Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

8 January 2021

Virtual Hearing

Name of registrant:	Mrs Lindsey Ann Foster
NMC PIN:	78Y1963E
Part of the register:	RN1: Adult – (1982) RN2: Adult Nurse – (1981)
Area of registered address:	England
Type of case:	Misconduct
Panel members:	Janet Kelly (Chair, Registrant member) Beth Maryon (Registrant member) Mary Golden (Lay member)
Legal Assessor:	Martin Goudie
Panel Secretary:	Leigham Malcolm
Facts proved:	Charges 1 a), b), c), d), 2 a), b), c), 3 a), b), c) & d)
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Foster's registered email address on 1 December 2020.

The panel took into account that the Notice of Meeting provided details of the allegations and set out that the hearing would take place virtually on or after 4 January 2021.

The panel accepted the advice of the legal assessor.

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

Details of charge

That you, being a registered nurse

1. *Failed to escalate Resident A's care to a hospital or GP after a fall on or after the 19th September 2018 when you knew or ought to have known*

   (a) That the combination of bruising to the forehead and the fact that the Resident was on anticoagulants required hospital care and/or monitoring
   (b) The steps at (a) were required because the risk of internal bleeding was caused or promoted by anti-coagulant treatment.
   (c) An unwitnessed fall from a wheelchair to the floor carried with it a clear risk of bony fracture or injury requiring hospital investigation
   (d) That enduring pain or discomfort on the following day [20th September] indicated a real risk of bony fracture or injury.

2. *Failed in your duty of candour in that you did not timeously report the fall of the 19th September 2018 to*

   (a) Your director, Ms.B
   (b) Safeguarding
   (c) CQC

3. *On various dates, dishonestly made statements that Resident A's lap-strap was fastened to her wheelchair prior to the fall of the 19th September 2018 when you knew that was not the case and sought thereby to conceal the true circumstances of the fall, namely*

   (a) You advised Ms C and Ms.D shortly after the fall to say that they had strapped Resident A by her lap-strap to her wheelchair.
   (b) In or about September 2018, you told your Director, Ms.B that Resident A was strapped into her lap-strap prior to the fall.
   (c) In an undated form, you notified the CQC that Resident A had managed to open her lap-strap.

(d) In answer to enquiries initiated by the Coroner of Derby and South Derbyshire, you indicated on the 4th December 2018 that Ms.C and Ms D had twice applied the lap strap before the fall.

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

Decision and reasons on facts

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

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

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

- Ms B, Director for New Lodge Nursing Home
- Ms C, Healthcare Assistant at New Lodge Nursing Home
- Ms D, Healthcare Assistant at New Lodge Nursing Home
- Mr E, Manager at New Lodge Nursing Home

The charges arose whilst Mrs Foster was employed as a registered nurse at the New Lodge Nursing Home ("the Home") from 10 April 2017 until 1 April 2019. Mrs Foster was originally employed in the position of Manager until 1 December 2018, and then in the capacity of staff nurse.

The concerns in this case arise following a resident suffering an unwitnessed fall from her wheelchair on 19 September 2018. Mrs Foster was on duty and assessed the Resident but did not contact the General Practitioner (GP) as she ought to have done and followed the policies in place at the Home when residents suffered any falls. When the Resident's

family visited the following day they raised concerns and requested a GP visit. It is alleged that Mrs Foster declined to seek medical intervention and she instead considered the resident was suffering from her usual arthritic pain and applied Fenbid gel to her leg.

The Resident was transferred to Royal Derby Hospital on 20 September as a result of the family's concerns. She had suffered a fractured hip. She subsequently deteriorated and passed away, from a condition unrelated to the fall, following palliative care provision in another home on 9 November 2018.

