Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
9 December 2019 – 17 December 2019

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Deborah Cooper
NMC PIN:	03C0023A
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse – Adult (17 February 2003)
Area of registered address:	England
Type of case:	Misconduct
Panel members:	Kathryn Eastwood (Chair, Registrant member) Pamela Campbell (Registrant member) Melissa D'Mello (Lay member)
Legal Assessor:	Nigel Mitchell
Panel Secretary:	Max Buadi
Nursing and Midwifery Council:	Represented by Katie Mustard, Case Presenter
Miss Cooper:	Not present and unrepresented
Facts proved:	1, 2, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 5, 22.3, 24 (in respect of 22.3), 27, 29, 34.3, 34.4, 35, 36.2, 37.1 39.1, 39.2, 40, 41.1 and 41.2
Facts proved by admission:	4.1, 4.2, 4.3, 6.1, 6.2, 6.3, 7, 8.1, 8.2, 9, 10.1, 10.2, 11, 12.1, 13, 14.1, 14.2, 15, 16.1, 16.2, 17, 18.1, 18.2, 19, 20.1, 20.2, 21, 22.1, 22.2, 23, 24 (in respect of 22.2), 25.1, 25.2, 26, 28, 30, 31, 32, 33, 34.1, 34.2, 36.1, 37.2 and 38

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 (Heard on Day 1)

The panel was informed at the start of this hearing that Miss Cooper was not in attendance and that the Notice of Hearing letter had been sent to Miss Cooper's registered address by recorded delivery and by first class post on 8 November 2019.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Miss Cooper's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Ms Mustard, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Cooper 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 Miss Cooper (Heard on Day 1)

The panel next considered whether it should proceed in the absence of Miss Cooper. The panel had regard to Rule 21(2), which states:

> *'**21.**— (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*
>
> *(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;*
>
> *(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or*
>
> *(c) may adjourn the hearing and issue directions.'*

Ms Mustard drew the panel's attention to an email from Miss Cooper's former representative, dated 21 November 2019. The representative informed the NMC that, as per Miss Cooper's instruction, she is no longer representing her.

Ms Mustard then drew the panel's attention to an email from Miss Cooper, dated 25 November 2019, which stated:

> *"I am writing to inform you that I will not be attending my hearing on 9th December and I will not be engaging with the hearing.*
>
> *I understand that the hearing will still go ahead and I will abide by their decision.*

I have become disillusioned with the nursing profession and will no longer be working as a registered nurse from the end of november 2019."

In a subsequent email, dated 27 November 2019, the NMC asked if she was content with the hearing proceeding in her absence. Miss Cooper responded, in an email on the same day:

"Yes that is fine with me."

Ms Mustard then drew the panel's attention to another email from Miss Cooper dated 6 December 2019. The NMC had asked her if she was still not going attend the hearing. She stated:

"…I am not attending, [PRIVATE]"

Ms Mustard submitted that Miss Cooper had stated in three emails that she was aware of the hearing, confirmed that she was not attending and consented to the panel proceeding in her absence. She also told the panel that Miss Cooper had not made a request for an adjournment. Ms Mustard submitted that the NMC had prepared for this hearing and have three witnesses due to attend. Ms Mustard submitted that there is a strong public interest in the expeditious disposition of the charges.

She invited the panel to continue in the absence of Miss Cooper on the basis that she had voluntarily absented herself.

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 has decided to proceed in the absence of Miss Cooper. In reaching this decision, the panel has considered the submissions of Ms Mustard, Miss Cooper's emails and the advice of the legal assessor. It has 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:

- No application for an adjournment has been made by Miss Cooper;
- Miss Cooper made it clear that she is not attending and is content for the hearing to proceed in her absence so adjourning serves no purpose;
- One witness is due to attend today to give live evidence, others are due to attend tomorrow;
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Cooper. The panel will draw no adverse inference from Miss Cooper's absence.

Details of charge (Heard on Day 1)

That you a registered nurse whilst working at the Islington House Surgery

1. On 16 February 2018 did not seek advice from a General Practitioner in relation to a head injury suffered by patient 3594;

2. On 31 January 2018 did not seek advice from a General Practitioner in relation to patient 2240

3. Acted outside the scope of your practice on one or more of the following occasions:

3.1 On 22 February 2018 carried out a vaginal examination on patient 7946;

3.2 On 15 January 2018 with respect to patient 2840 carried out a respiratory examination on the patient.

3.3 On 12 February 2018 did not seek advice in relation to patient 1196 prior to referring her to gynaecology.

3.4 On 23 January 2018 carried out a breast examination of patient 2729

3.5 On 6 February 2018 referred patient 561 for a community ECG instead of cardiology

3.6 On 20 February 2018 in relation to patient 2700 carried out a chest examination of the patient.

4. On 29 March 2018 added the following codes into the records of patient 4019

4.1 patient on maximal tolerated therapy for diabetes;

4.2 excepted from asthma quality indicators: informed dissent

4.3 seasonal influenza vaccination denied

5. Your actions at charge 4 were dishonest in that you added the codes at 4.1-4.3 in order to create the impression that the patient had been contacted/seen on 29 March 2018 when you knew they had not.

6. On 2 February 2018 added the following into patient 2450 records dated 26 October 2017

6.1 that a COPD annual review had taken place;
6.2 that oxygen saturation was at periphery 98%
6.3 there was a grade 4 on the MRC breathlessness scale

7. Your actions at charge 6 were dishonest in that you did not attend the home visit on the 26 October 2017 therefore you knew that the entries referred to at charges 6.1 – 6.3 were false.

8. On 10 March 2017 recorded on patient 2385 records that the following had taken place on 25 January 2018;

8.1 A chronic obstructive pulmonary disease annual review
8.2 MRC Breathlessness Scale : grade 4

9. Your actions at charge 8 was dishonest in that you sought to create the impression that patient 2385 had been reviewed on the 25 January 2018/and or 10 March 2018 when you knew that this was not the case.

10. On 2 February 2018 edited the telephone consultation notes for patient 1825 dated 24 January 2018 to add

10.1 that a chronic obstructive pulmonary disease annual review had taken place

10.2 recorded that a grade 4 on the MRC breathlessness scale had been observed

11. Your actions at charge 10 were dishonest in that you sought to create the impression that the entries referred to at 10.1-10.2 had taken place when you knew they had not.

12. On 29 March 2018 edited the telephone consultation notes for patient 1825 dated 24 January 2018 to add

12.1 that a seasonal influenza vaccination had been declined

13. Your actions at charge 12 was dishonest in that you sought to create the impression that the entry made at 12.1 had taken place when you knew that it had not.

14. On 2 February 2018 added the following into patient 1522 notes dated 20 December 2017

14.1 chronic obstructive pulmonary disease annual review;

14.2 MRC Breathlessness Scale: Grade 2

15. Your actions at charge 14 were dishonest in that you sought to create the impression that the reviews at 14.1 and/or 14.2 had been carried out when you knew they had not.

16. On 29 March 2018 added the following into patient 704 notes dated 12 February 2018

16.1 chronic obstructive pulmonary disease annual review

16.2 MRC breathlessness scale: grade 4

17. Your actions at charge 16 were dishonest in that you sought to create the impression that the reviews at 16.1 and/or 16.2 had been carried out when they had not.

18. On 2 February 2018 added the following into patient 1077 records dated 26 September 2017

18.1 chronic obstructive pulmonary disease annual review

18.2 MRC breathlessness scale: grade 2

19. Your actions at charge 18 were dishonest in that you sought to create the impression that the reviews at 18.1 and/or 18.2 had been carried out when they had not.

