Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
10 – 14 May 2021

Virtual Hearing

Name of registrant:	Rosaline Appice
NMC PIN:	04H0060C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 5 August 2004
Area of registered address:	Hertfordshire
Type of case:	Misconduct
Panel members:	Tim Skelton (Chair, Lay member) Michael Duque (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Patricia Crossin
Panel Secretary:	Jasmin Sandhu
Nursing and Midwifery Council:	Represented by Helen Guest, Case Presenter
Ms Appice:	Not present and not represented
Facts proved:	Charges 1, 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 3
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Appice was not in attendance and that the Notice of Hearing had been sent to Ms Appice's email address by secure email on 9 April 2021.

The panel considered whether notice of this hearing had been served in accordance with the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules). It noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a Notice of Hearing may be sent to a registrant's registered address by recorded delivery and first-class post, or to a suitable email address on the register.

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

Ms Guest 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 Ms Appice has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Appice

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

Ms Guest directed the panel to a series of emails and telephone calls made by the NMC to Ms Appice, dated 27 and 30 April 2021. Ms Guest submitted that there had been no response or engagement by Ms Appice in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Ms Appice. In reaching this decision, the panel has considered the submissions of Ms Guest and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba [2016] EWCA Civ 162*, and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Appice;
- Ms Appice has not responded to any of the NMC's emails or telephone calls about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses will attend today to give live evidence and others are due to attend;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events;
- The charges relate to events that occurred in 2017; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Appice in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage to Ms Appice is the consequence of her decision to absent herself from the hearing, waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse, whilst working at Kestrel Grove Residential and Nursing Home:

1. *On or about 15 January 2017, having been made aware of an incident whereby Resident A was said to have behaved in a sexually inappropriate*

manner towards Resident B, failed to escalate the matter to either the Home's safeguarding team and/or the Home's manager. **[FOUND PROVED]**

2. *On or around the night shift of 29-30 July 2017, in respect of Resident C:*

(a) failed to administer cardiopulmonary resuscitation ('CPR'), without clinical justification, in that you incorrectly identified that Resident C was subject to a "do not attempt resuscitation" notice ('DNAR'). **[FOUND PROVED]**

(b) failed to ensure that an ambulance was called, without clinical justification, in that you incorrectly identified that Resident C was subject to a 'DNAR'. **[FOUND PROVED]**

(c) incorrectly supplied information for a GP that Resident C was the subject of a 'DNAR'. **[FOUND PROVED]**

(d) failed to correct the information referred to in charge 2(c), personally, in a timely manner. **[FOUND PROVED]**

(e) failed to record on Resident C's notes why you did not attempt CPR on Resident C. **[FOUND PROVED]**

(f) provided a statement to the home manager saying that you had administered chest compressions to Resident C when you had not done so. **[FOUND PROVED]**

(g) stated in a disciplinary meeting on 17 August 2017 that you had administered chest compressions to Resident C when you had not done so. **[FOUND PROVED]**

(h) incorrectly informed the family of Resident D that their relative's condition had deteriorated. **[FOUND PROVED]**

(i) failed to notify the family of Resident D personally, in a timely manner, that you had made a mistake in telling them that the condition of their relative had deteriorated. **[FOUND PROVED]**

3. And your actions as specified in charges 2 (f) and/or 2 (g) were dishonest in that you attempted to give the impression that you had started to administer CPR to Resident C at the relevant time, when you had not done so. **[FOUND PROVED]**

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

Decision and reasons on application to admit written statement of Dr 1

The panel heard an application made by Ms Guest under Rule 31 to allow the written statement of Dr 1 into evidence without formal proof. Although Dr 1 was willing to engage with the hearing, due to work commitments it was appropriate to consider as to whether it was essential for her to engage online.

Ms Guest submitted that even though Ms Appice has not agreed to have Dr 1's statement read into evidence, she was given sufficient time to object or dispute this statement if she wished to do so.

In the preparation of this hearing, the NMC had informed Ms Appice that it was their intention for Dr 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Dr 1, Ms Appice has decided not to attend this hearing. Furthermore, there is no evidence to suggest that Ms Appice has objected to Dr 1's

statement. On this basis, Ms Guest advanced the argument that there was no lack of fairness to Ms Appice in allowing Dr 1's written statement into evidence.

The panel heard advice from the legal assessor, who referred it to Rule 31 and the cases of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* and *Enemuwe v NMC [2015] EWHC 208 (Admin*).

The panel gave the application in regard to Dr 1's written statement serious consideration. It noted that Dr 1'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 knowledge and belief' which was signed by her.