Mrs Foster had not informed the Directors / Owners of the Home of the incident. As a result the Care Quality Commission (CQC) were also not notified. An investigation was undertaken once Mrs Foster had notified the Director on 23 September 2018. At the time, the carers who transferred the Resident gave statements that she had been wearing a lap strap when she fell from her wheelchair. When new management was in place they raised concerns as to how the Resident fell in the circumstances. Further enquiries revealed that the Carers had lied in their statements regarding the lap strap. They had done so on the advice of Mrs Foster. Mrs Foster admitted this when challenged and has given a written account confirming this and expressing some regret and remorse for it. The admission was only as a direct result of a further interview with Ms B regarding the incident and upon being informed of the carers' admissions. This came to light in March 2019. Mrs Foster resigned on 2 April 2019.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor which included reference to *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.*

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

Charge 1

1. *Failed to escalate Resident A's care to a hospital or GP after a fall on or after the 19th September 2018 when you knew or ought to have known*

Charge 1 (a)

(a) That the combination of bruising to the forehead and the fact that the Resident was on anticoagulants required hospital care and/or monitoring

This charge is found proved.

In reaching this decision, the panel took into account of all of the evidence before it, including the witness statements of Ms B, Ms C and Ms D, along with the chronology of events.

The panel bore in mind that Mrs Foster was an experienced nurse at the time of the incident and was familiar with Resident A's state of health and care needs. The panel noted from the witness statements and chronology of events that the incident occurred on 19 September 2018. However, despite being frail and complaining of discomfort, Resident A was not admitted to hospital until 20 September 2018, when her family expressed their concerns.

The panel identified evidence that Mrs Foster was aware of Resident A's unwitnessed fall. The panel considered that a nurse of Mrs Foster's experience ought to have known that the combination of bruising to Resident A's forehead and the fact that the Resident was on anticoagulants required hospital care and/or monitoring, and ought to have been escalated to the GP. Further, the panel identified policies in place at the Home, including a Policy on Falls dated September 2018, which Mrs Foster failed to follow. For these reasons the panel found this charge proved.

Charge 1 (b)

(b) The steps at (a) were required because the risk of internal bleeding was caused or promoted by anti-coagulant treatment.

This charge is found proved.

The panel considered that a nurse of Mrs Foster's experience ought to have known that steps at Charge 1 (a) above were required because the risk of internal bleeding was caused or promoted by anti-coagulant treatment. Further, Mrs Foster admitted in her statement to the coroner that she should have recognised the increased risk to the resident following a fall required a review by a GP, especially when she was taking anti-coagulant medication. The panel therefore found this charge proved.

Charge 1 (c)

(c) An unwitnessed fall from a wheelchair to the floor carried with it a clear risk of bony fracture or injury requiring hospital investigation

This charge is found proved.

The panel considered that a nurse of Mrs Foster's experience ought to have known that an unwitnessed fall from a wheelchair to the floor carried with it a clear risk of bony fracture or injury requiring hospital investigation. Further, within the evidence before it the panel identified a Policy on Falls dated September 2018, which was in place at the time of the incident and which Mrs Foster failed to follow. The panel therefore found this charge proved.

Charge 1 (d)

(d) That enduring pain or discomfort on the following day [20th September] indicated a real risk of bony fracture or injury.

This charge is found proved.

The panel considered that a nurse of Mrs Foster's experience ought to have known that enduring pain or discomfort on the following day [20th September] indicated a real risk of bony fracture or injury. The panel also took into account the statement of the Resident's

daughter in-law, which outlined the Resident's distress that she raised with Mrs Foster at the time. The panel therefore found this charge proved.

Charge 2

> 2. *Failed in your duty of candour in that you did not timeously report the fall of the 19th September 2018 to*

Charge 2 (a)

> *(a) Your director, Ms.B*

This charge is found proved.

In reaching this decision, the panel also had regard to the witness statement of Ms B and the chronology of events. There was evidence before the panel that the incident occurred on the 19 September 2018 but Mrs Foster delayed reporting the fall to the director of the Home until 23 September 2018, a delay of four days. The panel also noted Mrs Foster's response to questions by the coroner, in which she stated that reporting Resident A's fall 'slipped her mind'.