20. On 2 February 2018 added the following into patient 1510 records dated 19 July 2017

20.1 chronic obstructive pulmonary disease annual review

20.2 MRC breathlessness scale: grade 3

21. Your actions at charge 20 were dishonest in that you sought to create the impression that the reviews at 20.1 and/or 20.2 had been carried out when they had not.

22. On 22 March 2018 and/or 3 April 2018 changed patient 826 records dated 25 January 2018 by

22.1 altering the patients blood pressure reading to 130/80

22.2 adding a diabetic annual review

22.3 adding a health education – weight management

23. Your actions at charge 22.1 was dishonest in that you provided what you knew to be an incorrect blood pressure reading of 130/80

24. You actions at charge 22.2 and/or 23.3 was dishonest in that you sought to create the impression that the reviews had taken place when you knew that they had not (the panel determined that it was in fact 22.3 and not 23.3)

25. On 2 February 2018 and 22 March 2018 changed patient 1595 records dated 14 December 2017 by

25.1 amending to say that the patient was now under the care of a retinal screener

25.2 altering the patients blood pressure reading to 112/80

26. Your actions at charge 25.1 was dishonest in that you amended the patient records to say that the patient was under the care of a retinal screener when you knew that this was not the case;

27. Your actions at charge 25.2 was dishonest in that you provided what you knew to be an incorrect blood pressure reading of 112/80

28. On 22 March 2018 changed patient 4514 blood pressure reading dated 21 February 2018 to 122/80

29. Your actions at charge 28 was dishonest in that you provided what you knew to be an incorrect blood pressure reading on 122/80

30. On 22 March 2018 changed patient 3508 blood pressure reading dated 17 January 2017 to 119/80

31. Your actions at charge 30 were dishonest in that you provided what you knew to be an incorrect blood pressure reading of 119/80

32. On 22 March 2018 changed patient 2001 blood pressure reading dated 27 February 2017 to 140/80

33. Your actions at charge 32 were dishonest in that you provided what you knew to be an incorrect blood pressure reading of 140/80

34. On 31 May 2018 acted outside the scope of your practice in relation to patient 6582 in that you

34.1 undertook an neurological examination

34.2 referred him to ECG

34.3 referred him to the Transient Ischaemic Attack clinic

34.4 did not seek advice from a GP in a timely manner

35. On 31 May 2018 acted outside the scope of your practice in relation to patient 2997 in that you carried out a chest examination of him

36. On 24 May 2018 acted outside the scope of your practice in relation to patient 3096 in that you

36.1 gave an incorrect diagnosis of postural hypertension

36.2 did not refer the matter to a GP

37. On 23 February 2018 acted outside the scope of your practice in relation to patient 557 in that you

37.1 Undertook a new/clinical/gynaecological assessment

37.2 Took a swab

38. On 24 April 2018 acted outside the scope of your practice in relation to patient 1313 in that you referred the patient for an ECG.
39. On 24 July 2017 acted outside the scope of your practice in relation to patient 430 in that you
39.1 carried out a neurological assessment
39.2 did not advise the patient to see a GP

40. On 25 April 2018 acted outside the scope of your practice in relation to patient 694 in that you referred the patient for an ECG

41. On 18 May 2018 acted outside the scope of your practice in relation to patient 501730 in that you
41.1 carried out a neurological examination
41.2 did not refer the patient to a GP

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

Amendment of typographical errors

The panel on its own violation decided to amend the blood pressure reading in charges 28 and 29 from 112/80 to 122/80. It was clear from the statements and exhibits in the case that this was a typographical error. The panel also changed the spelling in charge 34.3 form “Ishemic” to “Ischaemic”

Facts

At the outset of the hearing, the panel heard from Ms Mustard, who informed the panel that Miss Cooper via correspondence with the NMC had made full admissions to

charges 4.1, 4.2, 4.3, 6.1, 6.2, 6.3, 7, 8.1, 8.2, 9, 10.1, 10.2, 11, 12.1, 13, 14.1, 14.2, 15, 16.1, 16.2, 17, 18.1, 18.2, 19, 20.1, 20.2, 21, 22.1, 22.2, 23, 24 (in respective of 22.2), 25.1, 25.2, 26, 28, 30, 31, 32, 33, 34.1, 34.2, 36.1, 37.2 and 38.

The panel therefore finds these charges proved, by way of Miss Cooper's admissions.

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

The panel has drawn no adverse inference from the non-attendance of Miss Cooper.

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:

- Dr 1: GP who worked predominantly at the Rutherford Medical Centre – sister practice to the Islington House Surgery (the Surgery). GP Partner who took over the Surgery in 2016.

- Dr 2: GP who worked predominantly at the Rutherford Medical Centre. GP Partner who took over the

Surgery in 2016. Made the referral to the NMC.

- Ms 1: Practice Manager at the Surgery.

Background

On 6 August 2018, the NMC received a referral about Miss Cooper's fitness to practise from Dr 2 on behalf of the Islington House Surgery ('the Surgery'). At the time of the concerns, Miss Cooper had been working as a Practice Nurse for the Surgery since 2004. She had formerly been employed by a General Practitioner (GP) who had retired from the Surgery which had been taken over by Dr 1, Dr 2, Dr 3 and others in 2016. During the three month handover period with the retiring GP, multiple meetings occurred where the new Doctors outlined the ethos and expectations of how the practice would operate going forward.

In February 2018, there was a meeting with the GP partners in relation to discrepancies in the way that Miss Cooper was recording mental health reviews. It is alleged that Miss Cooper was recording information in these reviews which made it appear that the practice had seen these patients when in fact it had not. During this meeting, Miss Cooper was informed by the partners of their expectations. She was told that she should not compromise care in order to make it look as if certain targets had been met. The partners believed that Miss Cooper was falsifying records to show that targets had been met.

On 31 May 2018, Dr 1 became concerned when Miss Cooper asked for advice about a patient she (Miss Cooper) had seen herself. Miss Cooper allegedly mentioned that she had listened to this patient's chest and stated that it was clear. Dr 1 was concerned as listening to a patient's chest was not within the scope of Miss Cooper's role as a practice nurse. Dr 1 reviewed the patient herself and, in doing so, realised that the

situation was not in fact as Miss Cooper had described, in that the patient's chest was not clear.

On that day, Dr 1 emailed the other partners within the Surgery to raise her concerns. This was discussed with Ms 1 and it was agreed that Miss Cooper needed to be told directly about the remit of her role, namely what she should and should not be doing.

A meeting was held on 7 June 2018. Dr 1 and Ms 1 met with Miss Cooper to discuss the concerns of the incident that occurred on 31 May 2018. After that date Miss Cooper had some annual leave booked. Miss Cooper did not return from her annual leave as she subsequently took sick leave.

The Surgery was concerned about the incidents that allegedly took place in February 2018 and on 31 May 2018 and asked the NMC for advice on how they should proceed. The NMC advised them to investigate the matter further to see if there was any other information that would corroborate their concerns.

Dr 1 and Dr 2 reviewed the patient records of the patients that Miss Cooper had seen in the preceding six month period. Both Doctors found that there was no actual patient harm within their review. However, they did allegedly find instances of Miss Cooper altering records, undertaking various types of assessments and giving various types of diagnosis which fell outside her remit.

Miss Cooper was asked to attend a meeting on 4 July 2018 to discuss what had been found. Following this meeting Miss Cooper was suspended to allow time for her to review the matters of concern and provide a written response to each of them. However Miss Cooper resigned from the practice on 10 July 2018 before this could take place.

The practice subsequently made a referral to the NMC.

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

The panel considered the witnesses and found:

The panel considered the evidence of Dr 1 to be credible and reliable. It noted she had a good recollection of the events and was professional and clear in her evidence.

