Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
21 – 29 June 2021

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	Susan Dorinda Tate
NMC PIN:	83D0386E
Part(s) of the register:	Registered Nurse – Adult Nursing Level 2 – June 1985 Level 1 – May 1997 Children Nursing – December 1999 Health Visitor/Community Practitioner Nurse Prescriber – July 2005 Midwife – May 2010
Area of registered address:	Northamptonshire
Type of case:	Misconduct and Health
Panel members:	David Evans (Chair, Lay member) Rachel Jokhi (Registrant member) Mary Scattergood (Registrant member)
Legal Assessor:	Michael Epstein
Panel Secretary:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mrs Tate:	Present and represented by Thomas Buxton, Counsel instructed by the Royal College of Nursing (RCN)

Facts proved by admission:	Charges 1, 2a), 2b), 3 (in its entirety), 4, 5a) (in its entirety), 5b), 5f), 5g), 5h), 7i), 7ii), and 8i),
Facts proved:	Charges 2c), 5c) 5d), 5e) (in its entirety),
No Case to Answer:	Charges 6 and 9
Facts not proved:	Charges 7iii, 8ii., 10
Fitness to practise:	**Impaired**
Sanction:	**Strike-Off Order**
Interim order:	**Interim Suspension Order**

Details of charge

That you, a registered nurse and midwife:

1. [PRIVATE]

2. On 3 January 2017, whilst working on the Rowan Ward of Kettering Hospital, in relation to Patient B:
    a. Made no entry in the notes between 15:30 and 16:30;
    [PROVED BY ADMISSION]
    b. Provided no explanation in the notes as to why the CTG had stopped between 15:59 and 16:31;
    [PROVED BY ADMISSION]
    c. Did not properly escalate concerns in that you bleeped the Registrar using the normal bleep as opposed to the fast bleep. **[PROVED]**

3. On 26 January 2017, whilst working in the Delivery Suite of Kettering Hospital, after discharging Patient A: **[PROVED BY ADMISSION in its entirety]**
    a. Told Colleague A that the meconium stained pads were not Patient A's and/or that Patient A had brought her pads in a Sainsbury's bag and/or that the liquor on the pads you had seen was clear;
    b. Told Colleague A that you had phoned Patient A and/or that Patient A had confirmed that her liquor was clear;
    c. Told Colleague B that the meconium stained pads were not Patient A's and/or that Patient A had brought her pads in a Sainsbury's bag;
    d. Told Colleague B that you had phoned Patient A and/or that Patient A confirmed that the clear bag with the meconium stained pads was not hers;
    e. Told Colleague C that you had phoned Patient A and/or that you left a message on her answerphone.

4. Your actions at charge 3 were dishonest in that you intended to give the impression that the meconium stained pads did not belong to Patient A and that there was no reason for you not to discharge her. **[PROVED BY ADMISSION]**

5. Whilst working at Midland Care Home:
    a. Did not request further stock of Butrans patches for Resident C:
        i. On 30 January 2018 when the stock level was one; **[PROVED BY ADMISSION]**
        ii. On 6 February 2018 when the stock level was zero. **[PROVED BY ADMISSION]**
    b. On 7 February 2018 signed that you had given Isosorbide Nitrate to Resident D when you had not; **[PROVED BY ADMISSION]**
    c. On or around 16 February 2018 did not follow up with the GP surgery and/or the pharmacy a prescription of Amlodipine for Resident E; **[PROVED]**
    d. On 22 February 2018 incorrectly calculated the stock levels of Zomorph for Resident F; **[PROVED]**
    e. On or around 26 February 2018 in relation to an unknown resident:
        i. Did not record the date that you opened a new box of Warfarin tablets; **[PROVED]**
        ii. Administered Warfarin to the resident but failed to sign the MAR chart. **[PROVED]**
    f. On 9 April 2018 signed that you had given Resident G his Gabapentin medication when you had not; **[PROVED BY ADMISSION]**
    g. On 10 April 2018 signed that you had given Resident C his morning medications when you had not; **[PROVED BY ADMISSION]**
    h. Between January and April 2018 used blue ink as opposed to black ink to complete medication administration records. **[PROVED BY ADMISSION]**

6. On 23 February 2018 signed the initials of Colleague D as second checker for Zomorph when she had not been present. **[NO CASE TO ANSWER]**

7. On 6 March 2018, in relation to Resident H, after being alerted to by a carer to her head wound:
    i. Did not document and/or photograph it; **[PROVED BY ADMISSION]**
    ii. Did not complete an accident report; **[PROVED BY ADMISSION]**
    iii. Did not pass the information over at handover. **[NOT PROVED]**

8. On 8 April 2018:
    i. Signed the initials of Colleague E on the MAR chart of Resident F when he was not present. **[PROVED BY ADMISSION]**
    ii. When asked by Colleague E how his initials were on the chart told him that you did not do it and/or did not know who had done it. **[NOT PROVED]**

9. Your actions at charge 6 were dishonest in that you intended to give the impression that Colleague D had been present as a second checker when she had not. **[NO CASE TO ANSWER]**

10. Your actions at charge 8 were dishonest in that you intended to give the impression that Colleague E had given the medication and/or that it was not you that had made the entry. **[NOT PROVED]**

AND, in light of the above, your fitness to practise is impaired by reason of your health in relation to charge 1, and by reason of your misconduct in relation to charges 2 to 10.

