Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 21 March 2022 – Friday 25 March 2022

Virtual Hearing

Name of registrant:	**Sarah Morrall**
NMC PIN:	91Y0134E
Part(s) of the register:	Registered Nurse – RNA Adult Nursing – July 2000
Area of registered address:	North Yorkshire
Type of case:	Misconduct
Panel members:	Mary Hattie (Chair, Registrant member) Tracey Chamberlain (Registrant member) Isobel Leaviss (Lay member)
Legal Assessor:	Andrew Granville-Stafford
Hearings Coordinator:	Khadija Patwary
Nursing and Midwifery Council:	Represented by Suzanne Fewins, Case Presenter
Mrs Morrall:	Present and represented by Keith Rowley
Facts proved:	Charges 2)a), 2)b), 2)c), 2)d), 2)e), 2)f), 2)g), 3), 4)a), 4)b) and 4)c)
Facts not proved:	Charge 1)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a Registered Nurse:

Whilst employed at Lister House Care Home;

1) On or around 18 January 2019 incorrectly administered an extra dose of 20mg Mementine to Resident A. **(not proved)**

2) On or around 5 February 2019;
   a) Did not administer 30mg Cinacalcet to Resident B as prescribed. **(proved)**
   b) Did not record that you had omitted the administration of 30mg Cinacalcet to Resident B, in Resident B's MAR Chart. **(proved)**
   c) Did not record the incident in a significant incident form. **(proved)**
   d) Inaccurately altered Resident B's MAR chart to indicate that you had administered 30mg Cinacalcet to Resident B. **(proved)**
   e) Did not record that your entry on Resident B's MAR chart was a retrospective entry. **(proved by admission)**
   f) Used an incorrect format to amend/alter Resident B's MAR Chart. **(proved by admission)**
   g) After handover when talking to Colleague A, used words to the effect "I will lose a tablet and sign for the omitted dose." **(proved)**

3) Your actions in one or more charges 2 b, 2 c), 2 d), 2 e) 2 f) & 2 g) above were dishonest, in that you falsified records to conceal that you had failed to administer medication to Resident B. **(proved)**

Whilst employed at the Moors Care Centre ('the Centre');

4) On or around 24 July 2019 did not accurately enter Resident C's medication/prescription onto the Centre's Icare System, in that you;
   a) Only entered that Resident C was to receive Levetiracetam, 1 tablet for 5 days. **(proved by admission)**
   b) Did not enter that Resident C's Levetiracetam had to increase to 2 tablets daily, after 5 days. **(proved by admission)**
   c) Incorrectly discontinued Resident C's Levetiracetam after the first 5 days. **(proved)**

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

Decision and reasons on application to amend the charge

The panel determined to amend the wording of which was originally "*whilst employed at Lister House Case Home" to "whilst employed at Lister House Care Home."*

The proposed amendment was to ensure accuracy.

"That you, a Registered Nurse:

Whilst employed at Lister House ~~Case~~ ***Care*** *Home;*

1) On or around 18 January 2019 incorrectly administered an extra dose of 20mg Mementine to Resident A.

2) On or around 5 February 2019;
   a) Did not administer 30mg Cinacalcet to Resident B as prescribed.
   b) Did not record that you had omitted the administration of 30mg Cinacalcet to Resident B, in Resident B's MAR Chart.
   c) Did not record the incident in a significant incident form.

d) *Inaccurately altered Resident B's MAR chart to indicate that you had administered 30mg Cinacalcet to Resident B.*
e) *Did not record that your entry on Resident B's MAR chart was a retrospective entry.*
f) *Used an incorrect format to amend/alter Resident B's MAR Chart.*
g) *After handover when talking to Colleague A, used words to the effect "I will lose a tablet and sign for the omitted dose."*

3) *Your actions in one or more charges 2 b, 2 c), 2 d), 2 e) 2 f) & 2 g) above were dishonest, in that you falsified records to conceal that you had failed to administer medication to Resident B.*

Whilst employed at the Moors Care Centre ('the Centre');

4) *On or around 24 July 2019 did not accurately enter Resident C's medication/prescription onto the Centre's Icare System, in that you;*
   a) *Only entered that Resident C was to receive Levetiracetam, 1 tablet for 5 days.*
   b) *Did not enter that Resident C's Levetiracetam had to increase to 2 tablets daily, after 5 days.*
   c) *Incorrectly discontinued Resident C's Levetiracetam after the first 5 days.*

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

Mr Rowley, on your behalf, supported the proposed amendment.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Decision and reasons on application to admit telephone evidence

The panel heard an application made by Ms Fewins under Rule 31 to allow Witness 1 to give their evidence over the telephone. Ms Fewins informed the panel that Witness 1 is present at this hearing and explained that Witness 1 was unable to join via video link as she does not have access to a smart phone or laptop.