The panel considered the evidence of Dr 2 to be credible and reliable. It noted that he listened to questions carefully, had sound knowledge on the matters and was clear about what he did know. He had a good recollection of the events. The panel noted he had a broad approach to nursing practice and conceded that practice nursing may have been different in 2004 when Miss Cooper had joined the practice. He was clear about what was expected in the Surgery and gave helpful evidence to the panel in respect of the charges.

The panel considered the evidence of Ms 1 to be credible and reliable. The panel noted that she tried to be helpful in explaining the transition from the previous GP partners to the current ones. She had a good recall of the events. The panel noted her evidence that she had felt uncomfortable when Miss Cooper needed to be reprimanded but had recognised it had to be done. It noted that she had an administrative role and was not involved with the clinical side of the practice. She was not aware of the scope of Miss Cooper's practice.

The panel also had regard to the reflective statement of Miss Cooper. She stated that she had been trained to undertake basic examinations which were not meant to be diagnostic and was deemed competent by her previous employers. However the panel had no evidence of this training i.e. certificates or other evidence.

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

Charge 1

1. On 16 February 2018 did not seek advice from a General Practitioner in relation to a head injury suffered by patient 3594;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1, Dr 2 and the contemporaneous patient notes for patient 3594.

The panel noted the witness statement of Dr 2 which stated:

> “The Registrant had been asked to visit the patient as he had a fall and banged his head and there was an open wound in his scalp of approximately 3 centimetres long.”

The panel took account of the patient notes recorded on 16 February 2018 which state that at 11:24:31 Miss Cooper entered:

> “verbal advice given to daughter re head injurie [sic] and sign of concussion”
>
> “daughter aware to contact medical help any signs of concussion”

The panel noted the oral evidence of Dr 2 where he stated that the advice given by Miss Cooper, regarding looking for signs of concussion, was appropriate but that there was nothing within the patient notes to suggest that she had discussed this with a GP – and that this should have been discussed.

This was reaffirmed in Dr 2’s witness statement where he stated:

> “However once she had noted that there was a head injury I consider that she should have discussed the case with a GP.”

The panel noted the oral evidence of both Dr 1 and Dr 2. Both stated that Miss Cooper was acting outside her remit as a practice nurse by undertaking an examination and diagnosis of the patient who was “acutely unwell” and suffering from hypertension and kidney disease amongst other symptoms. Dr 1 stated that any nurse undertaking this type of clinical assessment should have formally recognised clinical examination and diagnosis qualifications. Additionally, Dr 2 in his oral evidence stated that there were clinical examination modules available at universities. Such courses comprise both academic and assessed practical learning. However, it was his understanding that Miss Cooper did not have such qualifications. This was based on informal discussions he had with Miss Cooper about her career aspirations. Miss Cooper had not undertaken any such formal training. For these reasons Miss Cooper was expected to seek the advice of a GP in relation to any patients who presented with acute symptoms.

Having regard to the totality of the evidence, the panel considered that it was clear from the patient notes that Miss Cooper examined the patient but did not seek advice from a GP in relation to the head injury suffered by patient 3594. The panel was of the view that Miss Cooper, as a practice nurse, should have known that when a patient fell and sustained a head injury this could be for multiple causes some of which are serious. The panel accepted the evidence of Dr 1 and Dr 2 that the underlying causation needed to be investigated by a GP – and that Miss Cooper did not make this referral.

The panel accepted that this was an acutely unwell patient who should have been examined by a GP. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct an independent investigation and make a

diagnosis. The panel was of the view that as a result there was a potential risk to the patient also taking into account that he suffered from hypertension.

The panel concluded that on the balance of probabilities Miss Cooper did not seek advice from a GP in relation to a head injury suffered by patient 3594.

Therefore, this charge is found proved.

Charge 2

2. On 31 January 2018 did not seek advice from a General Practitioner in relation to patient 2240

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 2240.

The panel had regard to the witness statement of Dr 2 where he states:

> "*Patient 2240 reports to the Registrant that she is getting bruising over her body and she is not sure why. Bruising can be an indicator for several serious conditions and whilst she did the correct thing by taking a blood sample and suggesting a review if it didn't settle again this is investigation and diagnosis above the remit of her role…*"

The panel took account of the oral evidence of Dr 2. He stated that spontaneous bruising with no trauma requires careful assessment as there may be systemic causes which can be serious. He continued to say that this may be missed or not thought about by someone with no formally recognised clinical examination and diagnosis

qualifications. This is why Miss Cooper should have referred to a GP. He reaffirmed this in his witness statement:

> "*…I would have expected her to have discussed it with one of the general practitioners in the Practice and documented her discussions.*"

The panel took account of the patient notes recorded on 31 January 2018 which state that at 09:30:25 Miss Cooper entered:

> "*bloods taken and review if doesn't settle*"

It was not clear who this review would be with or when. There is nothing within the notes to suggest that Miss Cooper had any discussion with a GP.

The panel was of the view that as a practice nurse, Miss Cooper should have been aware that bruising could have multiple causes and should have sought advice from a GP regarding this. The panel also noted that both Dr 1 and Dr 2 stated that there was nearly always a GP available in the building. Furthermore, if both GP's were on a house call then they could be contacted by telephone. The panel noted that while Miss Cooper acted correctly by taking a blood sample this only partially addressed the needs of the patient.

Having regard to the totality of the evidence the panel accepted that this was an acutely unwell patient who should have been examined by a GP. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct an independent investigation and make a diagnosis.

The panel concluded that on the balance of probabilities Miss Cooper did not seek advice from a GP in relation to patient 2240.

Therefore, this charge is found proved.

Charge 3

3. Acted outside the scope of your practice on one or more of the following occasions:

Sub-charge 3.1

3.1 On 22 February 2018 carried out a vaginal examination on patient 7946;

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1, Dr 2, Miss Cooper's reflective statement and the contemporaneous patient notes for patient 7946.

The panel noted the patient notes recorded on 22 February 2018 which states:

> "*O/E – vaginal examination no thrush seen, normal appearance*"

The panel heard evidence from Dr 1 who stated that 'O/E' means 'on examination'. The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper carried out a vaginal examination on patient 7946.

The panel turned its attention to the stem of the charge. It noted further in the patient notes that Miss Cooper recorded on 22 February 2018 at 10:10:24:

> "*send off swab and review with results*"

In the oral evidence of Dr 1 and Dr 2 both agreed that Miss Cooper would have been qualified to undertake smears. However, they stated that they had no evidence that

Miss Cooper had any formally recognised clinical examination and diagnosis qualifications which would qualify her to undertake a vaginal examination of this nature.

The panel noted Dr 2's witness statement which stated:

> "*Patient 7946 was complaining of intermittent thrush for three months and the Registrant undertook a vaginal examination where she confirmed that no thrush was seen and there was a normal appearance.*
>
> *…this is not something which we would expect the Registrant to undertake as a Practice Nurse….here she is diagnosing and managing a condition which is not part of her remit.*"

The panel took account of Miss Cooper's reflective statement which stated:

> "*I had training to carry out basic examinations and I was deemed competent by my previous employer*"

However the panel had no evidence to corroborate this.

The panel was of the view that Miss Cooper undertook this vaginal examination because of the symptoms presented to her. It noted that whilst both Dr 1 and Dr 2 confirmed that Miss Cooper could undertake smears it also noted that Dr 2's evidence was that she was diagnosing and managing a condition which was not within her scope of practice.

The panel concluded that on the balance of probabilities, by carrying out a vaginal examination on patient 7946, Miss Cooper acted outside the scope of her practice.

Therefore, this sub-charge is found proved.

Sub-charge 3.2

3.2 On 15 January 2018 with respect to patient 2840 carried out a respiratory examination on the patient.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 2840.