The panel first considered the relevance of Dr 1's evidence in this case. It decided that the evidence was particularly relevant to charge 2c, which related to Ms Appice allegedly informing Dr 1 that Resident C was subject to a DNAR. The panel bore in mind that Ms Appice has not disputed or challenged that this happened.

The panel next considered whether Ms Appice would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Dr 1 to that of a written statement. It noted that since Ms Appice had been provided with a copy of Dr 1's statement and, as the panel had already determined that Ms Appice had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

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 Dr 1 and the opportunity of questioning and probing that testimony. However, there was a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Dr 1. The panel kept in mind that it could decide how much weight is to be given to this evidence at a later stage, once having heard and evaluated all of the evidence before it.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Guest on behalf of the NMC. The panel has drawn no adverse inference from the non-attendance of Ms Appice.

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: Staff Nurse – Kestrel Grove Residential & Nursing Home
- Ms 2: Night Care Assistant – Kestrel Grove Residential & Nursing Home
- Ms 3: Registered Nurse – Kestrel Grove Residential & Nursing Home
- Ms 4: Acting Matron (at time of Charge 2) – Kestrel Grove Residential & Nursing Home

- Ms 5: Care Home Manager – Kestrel Grove Residential & Nursing Home
- Ms 6: Team Manager (social worker) – Hertfordshire County Council, Adult Care Services

Background

On 2 August 2017, the NMC received a referral from Ms Appice's employer, the Kestral Grove Residential and Nursing Home (the Home), in relation to concerns with Ms Appice's nursing practice. The allegations relate to two separate incidents which occurred at the Home on 15 January 2017, and 29-30 July 2017.

In February 2017, the registered Home Manager (Ms 5) was investigating a safeguarding issue concerning a male resident's behaviour towards a female resident. After a search of the Home's records was made during this investigation, an entry by Ms Appice was found on 15 January 2017, when she had been the nurse in charge of the relevant night shift. The entry disclosed that a carer had informed Ms Appice that a male resident had touched a female resident in a sexual way. However, it is alleged that Ms Appice did not raise the matter at the handover to the day staff or report the matter directly to Ms 5.

As Ms 5 was unaware of the incident at the time it occurred, no safeguarding action plan was initiated, and a further similar incident occurred a month later. At a meeting on 2 March 2021, Ms Appice confirmed that she had not told the nurses about the incident on the morning handover, nor had she informed Ms 5.

Moving to the second event, this incident is alleged to have occurred during the night shift of 30 July 2017, involving the death of a service user, Resident C. It is alleged that Resident C was found in bed, cold and pale, experiencing breathing difficulties. When

Resident C was attended to by Ms Appice, it is alleged that she did not call for an ambulance, nor did she perform Cardiopulmonary Resuscitation ('CPR') on the resident.

Furthermore, it is alleged that when Ms Appice contacted Dr 1, who later attended to confirm the death of Resident C, she gave incorrect information to the doctor, namely that Resident C was subject to a Do Not Attempt Resuscitation (DNAR) notice, when in fact this was not the case. Dr 1 subsequently raised queries as to why the emergency service had not been called, why she had been given the incorrect information, and why CPR had not been started. It is further alleged that Ms Appice then incorrectly claimed that she had performed CPR on Resident C.

It is further alleged that, Ms Appice contacted the family of a different service user (Resident D) with the same last name as that of the deceased (Resident C) and reported that their relative was deteriorating. When that mistake was realised, it is alleged Ms Appice failed to call Resident D's family in a timely manner to correct her mistake.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred it to the cases of *Ivey v Genting Casinos [2017] UKSC 67*, *Re H (Minors) (Sexual Abuse; Standard of Proof) 1996 AC 59, Re D [2008] UKHL 33, Re B [2008] UKHL 35, Re D [2008] UKHL 33, and Enemuwe v NMC.*

The panel considered the oral evidence from the witnesses and the documentary evidence exhibited by them, along with the documentary evidence from both the NMC and the written statements made by Ms Appice during the Home investigation and the subsequent NMC investigation. In relation to the evidence of the witnesses, the panel made the following conclusions:

Ms 1: The panel considered the evidence of Ms 1 to be credible and professional. Ms 1 was honest in admitting when she could not remember something and did not attempt to embellish her account. The panel also noted that she was consistent in her account of events through her written statement, Home investigation statement, and oral evidence.

Ms 2: The panel considered the evidence of Ms 2 to be credible. Whilst there were some inconsistencies between her oral evidence and written statement, the panel had regard to the fact that English was not Ms 2's first language. Furthermore, the panel found Ms 2 to be very helpful when clarifying substantive matters arising from the night shift in question. When she was questioned, she remained consistent and detailed in her answers.

