Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

29 January 2020 – 5 February 2020

14 – 22 January 2021

14 – 18 June 2021

Virtual Hearing

Name of registrant:	Heidi Murena Ratcliffe
NMC PIN:	13H2299E
Part(s) of the register:	Registered Mental Health Nurse – Sub Part 1 (19 September 2014)
Area of registered address:	Hertfordshire
Type of case:	Misconduct
Panel members:	John Vellacott (Chair, Lay member) Diane Corderoy (Registrant member) Gill Mullen (Lay member)
Legal Assessor:	Peter Jennings
Panel Secretary:	Sam Headley (29 – 3 February 2020, 5 February 2020) Roshani Wanigasinghe (4 February 2020) Tara Hoole (14 – 22 January, 14 – 18 June 2021)
Nursing and Midwifery Council:	Represented by Robert Benzynie, Case Presenter (29 January – 5 February 2020) and George Hugh-Jones QC, Case Presenter (14 – 22 January, 14 – 18 June 2021)
Miss Ratcliffe:	Present via telephone on 30 January 2020 and 5 February 2020, not represented

	Not present and not represented on 29, 31 January and 3, 4 February 2020 and 17 – 18 June 2021. Present on 14 – 22 January and 14 – 16 June 2021, not represented
Facts proved by admission:	**1, 2, 3 and 4a**
Facts proved:	**4b, 5a, 7 and 9**
Facts not proved:	**5b, 6 (Deleted) and 8**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of notice of hearing (29 January 2020)

The panel was informed at the start of this hearing that Miss Ratcliffe was not in attendance and that the notice of hearing letter had been sent to Miss Ratcliffe's registered address by recorded delivery and by first class post on 13 December 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 Ratcliffe's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Benzynie, 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 Ratcliffe has been served with the notice of hearing in accordance with the requirements of Rules 11 and 34.

The panel noted that the Rules do not require delivery.

Decision and reasons for the hearing continuing on some days in Miss Ratcliffe's absence

The panel adjourned for the first day so as to give Miss Ratcliffe the opportunity to attend on the second day and not be prejudiced.

On the second day of the hearing (30 January 2020), the NMC contacted Miss Ratcliffe who informed it that she could not attend in person and that she would like to attend by telephone, but was unsure about what times she could be available due to family and personal commitments. On that day, Miss Ratcliffe attended the hearing by telephone. The hearing was opened and the charges were read into the record, Miss Ratcliffe made certain admissions and Mr Benzynie made his opening submissions.

At the close of the second day of the hearing, it was arranged that Miss Ratcliffe would be in contact later that day with the panel secretary and Mr Benzynie to discuss when she would be able to attend by telephone.

On the third day (31 January 2020), Mr Benzynie informed the panel of the details of the numerous attempts made by members of NMC staff to make contact with Miss Ratcliffe in order to ascertain what days and times she could be in attendance at the hearing. Miss Ratcliffe had not replied, save for one email, dated 31 January 2020, in which she stated (in relation to the third day) that: *"… I will be unavailable to take part by telephone or in person. Please continue in my absence."*

Mr Benzynie invited the panel to continue with the hearing that day despite the absence of Miss Ratcliffe.

In the light of these matters, the panel determined to continue with the hearing that day in Miss Ratcliffe's absence so that the witnesses could begin giving evidence.

Details of charge (as amended)

That you, a registered nurse:

1. Did not read Patient A's medical notes, in sufficient detail to understand his condition, clinical history and relapse indicators:

a. When you took over his care on 31 October 2016; **(Proved by way of admission)**
b. Within a reasonable time of taking over his care; **(Proved by way of admission)**
c. At any time prior to 15 September 2017. **(Proved by way of admission)**

2. Did not contact and/or see Patient A on a fortnightly basis as required by Patient A's care plan. **(Proved by way of admission)**

3. Did not contact Patient A until telephoning him in December 2016. **(Proved by way of admission)**

4. Did not review or conduct an updated risk assessment of Patient A's care plan in:
a. November 2016, **(Proved by way of admission)**
b. May 2017. **(Found proved)**

5. Did not arrange a review of Patient A's medication despite Patient A expressing concern about his raised anxiety levels and his need to have greater access to services on:
a. 09 August 2017 **(Found proved)**
b. 01 September 2017. **(Found not proved)**

6. [DELETED]

7. Did not escalate to anyone that you were struggling to meet Patient A's basic nursing requirements. **(Found proved)**

8. Did not provide Patient A with the ~~24 hour mental health emergency~~ out-of-hours service user's phone number. **(Found not proved)**

9. Were aware your lack of engagement with Patient A unreasonably put Patient A's safety at risk but chose to continue anyway, ~~causing and/ or~~ contributing to Patient A's death. **(Found proved)**

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

Decision and reasons on application to admit telephone evidence

The panel heard an application by Mr Benzynie under Rule 31 to allow Witness 3 to give their evidence over the telephone. Mr Benzynie informed the panel that Witness 3 explained they were unable to attend today due to other personal commitments. Witness 3 had been in attendance for the first two days and had now been inconvenienced by not having their evidence heard on the days that they were invited to attend.

In the preparation of this hearing, the NMC had indicated to Miss Ratcliffe in the Case Management Form (CMF), dated 30 October 2019, that it was the NMC's intention for Witness 3 to provide live evidence to the panel. Miss Ratcliffe is not present on the day when Witness 3 can attend this hearing by telephone and give evidence. On this basis Mr Benzynie advanced the argument that there was no lack of fairness to Miss Ratcliffe in allowing Witness 3 to give evidence over the telephone. It was uncertain whether Witness 3 could now be available on any other day during the period scheduled for this hearing.

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and was signed by her.

The panel considered whether Miss Ratcliffe would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of telephone evidence.

The panel considered that Miss Ratcliffe had been provided with a copy of Witness 3's statement and, as the panel had already determined, Miss Ratcliffe was aware of the hearing and had asked the panel to continue with hearing the evidence of witnesses that day. It noted that, as Miss Ratcliffe would not be present on that day anyway, she would not be disadvantaged by not being able to ask her questions in person.

There was also public interest in the issues being explored fully which supported receiving this evidence by way of telephone in the proceedings. The panel bore in mind that it was unclear whether Witness 3 could be present on any of the other days scheduled for the hearing. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 3.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Witness 3 to give evidence remotely over the telephone. The panel would give the evidence what it judged to be appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application for hearing to be held in private

During the evidence of Witness 2, Mr Benzynie made a request that parts of this case be held in private on the basis that proper exploration of Miss Ratcliffe's case involves reference to her health and her family's private life. The application was made pursuant to Rule 19 of the Rules.

Rule 19 states:

*‘**19.**— (1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.*

…

…

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, “in private” *means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.’*

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to Miss Ratcliffe’s health and family life, the panel determined to hold such parts of the hearing in private as and when these issues

are raised. It was satisfied that this was justified and that it outweighed any prejudice to the general principle of public hearing.

Decision and reasons on application to adjourn the hearing until a later date

On 5 February 2020, Mr Benzynie made an application to have the hearing adjourned until a later date on the grounds that the NMC needed to call another witness, Dr 6, to address some of the charges and to grant Witness 5 the opportunity to give live evidence. Miss Ratcliffe was present, by telephone, during this application.

Mr Benzynie set out the background of Miss Ratcliffe's case and referred to some of the documentation from the coroner's inquest in order to assist the panel in understanding the relevance of Dr 6's report.

Mr Benzynie submitted that an adjournment would permit Witness 5, who was a manager at the Whiteleaf Centre (the Centre), to attend the hearing in person. He told the panel that Witness 5 had produced a witness statement for the hearing but could not attend in person due to sickness. Mr Benzynie submitted that, if an adjournment was granted, the panel could hear Witness 5's evidence in person, which is always preferred in these proceedings.