The panel took account of the patient notes recorded on 15 January 2018 at 11:51:25 which state:

> "*on examination chest clear, temp normal, bp normal, pulse rate normal, oxygen level normal.*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper carried out a respiratory examination on patient 2840.

The panel turned its attention to the stem of the charge. The panel noted the witness statement of Dr 2 which states:

> "*You need to be an Advanced Nurse Practitioner or have clinical examination qualifications to do this kind of examination. What the Registrant should have done was to come and get one of the general practitioners to see Patient 2840.*"

Dr 2 in his oral evidence stated that a respiratory examination involves auscultation. This involves using a stethoscope to listen to the chest and making a diagnosis. He stated that a nurse with additional qualifications could undertake such an assessment. However, he stated that Miss Cooper was making a diagnosis on an "*acutely unwell*" patient without any formally recognised clinical examination and diagnosis

qualifications. As a result, he stated Miss Cooper should have sought advice. He states that you must be an advanced practitioner to undertake this kind of assessment and in doing so Miss Cooper was acting outside of her scope of practice.

The panel asked Dr 2 what the risks were of a person who was not qualified in undertaking such an assessment. He stated that the patient could receive the wrong care because the assessment may not have been done correctly. He also said that the patient could be falsely reassured because they have been told that their chest is clear and this could have very serious consequences.

Having regard to the totality of the evidence the panel accepted that this was an acutely unwell patient who should have been examined by a GP. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct a respiratory examination.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by undertaking a respiratory examination on this patient.

Therefore, this charge is found proved.

Sub-charge 3.3

3.3 On 12 February 2018 did not seek advice in relation to patient 1196 prior to referring her to gynaecology.

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 1196.

The panel noted the witness statement of Dr 2 which states:

> "*Patient 1196 reported that she had abnormal vaginal bleeding for approximately six months. Following this consultation the Registrant referred Patient 1196 to gynaecology. There is no evidence of any discussion with a General Practitioner before this was undertaken.*"

Dr 2 repeated this in his oral evidence and stated that Miss Cooper acted outside of her scope of practice by making the referral to gynaecology instead of discussing it with a GP. He said that based on the clinical presentation of the patient Miss Cooper should have sought advice instead of making the referral to gynaecology.

Dr 2 in his witness statement also stated:

> "*Historically it appears that the Registrant had been given power to refer directly to the hospital but we would have expected her to discuss any referral with us so that we could follow it up.*"

The panel bore in mind the evidence of Dr 2 who stated that Miss Cooper may have had the authority to make referral under the previous partners. However, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to make the referral. It concluded that, on the balance of probabilities, Miss Cooper was acting outside of her scope of practice by not seeking advice prior to referring the patient to gynaecology.

Therefore, this sub-charge is found proved.

Sub-charge 3.4

3.4 On 23 January 2018 carried out a breast examination of patient 2729

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 2729.

The panel took account of the patient notes recorded on 23 January 2018 which state that at 09:12:30 Miss Cooper entered:

> "*O/E – general breast exam. NAD appears quite boney [sic] between the breasts*"

The panel accepted that, based on the patient notes, it was clear that Miss Cooper carried out a breast examination of patient 2729.

The panel turned its attention to the stem of the charge. The panel noted that Dr 2 in his witness statement stated:

> "*I do not believe that she had the training to do this and again I would have expected the Registrant to come and ask one of us to undertake the investigation and or have asked Patient 2729 to come in and see one of us.*
>
> *…by undertaking an examination she may have given Patient 2729 false reassurance that everything was fine.*"

In his oral evidence, Dr 2 stated that Miss Cooper had undertaken a general breast examination which was not within the remit of a practice nurse. He also stated that Miss Cooper was never asked to undertake clinical examinations on "*acutely unwell*" patients.

The panel accepted the evidence of Dr 2 and noted that he recognised that Miss Cooper advised the patient to seek advice from a doctor. However the panel concluded in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to undertake a breast examination on this patient.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by undertaking such an examination.

Therefore, this sub-charge is found proved.

Sub-charge 3.5

3.5 On 6 February 2018 referred patient 561 for a community ECG instead of cardiology

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 561.

The panel took account of the patient notes recorded on 6 February 2018 which state that at 08:26:22 Miss Cooper entered:

"*Refer for ECG recording*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper referred patient 561 for a community ECG.

The panel turned its attention to the stem of the charge. The panel noted the witness statement of Dr 2 which stated:

> "*Patient 561 had presented to the Registrant on 6 February 2018 complaining of chest heaviness and heart racing…Patient 561 had lots of risk factors, he was overweight, an ex-smoker with high blood pressure and a drinker. Community ECGs can take quite a long time to be undertaken and his complaint was that he was feeling a heavy weight on his chest would have raised alarm bells for me. I would have referred him immediately to cardiology*."

The panel also noted the oral evidence of Dr 2. He said that given the acute presentation of the patient, based on national guidelines, it was wrong for Miss Cooper to make a referral to the ECG department. He stated that Miss Cooper should have discussed this with a GP, and if necessary, the GP would have raised the matter with the cardiology department.

Having regard to the totality of the evidence the panel accepted that this was an acutely unwell patient who should have been examined by a GP. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct an independent investigation, make a diagnosis and a subsequent referral.

The panel concluded that, on the balance of probabilities, by referring patient 561 for a community ECG instead of cardiology, Miss Cooper was acting outside of her scope of practice.

Sub-charge 3.6

3.6 On 20 February 2018 in relation to patient 2700 carried out a chest examination of the patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2 and the contemporaneous patient notes for patient 2700.

The panel took account of the patient notes recorded on 20 February 2018 which state that at 16:43:13 Miss Cooper entered:

> "*o/e slight wheeze upper right lung, rest of chest cear [sic]*'

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper carried out a chest examination on patient 2700.

The panel turned its attention to the stem of the charge. The panel had regard to the witness statement of Dr 2 which stated:

> "*Here the Registrant had undertaken a home visit and again she carried out an examination where she found a light wheeze in the upper right lung rest of chest clear [sic]. I know that she would have carried out peak flow test and other asthma related tests as a Practice Nurse but she should not be carrying out these types of examinations which exceed the remit of a Practice Nurse.*
>
> *…this sort of examination is usually done by a clinician with the appropriate examination qualifications. Nurses at the practice do not routinely carry out auscultation of patients [sic] chests or hearts.*"

Having regard to the totality of the evidence the panel accepted that this was an acutely unwell patient who should have been examined by a GP. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to carry out a chest examination.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by undertaking a chest examination on this patient.

Therefore, this sub-charge is found proved.

Charge 5

5. Your actions at charge 4 were dishonest in that you added the codes at 4.1-4.3 in order to create the impression that the patient had been contacted/seen on 29 March 2018 when you knew they had not.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 2, the diary for Miss Cooper dated 29 March 2018 and the contemporaneous patient notes for patient 4019.

The panel bore in mind that Miss Cooper admitted charge 4. The panel took account of the patient notes recorded on 29 March 2018 which show that Miss Cooper entered:

> *“Patient on maximal tolerated therapy for diabetes*
>
> *Excepted from asthma quality indicators: Informed consent*
>
> *Seasonal influenza vaccination declined*”

The panel had regard to the witness statement of Dr 2 which states:

> "*I believe that this patient was not seen by the Registrant at the surgery on 29 March 2018. On that date, the Registrant added 3 separate clinical codes on the system for the above patient which related to diabetes, asthma and influenza. I have checked the system and the Registrant did have an afternoon surgery booked. The Registrant had 5 patients booked. Patient 4019 was not one of these patients. The Registrant had also blocked out time for non-clinical work to be done on that day and so she would not have seen patients during that time that was blocked out in the day. The only way patient 4019 could have been seen would have been if the patient walked into the surgery and was seen. However, if the patient walked in and was seen, then the patient would have been booked into the system.*
>
> *…There were no consultation notes for this patient on the above.*"

The panel noted the oral evidence of Dr 2. He stated that someone could get this data from elsewhere without having seen the patient. However, he could not find the source of Miss Cooper's data anywhere and that it was highly unlikely she would have had access to any information outside of what he was reviewing. He stated that this review was being conducted retrospectively so any information Miss Cooper had used should be on the system.