Ms 3: The panel considered the evidence of Ms 3 to be credible and consistent. She was clear and confident in her oral evidence and admitted when there was something she did not remember. The panel also noted that her written statement, Home investigation statement, and oral evidence were consistent with one another.

Ms 4: The panel considered the evidence of Ms 4 to be credible. Ms 4 was helpful when explaining the procedures and actions which were expected to have been followed at the Home. Ms 4's written statement and oral evidence were consistent with one another.

Ms 5: The panel considered the evidence of Ms 5 to be very credible in relation to charge 1. Ms 5 was helpful and direct in her answers; she was able to support her account of events with the relevant policies and procedures. The panel found Ms 5 to be very confident and professional in her evidence.

Ms 6: The panel considered the evidence of Ms 6 to be credible. Ms 6 was very clear when explaining the details of the safeguarding investigation carried out by her agency. The panel considered her evidence to be clear and informative as regards to the safeguarding incident on the night of 29-30 July 2017.

The panel noted that Ms Appice was not in attendance, so it was not able to assess her credibility. It gave regard to the written documentation provided by her, namely her Home investigation statement, her letter regarding the disciplinary decision, dated 23 August 2017, along with her responses during the Home disciplinary meeting on 17 August 2017.

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

Charge 1

That you, a registered nurse, whilst working at Kestrel Grove Residential and Nursing Home:

1. *On or about 15 January 2017, having been made aware of an incident whereby Resident A was said to have behaved in a sexually inappropriate manner towards Resident B, failed to escalate the matter to either the Home's safeguarding team and/or the Home's manager.*

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence provided by Ms 5.

In her evidence Ms 5 provided the panel with details of the safeguarding policy at the Home, which sets out the types of issues requiring action. Within section 2.1.4 of the policy, reference is made to types of abuse, which included "*sexual abuse / harassment*". In section 3 of the policy, the procedure is set down as to what should be done in the event of such an issue being suspected, namely that "*this will be reported immediately to the Manager, if on duty, or the staff nurse in charge, who will take the appropriate action*". Ms 5 also provided evidence of the safeguarding flowchart which provided direction in the event of abuse being suspected.

Ms 5 also provided the panel with the extract from Resident A's care notes where Ms Appice recorded the incident on 15 January 2017. Taking this evidence into account, the panel was satisfied that Ms Appice was the nurse who recorded the incident involving Residents A and B. The panel was satisfied that the circumstances of this incident met the

requirements of the Home safeguarding policy and required a report to the manager to allow further inquiries to take place.

The panel next considered Ms 5's evidence that Ms Appice told her that she didn't report the incident because "*she assumed we are reading the all notes made on the daily system*". Ms 5 gave evidence that Ms Appice did not raise this incident during her handover to the day staff and that this was something she expected her to do. The panel therefore determined that Ms Appice's actions fell short of the requirements as set out in the safeguarding policy, as she failed to escalate the concerns to the Home Manager, or any other nurse in charge. The panel held that Ms Appice would have been expected to be fully aware of the requirements of the Home's policy which was straightforward and clear.

The panel determined on the balance of probabilities that this charge was found proved.

Charge 2a)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(a) failed to administer cardiopulmonary resuscitation ('CPR'), without clinical justification, in that you incorrectly identified that Resident C was subject to a "do not attempt resuscitation" notice ('DNAR').

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence from Ms 1, Ms 2, Ms 4, and the Home investigation statements.

In her oral evidence, Ms 2 informed the panel that when she attended Resident C, in her bedroom on the night in question, she found her to be "*pale"* and *"agitated*". She gave evidence to the panel that she sent a colleague to find Ms Appice while she remained in the room with Resident C. She said that Ms Appice had attended and after looking at Resident C, left the room to obtain blood pressure and oxygen saturation equipment, returning shortly after. She described Ms Appice as standing beside Resident C's bed and said that she 'hit', at least twice, the upper chest-shoulder area of Resident C.

Whilst the panel acknowledged that Ms 2 was not entirely consistent with the account of Ms Appice's contact with Resident C's chest, it was clear that Ms 2 fully understood what actions were involved in administering CPR. Ms 2 throughout her written and oral evidence was consistently resolute that CPR did not take place. Furthermore, in Ms 4's oral evidence, she was able to provide the panel with a precise account of what CPR entailed. Ms 4 confirmed to the panel on questioning that Ms Appice's actions as described by Ms 2 did not amount to administering CPR.

The panel further noted that there was no mention of CPR being administered to Resident C in their notes which were recorded in the case notes by Ms Appice, shortly after the events.

Taking all of this evidence into account, the panel was satisfied that Ms Appice's interactions towards Resident C did not amount to CPR.