Mr Rowley submitted he does not oppose the application.

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

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 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 information, knowledge and belief' and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 1 to that of telephone evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Witness 1 to give evidence remotely over the telephone but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Rowley, who informed the panel that you made admissions to charges 2)e), 2)f), 4)a) and 4)b).

The panel therefore finds charges 2)e), 2)f), 4)a) and 4)b) 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 Ms Fewins on behalf of the NMC and by Mr Rowley.

The panel accepted the advice of the legal assessor.

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:

- Witness 1: Registered Nurse at the Home at the time of the incident

- Witness 2: Interim Manager at the Home at the time of the incident

- Witness 3: Registered Nurse at the Home at the time of the incident

- Witness 4: Manager at the Centre at the time of the incident

The panel also heard evidence from you under affirmation.

Background

Charges 1, 2 and 3 arose whilst you were employed as a registered nurse by Lister House Care Home (the Home) from September 2005. It is alleged that on the 18 January 2019, you administered an overdose of 20mg of Memantine to Resident A. Witness 3 conducted a medication count on 19 January 2019 and noted the discrepancy. Witness 3 noted that there should have been 16 memantine tablets, however there were only 14 and she reported the incident immediately in line with the care homes policy.

It is also alleged that on 6 February 2019, a gap in Resident B's MAR chart on 5 February 2019 was identified by Witness 1. Resident B was prescribed Cinacalcet twice a day, however, she noticed that there was no signature in the tea-time box to say that Resident B had received their medication on 5 February 2019. Witness 1 counted the cinacalcet tablets before administering medication to Resident B when she counted 26 and she also noted a gap in the signature line that led her to believe that the dose had been omitted. In her written statement she stated "*I did this count three times*." She recorded the tablet count on the MAR chart as "*25*" endorsed with her initials following administration of medication. Witness 1 explained to you that it appeared you had missed Resident B's tablet and during this discussion it is alleged that you stated to Witness 1 that you had not administered the tablet to Resident B. It is alleged that you failed to administer 30mg of Cinacalcet to Resident B. Witness 1 suggested to you that you completed a significant

incident form which would allow you to explain the omission, she said that you told her that you would fill in the form.

On Witness 1's next shift on 12 February 2019, she noticed that the number under her initials on her entry on the MAR chart for 6 February 2019 for Resident B had been amended. She also noted that a signature and a number had been written in the previously empty boxes covering the 5 February 2019. The initials were "*SM*". Witness 1 was concerned that her entry had been amended and submitted a significant incident form and wrote a statement. Witnesses 1, 2 and 3 all referred to a significant number of drug errors having occurred around that period. Witness 2 in her statement, stated that "*this matter went straight to a formal investigatory meeting as this was more than just a medication error*."

It is alleged that you had overwritten Witness 1's entry on the chart from the 6 February 2019 and had made new entries for the 5 February 2019 retrospectively. You had not used the agreed format for altering resident's MAR charts. You wrote over the top of and changed the original entry on the chart, obliterating the original entry. It is alleged that you used an incorrect format to amend Resident B's MAR chart and that you intentionally and dishonestly attempted to conceal this medication error by falsifying medical records.

You subsequently left the Home and commenced employment at The Moors Care Centre (the Centre) on 24 May 2019. You were employed as the Nurse in Charge of the nursing floor at the Centre. It is alleged that on 24 July 2019, you entered Resident C's medication data into the Centre's system incorrectly. The medication was apparently clearly labelled and stated that one tablet is to be given for 5 days and is then to increase to one tablet twice daily. You had failed to include that the tablets prescribed increased to two tablets per day from one, after the first 5 days. It is alleged that you incorrectly discontinued Resident C's medication (Levetiracetam) after the first 5 days. The error was noted on 2 August 2019 and a meeting was held on 7 August 2019.

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

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

Charge 1)

Whilst employed at Lister House Care Home;

1) On or around 18 January 2019 incorrectly administered an extra dose of 20mg Mementine to Resident A.

In reaching this decision, the panel took into account Witness 2 and 3's statements and oral evidence. Witness 3 stated that she was sure that there were 14 tablets and not 16 which was entered the day before by you. This was reported the next day, but an investigation was not held until the second incident had occurred. The panel was of the view that the investigation was not duly robust. The investigating manager at the Home interviewed you but did not interview the nurse reporting the error or other nurses who had access to the Resident's medication box and administered medication to them during the period between your count and that of Witness 3. It heard that the medication cupboards could be full and chaotic. The waste bin was situated under the medication cupboard and had been emptied twice within the intervening period. It determined that the MAR drug count states that there were two 20mg of Mementine (40mg in total) missing and yet the charge refers to 20mg only. It noted that there was not an explanation of what happened to the other 20mg. Witness 2 informed the panel there was a practice within the Home of entering a decreasing medication count without actually performing the count itself. The panel was not satisfied, on the balance of probabilities, that the evidence showed that the explanation for the missing medications was that you had administered an overdose of 20mg of Mementine on 18 January 2019 to Resident A.

