-off order is proportionate to the findings of the panel in respect of the charges and the subsequent decision in respect of impairment and misconduct.

Ms Khan outlined what she said were the aggravating and mitigating features in this case. She submitted that the alternative sanctions the panel has the power to consider would not sufficiently protect the public. Mr Hodgson failed to conduct observations for vulnerable patients in an emergency setting, fraudulently recorded observations, thereby putting those patients at risk of serious harm, and wrongly informed Colleague A of instructions he said were given by Dr 7. She submitted that these were all dishonest behaviours and indicate attitudinal problems. She further submitted that Mr Hodgson's initial misconduct was repeated one month after his failings in February 2021 were

brought to his attention, which demonstrates a *'pattern of dishonesty'.* She submitted that the panel has no evidence of remediation or insight from Mr Hodgson and therefore he remains a risk to public safety.

Ms Khan submitted that allowing Mr Hodgson to continue practising would undermine public confidence in the profession and the NMC as the regulator. She asked the panel to consider a striking-off order to mark the importance of protecting the public and to maintain public confidence in the profession.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found that Mr Hodgson's fitness to practise is currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- There was a repetition of the misconduct in March 2021 despite his failings in February 2021 being brought to his attention.
- Mr Hodgson's misconduct put patients at risk of harm; those patients were vulnerable by reason of their being in the resuscitation room.
- Mr Hodgson was an experienced nurse who was in a position of trust having recently been selected for promotion to a Band 6 role.
- Mr Hodgson's misconduct indicates a serious deep seated attitudinal problem.
- Dishonesty is always serious, and this was towards the higher end of the spectrum.
- Lack of meaningful engagement with the NMC, providing the panel with no evidence of remorse, insight or his understanding of the effect of dishonesty on the reputation of the profession.

The panel could not identify any mitigating features in this case.

The panel took into account the NMC's Guidance on 'Considering sanctions for serious cases' (SAN-2). In examining the factors in 'Cases involving dishonesty', the panel found that none of the factors at the less serious end of the spectrum were engaged. By contrast, it considered that many of the serious factors were engaged, including:

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

The panel considered that Mr Hodgson was in a position of power as an experienced nurse recently selected for promotion to a Band 6 role and therefore, he should have fully understood the serious implications and risk of harm of his failure to conduct observations and his falsification of patient records. The panel considered Mr Hodgson's actions to be premeditated as he deliberately inserted false data into the Nerve Centre system knowing this data would be relied upon by other colleagues and therefore put patients at direct risk of harm.

The panel went on to consider the background of the incidents which included evidence from Colleague A, Dr 7 and Ms 4.

In Colleague A's witness statement, it was stated:

> *'Throughout the shift on 11 February 2021, I felt that Stephen was avoiding doing the more "menial" tasks that didn't interest him. When someone was very poorly, he would be there ready to "go, go, go", but as soon as the person was stable, he was nowhere to be seen.'*

In Dr 7's witness statement, it was stated:

> *'I felt this may have been Stephen being a bit work avoidant, as the lowered NEWS meant he would not need to transfer the patient. This reflects how Stephen was generally - if something was interesting, he'd be right there; otherwise, he wasn't very forthcoming.'*

In the Trust's 'Witness Investigation Statement' of Ms 4 dated 25 March 2021, she stated in response to a question:

> *'…I don't usually work with [Mr Hodgson] I wouldn't feel comfortable raising it with [Mr Hodgson] as I find he can be quite unapproachable and dismissive…'*

The panel determined that the above factors and the written evidence are indicative of Mr Hodgson having a deep-seated attitudinal problem.

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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Hodgson's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Hodgson's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing a conditions of practice order on Mr Hodgson's registration would be a sufficient and appropriate response. The panel determined that there are no practicable or workable conditions that could be

formulated, given the nature and seriousness of the charges in this case. The misconduct identified in this case was attitudinal in nature and therefore not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Hodgson's registration would not adequately address the seriousness of his misconduct and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The panel considered that Mr Hodgson's misconduct consisted of a repeated instance of putting patients at risk of harm and dishonesty despite receiving a warning a month prior. It took the view that Mr Hodgson's dishonesty is at the higher end of the spectrum and is indicative of a deep-seated attitudinal problem. The panel also bore in mind that it had no evidence of remorse or insight before it from Mr Hodgson. Therefore, it found a consequent risk of repetition.

The panel considered that Mr Hodgson's misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that the serious breach of the fundamental tenets of the profession evidenced by Mr Hodgson's actions is fundamentally incompatible with his remaining on the register as a nurse.

The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in his case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel considered that Mr Hodgson's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with his remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Hodgson's actions were serious and to allow him to continue practising put patients at risk and 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 effect of Mr Hodgson's actions in bringing the profession into disrepute by adversely affecting the public's view of how registered nurses should conduct themselves, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this order was also 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.

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 Mr Hodgson's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Khan. She invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive Striking-off order takes effect.

The panel heard and 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 as it concluded that to do otherwise would be incompatible with its earlier findings. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.

This will be confirmed to Mr Hodgson in writing.