In considering whether Ms Appice incorrectly identified that Resident C was subject to a DNAR, the panel first had regard to Ms 2's evidence. In her Home statement, Ms 2 stated that Ms Appice told her that Resident C was "*not for emergency and she's on the way anyway*". In Ms 1's Home investigation statement, she stated that she thought Ms Appice told her that Resident C "*had a DNACPR form in place*". In addition the panel took account of Ms 1's evidence that Ms Appice told her Resident C "*was not for resuscitation*".

The panel took into account, when considering this charge, the Home DNACPR matrix, which clearly indicated that Resident C did not have a DNA-CPR requirement.

Taking all of this evidence into account, the panel found that on the balance of probabilities, it is more likely than not that Ms Appice incorrectly identified that Resident C was subject to a DNAR.

Charge 2b)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(b) failed to ensure that an ambulance was called, without clinical justification, in that you incorrectly identified that Resident C was subject to a 'DNAR'.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence from Ms 4, the oral evidence from Ms 1, Ms 2's Home investigation statement, and Ms Appice's responses, as noted in the minutes the disciplinary meeting on 17 August 2017.

In her evidence, Ms 4 stated that it was the Home's policy to call an emergency ambulance in circumstances such as this. Ms 1 stated that during the handover the following morning that Ms Appice told Ms 3 "*there wasn't enough time to call an ambulance anyway*". Further, the panel noted that in Ms 2's Home investigation statement, she said she asked Ms Appice to call an ambulance.

The panel also noted Ms Appice's responses during the disciplinary meeting, when she was questioned as to why she did not call an ambulance. Ms Appice is noted as saying "*maybe it was shock; there was no time to call*".

The panel noted that Ms Appice in her response to the disciplinary hearing, stated that as she was "*dealing with the resident, I was unable to call 999… In hindsight, I should have asked someone to call 999, but it was a very stressful situation I was trying to deal with*".

Taking all of the evidence into account and having previously found that Ms Appice incorrectly identified Resident C was not subject to a DNAR, the panel was satisfied on the balance of probabilities that Ms Appice did not call an ambulance.

Charge 2c)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(c) incorrectly supplied information for a GP that Resident C was the subject of a 'DNAR'.

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's evidence and the minutes from Ms Appice's disciplinary meeting, as contained in the evidence from Ms 4.

In her evidence Ms 3 stated that when dealing with the doctor on the morning of 30 July 2017, she realised that Dr 1 was under the impression that Resident C was subject to a DNAR, when this was not correct. The panel noted that during the disciplinary meeting, Ms Appice accepted that she had given Dr 1 incorrect information as she had picked up the wrong file, namely the file for Resident D, who shared a similar second name to Resident C. The disciplinary meeting minutes noted Ms Appice stated that she had called Resident D's family first and then the out of hours doctor and had realised straight away

she had used the wrong file when she noted it was a red folder and saw the attached photo.

The panel was therefore satisfied on the balance of probabilities that Ms Appice had incorrectly told Dr 1 that Resident C was subject to a DNAR notice.

Charge 2d)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(d) failed to correct the information referred to in charge 2(c), personally, in a timely manner.

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's evidence, Resident C's case notes provided by Ms 4, and the minutes from Ms Appice's disciplinary meeting, as contained in the evidence from Ms 4.

In her evidence, Ms 3 stated that she was the one who corrected Dr 1's misconception in relation to Resident C's DNAR notice. The panel noted the contents of Resident C's case notes, as provided by Ms 4, where an entry was made correcting the information supplied to the GP. In the disciplinary meeting minutes, Ms Appice is noted as accepting that she did not correct the information given to the family of Resident C nor Dr 1.

The panel therefore determined on the balance of probabilities that Ms Appice failed to correct the information referred to in charge 2c).

Charge 2e)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(e) failed to record on Resident C's notes why you did not attempt CPR on Resident C.

This charge is found proved.

In reaching this decision, the panel took into account the Resident C's case notes as provided by Ms 4. The entry made by Ms Appice did not record why CPR was not administered. The panel was therefore satisfied on the balance of probabilities that this charge is proved.

Charge 2f)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(f) provided a statement to the home manager saying that you had administered chest compressions to Resident C when you had not done so.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence provided by Ms 4 and Ms 2's oral evidence.

Ms 4 provided the panel with a statement from Ms Appice obtained during the Home investigation. In this statement, Ms Appice stated that she gave Resident C "*several compressions on her chest…at least for more than 2 minutes up to 5 minutes*". In the minutes of the disciplinary meeting, Ms Appice is noted as saying that she "*pinched*" Resident C's shoulder and "*tried chest compressions*".