<u>Schedule 1 (private, not to be published)</u>
[PRIVATE]

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

At the outset of the hearing, Mr Kennedy made a request that this case be held partially in private on the basis that proper exploration of your case involves your health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Buxton indicated that he supported the application that any reference to your health should be heard in private.

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.

The panel determined to go into private session in connection with your health as and when such issues are raised in order to protect any reference to your health, as these matters are inextricably linked to this case.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Buxton that there is no case to answer in respect of charges 6 and 9. This application was made under Rule 24(7).

In relation to this application, Mr Buxton submitted that Colleague D in her oral evidence stated that signing the initials was an exercise of clarification. Both Charge 6 and charge 9 refer specifically to the role of second checker. Mr Buxton reminded the panel that Colleague D acknowledged that they were working together checking the stock and administering the drug itself. He submitted that the entry made by you and signed by Colleague D in the controlled drug book accurately shows that the drug administration was carried out by you and Colleague D together. He submitted that the purpose of a second

checker is to ensure that the drugs were entered correctly, he submitted that you and Colleague D working together therefore means that there was a second checker. He submitted that the evidence shows that a mistake had occurred in the miscalculation of a drug and that you and Colleague D were working together to correct and update the record, you annotated the record with yours and Colleague D's initials, but this was not a record of drug administration. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

Mr Kennedy submitted that the evidence before the panel is that you and Colleague D worked together on an investigation in relation to a number of tablets. He acknowledged that Colleague D stated that you and she had been doing that together. Mr Kennedy stated that it is clear from the evidence that Colleague D was present. He therefore agreed with Mr Buxton and invited the panel to let charge 6 fall. He submitted that charge 9 is intrinsically linked with charge 6 and should therefore fall as well.

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

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 6 and therefore also charge 9 proved. It noted that you and Colleague D were undertaking an exercise of clarification on the Medication Administration Record (MAR) and that Colleague D stated that she was present and was therefore the 'second checker'. The panel therefore agreed with Mr Buxton and Mr Kennedy that the evidence before it would not lead to charge 6 being proved. It noted that charge 9 was intrinsically linked to charge 6 and that it would

therefore also not be found proved. The panel therefore decided that there was no case to answer in respect of charge 6 and 9.

Background

The charges arose whilst you were employed as a registered midwife by Kettering General Hospital NHS Foundation Trust ('the Trust'). You started your employment at the Trust in May 2010 but were dismissed from your role in October 2017.

On 3 January 2017, whilst working on the Rowan Ward of the Trust you failed to properly escalate concerns with regards to Patient B's cardiotocography ('CTG'). It showed that the baby had been in distress and urgent action was needed. It is alleged that you bleeped the Registrar, however, failed to use the emergency bleep 2222. It is further alleged that you did not make any notes in the patient records regarding the CTG between 15:30 and 16:30 and were therefore not able to provide an explanation as to why the CTG had stopped between 15.59 and 16.31.

An alleged incident occurred on 26 January 2017, at 10:00. Patient A arrived at the Delivery Suite of the Trust after calling in to report that she thought her waters had broken. You took over Patient A's care after the Suite Coordinator conducted a CTG. Patient A was admitted at 39 weeks and 2 days of her pregnancy, with a history of pre-labour spontaneous rupture of membranes. She attended with her husband and was discharged by you at 13:36 to return for induction of labour in 24 hours. A clear bag of heavily meconium-stained pads was subsequently discovered next to the bed Patient A had occupied, by a senior midwife. You were asked if the pads belonged to Patient A. You stated that Patient A had brought pads in a Sainsbury's bag and that, from Patient A's vaginal examination, you had seen clear liquor. You initially stated that you had called Patient A to confirm that the pads did not belong to her and that Patient A had confirmed that the liquor was clear. The Senior Midwife called Patient A, who stated that she had not been contacted by you and that she had brought in stained pads. Patient A was advised to return to the Delivery Suite. Upon being questioned again later in the day, you said that

you had called Patient A but had left a message on an answer machine. The Lead Midwife explained that the presence of meconium liquor in a patient admitted at 39 weeks can indicate fetal distress, which may be catastrophic for the baby. You were sent home from your shift.

There are additional concerns regarding an underlying health issue affecting your ability to practise without restriction.

Further concerns were raised by Midland Care Home ('the Home') where you were employed as a registered nurse from mid-January 2018.

It is alleged that between January 2018 and April 2018 you made a number of medication errors by either not correctly dispensing, documenting or both when you were responsible for administering the medication. This allegedly included signing that you had given medication when you had not, not following up with the GP surgery or pharmacy regarding an Amlodipine prescription, not recording the date you opened a new box of Warfarin and using blue as opposed to black ink when completing medication administration records.