This charge is found NOT proved.

In light of the above, the panel therefore finds charge 1) not proved.

Charge 2)a)

Whilst employed at Lister House Care Home;

2) On or around 5 February 2019;
    a) Did not administer 30mg Cinacalcet to Resident B as prescribed.

In reaching this decision, the panel took into account Witness 1's statement and oral evidence and your own admission that you did not sign the MAR chart for this medication on the 5 February 2019. The panel heard the evidence of Witness 1 that they counted the drug three times the following morning and the count showed 26 tablets which indicated that the drug had not been administered previous tea time. There was a gap in the MAR chart where a signature should have been to indicate that it was given.

Witness 1 in her written statement and oral evidence stated that she told you of the missing signature and incorrect count and you had said "*oh shit I forgot to give it*." She confirmed this under cross examination and was very sure this was what she heard you say. The panel heard your evidence that you could not recollect this conversation with Witness 1 and that you don't believe that you would have said this. Witness 1 told the panel she was very angry at her entry having been amended and worried that an error would be attributed to her. In her statement written at the time she said that when she advised you of the error you said that you would lose the tablet and sign for the omitted dose. She went on to say that she told you, you can't do that it's only Cinacalcet it's unlikely to have done any damage and you need to own up. In her statement to the NMC she stated she had also said to you "Remember the NMC" as you had both gone to the NMC for another nurse who signed for a drug they had not given. Given the consistency and the detail of her evidence and the length of conversation she reported the panel's view was that it was unlikely she misunderstood your comment.

The panel considered your written submission that you believed you administered the Cinacalcet to Resident B and your description of administering this via a PEG tube. However, in your oral evidence you were not able to provide a satisfactory explanation for the additional tablet counted by Witness 1 or your failure to sign the MAR chart. When cross examined about the comments reported by Witness 1 you were vague in your response, and you said you could not recall the conversation and could not give a satisfactory reason as to why Witness 1 would say this if it were not true.

Both you and Witness 1 told the panel that there was no ill feeling between you, and you had a mutual respect for each other. It was of the view that Witness 1's evidence was credible as it was clear and straight forward and there was no reason given as to why Witness 1 would lie.

Given the drug count undertaken by Witness 1 indicated a dose had been omitted and you had failed to sign for the dose at the time, the panel is satisfied that all the evidence before it proved that you failed to administer Cinacalcet to Resident B at the tea time drug round on 5 February 2019.

This charge is found proved.

In light of the above, the panel therefore finds charge 2)a) proved.

Charge 2)b)

Whilst employed at Lister House Care Home;

2) On or around 5 February 2019;
b) Did not record that you had omitted the administration of 30mg Cinacalcet to Resident B, in Resident B's MAR Chart.

In reaching this decision, the panel took into account its determination on charge 2)a) and the evidence of the MAR chart. You accept that you did not make a recording of the omitted dose, albeit your case was that you had not omitted to give it. However, the panel has determined that you did not administer 30mg of Cinacalcet to Resident B on 5 February 2019, and it follows accordingly that you did not record that you had omitted to administer 30mg Cinacalcet.

This charge is found proved.

In light of the above, the panel therefore finds charge 2)b) proved.

Charge 2)c)

Whilst employed at Lister House Care Home;

2) On or around 5 February 2019;

c) Did not record the incident in a significant incident form.

In reaching this decision, the panel took into account the evidence considered from charge 2)a). The panel found charge 2)a) proved which states that you "*did not administer 30mg Cinacalcet to Resident B as prescribed*" and there is evidence from Witness 1 that she brought the incident to your attention and had suggested that you submit an incident form and she told the panel that you said you would do so. In your evidence you accepted that you had not submitted a significant incident form and you acknowledged that had you failed to administer the medication you would be required to submit an incident form. The panel determined that the responsibility to complete a significant incident form was on you, and you had failed to do so.

This charge is found proved.

In light of the above, the panel therefore finds charge 2)c) proved.

Charge 2)d)

Whilst employed at Lister House Care Home;

2) On or around 5 February 2019;
d) Inaccurately altered Resident B's MAR Chart to indicate that you had administered 30mg Cinacalcet to Resident B.

In reaching this decision, the panel took into account the evidence considered from charge 2)a). In your evidence you accepted that you retrospectively amended the MAR chart to indicate you administered the medication. However, the panel has found that you did not administer the medication and therefore it was an inaccurate alteration of the record.