The panel had regard to Ms 2's evidence, when she said she was with Ms Appice during the time of this incident. Ms 2 was clear in her oral evidence that Ms Appice "*hit*" Resident C's shoulder-chest area twice but did not administer chest compressions. As previously noted, the panel noted Ms 2 to be a reliable and credible witness.

On the balance of probabilities, the panel found that Ms Appice did not administer chest compressions to Resident C, despite having said to have done so. Consequently, it found charge 2f to be proved.

Charge 2g)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(g) stated in a disciplinary meeting on 17 August 2017 that you had administered chest compressions to Resident C when you had not done so.

This charge is found proved.

In considering this charge, the panel took into account its findings in charge 2f.

The panel determined that based on the oral evidence provided by Ms 2, whom it regarded as a credible witness, Ms Appice had not administered chest compressions, despite having stated at her disciplinary meeting that she had "*tried chest compressions…all happened within 5 minutes…*".

Taking this evidence into account, the panel found this charge to be proved on the balance of probabilities.

Charge 2h)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(h) incorrectly informed the family of Resident D that their relative's condition had deteriorated.

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's Home investigation statement, Ms 3's written statement, the disciplinary meeting minutes contained in Ms 4's evidence, and Ms Appice's response to the disciplinary meeting.

In her Home investigation statement, Ms 1 stated that Ms Appice "*also told us that she had called [Resident D's] family, in error, to inform them that they were deteriorating*". Furthermore, Ms 3 stated in her evidence that Ms Appice had told her that she had called Resident D's family in error, rather than Resident C's family.

The panel also noted that Ms Appice as recorded in the disciplinary meeting minutes accepted that she had called the incorrect family, namely Resident D's relatives. In her letter dated 23 August 2017, Ms Appice further acknowledged this mistake stating "*As regards, correcting the information to the wrong family and the out of hours GP service, I repeat, it was a very stressful situation I was dealing with. It was my intention to make these calls. I also stated in the "handover" that I was going to make these calls, however due to the emotional and stressful I had, I forgot to make these calls. I apologise for this mistake and commit that it will not happen again".*

The panel concluded that based on the evidence of Ms 1 and 4, together with Ms Appice's own acknowledgment, that this charge is proved on the balance of probabilities.

Charge 2i)

On or around the night shift of 29-30 July 2017, in respect of Resident C:

(i) failed to notify the family of Resident D personally, in a timely manner, that you had made a mistake in telling them that the condition of their relative had deteriorated.

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's Home investigation statement, Ms Appice's letter dated 23 August 2017, and the disciplinary meeting minutes contained in Ms 4's evidence.

Ms 1 gave evidence that after Ms Appice told her she had contacted the incorrect family, she said that "*she would not call them back to correct her mistake*".

The panel also had regard to Ms Appice's acceptance, in her correspondence, that she did not call the family of Resident D back. In her letter dated 23 August 2017, Ms Appice stated "*It was my intention to make these calls… however due to the emotional and stressful I had, I forgot to make these* calls". Further, during the disciplinary meeting, it is noted that Ms Appice said "*I was going to call family but didn't*".

Taking all of the evidence into account, the panel found, on the balance of probabilities, that this charge is proved.

Charge 3)

And your actions as specified in charges 2 (f) and/or 2 (g) were dishonest in that you attempted to give the impression that you had started to administer CPR to Resident C at the relevant time, when you had not done so.

This charge is found proved.

After having confirmed the facts in charges 2f and 2g, the panel went on to consider whether Ms Appice's behaviour was dishonest by the standards of the ordinary decent people.

The panel first directed itself to its findings at charges 2f and 2g, and what evidence was presented as to what Ms Appice knew and believed.

The panel took into account statements made by Ms Appice during the Home investigation. In her statement, she stated that "*I called her name loudly and pinched her shoulder to seek for any responses and I gave her several compressions on her chest I could not recall how many, how long and how hard I did it however, I am sure that it was at least for more than 2 minutes up to 5 minutes*".

During the disciplinary meeting on 17 August 2017, Ms Appice is noted as not remembering how many compressions she had administered to Resident C. Ms Appice confirmed that she had not moved Resident C to the floor to administer CPR but had placed the bed flat before she started. She said she had stopped CPR because Resident C was dead. In Ms Appice's letter on 23 August 2017, Ms Appice stated that she had carried out several compressions on Resident C's chest. Ms 2's oral evidence, which the panel accepted, was clear and definite in that she did not observe Ms Appice carrying out CPR to Resident C.