Mr Benzynie told the panel that Miss Ratcliffe, before the commencement of the hearing, had completed the CMF and admitted to a number of charges, including charge 9. While Miss Ratcliffe still admitted to charge 1a, charge 1b, charge 1c, charge 2, charge 3 and charge 4a, she had changed her position on charge 9 the day before the start of this hearing. Mr Benzynie submitted that Dr 6 was now needed as a witness to assist the panel in relation to charge 9; he had not initially been warned as a witness in the light of the admission to charge 9.

Mr Benzynie told the panel that Dr 6 was not available to attend at the time originally allocated for this hearing. He submitted that Dr 6's evidence goes to the heart of charge 9, as well as assisting with some of the other charges. He also submitted that Dr 6 should be permitted to attend in person at a later date to answer any questions from the panel. Mr Benzynie initially invited the panel to look at Dr 6's report for the purpose of its decision as to whether to grant the adjournment.

Miss Ratcliffe told the panel that she objected to the panel receiving the report from Dr 6. She submitted that the report was biased because it was produced by an expert funded by the relatives in this case.

Miss Ratcliffe objected to the hearing being adjourned today as the proceedings have gone on for quite a while now and she was keen for the hearing to come to a conclusion.

Mr Benzynie, after providing the background to Miss Ratcliffe's case, accepted that Dr 6's report may not need to go before the panel at this point in order to make a decision as to whether it needs to adjourn to hear Dr 6's live evidence.

The panel heard and accepted the advice of the legal assessor.

The panel considered the submissions made by Mr Benzynie and Miss Ratcliffe. It determined that the panel did not require Dr 6's report at this stage, as there was sufficient information before it to make a decision in relation to the adjournment. The panel considered that if Dr 6 was able to attend in person, he could be questioned about his evidence fully.

The panel further determined that the hearing should be adjourned so that Dr 6 and Witness 5 can attend to give evidence at Miss Ratcliffe's hearing. It noted that Dr 6 is not available during the current period of this hearing and considered that his evidence would be very relevant to the decision in relation to charge 9. The panel considered

that, although it would be inconvenient to Miss Ratcliffe, it would not be unjust to Miss Ratcliffe to grant an adjournment as doing so would permit the panel to hear her case fully in order to make a fairer decision.

The panel was mindful that an adjournment would allow the panel an opportunity to draw its own conclusions on Dr 6's evidence after he had been questioned orally. It considered that an adjournment would also give Miss Ratcliffe the opportunity to ask Dr 6 her own questions to address any concern of bias. The panel also bore in mind that it is now extremely unlikely that the hearing will finish during the time scheduled and that it would therefore need to be adjourned in any event.

The panel considered that, since it was minded to adjourn so that Dr 6 could attend and give evidence in person, it would be relevant and fair to hear Witness 5's evidence in person at a later stage when she is available to be at the hearing.

At the invitation of the chair, the legal assessor pointed out that the panel's duty of enquiry required it to be proactive in ensuring that the charges properly reflect the nature and seriousness of the criticisms that are being made of Miss Ratcliffe and that it is presented with evidence which sufficiently addresses those concerns. He drew attention to the fact that some charges may, as currently worded, not describe the concerns adequately and that there are matters which would need to be addressed which are not covered by the evidence which has been presented so far.

The panel was conscious of its duty to ensure that the hearing was fair to Miss Ratcliffe: it therefore drew attention to these concerns rather than giving specific advice on what evidence the NMC should or should not adduce. The panel trusts that these matters would be addressed between now and the reconvened hearing and that any further evidence or changes in the nature of what is alleged will be communicated a sufficient period before the reconvened hearing for Miss Ratcliffe to have a fair opportunity to consider what she needs to do in response to them.

This decision will be confirmed to Miss Ratcliffe in writing.

That concludes this determination.

The hearing adjourned part heard on 5 February 2020.

Hearing resumed on 14 January 2021

The hearing resumed on 14 January 2021, Day 7 of these proceedings, by way of virtual hearing due to the Covid-19 pandemic.

Decision and reasons on application pursuant to Rule 28 to amend charge 8

On Day 7 (14 January 2021) Mr Hugh-Jones, on behalf of the NMC, made an application under Rule 28 of the Rules to amend the wording of charge 8.

The proposed amendment was to amend the type of telephone number from an 'emergency' number to an 'out-of-hours' number. It was submitted by Mr Hugh-Jones that the proposed amendment would provide clarity and more accurately reflect the evidence.

Further, Mr Hugh-Jones submitted that no injustice would be caused by this amendment because:

a) The substance of the allegation (for practical purposes) remains the same.
b) The amendment goes to the issue of terminology.
c) The panel's enquiries of the witnesses would not have been materially altered.

Original charge 8

8. Did not provide Patient A with the 24 hour mental health emergency number.

Proposed charge 8

8. Did not provide Patient A with the ~~24 hour mental health emergency~~ **out-of-hours service user's telephone** number.

You did not object to the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel carefully considered this application. The panel noted that the evidence it had heard was that there was no 24 hour emergency number but there was an out-of-hours number. The panel considered that it would not have asked any materially different questions of the witnesses already heard as the amendment simply relates to terminology.

The panel was therefore of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to make the amendment, as applied for, to ensure clarity and accuracy.

Decisions and reasons on application pursuant to Rule 31 to admit the hearsay evidence of Witness 5

On Day 7 (14 January 2021), the panel heard an application made by Mr Hugh-Jones under Rule 31 to allow the written statement and relevant exhibits of Witness 5 into evidence. Mr Hugh-Jones informed the panel that Witness 5 was not able to provide

evidence because of her health. This was evidenced by a medical certificate [PRIVATE].

Mr Hugh-Jones submitted that it was clear that Witness 5's evidence was relevant. He submitted that, whilst her evidence is important, it is not solely determinative of the matters in this case. He described it as '*non-central'* evidence which nonetheless may be helpful to the panel in determining some of the particulars.

Mr Hugh-Jones submitted that it would be fair to allow Witness 5's evidence; he pointed out that her evidence included matters advantageous to you as well as to the NMC.

Mr Hugh-Jones therefore submitted that Witness 5's evidence was fair and relevant and that there was no real prejudice to you in receiving the evidence in this way. He therefore invited the panel to allow Witness 5's evidence.

You told the panel you had no objection to this.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Witness 5 serious consideration. The panel accepted that Witness 5 is clearly unable to attend because of her health. The panel noted that Witness 5's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and was signed by her.

The panel considered that Witness 5's evidence is clearly relevant but that it is not the sole and decisive evidence on any charge. Therefore the panel considered that Witness

5’s evidence would not be wholly determinative but that it may assist in its consideration of the charges.

The panel considered whether you would be disadvantaged by the change in the NMC’s position from reliance upon the oral testimony of Witness 5 to the written statement. You have indicated to the panel that you do not object to Witness 5’s written evidence being admitted. Further the panel considered that there are parts of Witness 5’s statement which may be beneficial to you.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 5, but the panel would give what it deemed appropriate weight to the statement once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application pursuant to Rule 28 to amend charge 6

At the close of the NMC case on Day 8 (15 January 2021) Mr Hugh-Jones, on behalf of the NMC, made an application under Rule 28 of the Rules to amend charge 6 by deleting it in its entirety.

Original charge 6

6. Did not confirm with Patient A that he had secured a place on an Anxiety Management Course due to start on 22 September 2017.

Mr Hugh-Jones submitted that the simple point was that there is no evidence that you had received notification that Patient A had secured a place on the Anxiety Management Course. He referred the panel to the documentation before it, in which there is no written confirmation of the course. He further highlighted that there was no witness who said that you had received such confirmation. Mr Hugh-Jones said that

there was some suggestion that you had a duty to chase whether Patient A had a place on the course, but in any event there is no evidence that you did not chase it. He therefore submitted that there was a shortage of evidence in respect of charge 6 and invited the panel to amend it by deleting the charge.

You did not object to the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel carefully considered this application. The panel could see no evidence before it to support charge 6. In any event the panel considered, from the evidence it has heard, that there was some ambiguity over whose responsibility it would have been to inform Patient A of his place on such a course. The panel therefore considered that it would be unfair for this charge to continue.

In light of this the panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed course of action. The panel therefore determined to delete charge 6 in its entirety.