In addition, the panel had regard to The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"), specifically the section 'preserving safety' and the duty of candour:

> *The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress."*
>
> *14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.*

On the evidence before it, the panel considered that Mrs Foster failed to report Resident A's fall to her Director in a timely manner and was not open about what had taken place with Resident A, her relatives or colleagues, therefore placing her in breach of her duty of candour. The panel therefore found this charge proved.

Charge 2 (b)

(b) Safeguarding

This charge is found proved.

Similarly, the evidence before the panel indicated that the incident occurred on the 19 September 2018 but Mrs Foster first reported the fall on 23 September 2018, to her Director of the Home, and no referral was made to Safeguarding until after that. The panel therefore found this charge proved.

Charge 2 (c)

(c) CQC

This charge is found proved.

Again, the evidence before the panel indicated that that the incident occurred on the 19 September 2018 but Mrs Foster did not report the fall to the CQC until 24 September 2018, having been instructed to by Ms B. The panel therefore found this charge proved.

Charge 3

3. *On various dates, dishonestly made statements that Resident A's lap-strap was fastened to her wheelchair prior to the fall of the 19th September 2018 when you knew that was not the case and sought thereby to conceal the true circumstances of the fall, namely*

Charge 3 (a)

(a) You advised Ms C and Ms.D shortly after the fall to say that they had strapped Resident A by her lap-strap to her wheelchair.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, including all of Mrs Foster's statements, the statements of Ms C and Ms D, and the coroner's report.

The panel had careful regard to Mrs Foster's statement dated 1 April 2019, in which she stated:

> *"... I was not clear in my previous statement... I confirm that I was aware, and unfortunately made an error, which I deeply regret. I was also worried and concerned for the carers involved. I advised them to say that they had put the seatbelt on, as I feared that both careers were terrified of the situation, that they had failed to put the seat belt on. I know what I did was wrong, but at the time nobody knew that Res A was going to deteriorate and suffer a fractured hip."*

The panel noted Mrs Foster's responses to questions put to her by the coroner on 4 December 2018, during which she stated:

> *"the lap strap was in situ... it was noted that the lap strap buckle was found missing at the time when I attended the scene and after careful clinical assessment, she was hoisted back to another wheel chair due to the faulty strap."*

In view of the evidence before it, and Mrs Foster's admission that she was in fact aware that the lap strap had not been used, and advised Ms C and Ms D to report otherwise, the panel found that she had made dishonest statements. The evidence before the panel suggests that Mrs Foster gave false statements to the coroner, statements which she confirmed were erroneous in her statement dated 1 April 2019. The panel therefore found this charge proved.

Charge 3 (b)

(b) In or about September 2018, you told your Director, Ms.B that Resident A was strapped into her lap-strap prior to the fall.

This charge is found proved.

In reaching this decision, the panel had regard to the statement from Ms B and the admissions made by Mrs Foster in her statement of 1 April 2019. The panel found this charge proved.

Charge 3 (c)

(c) In an undated form, you notified the CQC that Resident A had managed to open her lap-strap.

This charge is found proved.

In reaching this decision, the panel had regard to an undated CQC notification letter in which Mrs Foster wrote:

"...the individual had managed to open the lapstrap..."

In view of the evidence before it, and Mrs Foster's admission that she was in fact aware that the lap strap had not been used, the panel found this charge proved.

Charge 3 (d)

(d) In answer to enquiries initiated by the Coroner of Derby and South Derbyshire, you indicated on the 4th December 2018 that Ms.C and Ms D had twice applied the lap strap before the fall.

This charge is found proved.