The panel found that Ms Appice did not administer CPR to Resident C. The panel found that having realised she had mistakenly identified Resident C for Resident D,

she was dishonest in stating that she had carried out CPR when she had not done so. The panel further noted that there is no reference in Resident C's care notes which were completed by Ms Appice, that CPR was administered. In its deliberations, the panel had regard to Ms 2's oral evidence that she was present with Ms Appice in Resident C's bedroom during the time of this incident and was clear that CPR was not administered by Ms Appice.

The panel determined that Ms Appice incorrectly identified that Resident C was subject to a DNAR and as a result, did not carry out CPR. On realising her mistake, Ms Appice dishonestly attempted to cover her mistake by saying she had administered chest compressions, when in fact she had not done so.

Taking all the evidence into account, the panel found on the balance of probabilities, that Ms Appice's statements to the Home Manager during the investigation, and at the disciplinary meeting on 17 August 2017, were dishonest in relation to her administering CPR to Resident C.

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 amounted to misconduct and, if so, whether Ms Appice's fitness to practise is currently impaired. Whilst there is no statutory definition of fitness to practise the NMC has defined it 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 amounted to misconduct. Secondly, only if the facts found proved amounted to misconduct, the panel must decide whether, in all the circumstances, Ms Appice's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Guest invited the panel to take the view that the facts found proved amounted to misconduct. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific standards which she submitted Ms Appice had breached.

Ms Guest submitted that whilst a breach of the code alone does not amount to misconduct, the concerns raised in relation to Ms Appice's practice were sufficiently serious to warrant a finding of misconduct. She stated that the allegations, which have been found proved in their entirety, are very serious, concerning vulnerable patients being put at risk of serious harm. She submitted that Ms Appice had failed to identify a patient correctly and although she admitted this to her colleagues, she failed to put things right. She said Ms Appice compounded her mistake by dishonestly asserting that she had administered CPR to Resident C when she had not done so. Ms Guest said that Ms Appice's failings fell far short of the expected standard of registered nurses and consequently, amounted to serious misconduct.

Submissions on impairment

Ms Guest 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. Ms Guest referred to the panel to the Shipman test, approved in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery*

Council (2) and Grant [2011] EWHC 927 (Admin) ("Grant") and submitted that all 4 limbs of this test have been engaged.

Ms Guest submitted that when considering current impairment, looking at past actions can be a good indicator of future behaviour. She stated that although the charges relate to two specific shifts, Ms Appice's failure to take action following the initial incident in charge 1 led to Resident A being subjected to a further similar incident at a later stage. As a result, she invited the panel to consider Ms Appice's conduct over a length of time, rather than two single shifts. Ms Guest added that concerns in Ms Appice's practice had a considerable impact since it involved 4 different patients, and their families.

When considering Ms Appice's behaviour since the incidents occurred, Ms Guest submitted that there had been no evidence of any real insight, remorse, or remediation on Ms Appice's behalf. Whilst there was some indication of an apology during her disciplinary meeting, she said Ms Appice does not appear to have made any meaningful efforts to reflect upon or remediate the concerns in her nursing practice.

Ms Guest submitted that in light of the seriousness of the incidents, together with a lack of real remediation and insight, there is a risk of repetition in this case, and it would be appropriate and proportionate for the panel to make a finding of impairment. She further referred the panel to the findings made against Ms Appice by a Nursing and Midwifery Fitness to Practise panel in May 2012. She noted that Ms Appice faced an allegation of dishonesty on this occasion and a caution order for a period of 5 years was imposed. She submitted that Ms Appice therefore did not have an unblemished record. She told the panel that the caution order was still in place during the events set out in charge 1 and had only recently expired before the events in charge 2.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Cohen v General Medical Council [2008] EWHC 581 (Admin), General Medical Council v Meadow [2007] QB 462 (Admin), Bolton v Law Society [1994] 1 WLR*

512, General Medical Council v Nwachuku [2017] EWHC 2085 (Admin), Mallon v Nursing and Midwifery Council [20007] CSIH 17, Dey v General Medical Council [20001] UKPC 48, Cheatle v GMC [2009] EWHC 645 (Admin) and *CHRE v Nursing and Midwifery Council and Grant [2011] EWHC 929 (Admin).*

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 Ms Appice's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Appice's actions amounted to a breach of the Code.