This charge is found proved.

In light of the above, the panel therefore finds charge 2)d) proved.

Charge 2)g)

Whilst employed at Lister House Care Home;

2) On or around 5 February 2019;
e) After handover when talking to Colleague A, used words to the effect "I will lose a tablet and sign for the omitted dose."

In reaching this decision, the panel took into account Witness 1's statement and oral evidence and your statement and oral evidence. Witness 1 in her written statement and oral evidence stated that she told you of the missing signature and incorrect count and you had said "*oh shit I forgot to give it*." She confirmed this under cross examination and was very sure this was what she heard you say. The panel heard your evidence that you could not recollect this conversation with Witness 1 and that you don't believe that you would have said this. Under cross examination you were asked whether Witness 1 was lying, and you said you could not answer that and you said you were not going to call her a liar.

In her statement written at the time Witness 1 said that when she advised you of the error you said that “I will lose the tablet and sign for the omitted dose”. She went on to say that she told you, you can’t do that it’s only Cinacalcet it’s unlikely to have done any damage and that you need to own up. In her statement to the NMC she stated she had also said to you “*Remember the NMC*” as you had both gone to the NMC for another nurse who signed for a drug they had not given. Given the consistency and the detail of her evidence and the length of conversation she reported the panel’s view was that it was unlikely she misunderstood your comment. Further the panel found that Witness 1 was a credible witness and accepted her evidence.

The panel noted that you did not clearly state that the comment was not made. The panel concluded that it was more likely than not that Witness 1 did hear that comment from you and that it was not misheard. It was of the view that this was supported by all the other evidence and the findings from the other charges that the drug had not been administered.

This charge is found proved.

In light of the above, the panel therefore finds charge 2)g) proved.

Charge 3)

3) Your actions in one or more charges 2 b, 2 c), 2 d), 2 e) 2 f) & 2 g) above were dishonest, in that you falsified records to conceal that you had failed to administer medication to Resident B.

In reaching this decision, the panel took into account your evidence and your admissions in relation to charges 2)e) and 2)f).

Given that the entirety of charge 2 was found proved, it determined that your actions in amending the record to indicate the drug had been given and not reporting the omission was intended to conceal your error. The panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

The panel was satisfied that you falsified Resident B's MAR chart to conceal the fact that you had not administered Cinacalcet to them on 5 February 2019, both by retrospectively inserting in the chart that you had given the medication when you had not and by altering the count entered by the registered nurse (Witness 1) who did the drug round the following morning.

The panel then went on to consider whether your actions were dishonest by applying the standards of ordinary decent people. The panel determined that ordinary, decent people would find it dishonest to amend a medication chart to indicate a drug had been given when it had not.

This charge is found proved.

In light of the above, the panel therefore finds charge 3) proved.

Charge 4)c)

Whilst employed at the Moors Care Centre ('the Centre');

4) On or around 24 July 2019 did not accurately enter Resident C's medication/prescription onto the Centre's Icare System, in that you;

c) Incorrectly discontinued Resident C's Levetiracetam after the first 5 days.

In reaching this decision, the panel took into account the screenshots of the computerised drug system provided by Witness 4, Witness 4's evidence and your evidence. In your evidence you said that you entered the first five days dosage correctly in the system and discontinued but what you accept you did not do was to come back and enter the remaining higher dosage as a new entry on the system. You state that you remember feeling that this was your responsibility and still do.

Witness 4 told the panel that this was one prescription, and it was standard procedure to enter the whole prescription in one go at the same time. By failing to enter the second part of the prescription you incorrectly discontinued Levetiracetam after the first five days.

The panel found that you admitted the charges 4)a) and 4)b) and by reason of those admissions you incorrectly discontinued Resident C's Levetiracetam after the first 5 days.

This charge is found proved.

In light of the above, the panel therefore finds charge 4)c) proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

Ms Fewins, in her written submissions dated 24 March 2022, stated that:

'Misconduct is a matter for the Panel's professional judgment. The leading case is Roylance v GMC [2000] 1 AC 311 which says:

"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

In Calhaem v GMC [2007] EWHC 2006 (Admin) Mr Justice Jackson commented on the definition of misconduct and he stated:

'it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'

Mr Justice Collins in Nandi v GMC [2004] EWHC 2317 (Admin) stated that:

"the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

The NMC Code sets the professional standards of practise and behaviour for nurses, midwives and nursing associates and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. The values and principles within are not negotiable.

The NMC submits that Registrant's actions fell far short of what would be proper in the circumstances and of the standards expected of a registered nurse. The Panel will be familiar with what the The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) ("the Code") stipulates. It is submitted

that the Registrant breached the Code as well as departing from policies in place at both Lister House and The Moors Care Centre.