The panel also noted that nothing within Miss Cooper's diary, for 29 March 2018, suggests that she saw patient 4019.

The panel determined that Miss Cooper knew that she had not contacted/seen patient 4019 and that she had entered the data to create the impression that the patient had been contacted/seen by her on that day.

Applying the standards of ordinary decent people, the panel considered that, by adding the codes at 4.1 to 4.3 Miss Cooper intended to create the impression that the patient had been contacted/seen on 29 March 2018 when she knew they had not. The panel concluded that on the balance of probabilities Miss Cooper's actions in relation to charge 4.1 to 4.3, based on the test in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67*, were both subjectively and objectively dishonest.

Therefore this charge is found proved.

Charge 22

22. On 22 March 2018 and/or 3 April 2018 changed patient 826 records dated 25 January 2018 by

Sub-charge 22.3

22.3 adding a health education – weight management

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1, the diary of Miss Cooper dated 3 April 2018 and the contemporaneous patient notes for patient 826.

Dr 1 stated that patient 826 came into see Miss Cooper on 25 January 2018. However, while Miss Cooper had patient appointments on 3 April 2018, none were with patient 826. In addition there is nothing to suggest that this patient was spoken to on the phone on 3 April 2018.

The panel took account of the patient notes recorded on 3 April 2018 which shows that at 16:10:35 Miss Cooper entered:

"*Health education – weight management*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper changed patient 826's records by making an entry. Additionally, the panel also noted that nothing within Miss Cooper's diary, for 3 April 2018, suggests that she saw patient 826.

The panel concluded that on the balance of probabilities, Miss Cooper changed patient 826's records by adding, on 3 April 2018, "*Health education – weight management*".

Therefore, this sub-charge is found proved.

Charge 24

24. You actions at charge…22.3 was dishonest in that you sought to create the impression that the reviews had taken place when you knew that they had not

The panel has decided that Miss Cooper did change patient 826's record by adding a health education – weight management entry. The panel determined that this would give the impression to any person reading the notes that a review taken place when it had not. Further the panel determined that Miss Cooper would have known that such actions would give that impression.

Applying the standards of ordinary decent people the panel considered that Miss Cooper's actions by adding "*health education – weight management*" were intended to create the impression that a review had taken place when it had not. The panel concluded that on the balance of probabilities that Miss Cooper's actions based on the test in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67*, were both subjectively and objectively dishonest.

Therefore this charge is found proved.

Charge 27

27. Your actions at charge 25.2 was dishonest in that you provided what you knew to be an incorrect blood pressure reading of 112/80

This charge is found proved

Miss Cooper has admitted that on 22 March 2018 she altered patient 1595 records dated 14 December 2017 by altering the patient's blood pressure reading from 112/88 to 112/80.

The panel determined that Miss Cooper by changing the records in this way would know that this would give a misleading impression to anybody reading the notes.

Applying the standards of ordinary decent people the panel considered that Miss Cooper's actions were intended to create the impression that, on 22 March 2018, a review of patient 1595's blood pressure had taken place when she knew it had not. The panel concluded that on the balance of probabilities Miss Cooper's actions based on the test in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67*, were both subjectively and objectively dishonest.

Therefore, this charge is found proved.

Charge 29

29. Your actions at charge 28 was dishonest in that you provided what you knew to be an incorrect blood pressure reading of 122/80

This charge is found proved.

Miss Cooper has admitted that on 22 March 2018 she changed patient 4514 records dated 21 February 2018 by altering the patient's blood pressure reading from 122/84 to 122/80.

In reaching this decision, the panel took into account the evidence of Dr 1, the diary for Miss Cooper dated 22 March 2018 and the contemporaneous patient notes for patient 4514.

The panel also noted that on 21 February 2018, on the same patient note, Dr 3 had entered at 11:16:03:

> "*from 122/84 mmhg*"

The panel took account of the witness statement of Dr 2 which stated:

> "*This patient had a blood pressure reading of 122/84 recorded by Dr 3 (Dr McCann) on 21 February 2018. The Registrant amended the original record to 122/80 on 22 March 2018 at 15:40.*"

The panel bore in mind that Miss Cooper admitted to charge 28 and took account of the patient notes recorded on 22 March 2018 which shows that at 15:40:04 Miss Cooper entered:

> "*O/E – blood pressure reading 122/80 mmHg*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper had changed patient 4514's blood pressure reading. The panel noted the witness statement of Dr 1 which stated:

> "*…I have checked the Registrant's calendar for 22 March 2018. The Registrant had appointment slots booked throughout the morning. This included some telephone slots. In the afternoon the Registrant was booked for admin work. There is no record of the Registrant attended to this patient in that date."*

The panel noted that nothing within Miss Cooper's diary, for 22 March 2018, suggests that she saw patient 4514.

Applying the standards of ordinary decent people the panel considered that Miss Cooper's actions were intended to create the impression that, on 22 March 2018, a review of patient 4514's blood pressure had taken place when she knew it had not. The panel concluded on the balance of probabilities that Miss Cooper's actions based on the test in *Ivey* v *Genting Casinos (UK) Ltd t/a Crockfords* [*2017*] *UKSC 67* were both subjectively and objectively dishonest.

Therefore, this charge is found proved.

Charge 34

34. On 31 May 2018 acted outside the scope of your practice in relation to patient 6582 in that you

Sub-charge 34.3 and 34.4

34.3 referred him to the Transient Ischaemic Attack clinic

34.4 did not seek advice from a GP in a timely manner

Both these sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. The panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 6582.

The panel took account of Dr 1's witness statement which stated:

> "*The Registrant had seen Patient 6582 at 7:45 on 31 May 2019. He had had a collapse. She took a history, undertook a neurological exam, and then gave a possible diagnosis. She referred him for ECG and to the Transient Ischemic [sic] Attack clinic.*"

The panel noted that the patient consultation notes, dated 31 May 2019 at 7:45 confirm this where Miss Cooper has entered:

> "*possible TIA or vasovagal faint*
> *refer to rapid tia clinic*"

The panel noted that Dr 1 in her witness statement stated:

> "*…Then later in the morning she discussed it with Dr 3, and he said he didn't think she should do that and advised refer to cardiology. Here she did seek advice but should have asked Dr 3 to see patient 6582 or ask him to wait, not seek advice after the event.*
>
> *…The Registrant should not have attempted the diagnosis as she was not qualified to do so.*"

The panel also noted the patient notes recorded on 31 May 2018 which shows that at 09:45:24 Miss Cooper entered:

> "*he has suggested routine referral to cardiology rather than tia clinic*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper referred patient 6582 to the Transient Ischaemic Attack clinic (TIA). The panel had regard to Dr 2's oral evidence where she believed 'he' to be referring to Dr 3 and made an inference that Miss Cooper had made a referral to the TIA clinic. Dr 2 in her oral evidence and her witness statement said that Miss Cooper should have sought advice from a GP at the time she first saw the patient so an assessment could take place. Miss Cooper instead sought advice after making her own assessment so the GP advice was not sought in a timely manner.

Having regard to the totality of the evidence, the panel determined that in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct an independent investigation, make a diagnosis and a subsequent referral. Additionally the panel noted that Miss Cooper discussed the case with a GP two hours after seeing the patient which Dr 2 deemed not to be in a timely manner.