Decision and reasons on application of no case to answer

At the outset of Day 9 (18 January 2021), the panel considered an application from you that there is no case to answer in respect of charge 9. This application was made under Rule 24(7) of the Rules.

You submitted that there was no evidence in the documents or witness statements before the panel which supported this charge. Further, Dr 6 was unable to give a definitive answer on this charge. In these circumstances, it was submitted that this

charge should not be allowed to remain before the panel. You told the panel it was not your choice to have double the workload, to work in a team with high sickness levels or to experience personal problems.

Mr Hugh-Jones submitted that there was sufficient evidence before the panel in respect of charge 9. He directed the panel to the Care Programme Approach (CPA) policy document which is clear that patient notes and the care plan should be read. He submitted that there was evidence to confirm that you had viewed these policy documents.

Mr Hugh-Jones highlighted that you had made an admission to charge 9 in the Case Management Form but that you have since withdrawn this admission.

Mr Hugh-Jones directed the panel to Dr 6's evidence. Whilst Dr 6 was reluctant to give direct evidence as to charge 9, Dr 6 did say that looking at the notes was mandatory and that he would expect nurses to know that not reading the notes would put a patient's safety at risk.

Mr Hugh-Jones acknowledged that there was no direct evidence to support that you chose to continue in spite of being aware of the risk to Patient A. However, he submitted that the panel could draw inferences, from your admission that you did not read Patient A's notes, and that by doing this you would have known that you were putting Patient A at risk. He submitted that there was no good reason for you not reading Patient A's notes over an 11 month period and it was therefore a choice that you did not finish reading them. Mr Hugh-Jones submitted it was so professionally obvious that you must have known you were putting Patient A at risk by not reading the notes.

The panel took account of the submissions made and accepted the advice of the legal assessor.

In reaching its decision, the panel was solely considering whether sufficient evidence has been presented, such that it could properly find the facts proved on the balance of probabilities, and whether you therefore had a case to answer.

The panel considered that there was evidence that it was a requirement for every relevant member of staff to read and be aware of the CPA policy document which emphasises the importance of therapeutic engagement with a patient.

The panel considered that there was evidence from Dr 6 that it was "*mandatory*" to read patient notes, that it was important to do so and that not doing so could put a patient at risk. Further, in the panel's view a panel could properly find that a band 6 Care Co-ordinator would have been aware of the importance of reading a patient's notes and care plan.

The panel therefore considered that there was sufficient evidence presented that a panel could properly find proved that you '*Were aware your lack of engagement with Patient A unreasonably put Patient A's safety at risk*'.

In considering the second part of this charge '*but chose to continue anyway, causing and/ or contributing to Patient A's death*' the panel noted that choice is rarely unconstrained. It considered there to be sufficient evidence that a panel could properly find proved that you made such a choice. It also considered that on the basis of Dr 6's evidence a panel could properly find proved that this choice caused or contributed to Patient A's death.

The panel further considered there to be evidence in the form of the admissions you made in the investigation interview, your admissions to charges 1- 4a at the outset of this hearing and your previous admission, now withdrawn, to charge 9

The panel was therefore of the view that there has been sufficient evidence provided to support the charge. Based on the evidence before it, the panel does not accede to the

application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence. The panel emphasises that it is expressing no view as to what conclusion it will or will not reach on this charge, its decision is only that there is sufficient evidence that it *could* find the charge proved.

The panel adjourned part heard on 22 January 2021.

Hearing resumed on 14 June 2021

The hearing resumed on 14 June 2021, Day 14 of these proceedings, by way of virtual hearing. The panel handed down its written decisions on the previous applications and on its findings of fact.

Decision and reasons on application for your evidence to be held entirely in private

At the outset of Day 10 (19 January 2021) you told the panel that you did not feel comfortable giving evidence in the presence of Relative A, who was in attendance at the virtual hearing as an observer.

You told the panel that a lot of your evidence involved matters which are related to your personal and family circumstances as well as to your health. You explained that you were not legally represented but that you were doing your best to assist the panel. You told the panel you were uncomfortable that Relative A could see you on the video link, noting you could not see them, and were concerned about Relative A making a recording of your evidence without you or the panel being aware of, or able to prevent this.

The panel was made aware of an alleged incident which you said had made you feel intimidated by Relative A. You alleged that your manager received a telephone call from

Relative A shortly after you returned to work from an extended period of leave. It was your impression that Relative A had been angry and had threatened to come to the Centre where you worked. You told the panel that because of this telephone call, your manager had ensured you were escorted to your car when you left for the day. This left you feeling intimidated. You told the panel that you were trying your best as an unrepresented registrant and that you wished to be able to give the best evidence you could. To enable you to do this, you asked the panel to hear your evidence in private and to consider your witness evidence under Rule 23(1)(f) as you felt it applied in this instance.

Mr Hugh-Jones strongly opposed your evidence being held entirely in private. He submitted that it was in the public interest that relatives should be able to attend these proceedings and hear evidence. He drew the panel's attention to you being unable to attend the inquest into Patient A's death and submitted that this had effectively denied Relative A an opportunity to hear "your side of things".

Mr Hugh-Jones did not oppose any private or sensitive matters being heard in private under Rule 19.

Mr Hugh-Jones told the panel that the allegation against Relative A is unsubstantiated and it is vehemently denied by Relative A. He asked the panel to assess the legitimacy of your complaint. First, it should consider whether it is relevant or related. The alleged incident happened outside of your presence and could not be said to be intimidation in terms of you providing evidence at this hearing. Second, it should consider whether it is active or causal. The alleged incident is said to have occurred some two and a half years ago. Third, is the witness now in fear of giving evidence? Mr Hugh-Jones submitted that the claim under Rule 23(1)(f) did not meet the criteria. He submitted that this rule is a serious protection for witnesses who are in fear of giving evidence because of intimidation for the reason of giving evidence.

Mr Hugh-Jones submitted that there was no evidence to suggest that Relative A would make a screenshot of, or record, these proceedings but that your concerns regarding this may be mitigated by allowing Relative A to attend by audio only.

Mr Hugh-Jones reminded the panel that the underlying principle is that people with an interest should be allowed to attend regulatory hearings. Further, he submitted that it was in the public interest and in the interests of transparency that as much of the hearing as possible should be heard in public.

The panel accepted the advice of the legal assessor.

In respect of Rule 19 the legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

In respect of Rule 23 the legal assessor reminded the panel that Rule 23 deals with vulnerable witnesses. It states:

> ***'23.*** *(1) In proceedings before the Fitness to Practise Committee, the following may be treated as vulnerable witnesses:*
>
> *…*
>
> *(f) any witness who complains of intimidation.*
>
> *(2) After seeking the advice of the legal assessor, and upon hearing representations from the parties, the Committee may adopt such measures as it considers necessary to enable it to receive evidence from a vulnerable witness.*
>
> *(3) Measures adopted by the Committee may include, but shall not be limited to:*

(a) use of video links;

(b) subject to paragraph (4), use of pre-recorded evidence as the evidence in chief of a witness, provided always that such witness is available at the hearing for cross-examination and questioning;

(c) use of interpreters (including signers and translators); and

(d) the hearing of evidence by the Committee in private.

…'

The legal assessor reminded the panel that it was not within its remit to make a finding on the incident you have alleged made you feel intimidated. He advised the panel that it could take these matters into consideration in exercising its discretion and take what steps it considered appropriate, although it cannot resolve the matters in dispute. He pointed out that to join by audio only rather than by video link is the norm for observers in NMC virtual hearings.

The panel gave careful consideration to the matters before it and noted the documentation provided to it. It considered that its decision on how to proceed was finely balanced and took into account the submissions made by you and those made by Mr Hugh-Jones.

With regard to Rule 19, having heard that there will be substantial evidence involving reference to your health and personal circumstances, the panel determined to hold such parts of the hearing in private as and when these issues are raised. It was satisfied that this was justified and that it outweighed any prejudice to the general principle of a public hearing.