It is further alleged that on 6 March 2018 after being alerted by a carer to a resident's head wound you did not document or photograph the wound, you did not complete an accident report and you did not pass the information over to the nurse in charge, or the carers at handover.

It is also alleged that on 8 April 2018 when completing a MAR chart with regards to Resident F you signed the initials of Colleague E, when he was not present at the time the medication was given, nor was he on duty at that time. When confronted by Colleague E you allegedly stated that it was not you who signed with his initials, nor did you know who had done it. It is alleged that with these actions you intended to give the impression that Colleague E had given the medication, when he had not.

Facts

At the outset of the hearing, the panel heard from Mr Buxton, who informed the panel that you made full admissions to charges 1, 2a), 2b), 3 in its entirety, 4, 5a) in its entirety, 5b), 5f), 5g), 5h), 7i), 7ii), and 8i),.

The panel therefore finds charges 1, 2a), 2b), 3 in its entirety, 4, 5a) in its entirety, 5b), 5f), 5g), 5h), 7i), 7ii), and 8i) 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 Kennedy on behalf of the NMC and by Mr Buxton on your behalf.

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

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

- Ms 1: Delivery Suite Sister at Kettering General Hospital, at the time of the allegations

- Colleague B: Delivery Suite Co-Ordinator at Kettering General Hospital, at the time of the allegations

- Colleague D: Floor Manager at Midland Care Home

- Ms 2: Staff Nurse at Midland Care Home, at the time of the allegations

- Colleague E: Senior Carer at Midland Care Home, at the time of the allegations

- Mr 3: Home Manager at Midland Care Home, at the time of the allegations

The panel also heard evidence from you on affirmation.

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

The panel considered the evidence of the witnesses and made the following assessments:

Ms 1: The panel considered the evidence of Ms 1 to be credible. The panel found her to be a helpful witness who was fair to you and gave you credit when appropriate. Ms 1 was clear in her recollection of events. She was honest when she could not remember. The panel found her to be knowledgeable. The panel found Ms 1 to be a reliable witness.

Colleague B: The panel considered the evidence of Colleague B to be credible. Colleague B provided the panel a background to the events. Colleague B mainly talked to the charges you had already admitted and the significance of meconium. The panel found her to be clear, concise and informative. The panel found Colleague B to be a reliable witness.

Colleague D: The panel considered the evidence of Colleague D to be credible. Colleague D was trying to help the panel to the best of her abilities. The panel was of the view that Colleague D's evidence was in line with her written statement but was occasionally inconsistent. The panel was of the view that Colleague D was fair to you but seemed defensive of her own management at times. The panel found Colleague D to be not entirely reliable.

Ms 2: The panel considered the evidence of Ms 2 to be credible. The panel found Ms 2 to be helpful. Ms 2 provided a detailed picture of the Home and the work environment there. The panel found her to be clear and fulsome with her descriptions and providing useful context of the Home. The panel found her to be honest and a reliable witness.

Colleague E: The panel considered Colleague E to be forthright and clear in his evidence. However, the panel found that there were inconsistencies in his written and oral evidence over time. It therefore found Colleague E to be less reliable than other witnesses.

Mr 3: The panel was of the view that Mr 3 tried to help the panel to the best of his abilities. He provided the panel with an overview of the work environment within the Home, the support that was offered to you and the action plans that were created for you. The panel noted that Mr 3 was clear and consistent at the start of his evidence, however, became less consistent as time went on. The panel noted that Mr 3 became somewhat defensive when it came to his style of management. The panel therefore found him less reliable than other witnesses.

You: The panel was of the view that you were clear and direct describing your version of events. You were honest when you could not remember things and were prepared to answer any questions put before you. You seemed remorseful, reflective and accepted the responsibility for your actions to

some extent. However, the panel noted that at times you deflected the blame onto context and the fact that you had not worked in a care home for a considerable amount of years. It found that your answers to some of the charges were not necessarily plausible.

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

Charge 2c)

2. On 3 January 2017, whilst working on the Rowan Ward of Kettering Hospital, in relation to Patient B:
    c. Did not properly escalate concerns in that you bleeped the Registrar using the normal bleep as opposed to the fast bleep

This charge is found proved.

In reaching this decision, the panel took into account your, Ms 1 and Colleague B's written and oral evidence. It also took account of Patient B's medical notes and her CTG printout, the Datix entry for the incident as well as the Trust's guidelines for inducing labour and antenatal and intrapartum fetal monitoring.

The panel noted that in your evidence you were describing the situation as you remembered it. It noted that you knew the process of calling for an emergency and the measures to be taken in such an event. However, it also noted that you did not appear to recognise that the same emergency measures apply in the antenatal ward as in the labour ward.

The panel was of the view that when you were interpreting the CTG, although you did recognise the baby was in distress, and did undertake some appropriate resuscitative procedures, you did not appreciate the gravity of the event and recognise that this required an emergency response. When asked in cross examination what you would have

done in hindsight you stated that you should have used the fast bleep. The panel noted that the CTG indicates the baby was in distress and that you as a registered midwife with experience should have recognised this. The panel noted that you did contact the Registrar, however, did not do so with the urgency required and through the fast bleep. The panel was therefore of the view that you did not properly escalate the concerns as would be expected in an emergency situation.