The panel concluded that on the balance of probabilities Miss Cooper acted outside of her scope of practice by making a referral to the TIA clinic and not seeking the advice of a GP in a timely manner.

Therefore, both these sub-charges are found proved.

Charge 35

35. On 31 May 2018 acted outside the scope of your practice in relation to patient 2997 that you carried out a chest examination of him

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 2997.

The panel noted the witness statement of Dr 1 which stated:

> "*The Registrant came in to my room and said that she needed to ask me about a patient. She told me that was seeing an elderly man who was complaining of feeling breathless [sic]. She gave me a brief history and told me that she had listened to his chest and it sounded nice and clear.*"

The panel took account of the patient notes recorded on 31 May 2018 which state that at 08:56:29 Miss Cooper entered:

> "*o/e chest clear*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper carried out a chest examination on patient 2997.

The panel then went on to consider if undertaking a chest examination was outside the scope of practice for Miss Cooper. It noted the witness statement of Dr 1 which states:

> "*My immediate thought was, "Why have you examined this patient". She was not a Nurse Practitioner nor was she a GP*."

Dr 1 in her oral evidence and witness statement said that she examined the patient herself and determined that his chest was in fact not clear. Dr 1 explained the risks of a person who was not qualified undertaking such an assessment. She stated that the patient could receive the wrong care because the assessment may not have been done appropriately. She also said that the patient may be falsely reassured. This was reiterated in her witness statement:

> "*The patient's chest was not clear so it was a good thing that the Registrant came to see me as the patient could have been mismanaged.*"

The panel noted that Dr 1 saw the patient shortly after Miss Cooper did. It considered that Miss Cooper did not have the competency to undertake a chest examination this was evident not only from her lack of formal qualifications but also because her findings were different to that of Dr 1.

Having regard to the totality of the evidence the panel determined that, on the balance of probabilities, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to carry out a chest examination of this patient and therefore acted outside of her scope of practice.

Therefore, this charge is found proved.

Charge 36

36. On 24 May 2018 acted outside the scope of your practice in relation to patient 3096 in that you

Sub-charge 36.2

36.2 did not refer the matter to a GP

This sub-charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 3096.

The panel noted that there is nothing within the patient notes to suggest that Miss Cooper made a referral to a GP.

The panel had regard to the witness evidence of Dr 1 where she stated:

> "*Again she made a diagnosis of postural hypertension, but that is incorrect, the readings she has taken do not support such a diagnosis. She has taken a history of sorts, she has attempted a diagnosis, advised the patient and organised a follow up when she should have just referred Patient 3096 to a GP*."

The panel accepted the evidence of Dr 1 and noted that Miss Cooper's diagnosis was incorrect. The panel also bore in mind that Dr 1 in her oral evidence stated that the risks this posed was that the patient could receive inappropriate care because the assessment may not have been done correctly. She also said that the patient could be falsely reassured.

Having regard to the totality of the evidence, the panel determined, on the balance of probabilities, that Miss Cooper should have made a referral to a GP instead of making a diagnosis. By so doing, she was acting outside her scope of practice in relation to patient 3096.

Therefore, this sub-charge is found proved.

Charge 37

37. On 23 February 2018 acted outside the scope of your practice in relation to patient 557 in that you

Sub-charge 37.1

37.1 Undertook a new/clinical/gynaecological assessment

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 557.

The panel took account of the patient notes recorded on 23 February 2018 which state that at 11:45:50 Miss Cooper entered:

> "*O/E – vaginal examination bladder prolapse evident, cervix looks normal, no blood or discharge noted, no smell noted.*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper undertook a new/clinical/gynaecological assessment on patient 557.

The panel went onto consider whether this was acting outside of Miss Cooper's scope of practice. The panel noted the witness statement of Dr 1 which stated:

> "*Patient 557 complained of strong odour from her vagina. The Registrant would have been trained to conduct smears but her she has undertaken an intimate examination of Patient 557 and taken a swab. This gives Patient 557 a false sense of reassurance when the Registrant suggests a plan which may or may not be appropriate.*
>
> *……she was not trained to take a history from someone who has a systematic [sic] illness. The Registrant was acting outside of her competency by undertaking a new clinical / gynaecological assessment of the patient with a symptom. This type of sampling / assessment should be carried out by a doctor.*"

The panel accepted the evidence of Dr 2. The panel noted that Dr 1 recognised that Miss Cooper was able to undertake smears. However, she should have sought advice pertaining to a patient presenting with acute symptoms rather than undertaking a new clinical gynaecological assessment herself.

Having regard to the totality of the evidence the panel considered that this was a patient who had a systemic illness who should have been examined by a GP. The panel determined that in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct this new/clinical gynaecological assessment.

Therefore, the panel concluded that on the balance of probabilities Miss Cooper acted outside of her scope of practice in relation to patient 557 by undertaking a new/clinical gynaecological assessment.

Therefore, this sub-charge is found proved.

Charge 39

39. On 24 July 2017 acted outside the scope of your practice in relation to patient 430 in that you

Sub-charges 39.1 and 39.2

39.1 carried out a neurological assessment
39.2 did not advise the patient to see a GP

Both the sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. The panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 430.

The panel took account of the patient notes recorded on 24 July 2017 which state that at 13:58:38 Miss Cooper entered:

> "*Neurological assessment all is fine*"

The panel also had regard to the witness statement of Dr 1 which stated:

> "*She is undertaking both an examination she is not trained to do and then attempts a diagnosis she is not qualified to give.*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper documented that she had carried out a neurological assessment on patient 430. It also accepted the evidence of Dr 1. The panel concluded that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct a neurological examination.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by undertaking such an examination on this patient.

The panel further had regard to Dr 1's witness statement which stated:

> "*She did not give any advice that Patient 430 needed to see a general practitioner nor did she document any discussion with any of the Partners at the Practice.*"

The panel accepted the evidence of Dr 1. It noted that there was no evidence within the patient notes that she advised the patient to see a GP. The panel also noted that Dr 1 stated that this patient was presenting with "*acute symptoms*". The panel bore in mind that Dr 2 had stated what the risks were of a person who was not qualified in undertaking such an assessment. He stated that the patient could receive inappropriate care because the assessment may not have been done correctly. Additionally the patient could be falsely reassured.

The panel concluded that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to conduct a neurological examination and therefore should have made a referral to a GP.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by not referring the matter to a GP.

Therefore, the panel finds both the sub-charges proved.

Charge 40

40. On 25 April 2018 acted outside the scope of your practice in relation to patient 694 in that you referred the patient for an ECG

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 694.

The panel took account of the patient notes recorded on 25 April 2018 which state that at 09:02:57 Miss Cooper entered:

> "*refer for ecg to rule out any underlying cause as potassium was slihty [sic] raised*"

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper referred patient 694 for an ECG. The panel went onto consider whether this was acting outside of Miss Cooper's scope of practice.

The panel had regard to the witness evidence of Dr 1 where she stated:

> "*The Registrant refers Patient 694 for a community ECG which would take a couple of weeks. In light of the palpations [sic] you need to take an appropriate history, check for thyroid function, chest pain, breathlessness, legs swelling, and other symptoms. The ECG delays diagnosis of other possible problems. The patient could have a normal ECG but still have an underlying problem; they could deteriorate and become unwell. The Registrant gave false reassurance by referring Patient 694 for an ECG.*"

The panel also noted the live evidence of Dr 1. She stated that when you have a patient presenting with palpitations, it is not within the remit of a practice nurse to refer for an ECG. This was because this is an acutely unwell patient and therefore she should have told them to see a GP or to attend the Accident & Emergency department (A&E).