In respect of the application under Rule 23, the panel considered this matter and made the following observations. The panel is not here to adjudicate on matters or allegations outside of the charges. It is not within the panel's remit to make any judgement on

whether or not the alleged incident happened or not. You have explained your view and the panel has been told of Relative A's vehement denial regarding the allegation. The panel makes no decision on this allegation as a matter of fact.

The panel considered that Rule 23(1)(f) refers to someone who complains of intimidation and is subjective: only you are able to tell the panel whether or not you feel intimidated. The panel was of the view that you hold a perception that a threat was made and, without delving into matters surrounding that allegation (which would be outside the panel's remit), the panel accepted that you genuinely hold that belief. The panel was therefore satisfied that you are a witness who complains of intimidation and that under Rule 23(1)(f) you may be treated as a vulnerable witness.

The panel was also satisfied that the quality of evidence you are able to provide may be affected by this. The panel reminded itself of its responsibility to receive the best witness evidence possible in order to fulfil its role of protecting the public.

Nevertheless, the panel considered Relative A's position and the effect of excluding relatives from regulatory proceedings, particularly in a case of this kind. The panel considered that it is imperative that hearings be heard in public as far as possible and that this is in the interests of transparency and is therefore in the public interest. The panel considered it to be important for Relative A to be able to hear the parts of your evidence which do not relate to your health or personal circumstances and are not held in private.

The panel noted that Relative A was allowed to attend as an observer by video link (with their own webcam off and audio muted). The panel further noted that this course was exceptional; it is the normal NMC practice for observers in virtual hearings to attend by audio link only. This protects participants from the possibility of their personal data (including images) being recorded without their knowledge, as well as reducing the potential impact of additional participants on the video-conferencing technology.

Relative A made a specific request to observe this hearing and an exception was made owing to the nature of the allegations and Relative A's relationship to Patient A.

Having considered all of these matters, the panel decided that, in order to balance the concerns you have raised with the general principle of hearings being held in public and the particular interests of Relative A, the appropriate and proportionate direction is that Relative A should be invited to attend the public parts of your evidence by audio link only. The panel considered that this should assist you in providing the best evidence possible, thereby assisting the panel in its decision making, and would also provide Relative A with an opportunity to hear those parts of your evidence which are in public in the manner which is usual for observers attending virtual hearings.

For the avoidance of doubt, the panel stresses that it makes no findings in relation to the allegation regarding Relative A, nor should anything be implied from its decision to invite Relative A to join by audio only.

The panel considered this decision to be the reasonable and appropriate way forward considering fairness to all parties involved and the public interest. Relative A will be able to resume attendance by video link once you have completed your evidence.

Day 11 (20 January 2021)

You started your evidence on Day 11. However, due to unforeseen personal circumstances involving a panel member, these proceedings could not continue for the duration of Day 11 of the hearing.

You were informed of the circumstances regarding this and accepted the reasoning behind it.

Decision and reasons on recalling an NMC witness

On Day 12 (21 January 2021), at the close of your case, Mr Hugh-Jones made an application to recall an NMC witness, Relative A.

Mr Hugh-Jones submitted that certain matters had been raised during your evidence which were new and had not been put to Relative A when he gave his evidence. He submitted that this put Relative A at a disadvantage as he had not had an opportunity to speak to these matters during his evidence.

Mr Hugh-Jones told the panel that his questions would be limited to five topics: the frequency of Patient A's appointments being changed from fortnightly to every three weeks; Relative A's attendance at Patient A's consultations and the allegation that this may have been a barrier to building a therapeutic relationship; the day telephone number's use as an out-of-hours telephone number; the consultation of 9 August 2017; and the consultation of 1 September 2017.

Mr Hugh-Jones submitted it would be unjust, unfair and an exclusion of relevant evidence not to allow Relative A to respond to things which had not been put to him in evidence. He submitted that it would be in the interest of relevance and fairness to allow Relative A to be recalled in relation to these matters.

You opposed the application. You objected to Relative A being recalled as a witness on the basis that Relative A had been present (after giving their evidence) for most of the hearing since.

The panel accepted the advice of the legal assessor.

The panel considered whether it would be relevant and fair to recall Relative A.

The panel noted that the application has been made by Mr Hugh-Jones, on behalf of the NMC, as a result of your evidence.

The panel considered the points made by you during your evidence to be relevant to the charges. It was of the view that these points should have been put to Relative A during their evidence. However, the panel levelled no criticism at you for not having done so previously, given your unfamiliarity with the hearings process and your unavailability to attend parts of the hearing previously.

The panel considered that the five areas outlined by Mr Hugh-Jones were clearly relevant to the charges and would cover new matters raised by you. The panel noted that Relative A had chosen not to attend during your evidence and so would have no advantage in that way as they had not heard this new evidence.

The panel therefore decided to allow the application to recall Relative A subject to any further evidence being confined to the five areas outlined above. The panel considered it to be relevant and fair to recall Relative A.

Decision and reasons on application to amend the charges

On Day 13 (22 January 2021), following the legal assessor's drawing attention to the wording, the panel considered whether the charges which read *'did not'* should be amended to '*failed to'*.

Mr Hugh-Jones submitted that there was an underlying inference in the wording of the charges that you had failed to do something that was required. He submitted that his questioning of witnesses, including you, would not have been any different if the wording had been as now proposed as he had asked questions on the basis that things were not done when they should have been done. He submitted that it was a question

of semantics. He submitted that, in the interests of clarity, he was making an application to amend the relevant charges to read '*failed to'* instead of *'did not'*.

You objected to changing the charges at the eleventh hour. You said that the charges had been the same all the way through and that it was not fair to change the charges now, after hearing all of the evidence.

The panel accepted the advice of the legal assessor who reminded the panel that it could amend the charges at any time before it reached a finding of fact. He advised that the panel did not have the power to amend the charges it has already found proved by way of your admission. However, if the panel were so minded it could introduce further charges with similar wording to the charges admitted, except for changing the wording from '*did not'* to '*failed to'*.

The panel decided not to amend the charges at such a late stage. It considered that it would be unfair to you to amend the charges at this point in proceedings. The panel considered that it had taken the sequence of the charges to mean that things were not done and that this led to certain consequences. The panel therefore rejected the application to amend the charges from *'did not'* to *'failed to*'.

Background

You came onto the NMC register in September 2014. You were employed by Oxford Health NHS Foundation Trust (the Trust) in January 2015, first as a Band 5 Nurse at The Day Hospital and from July 2016 as a Band 6 Care Co-ordinator in the Treatment Team, Aylesbury Vale Adult Mental Health Team (the Team).

You were referred to the NMC on 22 May 2018 by Relative A. Relative A is a member of the family of Patient A, the patient involved in the matters which gave rise to this case.

Relative A raised a number of concerns with regard to your management of Patient A's care.

Patient A had a number of diagnoses including Autism, Anxiety disorder, Obsessive-compulsive disorder and Dyspraxia. By May 2016 Patient A was being seen by psychologists on a regular basis and had been prescribed Risperidone and Pregabalin for his diagnosed health conditions. Patient A had in place a Care Co-ordinator and a care plan which stated that he should be seen (or at least contacted) on a fortnightly basis. Patient A's Care Plan had been drawn up in May of 2016. According to the Trust's own standards of reviews every six months (as opposed to a national standard of 12 months) the Care Plan should have been reviewed / updated in November of 2016. The last CPA meeting to review Patient A's care was held in May 2016.

In September 2016 Patient A's previous Care Co-ordinator left. You were subsequently assigned as Patient A's Care Co-ordinator on 31 October 2016 and were responsible for his care in the 11 month period before his death. You met Patient A on a total of five occasions over the 11 months.

You first introduced yourself by way of a telephone call to Patient A on 29 December 2016.

You first met Patient A at a meeting on 20 February 2017. You then met with Patient A on 6 March 2017, 3 May 2017, 9 August 2017 and 1 September 2017. Patient A's case notes confirm you had telephone contact with Patient A on 9 February 2017, 18 May 2017, 19 July 2017.