The NMC submits that such actions would undermine the faith and trust that the public places in the nursing profession if they were to become aware that the professional standards of practise were not being met.

The NMC draws the Panels attention to the Code:

Promote Professionalism and Trust 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*
>
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> *20.4 keep to the laws of the country in which you are practising*
>
> *20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
>
> *20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*
>
> *20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way*

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

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

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times.

The facts found proven relate to Charge 2a-2b and 2g. Charged 2e and 2f were found proved by the Registrants admission. It is submitted by the NMC that each of these charges and actions fall far short of what would be proper in the circumstances.

In respect of Charge 3 which relates to dishonesty, it is submitted that this was a serious attempt by the Registrant to create a misleading impression that she had administered 30mg Cinacalet to Resident B on the 5th February 2019. It is submitted by the NMC that the Registrant's dishonesty falls far short of what would be proper. It further represents a serious breach of the Code.

It is submitted that honesty, integrity and trustworthiness are the bedrock of the nursing profession, and that the Registrant has breached a fundamental tenet of the profession in falsifying records in order to conceal her omission. This charge raises fundamental questions about the Registrant's trustworthiness as a nurse.

Charges 4a and 4b were found proven by the Registrant's admission. Charge 4c was found proven by the Panel. It is submitted that each of these charges and actions falls far short of what would be proper in the circumstances.
The proven charges represent medication errors which are escalating in seriousness, giving specific consideration to the element of dishonesty. It is submitted that these concerns fall within each of the three categories of

seriousness as they have placed patients at risk of unwarranted harm and raise questions about the Registrant's trustworthiness as a nurse.

It is submitted that in light of those charges prove, the Registrants fitness to practise is impaired by reason of their misconduct.'

Mr Rowley submitted that you are currently disappointed by the charges that were found proved. It has been a long process for the last three years. He submitted that you wanted to be heard and now you accept the decision of the panel. He informed the panel that you stated you want to conclude as soon as reasonably possible. Mr Rowley submitted that he is not going to dispute misconduct. He said that you have tried to act with honesty and integrity. He submitted that you accept your wrongdoing and he submitted that the panel should consider the context of the written and oral evidence from the witnesses as it sets out the background of the Home at the time that the incidents occurred.

Submissions on impairment

Ms Fewins 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Fewins, in her written submissions dated 24 March 2022, stated that:

> *'There is no definition of "impairment" provided by the NMC's legislative framework. The NMC does, however, define "fitness to practise" as the suitability to remain on the register without restriction. The panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC 2 (Grant) [2011] EWHC 927 (Admin):*
> *"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."*
>
> *This case also makes it clear that the public interest must be considered paramount and states:*
>
> > *"It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession."*

In applying these principles to the case at hand, the NMC submits that the Registrant's fitness to practise is impaired in that she has breached the fundamental principles of the profession and has acted dishonestly.

The Panel must consider the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence.

With regard to future risk, regard should be had to the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely, whether the concerns are easily remediable, whether they have in fact been remedied and whether they are highly unlikely to be repeated.

In determining current impairment, the Panel should consider whether the Registrant has demonstrated safe practice since these allegations, whether there has been any reflection or insight, and whether the Registrant has undertaken any further training to remediate his errors.

It is submitted by the NMC that the Registrant has not adequately reflected on her actions and no evidence of further training or insight has been produced at this stage. As such it is submitted that the Registrant's fitness to practise is impaired.'

Mr Rowley submitted that you were open and honest in relation to the Cinacalcet allegations and in relation to charge 4, you sought support and help at the time. He submitted that there was focus on the screenshots from computer system provided by Witness 4 which seems be a single focus as the only fail safe. He submitted that you sought help and undertook training which you passed. Mr Rowley referred the panel to a number of character references and submitted that you have been a nurse for a long time having no previous disciplinary findings against you. Mr Rowley submitted that in terms of remorse and reflection there is further evidence, and he referred the panel to the Case Management Form and your oral evidence. You have not been practicing as a nurse since

the allegations arose as you wanted to take the NMC proceedings with severity and seriousness.

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 and *Nandi v General Medical Council* [2004] EWHC 2317 (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, and that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those

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:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

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

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

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 the concerns and breaches identified were serious in particular the dishonesty charge which directly related to your nursing practice. It was of the view that you attempted to conceal an incident which directly an impacted resident and put them at risk of potential harm. Your actions had an impact on your fellow colleague as you had falsified their records relating to their nursing practice. It determined that the public will be concerned to know that you made two medication errors, both of which had the potential to cause harm and, you attempted to cover up one of these.