Having regard to the totality of the evidence the panel accepted that this was an acutely unwell patient who should have been examined by a GP or asked to attend A&E. Further, the panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to make the referral.

Therefore on the balance of probabilities Miss Cooper acted outside of her scope of practice by making a referral for an ECG for this patient.

Therefore, this charge is found proved.

Charge 41

41. On 18 May 2018 acted outside the scope of your practice in relation to patient 501730 in that you

Sub-charges 41.1 and 41.2

41.1 carried out a neurological examination
41.2 did not refer the patient to a GP

These sub-charged are both found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar have dealt with them under one heading. In reaching this

decision, the panel took into account the evidence of Dr 1 and the contemporaneous patient notes for patient 501730.

The panel took account of the patient notes recorded on 18 May 2018 which state that at 18:31 Miss Cooper entered:

> “neurological eaxamination [sic] nad
> no red flags
> safety netted
> tci again any concerns or worsening symptoms”

The panel also had regard to the witness statement of Dr 1 which stated:

> “*The Registrant has stated that she carried out a neurological examination and that no abnormality was detected. She did take a history and she comments about red flags and safety netting. I am not sure that she understood what red flags and safety netting was.*
>
> *…Taking a full neurological examination is not the responsibility of a practice nurse at all. Once a Patient had reported that he had a head injury she should have asked the doctor on duty to come and examine him.*”

The panel accepted that based on her own entries in the patient notes, it was clear that Miss Cooper carried out a neurological examination on patient 501730. It also accepted the evidence of Dr 1. The panel determined that, in the absence of any formally recognised clinical examination and diagnosis qualifications, Miss Cooper did not have the requisite knowledge or skills to undertake a neurological examination.

Therefore the panel concluded that, on the balance of probabilities, Miss Cooper acted outside of her scope of practice by undertaking a neurological examination.

It noted that there was no evidence within the patient notes that Miss Cooper advised the patient to see a GP. The panel also noted that Dr 1 stated that this patient was presenting with "*acute symptoms*". The panel bore in mind that Dr 2 had stated what the risks were of a person who was not qualified in undertaking such an assessment. He stated that the patient could receive inappropriate care because the assessment may not have been done correctly. Additionally the patient could be falsely reassured.

Having regard to the totality of the evidence the panel accepted that this was a patient presenting with acute symptoms who should have been examined by a GP.

Therefore the panel concluded, on the balance of probabilities, Miss Cooper acted outside of her scope of practice by not referring the patient to a GP.

Therefore, these sub-charges are both found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Cooper'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 suitability to remain on the register unrestricted.

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

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

Submissions on misconduct and impairment

Ms Mustard submitted that the charges relate to three main areas of concern:

- Acting outside scope of practice as practice nurse;
- Amending patient records; and
- Dishonesty relating to record keeping.

Miss Mustard submitted that Miss Cooper acting outside the scope of her practice as she did is sufficiently serious so as to attract a finding of misconduct, given the inherent risks to patients.

She submitted that record keeping is a fundamental, basic requirement of a registered nurse. Miss Mustard also submitted that amendments to patient's records are sufficiently serious to attract a finding of misconduct as they were contrary to both basic requirements and the Practice's accepted practice and policy.

Miss Mustard submitted that it is trite law that dishonesty amongst professional people is extremely serious. She submitted that the dishonesty in this case is particularly serious as it involved amending patient records which will always carry with it some risk to patients. Therefore this conduct, which is unacceptable, should be marked with a finding of misconduct.

Ms Mustard invited the panel to take the view that the facts found proved amount to misconduct.

Ms Mustard identified a number of breaches of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code).

Ms Mustard moved on to the issue of impairment and addressed the panel on the need to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She reminded the panel of the Dame Janet Smith test from the Fifth Shipman report and submitted that all four limbs are engaged in this case.

Ms Mustard invited the panel to make a finding of impairment on the grounds of public protection and public interest.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311*, *Cohen v. General Medical Council [2008] EWHC 581 (Admin)*,and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

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.'*

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

The panel reminded itself that a registered nurse is personally accountable under the NMC Code for acts and omissions in their practice. The panel had regard to the relevant version of the NMC Code (2015). The Code contains the underlying principles that guide the nursing profession and is in place to protect the public and to ensure that proper standards of the profession are upheld.

The panel deemed that Miss Cooper breached the following paragraphs of the code:

> ***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*

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 complete the necessary training before carrying out a new role

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…

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel accepted that there were three areas of concern:

- Acting outside scope of practice as practice nurse;
- Amending patient records; and
- Dishonesty relating to record keeping.

The panel considered whether Miss Cooper's conduct in acting outside her scope of practice amounted to misconduct.

The panel was of the view that Miss Cooper would have known that she was required to undertake formally assessed programmes in order to practice advanced clinical examinations including respiratory, neurological and breast examinations. Additionally, the panel noted that she was not seeking the advice of a GP when patients presented with acute symptoms thereby placing them at risk of serious harm. The panel also had regard to the fact that, despite her lengthy experience as a practice nurse, Miss Cooper did not follow national guidelines pertaining to patient 561 who should have been referred by the GP to the cardiology department.

The panel heard evidence that to undertake, respiratory, neurological or breast examinations you are required to have additional qualifications. The panel found that Miss Cooper did not have any such qualifications and therefore did not have the requisite knowledge or skills to undertake such examinations.

The panel considered the vaginal examination Miss Cooper undertook for patient 7946 (charge 3.1). The panel was of the view that the knowledge and skill needed to take a vaginal swab may be interpreted as being similar to the level of knowledge and skill needed to undertake a routine smear test. The panel considered that this charge arguably did not meet the threshold for serious misconduct.

However, the panel concluded that Miss Cooper acted outside her scope of practice by conducting investigations that she knew she was not fully qualified to do. The panel accepted that there was no evidence of actual patient harm. Notwithstanding, the panel was concerned at the risk of harm to patients arising from Miss Cooper's inadequate knowledge and skills where patients were misdiagnosed and may have been falsely reassured. For example, the panel was concerned that Miss Cooper undertook a chest examination and reported this as being clear when shortly thereafter Dr 1 found this to be incorrect.

The panel determined that Miss Cooper's actions in working outside her scope of practice amounted to serious misconduct.

The panel considered whether amending patient records amounted to misconduct.

Miss Cooper altered patient records on a number of occasions over a six month period and across a range of patients. Accurate, contemporaneous record keeping is a fundamental area of nursing practice. The panel considered that Miss Cooper would be aware that it was acceptable to edit patient notes if the original entry had omitted to mention something. As a registered nurse she would know that this would require a qualifying statement to explain that the entry was retrospective and why the additional entry was being made. The panel was concerned that there was no good reason to alter the findings of clinical examinations such as blood pressure readings, particularly when this was several months after the readings were taken. The panel determined that

altering these records without qualification in the circumstances of this case potentially put patients at risk of harm and amounted to serious misconduct.

The panel considered whether Miss Cooper's dishonesty amounted to misconduct.

The panel has already determined that Miss Cooper, by amending the patient records in this way, knew that this would give a misleading impression to anybody reading the notes. The panel concluded that Miss Cooper's actions in this respect amounted to serious misconduct.

Therefore the panel concluded that Miss Cooper's actions relating to the three main areas of concern amounted to serious misconduct both individually and collectively**.**

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Cooper's fitness to practise is currently impaired. This requires an assessment by the panel as to whether Miss Cooper's misconduct is easily remediable; whether it has been remedied and the likelihood of repetition of the misconduct. In addressing the question of the risk of repetition, the panel also considered the issue of insight. In assessing these matters the panel had careful regard to all the relevant information available to it.