Patient A's health deteriorated over the course of 2017. Patient A sadly died by suicide on 15 September 2017.

The charges include allegations that you did not provide the appropriate care to Patient A, that you did not recognise a deterioration in his health and that you therefore caused or contributed to his death.

Decision and reasons on facts

At the outset of the hearing (30 January 2020), you made admissions to charges 1, 2, 3, and 4a.

The panel therefore found charges 1, 2, 3 and 4a proved by way of your 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 Mr Hugh-Jones on behalf of the NMC and the submissions made by you.

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 oral evidence from five witnesses tendered on behalf of the NMC. In addition, the panel heard oral evidence from you under oath. The panel also had before it the written witness statement of Witness 5 (Team Manager of the Treatment Function within the Ayelsbury Adult Mental Health Team at the Trust at the time of the allegations).

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

Witness assessment

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from, including you, and made the following conclusions.

Witnesses called on behalf of the NMC were:

Witness 1 – Support Time Recovery Worker for the Trust at the time of the events. The panel considered the evidence of Witness 1 to be generally credible and reliable. He gave his evidence in a straightforward manner and was able to provide the panel with background information about his work with Patient A. Witness 1 did his best to assist the panel but was not able to provide much detail or information in respect of the charges.

Witness 2 – Mental Health Urgent Care Pathway Manager for the Trust. Witness 2 carried out the Root Cause Analysis Investigation into the standard of care Patient A received from the Trust prior to his death. The panel considered Witness 2 to be generally credible and reliable. The panel was of the view that Witness 2 provided useful evidence, albeit she could only speak to the outcome of the Root Cause Analysis Investigation, and she did her best to assist the panel.

Witness 3 – Deputy Manager of the Adult Mental Health Team (AMHT) at the Trust at the time of the events. Witness 3 was your line manager at the time of the incident. Witness 3 made concessions in her evidence; she told the panel that the workload of the whole team was high and painted a picture of a chaotic environment in the AMHT at the time. The panel considered that Witness 3 provided helpful and straightforward evidence. Overall, the panel considered Witness 3 to be clear, credible and reliable.

Dr 6 – Consultant Psychiatrist who produced an independent expert report into the standard of psychiatric care that Patient A received prior to his death. This report was not produced for the purpose of the NMC hearing. The panel considered the evidence of Dr 6 to be professional, credible and reliable. The panel noted that Dr 6 was not a

witness to the facts in this case. He spoke to his opinion and to the contents of his report. Dr 6 was clear when he could not answer questions and was not prepared to go beyond the scope of his knowledge. The panel therefore considered that his evidence was limited in certain respects. The panel considered that Dr 6 was helpful and did his best to assist the panel insofar as he felt able to comment.

Relative A – The panel considered the evidence of Relative A to be credible and reliable. The panel was of the view that Relative A had a good recollection of events, recalling certain things in some detail, and was as clear as could be expected given the significant passage of time. The panel considered Relative A to be measured and balanced in his evidence. He made concessions when required and did his best to assist the panel.

The panel also heard evidence from you on affirmation.

The panel considered your evidence to be, at least generally, credible and reliable. The panel considered that when you gave your evidence-in-chief you were open and candid in your evidence regarding your health and personal circumstances at the time. These clearly had a significant impact on you.

The panel considered that you were, at times, somewhat hesitant in your answers to cross-examination. You carefully considered the questions put to you by the case presenter and were sometimes defensive in your answers, although the panel accepted that you were nervous and it bore in mind that hearings can be an intimidating environment, particularly for unrepresented registrants. The panel noted that there were occasions when you gave apparently conflicting evidence, for example in relation to the out-of-hours telephone number, but that this was generally resolved by further questioning. The panel therefore considered that, whilst you were a credible witness, you were at times less reliable, perhaps due to the passage of time.

Panel's findings on facts

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

Charge 4b

4. Did not review or conduct an updated risk assessment of Patient A's care plan in:
   b. May 2017.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Dr 6's evidence, your oral evidence, Patient A's clinical case notes and the Care Programme Approach (CPA) policy.

The panel noted that your evidence regarding this charge is that you had a telephone conversation with Patient A on 18 May 2017 to '*monitor mood and mental state'*. You pointed out that, in the clinical case notes, there is a section entitled 'Risk' and your assessment was '*Low risk to [themselves] and others'*. You said this showed that you did a risk assessment in May 2017.

The panel considered the evidence provided by Witness 2. Witness 2 said that, whilst it was not specifically written in the CPA policy that a risk assessment had to be conducted via a physical meeting of people, there was an expectation that this would be the case. She told the panel that one cannot summarise a risk or think about risk in terms of the current situation if one does not meet the patient. She told the panel that updating the care plan and risk assessment would be ongoing and it would be updated each time you see a patient, especially if there was a significant change in the presentation or risk profile.

The panel noted the CPA policy provides that a risk assessment is an integral part of the care plan; it does not specifically state how a risk assessment should take place but in the panel's view it is implied that a risk assessment would be an in-depth assessment, not simply an informal consideration of risks and other matters that might, for example, go through one's mind when looking at documents or speaking on the telephone.

In the panel's view Witness 2's evidence that one cannot conduct a risk assessment without meeting the patient, is supported by the consideration that there may be physical signs and symptoms which could be missed if one does not see the patient.

The panel therefore rejected your evidence that you were able to conduct a suitable risk assessment over the telephone. You would be unable to see what else was going on with Patient A, such as their overall appearance, body language and behaviour. The panel preferred Witness 2's evidence as to what is involved in a risk assessment to your evidence. The panel noted that you had only met Patient A on a couple of occasions before this date. The panel considered that it would have been nearly impossible for you to have conducted a proper review and risk assessment with the limited contact and knowledge you had of Patient A, particularly given that you had not read his medical notes in sufficient detail to understand his conditions.

The panel accepted that you would be assessing risks, in a sense, whenever you came into contact with a patient. However, the panel understand the charge to relate to a formal risk assessment. The panel considered there to be no evidence that a formal review and updated risk assessment took place at any time after the last CPA meeting in 2016.

The panel considered that your contact with Patient A by telephone in May 2017 along with the short note relating to 'low risk' did not constitute a review of, or your conducting an updated risk assessment of, Patient A's care plan in the sense intended by the Trust's policy.

The panel therefore found this charge proved.

Charge 5a

5. Did not arrange a review of Patient A's medication despite Patient A expressing concern about his raised anxiety levels and his need to have greater access to services on:
   a. 09 August 2017

This charge is found proved.

In reaching this decision, the panel took into account Relative A's witness evidence, your evidence to the panel and Patient A's clinical case notes from 9 August and 1 September 2017.

Relative A told the panel that they had no memory of a referral for a medical review but that Patient A had discussed his medication with you on 9 August 2017. In Relative A's witness statement it is said that Patient A requested a medical review at his appointment with you on 09 August 2017 but that it did not materialise.

You told the panel that you had a verbal conversation with a secretary and asked that they arranged a review meeting. It is your position that the secretary did not carry this forward and book the review. The panel rejects this submission.

The panel had regard to Patient A's clinical case notes for 9 August 2017. In these there is no reference to a medication review being requested or record that you spoke to a secretary about a review meeting being arranged. The panel was of the view that if this had been done it should, and would, have been recorded.

The panel noted that Patient A's clinical case notes for 1 September 2017 do not contain any suggestion that a review had been asked for before. The panel considered it improbable that you would not have made a note on 1 September that the previously requested review had not taken place after being requested on 9 August 2017.

In light of the above the panel concluded that it was more likely than not that you did not arrange a review of Patient A's medication, despite Patient A expressing concern about his raised anxiety levels and his need to have greater access to services on 09 August 2017.

The panel therefore found this charge proved.

Charge 5b

5. Did not arrange a review of Patient A's medication despite Patient A expressing concern about his raised anxiety levels and his need to have greater access to services on:
   b. 01 September 2017.

This charge is found NOT proved.

In reaching this decision, the panel took into account Relative A's witness evidence, your evidence to the panel and Patient A's clinical case notes from 9 August and 1 September 2017.