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.'*

In relation to charge 1, the panel found breaches in the following sections of the Code:

> ***16 Act without delay if you believe that there is a risk to patient safety or public protection***
> *To achieve this, you must:*
> *16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices*
>
> ***17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection***

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

In relation to charge 2, the panel found breaches in the following sections of the Code:

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

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

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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

In relation to charge 3, the panel found breaches in the following sections of the Code:

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 and without discrimination, bullying or harassment

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In considering whether Ms Appice's failings in charge 1 did amount to misconduct, the panel had regard to the safeguarding policy which was in place at the Home. It found that this procedure clearly outlined what staff should and should not do in the circumstances that arose in charge 1. The panel considered that keeping patients safe is at the heart of a nurse's duty of care and noted that the events of charge 1 were repeated at a later date, putting Resident A at further risk of harm when this could have been prevented. The panel found Ms Appice's failure to keep a vulnerable patient safe by not escalating the concerns amounted to serious misconduct.

In consideration of whether Ms Appice's failings in charge 2 amounted to misconduct, the panel determined that Ms Appice's mistake in incorrectly identifying the treatment boundaries of her patient was the catalyst for the events of 29-30 July 2017. Most significantly, CPR was not given to a patient who was entitled to this treatment and she

died. It determined that the identification of Resident C was fundamental information which Ms Appice should have accessed and been familiar with, particularly since this patient was vulnerable and in distress. The panel considered that this behaviour was compounded by Ms Appice's subsequent errors and her lack of urgency in correcting these errors. The public rightly expect nurses to identify patient's needs and in particular ensure that these are met and that policies are adhered to. The panel therefore concluded that Ms Appice's actions with regard to charge 2 amounted to misconduct.

In relation to charge 3, the panel had regard to the importance of candour within the nursing profession. It considered that Ms Appice's repeated claims that she had carried out chest compressions when she had not done so were dishonest, and accordingly it made a finding that this amounted to serious misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Furthermore, nurses have a duty of candour to be honest if something has gone wrong in their treatment with patients.

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 first considered whether Ms Appice put patients at risk, and whether harm was caused as a result of her misconduct. It determined that Ms Appice's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel noted that Ms Appice's misconduct involved a number of different patients and their families, and that she had breached her duty of care to them. She had not followed clear Home policies and in relation to charge 2, her actions resulted in a formal safeguarding investigation which confirmed that the Home's policies and procedures in place at the time were thorough and appropriate.

The panel noted the risk of harm to Resident A arising out of the events as set out in charge 1 and also the risk of harm arising from the facts in charge 2, which concern the death of Resident C. The panel found Ms Appice, both in charge 1 and charge 2, had not protected vulnerable patients. The panel further noted Ms Appice's dishonest actions in attempting to conceal her mistakes and took account of the previous finding of dishonesty against her in May 2017. The panel noted that the caution order against Ms Appice was in place at the time of the first incident outlined in charge 1.

Consequently, the panel found all four limbs of the test as outlined above to be engaged in this case.

In considering insight, the panel determined that Ms Appice had demonstrated very little understanding of the impact of her actions, both on patients, and the wider public. The panel noted that there was some indication of an apology from Ms Appice, as recorded during her disciplinary meeting, but this was not sufficiently significant to suggest that she was remorseful and had reflected on her actions.

In relation to remediation, the panel bore in mind that the concerns relating to dishonesty are very difficult to remediate. Although, it also noted that the concerns in relation to Ms Appice's clinical failings were capable of remediation. The panel had regard to Ms Appice's completion of a safeguarding course, subsequent to the events in charge 1, but concluded that this alone did not reflect the seriousness of the concerns. In addition, Ms Appice expressed only limited remorse for her failings at the time, but she did not appear to appreciate the impact of these failings on Resident A.

In light of the lack of remediation and insight on Ms Appice's part, the panel was of the view that the risk of repetition in this case was high. It was not satisfied that Ms Appice would act differently if faced with similar situations in the future, and therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel considered that members of the public, if aware of all the facts of this case would be alarmed if Ms Appice was allowed to practise unrestricted. Therefore, having regard to the fact that the public confidence in the profession would be undermined if a finding of impairment were not made in this case, the panel determined that a finding of impairment on public interest grounds was also appropriate.

In light of the reasons outlined above, the panel was satisfied that Ms Appice's fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

Ms Guest informed the panel that the NMC had previously advised Ms Appice that it would be seeking the imposition of a striking off order if her fitness to practise was found to be currently impaired. In view of the findings of this case, Ms Guest invited the panel to consider a striking off order, in line with this sanction bid.

She submitted that Ms Appice's misconduct included a deliberate breach of the duty of candour and that she sought to cover up when things went wrong.

Ms Guest submitted that in this case, the aggravating factors included Ms Appice's failure to correct her initial errors, her lack of candour, and the fact that this was not the first finding of dishonesty against Ms Appice. Ms Guest stated that in light of the lack of any real insight, remorse, reflection, or remediation by Ms Appice, who was an experienced nurse, an order which does not restrict her practice would not be appropriate. Ms Guest therefore submitted that taking no action or a caution order should not be considered. Ms Guest directed the panel to the mitigation put forward by Ms Appice during the Home investigation and in her statements.