The purpose of these proceedings is to protect the public against the acts and omissions of those who are not fit to practise and to maintain public confidence in the profession and the regulatory process. The panel thus looks forward not back. However, in order to form a view as to Miss Cooper's suitability to practise today, the panel took account of the way she has acted or failed to act in the past.

The panel took into account Dame Janet Smith's test in the Fifth Shipman Report:

'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:

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

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

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

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

The panel determined that all four elements apply both to the past and to the future.

Miss Cooper's misconduct placed patients at unwarranted risk of harm. Further, it involved multiple acts of dishonesty carried out over a period of six months. This indicated a breach of the fundamental tenets of the profession and will undoubtedly have brought the profession into disrepute. In the panel's judgement, the public do not expect a nurse to act as Miss Cooper did as they require nurses to adhere at all times to the appropriate professional standards and to act to safeguard the health and wellbeing of patients and to behave with honesty and integrity. The panel was satisfied that the clinical concerns arising from Miss Cooper's misconduct, namely acting outside the scope of her practice and amending patient records should be capable of remedy.

The panel did acknowledge that Miss Cooper has admitted a large number of the charges including a number of those alleging dishonesty.

The panel considered Miss Cooper's reflective statement in which she acknowledged that the amendment of patient records was wrong and that dishonesty affects the trustworthiness of the profession. However Miss Cooper did not seem fully to understand the risk and potential consequences of acting outside the scope of her practice.

Miss Cooper has recently worked in a care home for over a year. She submitted a number of positive testimonials that speak to her professional and caring approach to nursing. It is not clear whether all the authors of the testimonials were aware of the full circumstances of the misconduct, including the dishonesty. In these circumstances the panel could only place limited weight on the testimonial evidence presented to it as they do not address the substance of the facts found proved.

In these circumstances the panel was not satisfied that Miss Cooper had remedied her misconduct and as a consequence there remains a risk of repetition.

Misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However in the panel's judgment, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all highly relevant to any consideration of the risk of repetition, as is the nature and duration of the dishonesty itself.

In the panel's judgment the risk of repetition is significant. This is due to Miss Cooper's limited insight, the absence of cogent evidence of remediation and the fact the dishonesty continued for a period of up to six months.

The panel therefore determined that a finding of impairment is necessary on public protection grounds.

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

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

The panel was satisfied that having regard to the nature of the misconduct in this case including the dishonesty, “*the need to uphold proper professional standards and public confidence in the profession would be undermined*” if a finding of current impairment were not made. For all the above reasons the panel decided that Miss Cooper’s fitness to practise is currently impaired by reason of misconduct on both public protection and public interest grounds.

Sanction

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Cooper off the register. The effect of this order is that the NMC register will show that Miss Cooper 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 to the Sanctions Guidance (SG) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement. The panel accepted the advice of the legal assessor who referenced the cases of *Atkinson v General Medical Council [2009] EWHC 3636 and Parkinson v NMC [2010] EWHC 1898 (Admin).*

Submissions on sanction

Ms Mustard informed the panel that in the Notice of Hearing, dated 8 November 2019, the NMC had advised Miss Cooper that it would seek the imposition of a striking off order if her fitness to practice was found to be impaired. She submitted that taking no further action or imposing a caution would be incompatible with the panel's finding of current impairment on grounds of public protection and public interest. Ms Mustard submitted that it would neither be proportionate nor workable to impose a conditions of practice order and that such an order would not address the dishonesty found proved. She further submitted that a suspension order would not be an appropriate sanction. Ms Mustard referred the panel to the SG in this regard. She submitted that the factors within the SG, indicating where a suspension would be appropriate, were not met in Miss Cooper's case. Ms Mustard submitted that Miss Cooper's dishonesty should be considered serious due to its direct risk to patients. She invited the panel to find that only removal of Miss Cooper's registration from the register would mark the seriousness of the matters found proved. She submitted that this was the only sanction that would

protect the public, maintain confidence in the nursing profession and uphold proper standards of conduct and behaviour.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Miss Cooper's conduct in this case had the potential to place a number of patients at a risk of serious harm;
- This was not an isolated incident. There were a number of cases involving numerous patients over a six month period;
- The failures relate to basic nursing practice and dishonesty relating to record keeping;
- Miss Cooper's lack of fully developed insight into the risks of acting outside the scope of her practice.

The panel also took into account the following mitigating feature:

- Admissions to a large number of charges including dishonesty.

Before assessing each sanction in ascending order, the panel considered the seriousness of Miss Cooper's dishonesty and referred to the SG in this regard, taking into account the relevant case law. The panel determined that Miss Cooper's dishonesty placed patients presenting with acute symptoms at direct risk of harm. The panel considered that Miss Cooper's dishonesty was premeditated and was repeated over a

period of six months. This was a systematic and long lasting deception. In light of all of these factors, the panel regarded Miss Cooper's dishonesty as serious.

The panel first considered whether to take no action but concluded that this would be incompatible with its findings of current impairment 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 this would be incompatibility with its findings of current impairment and the dishonesty identified. An order that does not restrict Miss Cooper'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 Miss Cooper's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the potential risks to patients. 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 conditions of practice on Miss Cooper's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the correspondence from Miss Cooper, dated 25 November 2019, where she stated her intention to leave the nursing profession at the end of November 2019. Additionally the panel has no evidence before it of Miss Cooper's willingness to undertake training or comply with conditions of practice. Therefore there are no practical or workable conditions that could be formulated given these circumstances. Additionally, the panel was of the view that the dishonesty identified in this case was not something that can be addressed through retraining. The panel concluded that placing conditions on Miss Cooper's registration would not adequately address the seriousness of this case, would not protect the public nor meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order would 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 aggravating factors that the panel took into account were that the misconduct found proved was not an isolated incident. It covered many instances and different types of misconduct including multiple acts of dishonesty carried out over a six month period. This placed patients at an unwarranted risk of harm. The panel was concerned that Miss Cooper had demonstrated attitudinal problems. This included her lack of recognition of the necessity for formal qualifications in clinical examination and her firm belief that she had competence in diagnostic examinations when this was not the case. Further, Miss Cooper had limited insight and did not fully realise or accept the risk and potential consequences of acting outside the scope of her practice. The panel noted that while it had no evidence of repetition of behaviour since the incidents it bore in mind that Miss Cooper is not working in the same environment as the Surgery. As a result, the panel deemed the risk of repetition to be significant.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Cooper’s actions is fundamentally incompatible with Miss Cooper remaining on the register.

The panel had particular regard to *Parkinson* where Mr Justice Mitting said:

> *“A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted*

dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure."

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction to mark the seriousness of Miss Cooper's misconduct – particularly her dishonesty. The panel had no evidence before it that this would not happen again and considered that it could not maintain confidence in the profession if Miss Cooper was not removed from the register.

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?*

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the seriousness of the misconduct identified, in particular Miss Cooper's prolonged period of acting outside the scope of her practice and acting dishonestly raised fundamental questions about her professionalism. The panel was of the view that Miss Cooper's conduct is fundamentally incompatible with her remaining on the register and to allow her to continue practising would not protect the public, would undermine public confidence in the profession and in the NMC as a regulatory body and would not uphold proper standards of conduct and behaviour.

The panel therefore determined that a striking off order is the only appropriate sanction in the circumstances of this case.

Interim order

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

Submissions on interim order

The panel next considered the submissions made by Ms Mustard that an interim order should be made in order to allow for the possibility of an appeal to be made and determined. She submitted that an interim suspension order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel considered an interim conditions of practice order but determined that in light of the panel's earlier findings and the circumstances of case, it concluded that this would be inappropriate.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months due to allow for the possibility of an appeal to be made and determined which the panel accepts may take a substantial period of time.

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

That concludes this determination.