In their oral evidence Relative A conceded that medication was discussed and that an outpatient review was requested on 1 September 2017.

You told the panel that you had the medication review meeting in your diary.

In addition, the panel noted the email from you dated 1 September 2017 in which you requested an outpatient appointment for Patient A with the consultant psychiatrist. The panel also took account of your notes of the meeting with Patient A in which you noted that his anxiety remained '*quite high every day*' and that he mentioned the anxiety group. Further you made a note to arrange an appointment with the consultant psychiatrist in relation to his medication.

The panel accepted the evidence that, on 1 September 2017, you noted Patient A's anxiety and that you took steps on the same day to arrange an appointment with the consultant psychiatrist for a medication review.

The panel therefore found this charge not proved.

Charge 7

7. Did not escalate to anyone that you were struggling to meet Patient A's basic nursing requirements.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2 and Witness 3's oral and written evidence along with your evidence.

The panel noted that the material from Witness 2's investigation, which indicated that you did not specifically raise that you were struggling to meet Patient A's basic nursing requirements. She said that she had been unable to find evidence of supervision or support provided to you. She observed that there were high sickness levels within the team as well as high vacancies and a rapid turnover of agency staff. She said the team '*appeared to be firefighting as opposed to carrying out long term work*'.

Witness 3 told the panel that she did not remember you raising any issues regarding Patient A. She also said that she had concerns regarding the team's caseload, including your caseload, but that there were issues with staff shortages which meant it was difficult to reduce caseloads appropriately.

You told the panel that you raised your concerns regarding your caseload with Witness 3 at the time. You said that your caseload had not reduced appropriately given the reduction in the number of hours you were working for the Team. You said that you told her you were struggling and unable to cope with the workload, due to the number of cases you were allocated and your personal circumstances at the time, and that Witness 3 was aware of that. Witness 3's evidence corroborated this. When asked whether you specifically raised issues regarding Patient A's care you admitted that you did not mention Patient A specifically.

The panel considered that it was clear that you had raised with management that you were struggling with the workload. However, little was done to alleviate this due to the issues the team was experiencing at the time.

However, the panel considered that the charge relates specifically to Patient A and whether you raised that you were struggling to meet his basic nursing needs. On the basis of the evidence it has heard, including your evidence at this hearing, the panel has concluded that you did not escalate to anyone that you were struggling to meet Patient A's basic nursing requirements.

The panel therefore found this charge proved.

Charge 8

8. Did not provide Patient A with the out-of-hours service user's phone number.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2, and Relative A as well as your evidence.

Initially during your evidence you said that you would have given Patient A a service users' out-of-hours phone number. Then, in reply to questioning, you told the panel that out-of-hours support could be reached by calling the daytime number as it was redirected out-of-hours. You said that there was no separate out-of-hours service users' phone number.

Witness 2 told the panel that there was no emergency number and that if there was an emergency, the emergency services should be called. She also said that the telephone number for the service was for a switchboard which would be redirected to an out-of-hours clinician outside of normal working hours.

Relative A told the panel that they had never had an out-of-hours number and that if things arose out-of-hours they would generally deal with things themselves and would not call the service. Relative A said that Patient A only had the daytime number and said that he would have saved any number he had been given on his telephone.

The panel noted that it appeared that the previous Care Co-ordinator (of whom Relative A spoke highly) had also not provided a separate out-of-hours number to Patient A, given that neither Patient A nor Relative A had a record of such a number.

The panel reminded itself that it is for the NMC to prove the charge. The panel considered that the NMC had not proved that there was a separate out-of-hours phone number for the service. Indeed, the evidence is to the effect that the daytime telephone number was redirected out-of-hours.

The panel further determined that in these circumstances the NMC had not proved that you had a duty to provide an out-of-hours phone number to Patient A.

The panel therefore found this charge not proved.

Charge 9

9. Were aware your lack of engagement with Patient A unreasonably put Patient A's safety at risk but chose to continue anyway, causing and/ or contributing to Patient A's death.

This charge is found proved in respect of 'contributing to'. The panel did not find this charge proved in relation to 'causing' Patient A's death.

In reaching this decision, the panel took into account all of the evidence before it including its previous findings.

The panel considered that this charge should be considered in three parts: First, were you aware that your lack of engagement with Patient A unreasonably put Patient A's safety at risk; second, if you were aware of this, did you make a choice to continue anyway; and third, if you were so aware and chose to continue, was this the cause of, or a contributory factor in, Patient A's death?

The panel first considered whether you were aware that your lack of engagement with Patient A unreasonably put his safety at risk.

The panel noted that Patient A was a vulnerable mental health patient with a complex history and previous history of attempted suicide. This was evident to the panel from his patient notes and from the evidence of Relative A.

The panel was in no doubt that the level of input Patient A received from you amounted to a lack of engagement and fell well below the level expected from a Care Co-ordinator. You have admitted that you did not read Patient A's medical notes in sufficient detail to understand his condition, clinical history and relapse indicators and that you did not have sufficient contact with Patient A in accordance with his care plan. The panel has found that you did not conduct a formal risk assessment in May 2017 or request a medication review following your contact with Patient A on 9 August 2017.

In the light of your admission that you did not read Patient A's notes, the panel concluded that you did not know of key indicators in Patient A's presentation and risk factors affecting him. You told the panel that you had read other patient's notes and consequently the panel concluded that you were aware of the importance of reading patient notes. Dr 6 also stressed the importance of reading patient notes, saying that this was essential and imperative in providing patient care. He told the panel that patient notes would provide the key indicators and 'red flags' to look for in terms of a patient's risk factors. He said in his oral evidence that if you do not understand the narrative you do not understand the patient.

The panel noted that this was not a one-off instance where you did not read patient notes; you had a total of five in-person consultations with Patient A without fully appraising yourself of his care notes. Even accepting the situation of the team and the issues with your workload, the panel considered that not reading the notes of a patient for nearly a year after taking over their care was a serious omission on your part. The panel considered that you would have been aware that you were putting Patient A at unreasonable risk, in particular by not familiarising yourself with his care notes but also by your lack of contact with him, given that you only had five in-person consultations over a period of ten or eleven months when his most up-to-date care plan stipulated fortnightly meetings. The panel also considered that you would have been aware, as a nurse, that by not conducting risk assessments and reviews on a regular basis, you were putting Patient A at unreasonable risk.

Having found that you were aware that your lack of engagement with Patient A unreasonably put his safety at risk, the panel moved on to consider whether you made a choice to continue this lack of engagement.

The panel considered that one always has a choice of how to proceed and that it is rare that this is a choice unconstrained by outside influences. The panel noted that, in your evidence, you said that you were just trying to carry on and get through. In the panel's view this demonstrated an element of decision-making on your part. You made a choice to continue providing care to Patient A without fully appraising yourself of his care needs.

The panel noted the evidence that you and the Team were under pressure and Witness 2's evidence that the Team *'appeared to be firefighting as opposed to carrying out long term work*'. The panel did note that your caseload was higher than it ought to have been and considered the factors that contributed to this as well as your personal circumstances. Nevertheless the panel considered that, as it found at charge 7, you did not escalate that you were struggling to meet Patient A's basic nursing needs. In the panel's judgment you chose to continue even though you were aware that your lack of engagement with Patient A put his safety at risk.

The panel therefore moved on to consider whether your actions were a causal or contributory factor in Patient A's death.

The panel considered that, had you read Patient A's notes and provided the appropriate level of engagement with his care, you would have been more aware of the key signs which indicated a deterioration in his mental health. You would have been aware, for example, of his history of attempted suicide. Dr 6 gave evidence that you would have had access to the resources of the multi-disciplinary team and that you should have accessed those resources to assist you to support Patient A. The panel considered that by not reading Patient A's notes, not adhering to the care plan and fortnightly meetings, not organising a CPA review, not conducting a formal updated risk assessment and not

ensuring that a medical review took place at the first sign of deterioration in Patient A's health, your actions had placed Patient A's safety at unreasonable risk and were contributory factors in Patient A's death.