Ms Guest went on to submit that a conditions of practice order would also not be suitable in this case. She submitted that workable conditions which would protect the public could not be formulated given Ms Appice's dishonesty and her serious misconduct, as well as the fact that Ms Appice has not indicated that she would be willing to comply with any potential conditions.

Ms Guest submitted that a suspension order would not be appropriate in the circumstances of this case as Ms Appice's actions are not compatible with the requirements of staying on the register. She said the charges against Ms Appice were not confined to one isolated incident, and in particular noted the previous finding against her of dishonesty. In light of the serious misconduct, combined with the lack of insight or remediation, Ms Guest submitted that a striking off order would be the only appropriate order in this case to sufficiently protect the public, and address the public interest.

The panel accepted the advice of the legal assessor who referred it to Article 29 of the Order, as well as several relevant cases including: *Bolton v Law Society [1994], Parkinson v NMC [2010] EWHC 1898 (Admin) 2009, Nicholas-Pillai v GMC [2015] EWHC 305 Admin, Southall v General Medical Council [2010] EWCA Civ 407,* and *Atkinson v General Medical Council (GMC) [2009] EWHC 3636 (Admin).*

Decision and reasons on sanction

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

The panel had regard to the aggravating factors in this case. It noted Ms Appice's previous finding of dishonesty, resulting in a caution order which was still in place at the time of the incident in charge 1. The panel considered that in charges 1 and 2,
Ms Appice's conduct had the potential to cause very serious harm to Residents A and C. The panel noted Ms Appice's lack of insight, reflection, and acknowledgment of the impact of her actions on Residents and their families. Ms Appice's serious misconduct amounted to multiple breaches of the Code and included acts of dishonesty.

Though it noted that there was some indication of an apology from Ms Appice during her disciplinary meeting, the panel considered this was limited and did not warrant consideration as a mitigating feature. Therefore, the panel determined that there were no substantial mitigating features in this case.

When considering the type of sanction to be imposed, the panel first considered whether to take no action or to impose a caution order. It concluded that this would be inappropriate given the seriousness of the misconduct and the finding of dishonesty. The

panel found that an order which does not restrict Ms Appice's conduct in some way would not protect the public, nor would it be in the public interest.

The panel next considered whether placing conditions of practice on Ms Appice's registration would be a sufficient and appropriate response. It was mindful that any conditions imposed must be proportionate, measurable and workable. It noted that some of the concerns in this matter are attitudinal, relating to Ms Appice's lack of candour and her dishonesty, both of which would be very difficult to address with conditions of practise. The panel was of the view that there are no practical or workable conditions that could be formulated to address these serious concerns, particularly where Ms Appice has presented no evidence of insight or remediation.

The panel took into consideration that not all of the concerns related to behavioural issues, and that some of the concerns were remediable and therefore capable of being addressed by conditions, particularly in relation to charge 1. However, in the absence of any engagement, real insight or remediation by Ms Appice, the panel was not satisfied that if it did impose conditions, Ms Appice would comply with them.

Accordingly, it concluded that looking at the totality of the concerns, the placing of conditions on Ms Appice's registration would not adequately address the seriousness of her misconduct and also would not adequately protect the public. It also found that a conditions of practice order would not address the public interest.

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; and*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel found that Ms Appice's conduct was not in line with the above factors. It considered that the concerns in this case could not be reduced to a single instance of misconduct and there has been no evidence of insight by Ms Appice. It also considered that Ms Appice's continued dishonesty following the previous finding suggested an inherent attitudinal problem. For these reasons, 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?*

Ms Appice's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrated that Ms Appice's actions constituted serious misconduct in the exercise of her professional duties and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel noted that the public expect nurses to provide safe care, and to be honest and act with integrity, and importantly to respond with candour when mistakes are made. Ms Appice failed in respect of all these requirements and placed vulnerable patients in her care at serious risk of harm.

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

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

This determination will be confirmed to Ms Appice 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 own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Guest, who submitted that an interim order is necessary to uphold the panel's substantive decision. She submitted that an interim suspension order for a period 18 months is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel had regard to the seriousness of the facts found proved and the reasons for its findings on the issues of misconduct, impairment and sanction set out in its substantive determination. 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 therefore considered that it was necessary to impose an interim suspension order for 18 months, it was of the view that not doing so would be incompatible with its earlier findings. The panel considered that the appropriate duration of the interim suspension order was for a period of 18 months, because of the length of time likely to be required for any appeal, if brought, to be determined or otherwise finally disposed of.

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.