The panel was satisfied that on the balance of probabilities, that it is more likely than not, that on 3 January 2017, whilst working on the Rowan Ward of Kettering Hospital, in relation to Patient B, you did not properly escalate concerns in that you bleeped the Registrar using the normal bleep as opposed to the fast bleep

Charge 5c)

5. Whilst working at Midland Care Home:
    c. On or around 16 February 2018 did not follow up with the GP surgery and/or the pharmacy a prescription of Amlodipine for Resident E;

This charge is found proved.

In reaching this decision, the panel took into account your and Colleague D's oral and written evidence. It also noted the log of conversation provided by the Home.

The panel noted that there is no evidence before it showing a record of a conversation with the GP surgery or the pharmacy regarding Amlodipine for Resident E. It noted that Colleague D stated in her written statement:

> '[Mrs Tate] *failed to follow up with the GP surgery and pharmacy about* [Resident E]'*s prescription for amlodipine, a blood pressure medication, leaving us with insufficient medication stock. I have a feeling this* [Resident E] *went to hospital and may have come back with a quantity of new medication mid-way through our monthly mediation ordering cycle, and* [Mrs Tate] *failed to request additional*

medication to make sure [Resident E] *had enough medication to last until the new cycle.*'

The panel noted that Colleague D confirmed this during her oral evidence. It further noted Colleague D's log of conversation, dated 16 February 2018 and signed by you and Colleague D, which states:

'*failed to follow up to surgery to prescribe, failed to follow up pharmacy*

[…]

Make sure to inform loyal Pharmacy if we need those mediations to [unreadable] – *up the monthly cycle. Please communicates via using Fax + make sure transmission report is keep for evidence + also write in diary + communication book.*'[sic]

The panel noted that you stated that you did contact the GP/Pharmacy to acquire the medication needed, but did not record it. It noted that you acknowledged that in nursing if there '*is no record then it has not been done*'. It noted that you appreciated the need of accurate record keeping in nursing.

However, the panel further noted that the requested medicines did not arrive. In this case it preferred Colleague D's evidence over yours and concluded that you did not contact the GP or the pharmacy to request more Amlodipine for Resident E.

The panel was therefore of the view that, on the balance of probabilities, it is more likely than not that whilst working at Midland Care home, on or around 16 February 2018, you did not follow up with the GP surgery and/or the pharmacy a prescription of Amlodipine for Resident E.

Charge 5d)

5. Whilst working at Midland Care Home:
    d. on 22 February 2018 incorrectly calculated the stock levels of Zomorph for Resident F;

This charge is found proved.

In reaching this decision, the panel took into account your and Colleague D's oral and written evidence. It also took account of the log of conversation dated 28 February 2018 and the medication records for Resident F.

The panel noted the medication records for Resident F. These show that the Zomorph for Resident F had a calculation error earlier on the sheet. The panel noted that whilst you did accurately subtracted the amount of Zomorph administered from the running total, the running total was inaccurate due to a calculation error earlier on. So whilst the arithmetic was correct the actual stock held was a different from that recorded.

The panel noted your explanation that whilst you counted controlled drug stock whilst working at the Trust every time a controlled drug was administered you had been told at the Home that this was not necessary. The panel however, noted that the nurse on night shift did count the stock in order to make a correct calculation of the Zomorph, which is when she discovered the error.

The panel was of the view that irrespective of what you might have been told at the Home it is a nurse's duty to count the controlled drugs before administering it, and to ensure that the stock number is correctly entered. The panel was therefore of the view that it was your duty as a registered nurse to calculate the Zomorph stock correctly, by counting the total number of tablets in stock, but you failed to do so.

The panel is therefore satisfied that, on the balance of probabilities, it is more likely than not that whilst working at Midland Care Home, on 22 February 2018, you incorrectly calculated the stock levels of Zomorph for Resident F.

Charge 5e) i.

5. Whilst working at Midland Care Home:
    e. On or around 26 February 2018 in relation to an unknown resident:
        i. Did not record the date that you opened a new box of Warfarin tablets;

This charge is found proved.

In reaching this decision, the panel took into account your, Colleague D's and Mr 3's oral and written evidence.

The panel noted that Colleague D and Mr 3 both stated that whilst there was no requirement nor a policy to date a newly opened box of Warfarin tablets, as it is not a controlled drug, they considered it to be best practice and asked you to do so.

The panel also noted that you admitted not recording the date that you opened the box of Warfarin, however denied the charge due to the fact that there was no obligation for you to do so.

The panel noted that there was no obligation for you to record the date, however, also noted that you acknowledged that you failed to do so.

The panel was therefore satisfied, that on the balance of probabilities, it is more likely than not that whilst working at Midland Care Home, on or around 26 February 2018, in relation to an unknown resident you did not record the date that you opened a new box of Warfarin tablets.

Charge 5e) ii.

5. Whilst working at Midland Care Home:
   e. On or around 26 February 2018 in relation to an unknown resident:
      iii. Administered Warfarin to the resident but failed to sign the MAR chart.