In respect of all the charges found proved, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if in light of the misconduct, your fitness to practise is currently impaired.

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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 residents were put at risk and that there was the potential for harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession, brought its reputation into disrepute and you acted dishonestly in the course of your duties. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that your insight is limited. It had regard to your written statement however, the panel determined that in your reflection you focused on how your actions impacted you. The panel noted that while you stated that no harm came to residents, you did not address the impact of your misconduct on the residents or their families. It was of the view that you did not address the impact of your misconduct on your colleague or the reputation of the profession.

In relation to remorse, the panel noted that you have demonstrated some remorse in your written submissions for this hearing.

The panel was satisfied that the misconduct in relation to drug errors is capable of remediation. However, the panel noted that it is difficult to remediate dishonesty. Therefore, the panel carefully considered the evidence before it in determining whether or not you have remedied your practice. The panel was of the view that you have not demonstrated your remediation, nor have you undertaken any relevant training.

The panel was of the view that you had not yet been able to demonstrate that you have remedied your practice or demonstrated full insight. You did not satisfy the panel that the risk of repetition was sufficiently reduced.

The panel therefore decided 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.

The panel concluded that public confidence in the profession would be undermined if a finding of current 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 determined 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 has been struck-off the register.

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

Submissions on sanction

Ms Fewins, in her written submissions dated 25 March 2022, stated that:

'The NMC invites the panel to impose a Striking-Off Order as the appropriate response in this case for the protection of the public and for the reason that it is in the public interest.

Proportionality
The Panel will be very familiar with the guidance and factors to consider before deciding on sanctions and the need to be proportionate to find a fair balance between the Registrant and the NMC's overarching principle of public protection.

To be proportionate, the panel should consider what action it needs to take to tackle the reasons why the Registrant is not currently fit for practise and seek the sanction that is enough to achieve public protection. The purpose of sanctions is to protect the public as opposed to punishing the Registrant.

Aggravating Features
Aggravating features are aspects of the case that make it more serious. They may mean that the panel needs to order a sanction that has a greater impact on the Registrant's practise.

The NMC submits that the following aggravating features are present in this case:

a) *Dishonesty which is linked directly to clinical practice;*
b) *Attitudinal and behavioural concerns;*
c) *Lack of remediation and insight into failings;*
d) *Failures of clinical practice linked to fundamental areas of nursing taking place across two separate care homes, suggesting a pattern of misconduct over a period of time;*
e) *Conduct which put patients at risk of suffering harm.*

Seriousness

It is submitted that all three categories of 'seriousness' are engaged in this case:

a) ***Serious concerns which are more difficult to put right:***

- *It is submitted that the Registrant breached the professional duty of candour to be open and honest when she failed to administer medication to Resident B as well as the various failings thereafter (Charge 2).*
- *This included a falsification of records in order to conceal that the Registrant had failed to administer the medication.*

- *The Registrants misconduct amounted to various breaches of the Code.*

b) ***Serious concerns which could result in harm to patients if not put right:***

- *It is submitted that the Registrant's misconduct against charges 2, 3 and 4 placed patients at risk of harm. It is submitted that the evidence shows that the Registrant is not able to keep clear and accurate records without falsification.*
- *It is further submitted that the Registrant was not open and candid when dealing with service users nor did she raise or escalate concerns when a mistake was made.*

- *It is submitted by the NMC that the Registrant has failed to uphold the reputation of the profession, by not acting with honesty and integrity.*

c) Serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates:

- *It is submitted that the Registrants conduct is so serious that they could affect the public's trust in the profession.*

Dishonesty

It is submitted by the NMC that the Registrant deliberately breached the professional duty of candour to be open and honest when she had made an error.

It is submitted that honesty, integrity and trustworthiness are the bedrock of the nursing profession, and that the Registrant has breached a fundamental tenet of the profession in falsifying records in order to conceal her omission. This charge raises fundamental questions about the Registrant's trustworthiness as a nurse.

It is submitted that this was a serious attempt by the Registrant to create a misleading impression that she had administered 30mg Cinacalet to Resident B on the 5th February 2019. This placed Resident B and C in direct risk of harm. This represents the most serious kind of dishonesty.

It is submitted that this form of dishonesty calls into question whether the Registrant should be allowed to remain on the register. It is the NMC's submission that the Registrant's actions are incompatible with continued registration.

The Registrant has had a long nursing career – however, it is submitted that the Registrant's conduct is so serious that a 'previously unblemished career' can be given limited relevance (Judge v NMC [2017] EWHC 817 Admin).

It is submitted that the Registrant has not been able to address the risks in her practice. There has been no evidence of further training or attempts to remediate the concerns and so the level of insight shown is limited. The impact of misconduct on the Registrant's colleague, the residents and their families, has not been addressed.