The panel noted Mrs Foster's responses to questions put to her by the coroner on 4 April 2018, during which she stated:s

> *"[Ms C] and [Ms D] states that they toileted Res A twice before the fall and on both occasions the lap strap was applied."*

Again, in view of the evidence before it, and Mrs Foster's admission that she was in fact aware that the lap strap had not been used, and advised Ms C and Ms D to report otherwise, the panel found that she had made dishonest statements. The evidence before the panel suggests that Mrs Foster gave false statements to the coroner, statements which she confirmed were erroneous in her statement dated 1 April 2019. The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Foster'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, Mrs Foster's fitness to practise is currently impaired as a result of that misconduct.

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

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of the Code in making its decision.

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

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Foster's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to significant and numerous breaches of the Code. The panel focused on the most serious breaches:

> *14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place*
>
> > *To achieve this, you must:*
> >
> > *14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

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

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

20 Uphold the reputation of your profession at all times;

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel bore in mind that Mrs Foster was in a position of authority at the time of the incident, and had authority over her colleagues. Mrs Foster failed to provide proper care to Resident A, and had misled Resident A's family, her line managers, and the coroner over an extended period of time and on numerous occasions. The dishonesty included involving two more junior colleagues, Ms C and Ms D. The panel therefore found that Mrs Foster's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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

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

The panel finds that the resident was put at risk and was caused physical harm as a result of Mrs Foster's misconduct. Mrs Foster's misconduct contained significant dishonesty and therefore breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Furthermore, the panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered Mrs Foster's statement to be self-centred, expressing remorse that her dishonesty was uncovered and not for the impact that her conduct had on the resident, colleagues, and the nursing profession. The panel was alarmed by Mrs Foster's comments, in particular:

> *"I know what I did was wrong but at the time nobody knew that Res A was going to deteriorate and suffer a fractured hip...*
>
> *...I have had to bear the weight of this guilt and I am glad now that I am able to tell the truth regarding the situation."*

The panel found nothing within the evidence before it to suggest that Mrs Foster had expressed any kind of apology for her misconduct and subsequent dishonesty.

The panel noted that nurses have a professional duty of candour; to be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. The panel considered Mrs Foster's attempts to cover up her misconduct to be a flagrant breach of her professional duty of candour, and to strike at the heart of safe and effective nursing practice.

Given the limited insight into the concerns, and the absence of any remorse or remediation, the panel is of the view that there is a risk of repetition of the conduct found proven. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Foster's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Foster'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 panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Prolonged dishonesty, four major lies from September 2018 to April 2019;
- The nature of those lies are incremental:
    a) To initiate the cover up;
    b) To conceal the truth from the investigation;
    c) To mislead the CQC;
    d) To mislead and lie to the coronial enquiry.

The panel also took into account the following mitigating feature:

- Mrs Foster's long and previously unblemished career;
- Mrs Foster was well liked by the residents and staff;
- The positive comments made about Mrs Foster's professionalism.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, the public protection issues identified as well as the dishonesty present, an order that does not restrict Mrs Foster'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 Mrs Foster's misconduct, and subsequent dishonesty, was not at the lower end of the spectrum and that a caution order would be inappropriate.

The panel next considered whether placing conditions of practice on Mrs Foster's registration would be a sufficient and appropriate response. The panel was of the view that there were no conditions which could be formulated to address dishonesty and ensure the

protection of the public. Furthermore, the panel concluded that the placing of conditions on Mrs Foster's registration would not adequately address the public interest in this case.

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

- *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 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 Mrs Foster's actions is fundamentally incompatible with Mrs Foster remaining on the register. The panel considered Mrs Foster's repeated and long standing dishonesty to be indicative of a deep seated attitudinal issue. An attitudinal issue which has been found to have caused patient harm and, if unaddressed, may cause further patient harm in the future. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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?*

Mrs Foster's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Mrs Foster's misconduct, and subsequent dishonesty, were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Foster in writing.

Decision and reasons on 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 Mrs Foster's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

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

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

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

That concludes this determination.