This charge is found proved.

In reaching this decision, whilst not having the MAR chart before it, the panel took into account, your and Colleague D's oral and written evidence and the log of conversation dated 26 February 2018.

The panel noted that Colleague D in her written evidence states:

> '[Mrs Tate] *failing to sign the MAR once she had administered the warfarin to the patient concerned. I think this was reported to me by another nurse the following day. We established that the warfarin had been administered as the resident concerned had capacity and is very complaint* [sic] *with their medication, so would know if she hadn't had it. As the resident said she'd had it, I checked with* [Mrs Tate] *the next day and she advised she did administer the medication but had not signed the MAR.*'

The panel noted that Colleague D confirmed this in her oral evidence and that this was also confirmed in the Log of conversation, dated 26 February 2018, which is signed by Colleague D and you.

The panel was therefore satisfied, that on the balance of probabilities, it is more likely than not that whilst working at Midland Care Home, on or around 26 February 2018, in relation to an unknown resident you administered Warfarin to the resident but failed to sign the MAR chart.

Charge 7 iii)

7. On 6 March 2018, in relation to Resident H, after being alerted to by a carer to her head wound:

    iii. Did not pass the information over at handover.

This charge is found NOT proved.

In reaching this decision, the panel took into account your, Colleague D's, Ms 2's and Mr 3's oral and written evidence. It also noted the accident report dated 7 March 2018 and the Adult Safeguarding Referral and Outcome Documents for Resident H.

The panel noted that there are inconsistencies across all witness statements. The panel heard that you claimed that you provided details of the injury to Resident H on the handover sheet, however, the panel had no handover sheet before it.

The panel further noted from Mr 3's evidence that he spoke to some, but not all, of the staff who received your handover. He also stated that he had seen the handover sheet and that it did not include any description by you of the injury to Resident H, but that handover sheet was not submitted in evidence.

The panel concluded that there is insufficient evidence that you did not present that information at handover.

The panel reminded itself that the burden of proof lies with the NMC. It was not satisfied that it has evidence to show that it is more likely than not that on 6 March 2018, in relation to Resident H, after being alerted to by a carer to her head wound you did not pass the information over at handover. The panel therefore finds this charge not proved.

Charge 8 ii)

8. On 6 April 2018:
   ii. When asked by Colleague E how his initials were on the chart told him that you did not do it and/or did not know who had done it.

This charge is found NOT proved.

In reaching this decision, the panel took into account your and Colleague E's oral and written evidence. It further took into account the log of conversation, dated 14 April 2018 and the medication administration record for Resident F, dated 26 March 2018.

The panel noted that Colleague E, in his written evidence to the NMC, stated:

> '*I asked her how someone could write my name as I hadn't been working and she replied that she didn't do it. I stated that she was the one doing all the whole medications round that morning so she would have to know. She continued to claim she didn't know who did it.*' [sic]

The panel further noted that whilst you admitted that you had written Colleague E's initials on the MAR chart there are inconsistencies between yours and Colleague E's versions of the incident. In particular there was no clear evidence presented to the panel which identified a point in time at which your initials were superimposed over the initials of Colleague E. The panel noted that in this case it is your word against Colleague E's neither of which is independently corroborated by other evidence.

In the absence of any further evidence, the panel was of the view that it could not find this charge proved.

The panel reminded itself that the burden of proof lies with the NMC. It was not satisfied that it has evidence to show that it is more likely than not that on 6 April 201, when asked

by Colleague E how his initials were on the chart told him that you did not do it and/or did not know who had done.

Charge 10

10. Your actions at charge 8 were dishonest in that you intended to give the impression that Colleague E had given the medication and/or that it was not you that had made the entry.

This charge is found NOT proved.

In reaching this decision, the panel took into account your, Colleague E's, Colleague D's and Mr 3's oral and written evidence. It further took into account the log of conversation, dated 14 April 2018 and the medication administration record for Resident F, dated 26 March 2018.

The panel noted that you accepted that you had signed Colleague E's initials on the MAR chart of Resident F.

When asked by Colleague D during a conversation on 14 April 2018 you stated that this was an error on your part. When talking about the motivation for this, it is recorded on the log of conversation:

> '*I wasn't thinking. I did not realised it wasn't sign* [sic] *I thought it was* [Colleague E] *then I realised it was me. Next time make sure I will double check before signing.*'

This is confirmed in Colleague D's written statement to the NMC that you had no explanation for your motivation:

> '*I asked why she put* [Colleague E]*'s initials in originally; she couldn't really explain it.*'

The panel noted that there were inconsistencies between the witnesses as to when your initials were written over the initials of Colleague E. This made it difficult to determine at what point in time you signed your own initials. It noted that you stated that you corrected your error before Colleague E commenced his shift.

The panel reminded itself of the test of dishonesty as set down in the case of *Ivey v Genting Casinos* [2017] UKSC 67. The panel noted your explanation that whilst you have been conducting the drug round you were distracted when administering a medication to Resident F. When you later realised that you had not signed the MAR chart you were once again distracted and mistakenly entered colleague E's initials instead of your own. You explained to the panel that this may be because his initials were in the previous column in the chart. Whilst the panel felt that this was difficult to understand it is in its opinion the most likely explanation.