However, the panel considered that your actions were only one aspect of a 'perfect storm' which appeared to have contributed to Patient A's death. The panel recognised that there were other factors impacting on Patient A at that time. The panel has heard that changes to the system and services had an effect on Patient A. Relative A explained that from early 2016 onwards the services which had been provided to Patient A were gradually eroded leaving Patient A effectively abandoned. Dr 6 explained that there were a number of changes in Patient A's care which meant that the support was not as robust or as consistent as it had been previously. Dr 6 told the panel that it was likely that the significant changes in 2015-2017 including the change of consultant, cessation of psychology sessions, the change in Care Co-ordinator (from one with whom Patient A had built up a good relationship to someone new), the introduction and then withdrawal of a support worker (Witness 1) and the loss of direct face-to-face contact and continuity of direct clinical care with a consultant psychiatrist were all factors which were likely to have contributed to a deterioration in Patient A's health and his rising levels of anxiety. Dr 6's conclusion was that the failures in an effective process of care delivery made a material contribution to the deterioration in Patient A's mental wellbeing prior to his suicide in September 2017. The pattern of therapeutic disengagement, coupled with a reduction in contact with members of the multidisciplinary team, was a change in the overall culture of care that is likely to have contributed to Patient A's rising level of anxiety. Dr 6 concluded that if Patient A had been receiving a 'reasonable' standard of care it was likely that his difficulties would have been appropriately addressed and his subsequent suicide avoided.

The panel determined that, whilst your lack of engagement was a contributory factor in Patient A's death, there were other and wider contributory and causal factors. It determined that you could not be held responsible for the failings in the mechanisms of care at the Trust.

The panel concluded that, on the balance of probability, you were aware that your lack of engagement with Patient A unreasonably put his safety at risk but that you chose to continue anyway and that this was a contributing factor in Patient A's death.

The panel therefore found this charge proved in respect of 'contributing to' but not proved in relation to 'causing' Patient A's death.

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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of*

general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

Mr Hugh-Jones invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Hugh-Jones provided written submissions to the panel in which he identified the specific, relevant standards where the NMC contends your actions amounted to misconduct. He referred to the comments of Jackson J in *Calhaem v GMC* [2007] EWHC 2606 (Admin) and Collins J in *Nandi v GMC* [2004] EWHC 2317 (Admin) respectively:

> '[Misconduct] *connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired*'.
>
> And
>
> '*The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner*'.

Mr Hugh-Jones took the panel through the chronology of your contact with Patient A and submitted there was a clear deterioration in Patient A over the course of 2017. He submitted there was a serious paucity of care for a vulnerable person and that your actions amounted to misconduct.

You did not make specific submissions regarding misconduct; rather you focused your submissions on impairment.

Submissions on impairment

Mr Hugh-Jones moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as its regulatory body. He included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Hugh-Jones submitted that the charges indicated a serious level of misconduct, with charge 9 likely to be the most serious charge that would be before a panel. He submitted that all of the charges found proved represented care which fell egregiously short of what Patient A and the public would have expected. He submitted that the public would be astonished and horrified to learn that you had not read Patient A's notes in ten months. He submitted that you were aware that your lack of engagement unreasonably put Patient A's safety at risk, that you chose to continue regardless of that known risk and you thereby contributed to Patient A's death. He submitted that your misconduct brought the profession into disrepute and breached fundamental tenets of the profession.

Mr Hugh-Jones invited the panel to consider whether your conduct is capable of remediation, whether it has been remediated, and whether your actions are likely to be repeated in future. He submitted that the misconduct in this case was so bad that remediation was difficult and repetition was likely. He noted that you reference attending two training courses but highlighted that these were uncertified.

Mr Hugh-Jones invited the panel to find that your fitness to practise is currently impaired.

You submitted that you have addressed the factors that were impacting on your practice at the time and that you do not think that your nursing practice is currently impaired.

You provided a reflective piece to the panel. In this you explained that when you returned to work you continued to practise as a nurse for over a year, with no concerns, until your PIN was suspended by the NMC in connection with this case. You stated that: *'During that time, I followed a robust action plan which included weekly supervision. I was up to date with my mandatory training and also completed a 3-day suicide prevention course and a 3-day advanced assessment skills course to improve my knowledge and skills further. I also completed the nursing mentorship course.'*
You also stated: '*What happened to patient A lays heavily on my heart and always will do. I am unable to change the past by i can change the way i practice in the future.' (sic)*
You recognised that you failed in your responsibility towards Patient A.

[PRIVATE]

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgements.

Decision and reasons on misconduct

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

The panel was of the view that your actions amounted to a breach of the Code, specifically:

1 Treat people as individuals […]

1.2 Make sure you deliver the fundamentals of care effectively.

1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

2 Listen to people and respond to their preferences and concerns.

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

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

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

8 Work co-operatively

8.2 maintain effective communication with colleagues

8.6. share information to identify and reduce risk.

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

13 Recognise and work within the limits of your competence

13.1 accurately identify, observe, and assess any signs …of worsening mental health in person receiving care.

13.2 Make a timely referral to another practitioner when action, care or treatment is needed.

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

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

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

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

20 Uphold the reputation of your profession at all times

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in this case the facts found proved represented a course of conduct which was a serious departure from the standards expected of a nurse.

The panel considered that there was a catalogue of errors and omissions over a ten-month period which included a failure to read Patient A's records and a lack of contact with Patient A, resulting in you having an insufficient knowledge and understanding of Patient A's background and needs. You omitted to carry out a proper risk assessment and did not act in a timely manner to escalate concerns raised by Patient A and their relative. In addition, you did not recognise or flag up your own health issues and your

difficulty in meeting Patient A's nursing needs. The panel has found that your actions over this period put Patient A at serious risk of harm and ultimately contributed to his death. The panel concluded that your behaviour over the ten months would be considered deplorable by other professionals.

The panel therefore found that your actions amounted to misconduct which was serious.

Decision and reasons on impairment

The panel next went on to decide if, as a result of your misconduct, your 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. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the … 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) *…'*

The panel has found that Patient A was put at unwarranted risk of harm as a result of your misconduct. Your lack of engagement with Patient A was a choice that you made at the time and you chose to continue knowing that this put Patient A's safety at risk. The panel has determined that this was a contributory factor in his death. The panel further considered that your misconduct had breached the fundamental tenets of the nursing profession and also brought the profession into disrepute.

Regarding insight, the panel took account of your reflective piece. The panel considered that you have developing but limited insight into your misconduct. You have reflected on the events which occurred over the ten-month period and you have acknowledged the steps you should have taken at the time, [PRIVATE]. However, the panel considered that your insight was primarily focused on yourself. You have not yet demonstrated an understanding of the full impact of your actions on Patient A and his family, your work colleagues and the nursing profession as a whole.

The panel noted that you have expressed some remorse for the impact of your actions on Patient A.

The panel considered whether your misconduct was remediable. The panel determined that although remediation may be difficult it was possible for you to fully remediate your misconduct and it acknowledged that you had taken some steps towards achieving this. You informed the panel that you attended courses on suicide prevention and advanced assessment skills although the panel has not had sight of any certificates to corroborate this. The panel also noted that you undertook these courses when you returned to work and that this was some two years ago. The panel accepted that it can be difficult to demonstrate remediation when not working as a nurse but considered there were other things that you might have done to demonstrate remediation in the last two years. For example keeping your nursing knowledge up-to-date, testimonials, [PRIVATE].

However, in the absence of full remediation and your limited insight the panel is of the view that there is a risk of repetition if you found yourself in similar circumstances. 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 are not only to protect, promote and maintain the health, safety, and well-being of the public and patients but also to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper professional standards for members of those professions.

The panel therefore went on to consider whether the need to uphold proper professional standards and maintain public confidence in the profession would be undermined if a finding of impairment of fitness to practise were not made. The panel considered your misconduct to be serious and to have contributed to the death of Patient A. The panel

considered that if a member of the public were made aware of all the circumstances of this case they would expect a finding of impairment on public interest grounds.