Sanction

The NMC would, therefore, invite the panel to impose a Striking-Off Order as the appropriate response in this case for the protection of the public and for the reason that it is in the public interest.

It is submitted that a Suspension Order may not adequately address the concerns when considering the attitudinal and behavioural concerns, lack of remediation or insight and the calculated dishonesty.

It is submitted that public confidence in the profession cannot be maintained if they are not removed from the register due to the severity of their misconduct.'

Mr Rowely, on your behalf, in his written submissions, stated that:

'The Registrant has personally prepared a statement which she would like to read to the Committee.

The following is that statement as said by The Registrant.

2.1 I understand what you have concluded and what you believe you have proven, through this process. I also understand that as a result you have had to conclude misconduct on my part and that my fitness to practise is impaired.

2.2 I would like to express my deep sorrow and disappointment of the outcome. I am also deeply ashamed by what you have concluded and sincerely remorseful, in particular for the allegations I have admitted and errors I recognise I made.

2.3 I wish to convey, with sincerity, that if I was to continue in nursing, I have learnt through my own self-reproach and deep regret to never repeat these actions again. In the future, I would never sign over a colleagues entry again. I would be mindful to ensure I sort advice and assistance from another colleague, to ensure any action I take is safe, witnessed and checked. I would also ensure any error I might make in the future is reported

and escalated for transparency, for the safety of patients first and for my own protection.

2.4 *I have no intention of diminishing my remorse for the allegations I have consistently and freely admitted. However, I now face a moral dilemma. The morale dilemma is that I know in my heart of hearts I have not acted dishonestly at any point. I feel I must not appease the panel in admitting to dishonesty in order to less the sanction that you might conclude. To do so, would be to lie to myself.*

2.5 *I can now see that one of the only hopes I had of proving my innocence required me to accuse a friend and colleague of lying and guess at what her motives were. I have said all along I cannot account for why...acted as she did in her evidence. I am aware she had made medication mistakes in the past herself. It is because of my integrity and firmly held belief that I cannot honestly and completely know what motivated...to give the evidence she did. I did not want to sling allegations, without evidence, to discredit...to my benefit. Therefore I said what I have consistently said and knew since the allegations were put to me on the 22nd February 2019.*

2.6 *I maintain that at no point have I lied or acted dishonestly to anyone since I was first made aware of these issues. I have simply sort to tell the..., the whole...and nothing but the..., whilst recognising that I made errors in my actions as I have freely admitted.*

2.7 *I do not believe two wrongs make a right. When I look in my heart of hearts, the.... is I cannot lie to you in the hope that you might mitigate my sanction. Therefore, I cannot give you the remorse you require in regard to the allegations of dishonesty. That said, I remain honestly and sincerely shamed and remorseful about the allegations I have freely admitted.*

2.8 *This experience has taught me to always be mindful of my actions, act with integrity and self-awareness both in my words and actions. As I have already stated I am filled with deep regret and shame for my actions and will continue to learn and grow as a person from this traumatic experience.*

2.9 I must therefore retain my honesty, integrity and dignity. Something I have held as a fundamental value throughout my life, career in nursing and throughout these incidents and process over the last 3 years.

2.10 I requests that this final statement is committed to record as part of the findings and conclusions of this hearing.

On behalf of the Registrant I ask that the committee consider that there is mitigation and circumstances that lessen the level of sanction and the need for a Strike-off order. That is the conduct is less serious, in line with the NMC guidance, because it is:

3.1 A one off incident in relation to the allegations 2a, b, c, d e, f and g, and as a result allegation 3. The allegations in relation to 4a, b and c the incident, are admitted and the panel should consider context as per the witness evidence. In respect of allegation 4a, b and c, The Registrant:

3.1.1 Struggled with the process of entering medication correctly onto a computer system, even after completing the competency training.

3.1.2 Recognised fallibility and the pressure of the environment and sort support.

3.1.3 That there was pressure in the environment to make decisions about priority in delivering patient care and a decision was made to focus on those other priorities at the time and this lead to the error. This unfortunately, and the Registrant sincerely regrets, lead The Registrant to forget to either return and enter the amended dose for the 2nd week and/or make a note in the nurse log about this, despite staying late in her shift to enter these medications. As a result the medication was inadvertently, and unintentionally, discontinued after the 1st week.

3.2 In respect of allegations 2 a, b, c, d, e and f, this was spontaneous conduct as per the Registrant's witness evidence and as supported by the evidence presented both verbally and orally.

3.3 There was no direct personal gain given what she has always admitted.

3.4 I also draw the committee's attention to the circumstances taking place in her private her life at the time on the incidents, [PRIVATE]

I would also add that there are mitigating factors.