The panel further noted that Colleague E was forthright during his evidence that you only overwrote his initials after he had highlighted the error to you and after you denied it. However, in the panel's view this evidence is undermined by the fact that in Colleague E's written statement he states that he saw both his and your initials on the MAR chart whilst in his oral evidence he claimed that the chart only had his initials and that you added yours after it was highlighted to you.

The panel therefore concluded that despite the implausibility of signing someone else's initials erroneously the NMC has not provided it with enough evidence to show that your state of mind was to be malicious or dishonest. It was of the view that an ordinary honest person, in knowledge of all the evidence before it, would not consider your error as a dishonest act but as a mistake.

The panel was therefore not satisfied, on the balance of probabilities, that it is more likely than not that your actions at charge 8 were dishonest in that you intended to give the impression that Colleague E had given the medication and/or that it was not you that had made the entry.

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 by reason of misconduct and reason of your health conditions. 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 Kennedy invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code).

Mr Kennedy identified the specific, relevant standards where your actions amounted to misconduct. He submitted that your actions, as found proved by the panel, fell seriously short of the standard expected of a registered nurse and midwife. The areas of failings were broad and covered medication administration and management, record keeping, escalation of concerns and honesty and could have resulted in serious patient harm. He therefore submitted that your actions do amount to misconduct.

Mr Buxton submitted that you acknowledge that your actions fell seriously short of the standards expected of a registered nurse and midwife. However, he submitted that charge 5d) does not amount to misconduct as it was an error resulting from an error previously made by another colleague.

Submissions on impairment

Mr Kennedy 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 a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kennedy addressed the panel on the matter of health. [PRIVATE]

Mr Kennedy referred the panel to the documentation provided by Mr Buxton on your behalf. However, he submitted that the references provided do not address how you cope with stress or address your capability regarding record keeping and medication administration and management. He therefore submitted that a risk of repetition remains given the lack of information of your performance in a nursing and midwifery setting since these events occurred.

Mr Kennedy submitted that given the serious dishonesty, and the lack of evidence of good practice of medication administration and management, record keeping, communication, how you cope in stressful situations a finding of impairment is necessary both for public protection and on public interest grounds.

Mr Buxton firstly addressed your current health and whether or not you are currently impaired by reason of your health conditions. [PRIVATE]

When addressing the panel regarding your impairment by reason of your misconduct, Mr Buxton invited the panel to take into account your long standing unblemished career as a nurse and midwife prior to the incidents. He stated that you have practiced across many disciplines and are clearly a devoted nurse and midwife. He stated that the concerns have brought you a large measure of shame and remorse. He submitted that the dishonesty and misconduct occurred at a particularly difficult time in your life and invited the panel to consider the historical background and context of your health issues.

Mr Buxton submitted that you have shown full insight in your reflective pieces. Whilst he acknowledged that the panel had found that you sought to explain the context of your failings, you in no way seek to blame others for these. You acknowledged that dishonesty lead to your colleagues and subsequently the wider public losing confidence and trust in you as a nurse and midwife. He submitted that you fully understand the public interest concerns connected to dishonesty. You acknowledged that dishonesty hard to remediate.

He acknowledged that in your current employment you work in a training capacity and have not therefore been able to demonstrate safe clinical practice. He submitted that it is a matter for the panel to decide whether the level of your deep reflection and acknowledgment diminishes the risk of repetition in terms of public protection. He submitted that your reflective pieces address your failings around record keeping, medication administration and management, communication and escalation. [PRIVATE] He explained that in your reflective piece you explain the context of your fallings and steps

you have taken to prevent errors of this kind. Mr Buxton invited the panel to take into account that you have acknowledged your failings.

Mr Buxton acknowledged that in acting dishonestly you sought to protect yourself and put your career before the safety of your patients. However, he submitted that you have shown that you are not a dishonest person and that you have learned a lesson from your failings.

Mr Buxton submitted that you have engaged with the NMC throughout the proceedings and admitted dishonesty in respect of charge 4. He submitted that you will not repeat such conduct in the future and invited the panel not to find you currently impaired. He stressed the clear insight and understanding and remediation on your side. He acknowledged that dishonesty is viewed seriously and may require a finding of current impairment on public interest grounds, however he submitted that you have remediated your dishonesty demonstrating honest practice whilst at the home and in your current employment.