The panel considered that a finding of current impairment was needed in order to maintain public confidence in the profession, and in the NMC as its regulator and to uphold proper professional standards. The panel therefore determined that a finding of impairment on public interest grounds was required.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. The panel accordingly directs the registrar to strike you off the register. This means that the NMC register will show that you have 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. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Hugh-Jones, whilst recognising that the decision on sanction was for the panel alone, submitted that the NMC considered a striking-off order to be the only appropriate sanction in this case and the only one which would be supported by the public.

Mr Hugh-Jones took the panel through the aggravating and mitigating factors, which, in the NMC's view, were present in this case. He also highlighted the SG and the Guidance on seriousness.

Mr Hugh-Jones submitted that your insight was virtually absent. He took the panel through examples of where he considered your insight to be lacking. He submitted that your reflective piece was 'shocking in its lack of detail' especially three and three quarter years after Patient A's death.

Mr Hugh-Jones submitted that remediation was not possible in this case. In the NMC's view this is an attitudinal case where choices have been made rather than a case where there was a genuine clinical error.

Mr Hugh-Jones also submitted that there was a pattern of misconduct over ten months in which you did not read Patient A's notes. He likened it to 'treating a patient with your eyes shut' and said it was intentionally reckless. He reminded the panel that it had found you had made a deliberate choice; that you were aware that you were putting Patient A at an unreasonable risk and chose to take that risk. He highlighted that you have made no apology and there is no evidence of testimonials or up-to-date knowledge. He submitted that there was a risk of repetition given the attitudinal issues the NMC considers to be present.

Mr Hugh-Jones recognised you had made some admissions to the charges at the outset and there was some evidence regarding your health and personal circumstances. However, he submitted that the mitigation in this case was distinctly lacking in potency. He said that your admissions were equivocal and that you contested charge 9 'tooth and nail' which, in his view, further demonstrated your lack of insight. He submitted that, without insight, the facts found proved, which were already serious enough to warrant the highest sanction, had become even more grave and deeply concerning.

Mr Hugh-Jones reminded the panel of the SG and submitted that your actions were fundamentally incompatible with registration. He submitted that the NMC's position is that this case is so serious and there is such a lack of insight that a striking-off order is the only option.

You provided written submissions for the panel but were not able to join the last two days of the hearing [PRIVATE].

In your written comments you explain the difficulties you have had in understanding and following the processes without a legal representative. You said that you struggled to know what was expected of you and when and that this had made it difficult for you to prepare. [PRIVATE].

You said that you are not seeking to use excuses but to explain factors. You said that you strongly believe that the significant issues you were experiencing at the time affected your practice and caused it to fall below standards. You said [PRIVATE], you failed in your job and for that you are deeply sorry and that being sorry will never be enough, to Patient A's family and towards your profession. You said you were unable to fulfil your duties to the standard to which they should have been carried out for Patient A and his family.

You explained that you tried to continue to work because of how bad things were at work and within the team. You understand that your attitude in doing so had contributed to Patient A's family losing a son and you recognised the impact and distress this caused. You said you know you will never be able to put this right, that this haunts you and will continue to do so, and that you are deeply sorry.

You said that you can see that you let Patient A's family down as they put their trust in you and the Trust to help and support them. You recognised that you fell below the standards expected of you as a professional and that this has reflected badly on the

Trust and the NMC. You said you are remorseful for Patient A's family's loss and the fact that you did not do your best for Patient A at the time.

You explained that in future if you were ever in a similar situation you would stop working immediately. You said that you have learnt a lot from this situation and would never let anything like this happen again.

You asked the panel to consider the least restrictive sanction it considered appropriate. You said that you were prepared to undergo any necessary training and that you would like the opportunity to return to work, with restrictions, and develop in your profession if possible.

Decision and reasons on sanction

Having found your 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:

- Your misconduct continued over a significant period of time;
- Your misconduct put Patient A at risk of harm and contributed to his death;
- You made a deliberate choice to carry on, although the panel recognised that this was a constrained choice in terms of your workload, the chaotic environment in the Team at the time as well as [PRIVATE];
- You have demonstrated only limited insight;

The panel also took into account the following mitigating features:

- You made some admissions at the outset;
- You have apologised, during this hearing, for your misconduct and you made some limited efforts to remediate the concerns;
- Your working environment at the time was described as ‘chaotic’ and ‘firefighting’. There was a high workload in the Team, staff shortages and a lack of support and supervision. You did raise concerns about your workload albeit this was not specific to Patient A;
- Personal mitigation including your difficult personal circumstances during this ten-month period and [PRIVATE].

The panel was aware that it could impose any of the following sanctions; take no action, make a caution order for a period of one to five years, make a conditions of practice order for no more than three years, make a suspension order for a maximum of one year, or make a striking-off order.

The panel considered the potential sanctions in ascending order of restrictiveness.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel has already found that your fitness to practise is impaired on the grounds of public interest as well as on public protection grounds. The panel concluded that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 your actions were not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. In addition, the panel has found your fitness to practise impaired on public

protection grounds and a caution order would provide no restriction on your practice. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

It then considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel considered that the misconduct identified in this case, whilst theoretically remediable, was not something which could be addressed through the imposition of conditions, especially in light of the panel's findings regarding your limited insight and remediation.

The panel was also of the view that there are no conditions which would be suitable given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of 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:

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

The panel accepted that there is no evidence of repetition since the incident, noting that you worked as a nurse unrestricted for a period of time prior to the NMC suspending your registration by an interim suspension order. In addition the panel did not consider that there was any evidence of harmful deep-seated personality or attitudinal problems.

The panel (whilst recognising your misconduct related to one patient) considered that this was not a single instance of misconduct, rather there was a catalogue of errors and omissions over a ten-month period. The panel has found that you were aware your lack of engagement put Patient A's safety at unreasonable risk and that you made a choice to continue without specifically raising that you were struggling to meet his needs.

Whilst you appear to have some insight into the contributory factors that your health and personal circumstances had on the standard of care you provided, the panel was not satisfied that you had sufficient insight into the impact of your actions on Patient A, their family, your colleagues or the reputation of the nursing profession. In the panel's view there is a significant risk that your misconduct may be repeated if similar circumstances were to recur.

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?'*

The panel considered that your actions, as highlighted by the facts found proved, were significant departures from the standards expected of a registered nurse. The panel considered that the serious breach of the fundamental tenets of the profession evidenced by your misconduct is fundamentally incompatible with you remaining on the register. Patients and the public would expect a nurse in charge of someone's care

(particularly in the position of a Care Co-ordinator) to appraise themselves of a patient's care notes, to have an appropriate level of contact with a patient in line with their care plan, to carry out proper risk assessments and to act in a timely manner to escalate concerns raised by patients and their relatives, as well as to recognise or flag up your own health issues and your difficulty in meeting a patient's nursing needs.

The panel recognised that the public interest considerations in this case are high, given the seriousness and nature of the charges found proved. The panel was of the view that the findings demonstrate that your misconduct was so serious that to allow you to continue to practise 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 only appropriate and proportionate sanction is a striking-off order. 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 declare to the public and the profession the standard of behaviour required of a registered nurse.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Hugh-Jones. He submitted that an interim suspension order, for a period of 18 months, should be made to cover the 28-day appeal period. He submitted that this was appropriate given the panel's findings.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. In reaching the decision to impose an interim order, 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 not to make such an order would be incompatible with its earlier findings and with the substantive sanction it has imposed. The panel first considered whether it was appropriate to impose an interim conditions of practice order, but considered that this was not appropriate for the reasons identified at the sanction stage.

The panel therefore decided to impose an interim suspension order for the same reasons as it imposed the substantive order and to do so for a period of 18 months in light of the likely length of time that an appeal would take to be heard if one were lodged.

In reaching its decision the panel bore in mind the effect of its order on you, professionally and financially. The panel was satisfied that the order is appropriate and proportionate and properly balances the impact of the order on you and the need to protect the public and to meet the public interest.

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

This determination will be confirmed to you in writing.

That concludes this determination.