4.1 The Registrant has shown insight and understands the problem in relation to the allegations she has admitted. She has also shown her desire to address the failings that she has always admitted. To this end I ask that you refer to pages 11 and 12 which were submitted yesterday and was written by The Registrant as part of her case management submission back in August 2020. In addition please include the above statement from the Registrant. In addition. The Registrant has not shown attitudinal and behavioural concerns and has tolerated unprofessional behaviour, seeking to remain professional and honest, whilst recognising her own errors as she has made as admitted.

4.2 The Registrant has also followed good practice in honouring the terms of the Suspension that has been in place on her for the last 3 years or more. In so doing, The Registrant has acted with Integrity. She recognises that she is not fit to practice currently and would need to undertake activities to come back up to date. To this end she would welcome guidance and counsel from the panel if they should see fit.

4.3 Finally as already noted The Registrant has had, and still has financial hardship. This has meant The Registrant has not been able to afford time or financial resource to maintain the currency of her practice, alongside the trauma of dealing with this process.

As noted above, The Registrant has acted with integrity in holding to the 'suspension order' that has been put in place for the last 3 years or more and the panel is asked to take this into consideration when handing down sanction.'

Mr Rowley also invited the panel to take into account the two character references that he had supplied on your behalf.

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 Sanction Guidance (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:

- Dishonesty which is linked directly to clinical practice;
- Attitudinal and behavioural concerns;
- Lack of remediation and insight into failings;
- Failures of clinical practice linked to fundamental areas of nursing taking place across two separate care homes; and
- Conduct which put patients at risk of suffering harm.

The panel also took into account the following mitigating features:

- The dishonesty charge is one off, but the panel gave this limited weight due to the clinical context in which it occurred;
- Personal mitigation relating to your circumstances at the time of the incident;
- In relation to Charge 2, the environment in the Home was stressful due to high levels of managerial change and that there had been a significant number of medication errors made by other staff in the Home; and
- Nurses were under pressure to reduce the number of medication errors.

In relation to Charge 4, it was an unfamiliar computerised system and there was time pressure. You were requesting assistance from another staff on the floor. However, the

panel did not consider this mitigation as you were aware you did not complete the task and knew at the time that the information was not passed onto the oncoming nurse.

The panel reject the suggestion that your action in charge 2 and 3 were spontaneous as the panel heard evidence that you had received advice from another registered nurse before making an alteration.

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 and would not protect the public to take no further action.

The panel next considered whether a caution order would be appropriate in the circumstances . The panel took into account the SG, which states that a caution order may be appropriate where:

> *"…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants 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 findings of dishonesty and the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest and would not protect the public 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 is of the view that there are no practical or workable conditions that could be formulated, given the dishonesty found proved in this case. The dishonesty identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of

conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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 considered that this was not a single instance of misconduct as there were two incidents within two separate settings. Further, it considered that you have not displayed sufficient insight into your misconduct and its impact on residents and your colleague, and that there remains a risk of the misconduct being repeated.

The panel gave consideration to your reflective piece, your submissions and your oral evidence. It found that you failed to demonstrate insight or remorse in relation to your dishonesty. The panel also found you had shown limited insight into the significance of your misconduct or remorse for your actions at the time of the investigations or since. It took account of the character references provided however, it attached limited weight to these, one of which was written prior to the second incident and this did not indicate they were aware it would be used during this process.

The panel has found that, because of your lack of insight, there is a likelihood of repetition and, as a consequence, you pose a risk to residents.

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. It would not be in the public interest or uphold professional standards.

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 determined that your misconduct raises serious concerns about your professionalism and considered that other nurses would find it difficult to place their confidence in a colleague who had acted in such a dishonest manner by altering not only theirs but another registered nurses' entry. This and the other medication errors placed residents at risk of harm. Further, members of the public would find it difficult to place their trust in a nurse who had falsified records and put residents at risk of potential harm. The panel noted that the public expect nurses to provide safe care, be honest and act with integrity, and importantly respond with candour when mistakes are made. You failed in respect of this.

Your actions were significant departures from the standards expected of a registered nurse 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. The panel has concluded that this is the only sanction which would be sufficient in this case to adequately protect the public, serve the public interest and maintain professional standards.

Interim order

As the substantive 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.

Decision and reasons on interim order

The panel considered the submissions made by Ms Fewins that an interim order should be made to cover the appeal period. She submitted that an interim order is necessary to protect the public, that it is in the public interest and to do otherwise would be inconsistent with the panel's substantive decision. She invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

Mr Rowley, on your behalf submitted that you do not oppose the interim order.
The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary to protect patients and is otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the

decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made 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.

This will be confirmed to you in writing.

That concludes this determination.