Mr Buxton also referred the panel to the testimonials submitted by you. Whilst he acknowledged that these do not address the charges directly, he pointed out that it is noted in the testimonial of your current employer that you have an open, honest and professional relationship with regard to the ongoing NMC process.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse or midwife, and that your actions amounted to a breach of the Code. Specifically:

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

10.3 complete records accurately […]*, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly

20.9 maintain the level of health you need to carry out your professional role

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 charges 2a), 2b) and 2c) amounted to misconduct, individually and cumulatively. It was of the view that keeping accurate and contemporaneous notes on a patient is vital for the protection and safety of the patient and is essential for the decision making of the wider multidisciplinary team. The panel was of the view that when a concern is noted an entry should be made, however, you did not make any notes retrospectively on a deteriorating patient. It was likely that this patient would have been moved from the antenatal ward to the labour ward therefore communication is key to ensure patient safety and correct action by the team caring for her. The accurate records are essential to demonstrate a patient's treatment, the discussions, decisions and actions taken regarding care provision. The panel noted that you had written some annotations of your actions on the CTG and that you had made an entry in the patient notes at 15.45, however, this was not sufficient to ensure the necessary level of essential record keeping and communication. Further, the panel was of the view that you did not escalate the concerns raised by the CTG appropriately in light of the concerns and there was potential for serious patient harm.

The panel was of the view that your actions in charge 3, in its entirety, and therefore also charge 4 amounted to misconduct. The panel considered that disguising that you failed to recognise the importance of the meconium stained pads and subsequently lying to your colleagues about the pads belonging to the discharged patient and contacting her about these represented a serious departure from the behaviour expected from a registered

nurse and midwife. As with charge 2, although your actions did not result in direct patient harm, there was the potential for serious patient harm.

The panel considered charge 5a), in its entirety, 5b), 5c), 5d), 5eii) 5f) and 5g) amounted to misconduct, individually and cumulatively. The panel noted that these reflected a series of medication administration and management failings, including record keeping. The panel was of the view that failing to correctly document medication, failing to give medication when necessary and failing to inform the GP or the pharmacy about medication that was low on stock for a patient could have had serious clinical implications. The panel noted that whilst in charge 5d) your miscalculation of the stock of medication had been as result of a previous mistake, it was your duty as a registered nurse to follow the correct process for controlled drugs, and this includes tallying up the stock of medication. The panel found this particularly serious, as you had stated that you have done so previously while working at a hospital, but after being told this was not necessary by the home, refrained from doing so.

The panel then considered charges 5ei) and charge 5h). It was of the view that these charges did not amount to misconduct. Noting the date you opened a non-controlled drug was a management direction, however, was not clinically necessary. Further, while the panel notes that writing in black ink to complete medication records is an unspoken standard, there is no obligation to use black ink.

The panel considered that your failings in respect of charges 7i) and 7ii) to amount to misconduct. It was your duty as nurse in charge to document a patient's head wound and complete an accident report, however you did not do so.

Finally, the panel considered charge 8i). The panel had accepted your explanation that you did not appropriately correct a simple writing error. It noted that your error did not result in any patient harm. It therefore concluded that charge 8i) did not amount to misconduct.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and midwife and amounted to misconduct.

Decision and reasons on impairment

Health

The panel acknowledged that in order to find a your fitness to practise impaired by reason of your health conditions, it must first establish whether you have a health condition that goes to the issue of your fitness to practise. If it does not, then there can be no subsequent finding of impairment of fitness to practise. If it does, the panel should go on to consider whether by reason of those health conditions your fitness to practise is impaired.

In reaching its decision, the panel bore in mind Rule 31(5) and considered all the documentary evidence adduced in this case together with the submissions made by Mr Kennedy and Mr Buxton.

[PRIVATE]

[PRIVATE]

[PRIVATE]

Misconduct

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

Nurses and midwives 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 and midwives with their lives and the lives of their loved ones. To justify that trust, nurses and

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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 doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel finds that patients were put at a real risk of harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not consider charges relating to dishonesty to be extremely serious.

Regarding insight, the panel noted that you made admissions to most of the charges early in the process. You have demonstrated an understanding of how your actions put the patients at a risk of harm, why your actions were wrong and how this impacted negatively on the reputation of the nursing and midwifery profession. The panel was of the view that you have demonstrated remorse when reflecting on your errors. However, the panel was of the view that whilst you explain your actions in your reflective pieces and you have not sought to blame other people for your mistakes, you are clear on the impact of the working environment at the Home on your practice. Whilst the panel acknowledged the context of the Home, it was also of the view that it would be expected of a registered nurse and midwife to highlight these issues and take appropriate action and escalate the situation to an appropriate person. The panel therefore considered that you show developing insight.

The panel was satisfied that whilst many of the instances of the misconduct may be remediable, the issue of dishonesty is more difficult to remediate. Therefore, the panel carefully considered the evidence before it in determining whether or not you have remedied your practice. The panel took into account the additional training you have undertaken and the reflective pieces written by you. The panel was of the view that the additional training you have undertaken does not address all of the charges and therefore does not mitigate the risk identified. The panel was further of the view that you have not fully taken account the errors made and have therefore also not fully remediated your behaviour.

Therefore, the panel is of the view that against the background of your not fully developed insight and partial remediation that there is a risk of repetition. [PRIVATE] The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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. It directs the registrar to strike you off the register. The effect of this order is 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 had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kennedy outlined the aggravating and mitigating features of the case. He submitted that the underlying issues of this case are too serious to take no action or impose a caution order. He further submitted that a conditions of practice order would not address the dishonesty found in this case.

Mr Kennedy then referred the panel to the SG, in particular cases involving dishonesty. He acknowledged that not all dishonesty is equally serious. However, he submitted that in this case you deliberately breached the professional duty of candour by covering up when things went wrong, and that there was a serious risk of harm to the patient in this case.

Mr Kennedy submitted that in this case, the dishonesty is so serious, that temporary removal from the register would be an insufficient sanction to protect the public and to satisfy the public interest. He therefore invited the panel to impose a striking-off order.

Mr Buxton submitted that you acknowledge and appreciate that this is an extremely serious matter which could result in you losing your registration.

However, Mr Buxton submitted that although the NMC is seeking a striking-off order, doing so would be disproportionate in the circumstances. He submitted that a striking-off order would fail to fully take into account that your personal circumstances are very different now from that which they were at the time of your failings and submitted that your health condition was a signification factor when considering your failings. On your behalf, he acknowledged the serious nature of your dishonesty [PRIVATE]

Mr Buxton reminded the panel that you have not been able to practise clinically and that you have therefore not had the opportunity to demonstrate that you are a safe practitioner who acts with integrity and who can be trusted. He submitted that a fully informed member of the public, in the knowledge of the particular circumstances of your private life would understand and acknowledge the pressures and strains that you were under which resulted in you failing to meet the high standards expected of you.

Mr Buxton invited the panel to take account of your insight, remediation and the shame and remorse you have demonstrated. He acknowledged the panel's observation that your insight was developing, but submitted on your behalf that your insight was significant and that there was no reason to suggest that you would ever appear before the NMC again in the future. He submitted that you have awaited the outcome of the regulatory process for many years, whilst regretting what happened and at the same time understanding and seeking to repay trust in those who might allow you to demonstrate that you are a good and safe practitioner. He submitted that there have been underlying reasons for your dishonesty, that you are not inherently a 'bad' or immoral individual and that you did not seek to blame your colleagues for your failure.

Mr Buxton submitted that a sanction that would not remove you from the register would be proportionate. He acknowledged that a conditions of practice order would be difficult to formulate as you have not practised in a clinical setting for some years. However, he submitted that the issues could be addressed through supervision and demonstration of safe documentation and medication administration and management.

He submitted that if the panel did not determine that a conditions of practice order was the appropriate sanction, a temporary removal from the register would be proportionate.

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:

- Serious dishonesty that could have resulted in serious harm to the patient and her unborn baby;
- The dishonesty was compounded by further lies;
- The motivation for your dishonesty was to put your own career before the needs and wellbeing of your patient;
- There were failures across both professions (midwifery and nursing);
- The failings occurred in different settings; and
- You were on a formal capability plan after concluding the informal capability plan.

The panel also took into account the following mitigating features:

- You have demonstrated developing insight;
- You have clearly demonstrated remorse;
- You have provided the panel with a fulsome apology;
- You have engaged fully in the regulatory process;
- You made admissions early in the process; and
- You were suffering from a health condition at the time of the incidents;

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel acknowledged that the clinical misconduct in this case could be addressed by retraining and a period of supervision. However it was of the view that there are no practical or workable conditions that could be formulated that could address the serious dishonesty in this case. Therefore, the panel concluded that the placing of conditions on your practice would not adequately address the seriousness of this case and would not adequately protect the public.

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

- […]
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- […]
- […]
- […]
- […]

The panel acknowledged that, with regard to your dishonesty, it was initially spontaneous and opportunistic and that the testimonials you provided attest to your honesty and developing insight. However, the panel was of the view that at the point of your dishonesty you were an experienced midwife and should have known that your dishonesty could have posed a significant risk to the unborn baby resulting in brain damage or even death. The panel acknowledged that you were under significant stress at that time and that you were suffering from health conditions. The panel was further particularly concerned about the level of insight you have shown into your dishonesty when you stated in your reflective piece:

‘*I panicked I tried to protect myself due to [PRIVATE] my fear of being on another capability plan, the fear of losing my career as a midwife that I had fought so long and hard to achieve [PRIVATE].*’

However, it was of the view that you compounded your initial dishonesty by further lies when you could have admitted to it and prevented any further potential risk and harm to the patient and unborn baby. The panel was of the view that by deliberately being dishonest to two different colleagues about having phoned the patient, you deliberately prevented your colleagues from phoning the patient themselves and taking steps to protect the mother and unborn baby.

The panel therefore determined that your dishonesty was at the very high end of seriousness.

The panel was therefore of the view that you actions represented a significant departure from the standards expected of a registered nurse and midwife. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

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 was of the view that your dishonesty raises fundamental questions about your professionalism and that the public confidence in nurses and midwives would not be maintained were you to maintain on the register. Your actions, in particular your serious dishonesty, represented significant departures from the standards expected of a registered nurse and midwife, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

Whilst the panel recognises the hardship this will cause you, it, nevertheless, considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse or midwife.

This decision 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 in your own interest until the

striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim order is necessary to protect the public for the reasons identified earlier by the panel in their determination until the striking off order comes into effect. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

Mr Buxton made no representations on your behalf.

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

Decision and reasons on interim order

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

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

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

That concludes this determination.